Housing-Focused Outreach

Informational Packet

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Public Policy and Housing: The Modern-Era Response

Outreach as a tool for engaging people living in the experience of homelessness has long been a stalwart of homelessness services delivery. Homelessness service agencies have used outreach as a method for reaching clients who are hard to serve or difficult to engage. For the longest time, outreach has focused on brining basic services and supplies to clients. The follow-up needed to move people out of the experience of homelessness has been facilitated through "brick and mortar" care and advocacy – and often times not directly on the streets. With the advent of the Housing First movement, homelessness service agencies are moving away from the idea of outreach as a mechanism for serving clients on the streets to outreach as a tool for moving clients off the streets. The new model of ***Housing-Focused Outreach*** works with a broad complement of partners to bring comprehensive housing and social services supports directly to clients, thereby moving them as quickly as possible out of the experience of homelessness. Housing focused outreach is about ending homelessness through concerted and collaborative approaches.

The first step in ending homelessness is identifying housing resources. The following document outlines a broad review of the history of supported housing in the U.S. and the various Federally funded programs that have been enacted to build "housing safety nets" for vulnerable and underserved populations. The hope is that the information contained in this handout packet will help outreach workers and homelessness service providers better advocate for the housing needs of the clients they serve.

The modern-era response related to housing and public policy is typically traced back to the 1960s. During this time the **United States Department of Housing and Urban Development (HUD)** was established as a Cabinet department in 1965 as part of President Lyndon Johnson's "Great Society" program. HUD's mission, as stated in part, is "to create strong, sustainable, inclusive communities and quality affordable homes for all."

During the 1960's and 1970's de-institutionalization of persons with mental illness and urban renewal became significant factors in a rise in homelessness. As the numbers of homeless persons increased, shelters began to emerge in the 1970's to supplement the rescue missions and related work of faith-based organizations. University of Pennsylvania professor Dennis Culhane describes how the New York City shelter system was a "patchwork of welfare hotels and rooming houses" until a 1979 State Supreme Court ruling in the class action lawsuit, **Callahan v. Carey**, found that the State's Constitution provided homeless men with a **right to shelter**. A 1982 ruling extended that right to homeless women.

Responding to evidence that homelessness was becoming a nationwide problem, Congress in 1983 created the **Emergency Food and Shelter (EFS) program**, to be administered by the **Federal Emergency Management Agency (FEMA).** (By 2007, the EFS program was providing grants to some 12,000 agencies for the prevention of homelessness via emergency rent and utility payments and the provision of emergency food and shelter services.)

Amid continuing discussions about the need for federal legislation to address homelessness, Congress passed the **Homeless Eligibility Clarification Act of 1986.** This Act removed

permanent address requirements and other barriers to accessing federal mainstream benefits like Supplemental Security Income, Aid to Families with Dependent Children, Veterans Benefits, Food Stamps, and Medicaid. The **Homeless Housing Act of 1986** created the **Emergency Shelter Grant (ESG)** program and a transitional housing demonstration program, both of which would be administered by the U.S. Department of Housing and Urban Development (HUD).

With homelessness worsening in the wake of a 1980s recession, Congress passed the **Stewart B. McKinney Homeless Assistance Act of 1987.** It consolidated existing programs and expanded the range of federally funded services for homeless people to include **transitional housing**, a **Supportive Housing** demonstration program, a program funding **renovation of single room occupancy (SRO) units** for homeless individuals, the **Health Care for the Homeless** program (originally grant funded in 1985 by the Robert Wood Johnson Foundation and Pew Charitable Trust), a **Community Mental Health Services (CMHS)** block grant program that expanded and renamed the **Projects for Assistance in Transition from Homelessness** (**PATH)** program in 1990, two demonstration programs providing **mental health and substance abuse treatment services** to homeless persons administered by the Department of Health and Human Services, **educational services** for homeless adults and children (administered by the Department of Education), a demonstration **job training** program administered by the Department of Labor, and targeted services for homeless veterans under the **Veterans Job Training Act**.

A 1990 amendment expanded eligibility for McKinney assistance, created the **Shelter Plus Care (S+C)** program (funding housing subsidies for homeless individuals with qualifying disabilities), expanded Health Care for the Homeless funding for at-risk and homeless children, transitioned the CMHS program into the PATH program, and clarified the obligations of states and local educational agencies in assuring the **access of homeless children and youth to public education**.

In 1992 amendments modified and expanded the **Supportive Housing Program**, authorized funding for the creation of "**safe havens"** for persons unwilling or unable to participate in supportive services, created a **Rural Homeless Housing Assistance** grant program, and consolidated the mental health services demonstration program and the alcohol and drug abuse treatment demonstration program into the **Access to Community Care and Effective Services and Support (ACCESS)** program targeting severely mentally ill people. In 2000 the Stewart B. McKinney Homeless Assistance Act was renamed the **McKinney-Vento Act.**

Between 1994 and 2009, HUD's use of the annual **NOFA (Notice of Funding Availability)** process dramatically re-shaped the landscape. It replaced uncoordinated competition among providers applying for grants to provide transitional and permanent supported housing and supportive services with a coordinated process based on the **Continuum of Care (CoC)** model. The CoC model required jurisdictional sign-off to ensure that grant requests were consistent with local Consolidated Plans. The concept of **"chronic homelessness"** (long-term street or shelter-based homelessness among single individuals with one or more disabling conditions, possibly including chronic substance abuse) was introduced, and the focus shifted to new grant making for **permanent supportive housing targeted for chronically homeless persons.**

The NOFA also encouraged coordinated planning between Continuums of Care and jurisdictional "**Ten Year Plans**" to end (chronic) homelessness; requiring communities receiving McKinney-Vento grants to:

- Gradually implement a **Homeless Management Information System (HMIS)** (a HUD-defined data base standard) to track use of shelters, transitional and permanent supported housing, and McKinney-Vento-funded supportive service programs
- Conduct **annual or semi-annual point-in-time counts of shelter and street homelessness**, indicating/estimating the prevalence of chronic homelessness, veteran homelessness, domestic violence, and targeted disabling conditions (substance abuse, mental illness, HIV/AIDS)
- Complete **Annual Progress Reports** describing the populations served by McKinney-Vento grants and the housing- and income-related progress that clients made
- Develop the capacity to derive annual Continuum-wide, HMIS-based unduplicated counts of homeless persons served, as part of the national **Annual Homeless Assistance Report (AHAR)**

In 2009, Congress passed the **Homeless Emergency and Rapid Transition to Housing** (**HEARTH) Act.** It broadens and attempts to unify **definitions of homelessness** across federal programs (especially HUD and the Department of Education). It legislatively **codifies the Continuum of Care model** and many of the elements of the McKinney-Vento program that HUD administratively implemented via the NOFA process, and incentivizes/funds stronger Continuum-based coordination and oversight of homeless services. HEARTH increases the focus on **family homelessness** by broadening the definition of chronic homelessness and requiring CoC/School District cooperation. It offers a more flexible approach to addressing **rural homelessness**.

HEARTH also integrates the Emergency Shelter Grant (renamed **"Emergency Solutions Grant"**) program, **Supportive Housing Program (SSH)** (McKinney-Vento-funded transitional and permanent supported housing and supportive services grant-funded programs), **Shelter Plus Care program**, and **Homelessness Prevention and Rapid Re-Housing Program** (**HPRP**), funded in 2009 under the federal **American Recovery and Reinvestment Act (ARRA)** and codifies requirements for data collection and reporting under **HMIS**.

As has been shown, a number of Federal initiatives in relation to housing, homelessness and related services have been implemented in the past decades, particularly since the 1980's. For many years these initiatives often operated independently of one another and were focused primarily on managing homelessness. As the focus has sharpened in the past few years on *ending* homelessness, there has been a strong push for these programs to work together and coordinate their efforts.

Three Homes

Ken Kraybill

***Home**: one's place of residence, domicile, house, the social unit formed by a family living together, a familiar or usual setting, congenial environment, the focus of one's domestic attention (home is where the heart is), habitat, a place of origin (salmon returning to their home to spawn), headquarters, an establishment providing residence and care for people with special needs, the objective in various games, out of jeopardy, in a comfortable position with respect to some objective, to a vital sensitive core (the truth struck home)* ***At home**: relaxed and comfortable, at ease (felt completely at home on the stage), in harmony with the surroundings, knowledgeable (teachers at home in their subject fields), on familiar ground*

Each of us “resides” in three homes.

The **first home** is the self – one’s primary home. This is the home of our very being and identity. The fundamental characteristics of this first home are physical, mental, emotional, social, and spiritual in nature.

This home must be kept warm, dry, safe and in good working order. It needs exercise, rest, nutrition and proper maintenance. It also needs to be nurtured and maintained through intellectual stimulation, emotional support, behavioral regulation, time for reflection, and development of a sense of purpose and meaning in connection to the outer world.

We receive our first home at birth. Early in our lives, we are utterly dependent on others to take responsibility for our care and well being. Gradually we come to claim more of this responsibility for ourselves.

Although we as human beings are wonderfully made with amazing capabilities, we are also created with considerable fragility and vulnerability. Even the strongest among us experience great frailty at times. Each of us requires the sustaining efforts of others in order to thrive. Despite our best efforts at self-care, we still need the knowledgeable care, love, and support that others can provide.

Our **second home** is that with which we are most familiar – the place where we live, our housing, where we “nest.” It refers not only to the physical structure in which we live but also to the kind of living environment we create within it.

Like the first home, this home possesses important physical, mental, emotional, social and spiritual characteristics. It offers safety and protection from the elements and the outside world. It provides an adequate, private space in which to properly attend to hygiene, rest, and nutrition needs.

This home serves as a base of operations and a place to keep and use one’s possessions. It offers a place of welcome, familiarity, and stability. In this home we can welcome guests, share in celebration and suffering, be creative and silly, be still and mindful, be intimate with loved ones, and find renewal of energy and purpose.

The design and structure of a typical middle-class house in our cultural context points to these functions. For example, we construct a foundation (stability, grounding), walls (protection, privacy), a roof (shelter, protection from the elements), doors (welcoming, shutting out), and windows (light, connection with the outside world).

Space is divided into a living room (relaxation, socialization, play), kitchen (hospitality, nutrition), bedroom (rest, intimacy), bathroom (hygiene), study (intellectual stimulation, meditation), closets (secrets), and a yard/garden (play, relaxation). This second home provides the necessary context for meeting the needs of the first home and an important foundation and link to the third home.

The **third home** in which we reside is the larger community, or more accurately, the multiple communities, from the local to the global, in which we are located. Here our interdependence with other people and organizations is fully evident. It is in the context of these various communities that we fulfill various roles and participate in the life around us. We give and receive, produce and consume, lead and follow, serve and are served.

There are numerous resources and opportunities for participation in this third home that permit us to meet the needs of our first and second homes. For example, it is in the context of the larger community that we are connected to health care, education, work, food procurement, transportation, socialization, purchasing goods, entertainment, the arts, politics, recreation and community service. This third home provides the social, economic, service and cultural context for our lives.

What implications does this notion of "three homes" have for care providers? People experiencing homelessness often do not feel "at home" in their own bodies, minds, and souls, have no housing to call home, and are disaffiliated from a meaningful role and purpose in the larger community.

It seems clear that if we are to help people end their ***home-less-ness***, we are compelled to direct our efforts even beyond addressing basic survival, health, and housing needs. As the saying goes, a house is not a home. We must assist them in turning their housing into a home. In addition, we must also help them be more attuned to their own personal conditions, needs and care. And we must help them find their "place" in the larger community.

Helping others move towards a greater sense of being "at home" in their lives begins in the context of relationship. For example, by offering a hospitable presence – "creating a free and friendly space for the stranger" (Henri Nouwen) – care providers make it possible for others to experience a taste of being "at home." The seeds planted in such a relationship can go a long way to help someone take the necessary steps towards greater stability in all three homes of their lives.

Housing First Principles

Housing First has been recognized as a promising practice by national researchers and policymakers. As a result, communities around the country are implementing projects that employ Housing First principles.

The National Alliance to End Homelessness (NAEH) defines the Housing First approach for addressing the chronic homelessness of disabled and vulnerable people as "a client-driven strategy that provides immediate access to an apartment without requiring initial participation in psychiatric treatment or treatment for sobriety."

Housing First is based on two core convictions:

1. Housing is a basic human right, not a reward for clinical success, and

2. Once the chaos of homelessness is eliminated from a person's life, clinical and social stabilization occur faster and are more enduring.

Housing First principles:

1. Move people into housing directly from streets and shelters without preconditions of treatment acceptance or compliance.

2. The provider is obligated to bring robust support services to the housing. These services are predicated on assertive engagement, not coercion.

3. Continued tenancy is not dependent on participation in services.

4. Units are targeted to the most disabled and vulnerable homeless members of the community.

5. Embrace harm reduction approach to addictions rather than mandating abstinence. At the same time, the provider must be prepared to support resident commitments to recovery.

6. Residents must have leases and tenant protections under the law.

7. Can be implemented as either a project-based or scattered site model.

Adapted from DESC, Seattle, WA *www.desc.org/housingfirst.html*

Common Barriers to Housing-Focused Outreach

- Trauma is pervasive in the lives of people experiencing homelessness. Trauma backgrounds can cause people to be suspicious of motives and offers of housing support.
- Lack of subsidies/vouchers
- Deficient mechanisms for "scaling" *Housing First* in local, regional and State efforts
- Social/community opposition to "handouts" and concepts/precepts of *Housing First*
- Political opposition toward *Housing First*
- Lack of available housing units – especially in rural areas and competitive metro markets
- Restrictive rental policies from area landlords
- Neighborhood pressure to exclude (NIMBY)
- Lack of funds for rental/utility deposits
- Available housing proximity from services/transportation issues
- Inability to identify most vulnerable within the homeless cohort (e.g. do local programs administer a "vulnerability index" or survey to identify most vulnerable or most underserved within communities or programs)
- Lack of support services/wrap-around services
- Housing is the first step in delivering wider supportive services
- Lack of services/supports integration
- Poor coordination amongst homelessness services delivery programs/providers
- Competition for the "neediest" among homelessness service programs/providers
- Poorly trained/untrained/no outreach capacity
- Ignorance/misinformation concerning *Housing First* programs

Common Solutions to Housing-Focused Outreach

- Lead with trauma informed practices and principles. It is not a stretch to assume that all of the clients you are serving in Housing-Focused Outreach have trauma backgrounds. If you are not already knowledgeable about trauma informed care, consider taking a course or attending a workshop (see: http://www.samhsa.gov/nctic/). You may consider brining a trauma trainer to your agency for a 2-day intense training (see: http://www.center4si.com/training/schedule.cfm).
- Housing options are very centric to local constraints and opportunities. Perhaps the best "tool" that outreach workers can use to better link clients into housing and developed a Housing-Focused Outreach model is to partner with local/regional housing authorities and not-for-profit housing development corporations.
- Build strong partnerships with "unconventional" transitional housing options (see: http://www.ucanchicago.org/host-home/). Consider how untapped capacity may be utilized and how you can bridge clients into transitional housing and supportive services – with a plan toward long-term affordable housing placements (see: http://www.i-fha.org and http://www.churches-united.org and http://cmtysolutions.org/projects/innovative-housing-dc).
- Identify resources and build strategic partnerships with programs delivering supportive employment, holistic healthcare (e.g. mental health, substance use, medical, dental, psychiatric, etc.), child-care services, parenting classes, social networking opportunities,

and reintegration services (see: http://homeless.samhsa.gov/organization/services-in-supportive-housing-41.aspx).

- Develop strong alliances with rental assistance programs (see: http://www.sdcounty.ca.gov/sdhcd/renters/section_eight.html) and supportive housing programs (http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/homeless/programs/shp).
- Meet with local transportation board to discuss the transportation needs of clients placed into affordable housing and the lack of accessible transportation (see: http://www.southernenvironment.org/uploads/publications/connecting_home_and_work.pdf).
- Hold "town hall meetings" or "brown bag" luncheon meetings to discuss Housing First and to describe how a Housing First model is saving communities around the country (see: http://www.usich.gov/usich_resources/research_and_evaluation/cost_effectiveness_studies/).
- Build strategic partnerships with other agencies or programs to "fill the gaps" on services delivery. As an example, partner with a local Medical or Nursing school to provide clinic services (see: http://fm.mednet.ucla.edu/?pageid=130).
- Meet with landlords and renters to develop alliances and support for placing clients into market-rate housing. Hold a breakfast "meet and greet" to bring together targeted landlords for a conversation about working together (see: http://people.cas.sc.edu/kloos/pubs/Landlords.pdf).
- Become more informed about housing advocacy and the various options that may exist for helping clients link into affordable housing (see: http://www.policylink.org/site/c.lkIXLbMNJrE/b.5136711/k.2D86/Affordable_Housing_Tool_Group.htm).
- Conduct a vulnerability registry event utilizing one of the Vulnerability Index (VI) tools; the 100K Homes program can help a community establish their own registry (see: http://100khomes.org/the-model and http://cmtysolutions.org/projects/los-angeles-project-50).
- Hold an intensive training event (moderated by an outside facilitator or TA specialist) that comprehensively covers the complexity of Housing-Focused Outreach (consider using the SAMHSA Street Outreach video series as an instructional tool; see: http://www.youtube.com/watch?v=tWKsgl9h5N8&feature=relmfu).
- Meet with other homelessness service agencies or programs in your area to develop a coalition. Consider ways that homelessness services agencies in your area can collaborate to more effectively support the elimination of chronic homelessness. One example of how this might work is to talk with other programs in your area about splitting "target populations" (i.e., established based on age, gender, critical needs, etc.) to focus services delivery. From an operational perspective – this splitting of target populations requires complex and thorough diligence toward the development of service agreements and memorandum around referrals, resource allocations, and accountability.
- Hold a rally at the local town/city hall. Bring together a wide partnership of homelessness service providers to advocate for Housing-Focused Outreach services and the need for more affordable housing options.

The 100,000 Homes Campaign

(http://100khomes.org)

The 100,000 Homes Campaign is a national effort of communities working together to identify, engage and housed the most vulnerable people in places across the country. Coordinated by Community Solutions (http://cmtysolutions.org) the 100K Homes Campaign works with local partners to identify creative housing solutions to end homelessness. The following document is a transcript taken from an email conversation with Mr. Mike Shore, Vice Chair of the Arizona Coalition to End Homelessness, the lead organization for Project H3 in Maricopa County and the Western U.S. Field Organizer for the 100,000 Homes Campaign.

Mike writes: "The 100,000 Homes Campaign took what was Outreach 1.0 and went straight to Outreach 3.0 as part of our Campaign initiative, *Project H3: Home, Health, Hope*. We call it Navigation, and it is a tool or mechanism of the broader Housing First strategy that we employ in our efforts. Therefore, the outreach is tied to the housing opportunities that we lined up for Project H3. The Navigators work from the list that we develop from an initial registry week and ongoing survey efforts using the vulnerability index (VI) (http://en.wikipedia.org/wiki/Homeless_Vulnerability_Index). The Navigators know that when they find a person on the VI registry, there is a housing opportunity designated for that individual.

This may be stating the obvious, but I think it's important to note that Navigation in this context does not exist as a stand-alone service. Navigators perform outreach activities in Project H3 (http://www.azceh.org/project-h3), but they know that they have housing as their primary tool. Before a 100K Homes Campaign, and even in ongoing efforts outside of or beyond Project H3 locally, outreach specialists would agree that they don't have housing lined up for the folks that they are engaging. So, it seems to me that outreach has to be part of a broader effort to end homelessness in communities where Housing First is not just the philosophy, but it is being implemented through policy and concrete programs.

So, in thinking of the activities that go into the process of lining up the supply of housing for Outreach 3.0, my suggestions would be for the Navigators and outreach workers to build bridges with broader stakeholders in the community. I see that responsibility as being a part of the whole system - not just the outreach teams. I think outreach teams can and should be part of that effort. For Project H3 efforts and activities, we often say that it is the responsibility of the "guys in the ties" to change systems and break down barriers so that the Navigators can focus on what they're exceptionally good at - which is the location of people, establishing trust and building rapport. The Navigators and outreach workers help clients navigate the various housing systems and link the clients into services once housing is established."

A few Resources:

Local/Regional

- Article on Navigation: http://www.phoenixnewtimes.com/2011-12-08/news/phoenix-s-most-at-risk-homeless-find-their-way-thanks-to-a-team-of-navigators/

- Video of Russell in housing talking about Project H3:

http://www.youtube.com/watch?v=0Rjkp4fjXyw&feature=relmfu

- Housing First for HUD-VASH in Phoenix - http://noplacelikehom.com/2012/02/super-bowl-of-hud-vash/

National

- Year 1 video for 100,000 Homes Campaign – Before and after photos – Inspiration galore! http://www.youtube.com/watch?v=Db-72KUuwpA&list=UU5ZYW_yXVomt5qg45qVZUuw&index=2&feature=plcp

- Housing 1000 (Santa Clara County's Campaign Initiative) video - http://www.youtube.com/watch?v=Db-72KUuwpA&list=UU5ZYW_yXVomt5qg45qVZUuw&index=2&feature=plcp

- Downtown San Diego Campaign Newsletter with housing resources lined up for Phase 2 - http://www.lesardevelopment.com/news-and-publications/newsletters/CampaignNewsletter_August2012.pdf

Homelessness Prevention Strategies

Emergency Homelessness Prevention

- Prevention hotline
- Revolving loan funds (pay less if paid back on time)
- Emergency funds (i.e. one time grants)
- Utility company interventions
- Police/constable/sheriff used as outreach
- Landlord-tenant mediations
- No wrong door to accessing homelessness prevention
- Payee services for rent payment
- Emergency medical/mental health crisis interventions
- Discharge planning interventions (mental health system/criminal justice/hospitals)
- Eviction prevention services/counseling – legal, financial, practical
- Court-involved tenancy preservation for people with disabilities

Preventative Services/Stabilization

- Financial literacy programming for tenants
- Third party payee for rent
- Education and support for landlords
- Education/job training for heads of household to increase earning potential
- Job link/direct employment programs for heads of household (including job creation and enterprise development)
- Tenant counseling on rights and responsibilities
- Links to mainstream resources (SSI, TANF, Medicaid)
- Links to community based services (health care, mental health care, etc.)
- Home based support services that enhance tenancy stabilization

Housing Related Interventions (to create affordable housing)

- Rolling stock housing
- Time limited rental subsidies/bridge subsidies
- Identification of privately owned affordable units – brokering with landlords
- Rental clearinghouse information
- Permanent affordable supportive housing for people with special needs
- Permanent affordable housing

U.S. Department of Housing and Urban Development, Homelessness Resource Exchange
www.hudhre.info/documents/HomelessPreventionStrategiesHandout.doc

Homelessness Services Delivery: *What Works*

These selected approaches and practices have been shown to be effective in addressing the needs of people experiencing homelessness and living with serious mental illness and/or substance use disorders.

Person-Centered Values
Person-centered care prioritizes the self-identified needs and preferences of the individual. The helping relationship is collaborative and invitational. Support, information, and options are offered. Services are tailored to the individual.

Trauma-informed
Homeless people report high levels of trauma, past and present. Viewing the lives of people through a “trauma lens” helps to understand their behaviors, responses, attitudes, and emotions as a collection of survival skills developed in response to traumatic experiences.

Belief in Recovery
People can and do recover from problems related to substance use disorders, mental illness, and homelessness. They experience recovery of hope, self-worth, and participation in meaningful relationships and activities.

Outreach and Engagement
Involves going out into the community and meeting homeless people where they are – on the streets, under bridges, in shelters and drop-in centers. Workers seek to develop trust with individuals and to provide or connect them with needed services.

Flexible, Low-Demand Services
Services are provided in an individualized manner, varying in frequency, duration, and scope depending on one’s changing needs and wishes. Participation in treatment is not required as a condition for continuing to receive services such as accessing entitlements or housing.

Housing First with Appropriate Supports
Emphasis is on placing people as early as possible into permanent housing units with low-demand supportive services offered by an interdisciplinary team of health, behavioral health, and social service providers. Housing itself is seen as a form of treatment.

Interdisciplinary Care Teams
Teams are composed of various health, behavioral health, and social service providers who work together to ensure that a homeless person’s needs are being addressed in an appropriate and coordinated manner.

Integrated Treatment and Services
Integrated treatment for co-occurring mental illness and substance use disorders
Refers to concurrent, coordinated clinical treatment of both mental illnesses and substance use disorders provided by the same clinician or treatment team. Integrated treatment has been shown to be more effective than a parallel or sequential treatment approach.

Motivational Interventions
Person-centered clinical strategies that seek to help people resolve ambivalence and move in the direction of change. Make ample use of open questions, affirmations, reflective listening, and eliciting change talk.

Self-help Programs
Programs are typically based on the AA 12-step method. Focus is on developing personal responsibility within the context of peer support. Participation has been shown to decrease substance use and inpatient treatment, and improve self-esteem and community adjustment.

Involvement of Consumers and Recovering Persons
Play important role in outreach, supporting peers in recovery, staffing agency programs, contributing as active members of planning councils, advisory boards, and community advocacy groups.

Long-term follow-up Support
The recovery process from homelessness, mental illness, addictions, etc. is neither a linear nor a short-term process for most people. Individuals require long term follow up support from an interdisciplinary team of care providers.

Prevention Services
Examples include appropriate discharge planning from institutions/hospitals/ treatment programs, short-term intensive support upon re-entry into the community, and provision of subsidized housing and adequate income support.

Adapted from Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Use Disorders, *DHHS Pub. No. SMA-04-3870. Printed 2003*

Relational Stages of Outreach and Engagement

Outreach and engagement is the process of coming along side of someone who is struggling with homelessness and related health and social concerns, and sharing the journey in a way that leads to healing, wholeness and stability in the community. Outreach and engagement activities can be seen as a movement through four overlapping, but distinct phases of relationship: approach, companionship, partnership, and mutuality.

Approach – Making a Connection

The approach phase involves observation and introduction. It is helpful to spend time simply watching, to see how a person acts, how they relate to others, what kind of space they need, how they seem to be experiencing their environment and responding to the world. Careful observation helps to shape an introduction. One might simply pass by with a nod or greeting or introduce oneself in some manner. The key is to begin generally as someone who cares, and define your role more specifically as the relationship develops and trust builds between the two of you.

Companionship – Developing the Relationship

At its simplest, companionship means sharing a little of the journey with another, standing or sitting with them, walking a little ways with another, listening, and hearing a person's story. Perhaps it may include suggesting some possibilities to assist someone along the way, maybe going with them to some destination, or arranging for another to accompany and help them.

Partnership – Enhancing Motivation and Linking

The partnership phase of outreach and engagement involves providing information, enhancing motivation, and introducing the person to others who can help or assist. In partnering with others – case managers, medical providers, social service programs, family members – a widening circle of care is created upon which the individual can rely for support and care in various aspects of their lives.

Mutuality – Supporting Wellness and Stability

In the mutuality phase, we recognize one another as fellow citizens and community members. The worker continues to encourage the other in making use of appropriate resources and supports the individual in becoming a stable part of the neighborhood and community. In time, it is recognized that the relationship has come to fruition and thus is brought to closure as appropriate.

Adapted from unpublished paper, Relational Outreach and Engagement, *by Craig Rennebohm*

Dilemmas: *What would you do if . . .*

…a woman who is pregnant admits to you that her boyfriend sometimes punches her in the face and the stomach, but it doesn't happen too often and besides, she really loves him?

…a young man, who has tested positive for HIV, tells you he makes money to survive by having sex, usually unprotected, with various customers?

…your client, who has experienced multiple traumatic brain injuries, repeatedly asks the same questions, acts impulsively, and becomes agitated quickly to the point of threatening others, desperately wants to live independently in his own housing?

… a woman, who refuses to fill out paperwork or permit you to help her with it, says she's "very smart" and does not need any help, but you believe she is unable to read and write?

… the local police ask you to accompany them on their walking beats to help intervene with certain problematic homeless people?

… your promotion of needle exchange and handing out bleach kits to clients who inject drugs is criticized by co-workers as "enabling" clients to continue using drugs?

… your client who is terminally ill refuses any further treatment and says he just wants to die under the bridge where he has been staying for several years?

… you learn that your developmentally disabled client is running drugs for a dealer, who gives the client money, gifts, and special attention?

… you wish to testify at a local hearing on homelessness, but are told by your superior that you are not permitted to engage in advocacy?

… a client you've known for a long time who lives under the freeway and has a long history of PTSD and alcoholism, says it's only a matter of time until he's going to commit suicide, but not to worry, because he'll do it alone and no one else will ever know?

… you finally have gotten your client into permanent housing, but it seems to be more of a problem than a solution; he feels walled in, doesn't like being alone, and is getting more and more depressed?

… your client tells you that she's proud of herself because she's cut down from smoking crack daily to only five days a week?

… you like your work and are committed to it, but find yourself "taking it home with you" – you think about your clients, have a hard time being attentive to your loved ones, and sometimes feel guilty for enjoying simple pleasures

… (*examples from your own experience*)

Professional and Ethical Guidelines for Outreach and Engagement

"Ethics is how we behave when we decide we belong together. "
David Steindl-Rast

The overriding philosophy of these guidelines is to treat others, as you would want to be treated. At the very least, do no harm. This applies not only to how we interact with homeless people but also with co-workers, supervisors, administrators, other agency staff, policy-makers, and so forth. With clients, providers are expected to consistently provide competent, compassionate care in whatever forms that may take.

It is prudent for providers to anticipate and identify ethical dilemmas that arise in outreach and to discuss these issues with supervisors and peers. The guidelines below are intended to prompt such discussions so as to increase adherence to ethical practice. These guidelines are intended to serve as an adjunct to agency-specific codes of ethics and other relevant policies.

- Commit yourself to being well prepared physically, intellectually, emotionally and spiritually for doing this work.
- Develop an awareness of the causes, experience, patterns and politics of homelessness.
- Continually increase your knowledge about health, mental health, and substance use disorders, including social service needs and resources.
- Present yourself in a genuine, hospitable manner.
- Maintain a perspective of objectivity with clients. Avoid being judgmental.
- Be respectful of others' desire for privacy and need to keep secrets. Be assertive but not intrusive in your outreach.
- Maintain confidentiality in your relationships.
- Keep your word. Be trustworthy and reliable.
- Respect people as ends, not means. Never exploit clients for personal or agency gain.
- Educate others about behaviors that can enhance their health and well being. Also, inform them of behaviors that might cause them to be susceptible to disease and/or bring harm to themselves or others.
- Don't attempt to intervene in areas in which you are not trained or competent.
- Do not withhold information from clients about other resources and services from which they could benefit.
- Devote some part of your time, no matter how little, to use your knowledge and experience to inform public planning and policy-making processes.
- Refrain from imposing your moral or religious beliefs on others.
- Refrain from having social or emotional relationships with clients outside of work.
- Do not use your own home to shelter clients.
- Never engage in sexual activity with clients.
- Do not accept cash from clients. Accept gifts only when it is culturally appropriate.
- Refrain from giving personal gifts or cash to clients.
- With the possible exception of pepper spray, never carry weapons.
- Never use alcohol or illicit drugs on the job.
- Develop practices of self-care and renewal within and outside the work setting.

Adapted from the California Association of Community Health Outreach Workers' Code of Ethics and other sources

Working Effectively in the Community

Ken Kraybill

Through your attitude, actions and words, serve an "ambassador" for homeless people in your encounters with others in the community.

Promote a spirit of collaboration with shopkeepers, police, clergy, and "natural helpers" in the neighborhood. They are valuable "eyes and ears" to assist you in your outreach efforts.

Develop and maintain a strong working relationship with at least one staff person from key social service organizations.

Offer to provide education and training for other organizations about issues related to homelessness. Likewise, invite them to provide relevant training for your team/organization.

Consider setting up an inter-agency consortium to meet training needs. Each participating agency hosts and provides a workshop on a rotating basis. A representative planning group chooses topics.

Go out on outreach "rounds" at selected agencies on a scheduled basis. This provides an opportunity to maintain regular contact with agency personnel, to accept referrals, make follow-up contacts, and provide consultation.

Participate in developing formal interagency agreements to address issues specific to the care of homeless people. For example, ways to expedite referrals, homeless-specific admission criteria, discharge planning, and sharing of information.

Provide advocacy on behalf of other community programs that are part of the larger network of services for homeless people.

Invite others to open houses, celebrations, farewells, fundraisers, and other special occasions. Attend other agencies' functions.

Make a special effort to reach out to organizations "on the fringes" of the human services community.

Set aside time at each staff meeting to discuss current and emerging advocacy issues at the local, state and national level.

Get involved in committees, boards, work groups and coalitions that are working to improve the lives of homeless people and to end homelessness.

Subscribe to listservs and periodicals working to end homelessness.

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