F. Outreach

The public health principles underlying the HCH philosophy are nowhere more evident than in the program's strong emphasis on outreach. As a means to improving the health of a community by taking services, health education and disease prevention to the most underserved, outreach has historic precedents going back to the 18th and 19th centuries in the urban slums of Europe and the United States.[2] Since that time public health practice has been committed to moving health services beyond the walls of traditional medical institutions, out into the community. That commitment is reflected today in HCH projects across the country, as they reach out to homeless people on the streets, under bridges, in shelters, soup kitchens, drop-in centers and wherever those most underserved are likely to be found.

HCH outreach is aimed at breaking down the psychological and systemic barriers to care faced by homeless people, which have been discussed in previous chapters. Activities designed to overcome those barriers range from establishing rapport for purposes of engaging people in services later, to disseminating information on services available from HCH or other agencies, to directly providing an array of medical, mental health and social services.

Although outreach is required of federally-funded HCH projects, the actual services provided as part of outreach vary greatly according to the needs in a particular community. This chapter will cover the essential elements of outreach, as answered by the following questions:

- What elements/principles define outreach in the HCH context?
- Where does outreach happen and how?
- What services can be provided through outreach?
- What role does outreach play in an HCH project?
- What obstacles do HCH projects face in doing outreach?
- Who should provide outreach services?

WHAT ELEMENTS/PRINCIPLES DEFINE OUTREACH IN THE HCH CONTEXT?

The term "outreach" can mean many things and encompasses a broad range of potential activities. To avoid "hinging the definition of outreach on any specific service activity," Morse[3] has suggested giving outreach a "process definition." Although his definition is specifically directed toward mental health outreach, it could easily apply to any HCH outreach activity in that it is "contact with any individual who would otherwise be ignored (or unserved)…in non-traditional settings for the purposes of improving their mental health, health, or social functioning or increasing their human service and resource utilization."

In some contexts, outreach may refer to interaction with other service provider organizations to inform them of HCH services and referral policies, or to do consultation or health education with the agency staff. This chapter, however, focuses on outreach in relation to an individual who is homeless. The first and most central element of HCH outreach is the goal of reaching homeless people who would otherwise not receive services.

Some people who are homeless are not engaged in services because they are unaware of what is available, either due to the complexity of the service system or being new to the area. For a variety of reasons, other people who are homeless actively avoid services of any kind. They may suffer from mental disorders that cause paranoia or lack of insight into their need for care. They may be substance abusers who cannot stay in shelters if they are drinking or using drugs, so they stay on the streets. They may be veterans suffering from post-traumatic stress syndrome, wary of the system. They may be women fleeing domestic violence, afraid to go to service sites for fear of encountering their batterer. They may be runaway or throwaway youth, convinced of their own immortality and suspicious of any agency trying to help them. Or they may simply be people who have had negative experiences with institutions in the past.

Schutt and Garrett comment that

> *In spite of these understandable reasons for rejecting services, research indicates that many homeless persons respond positively to offers of help that are made in an appropriate manner…The key is to provide help with the most immediate needs first – sandwiches for those living on the streets, showers, clean facilities, a pleasant environment, and physical health care for those staying in shelters – before attempting to address problems in social relations, psychiatric difficulties or substance abuse. Persistence and a gradual approach can pay off in the long run.*[4]

...(E)ven the most initially resistant and chronic substance abusers can be cajoled into accepting services if they are offered in an appropriate manner. Outreach workers must be sympathetic and non-judgmental, but at the same time, aggressive and persistent. Outreach efforts must be conducted on the client's turf and be able to meet basic, immediate needs such as food and clothing. Ongoing contact over long periods of time is often necessary in order to develop the level of trust which is critical to engaging some homeless clients – many of whom are wary of service systems which have failed to work for them, or which have treated them badly, in the past.[5]

Lydia Williams
Addiction on the Streets: Substance Abuse and Homelessness in America
National Coalition for the Homeless

While some HCH projects do outreach to the general population of people who are homeless, others reach out to vulnerable subgroups, such as people with mental disorders, substance abusers, people at risk for contracting HIV/AIDS, families with children, or runaway and throwaway youth. Many projects use a combination of both general and specialized outreach with different staff responsible for certain subgroups or locations.

Whoever the target for outreach is, no matter what services are provided or where, certain principles describe what makes outreach successful:[6, 7]

- A non-threatening approach
- Flexibility in the menu of services offered and the manner in which they are provided
- Repeated contact over extended periods of time, achieved by bringing services to clients rather than waiting for them to come to the services ("response to need rather than demand alone"[8])
- Allowing for flexible and varied times for client contact, including non-scheduled contacts
- Responding quickly to an individuals' perceived needs for food, money, and housing

- Conducting an assessment of the individual's comprehensive, holistic needs, and then tailoring services and strategies to meet those unique needs and characteristics

- Providing engagement services for clients who are reluctant or suspicious to receive help

- Patience in motivating clients to accept treatment and services

- Using a team approach to outreach

Regarding the element of patience and the amount of time it may take to actually engage clients in services, outreach staff who work with people who are homeless and have serious mental illness have reported that it can take about nine months to engage their clients into basic services, such as food, shelter, and health care programs; another three to six months to convince them of the value of obtaining benefits and taking medication; and another nine to 12 months to obtain permanent housing, with ongoing case management support.[9] Such time frames will vary widely – from days to years just to establish rapport – depending on the individual and the circumstances.

WHERE DOES OUTREACH HAPPEN AND HOW?

The "non-traditional" settings referred to in the definition above can generally be divided into two categories: fixed site and mobile. **Fixed-site outreach** includes the common HCH practice of establishing clinics in or near shelters, soup kitchens or other service facilities. Basically, HCH staff are "setting up shop" in a location where people who are homeless already gather. Fixed-site outreach could also include operating a drop-in center that offers a safe place to spend time, protected from the elements and the violence of the streets, as well as a place to receive other services such as showers, clothing, food or laundry facilities.

Mobile outreach moves around and can happen anywhere people who are homeless might be found. Options for carrying out mobile outreach include: mobile units (sometimes fully equipped as clinics – see chapter on "Strategies to Enhance Access"); vans or other vehicles; or on foot. Some outreach teams have set "routes" that they follow on specific days. Others may be more flexible, responding to the needs that particular day or searching out certain people they need to contact.

Drop-in centers, which are generally small, accessible, store-front locations, are often effective in engaging portions of the homeless mentally ill population that are typically not reached by other service interventions.[10] Distinguished from more formal programs by their casual accessibility, these centers can offer a place to sit during the day, a place to sleep at night, or both. They are particularly inviting to many homeless mentally ill individuals because they ask few questions and make no demands. Like other outreach efforts, they often become a bridge to the more formal service delivery and/or shelter network." [11]

Federal Task Force on Homelessness
and Severe Mental Illness
Outcasts on Main Street

Common street locations for outreach are under bridges and freeway overpasses, alleys, parks and vacant lots. In rural areas or on the fringes of urban areas, outreach workers may go to the riverbanks, foothills, wooded areas or desert. Mobile outreach can also frequent public facilities where people without homes may take shelter during the day, such as libraries or transportation terminals. Many outreach teams go to welfare hotels, cheap motels or SRO's where people live on the edge of homelessness. Some teams have special arrangements with jails, detox/treatment programs or other institutions to enter and make contact with ongoing HCH clients or potential clients regarding available services when they are released. And, of course, teams will often visit shelters, soup kitchens and other service locations.

Many HCH projects use a combination of both approaches to outreach, for example, operating a fixed-site clinic next door to a shelter, while sending teams out into the streets on a regular basis. This combination is particularly helpful in that the two approaches complement each other. Many times people are encountered during outreach who need more complex care than what can be provided on the street, in a shelter, or even in a mobile unit. They can then be referred to the fixed-site location which is usually better-equipped. Conversely, staff in fixed-site locations may depend on outreach workers to find clients who need follow-up.

WHAT SERVICES ARE PROVIDED THROUGH OUTREACH?

The menu of services that can be provided during outreach is limited only by imagination and resources. The continuum of options could be

divided into three general activities: (1) engagement strategies; (2) information and referral; and (3) direct services. The first two are more likely to happen on mobile outreach or at an HCH-affiliated drop-in center, while direct services could be provided during mobile outreach, at a drop-in center or at a fixed-site.

Engagement strategies

- Initiating non-threatening conversation
- Offering sandwiches and coffee or other food and beverage
- Offering blankets, sleeping bags, socks, hats, etc.
- Offering hygiene articles, sunscreen, condoms, etc.

Information and referral

- Offering information about available services from HCH or other agencies, including shelters, "safe havens" and other housing options as a transitional step between engagement and providing direct services

Direct services

- Providing medical care, mental health or substance abuse services directly
- Offering formal referrals for specialty care, dental care, mental health services, substance abuse treatment or other services not available from HCH
- Assessing a client's medical, psychiatric and social needs and developing a treatment plan
- Providing social service assistance (referrals to housing or shelter, accessing entitlements, replacing identification, etc.)
- Providing case management
- Counseling
- Facilitating support groups, life-skills training

- Health education/promotion
- Crisis intervention, such as links to emergency medical or psychiatric care
- Screening for specific diseases or disorders
- Advocating with other agencies for client to receive necessary services
- Other services that may be linked to the site, including food, clothing, showers, laundry, etc.

HCH projects pull from this menu of possible services to design an outreach program in response to the specific needs and characteristics of people who are homeless in their community. Some outreach teams may be trained and professionally skilled to respond at any level. For example, a team that includes a medical provider and/or a social worker could either provide direct services, triage for referrals, or limit their encounter to engagement strategies with those clients who are reluctant to accept services. Other outreach teams may only be qualified to engage clients and provide information on services, with referrals for direct services made to HCH sites or other agencies.

HCH staff who do outreach also need to be aware of other organizations involved in outreach work, so that efforts can be coordinated when possible. For example, some public health departments may do outreach focused on screening for HIV or TB. Some shelters or missions do out-

Street outreach must include the capacity for an emergency response as well as engagement. Homeless mentally ill individuals often are found living in life-threatening circumstances and/or in precarious locations...some homeless mentally ill individuals living on the streets are unable or unwilling to go indoors in below-freezing temperatures. For reasons such as these, crisis outreach teams need to be available to evaluate individuals and transport them, if necessary to emergency or inpatient services. Backup medical and psychiatric support is essential to ensure access to involuntary treatment when it is needed.[12]

Federal Task Force on Homelessness
and Severe Mental Illness
Outcasts on Main Street

reach on cold nights to help people find shelter. HCH outreach workers may want to collaborate with other outreach programs on a regular basis to enhance the effectiveness of their efforts.

WHAT ROLE DOES OUTREACH PLAY IN AN HCH PROJECT?

Outreach is the entryway to services and safety that otherwise might not be available for some homeless people. It serves as the crucial link between the streets and HCH services. Although HCH outreach workers may have contact on the streets with homeless people who do not need or never make use of HCH services, they are especially effective when they can identify and engage those people who need the services HCH has to offer. Outreach workers of any professional discipline should represent the compassion and respect that people who are homeless will find when receiving other HCH services. As the first contact with an individual who is homeless, outreach workers can ease the way into a trusting relationship with other HCH providers.

In addition to the assistance they provide to people who are homeless, outreach workers are also valuable to the HCH organization for:

- Providing follow-up on HCH clients, such as locating medical clients who need to be informed of lab results, or monitoring the progress or behavior of a case manager's client on the streets

- Assessing ongoing needs of people who are homeless, including changes in demographics such as increases in families or youth or particular cultural groups (useful for reports and funding proposals)

- Keeping HCH staff informed of health issues on the streets, including trends in drug-use or violence

- Serving as a HCH representative to other service agencies or public entities, including police officers and corrections facilities

- Guiding other HCH staff who normally work in clinical or administrative settings through outreach locations to keep them in touch with the realities of their clients' living situations

Some outreach programs have begun to take an even more active role in the case management of clients they encounter. For example, since the Milwaukee outreach team was first initiated, the function of outreach

The mobile outreach team in Milwaukee was among the first to be fully developed and to be studied carefully. The team uses a mobile van which daily tours the shelters, meal sites, and other congregating areas around the inner city. Its members are chosen for attributes that lessen social distance from clients, and they use strategies of relationship building and power sharing designed to create trust. Team members function as case finders, case managers, and advocates, dealing with multiple problems, meeting basic needs, and providing linkages between the clients and disparate parts of the human resource system. Its members maintain sustained contact with clients placed in various outreach programs (such as the correctional services homeless program) and often organize and engage in social activities with their clients, such as movies, bowling, picnics, and shopping.[13]

Barry Blackwell, MD, et al.
"Psychiatric and Mental Health Services"
Under the Safety Net: The Health and Social Welfare of the Homeless in the U.S.

workers has been expanded to include coordination of services within a continuum of care. Each team member maintains a minimum case load of 10 individuals for whom they function as the primary case manager, linking them to services and making sure they stay linked for as long as necessary to get them stabilized in transitional or permanent housing.[14]

WHAT OBSTACLES DO HCH PROJECTS FACE IN DOING OUTREACH?

One of the biggest obstacles to effective outreach work is the scarcity of resources to which people who are homeless can be referred once they are ready and willing to accept services. Williams discusses the effects of a shortage of substance abuse services in the community, based on a National Coalition for the Homeless survey:

> *Outreach efforts are only as successful as the outreach worker's ability to offer immediate access to the services desired by the client. However, backlogs in the treatment system are disrupting efforts by the programs we surveyed. Providers reported enormous frustration among outreach workers who, after months of contact, are unable to deliver on promised services once the client is ready to accept them.*[15]

The shortage of services may also be a reflection of lack of capacity in the HCH project. For example, a common lament of HCH case managers is that their case loads are "maxed out" and yet the outreach workers keep finding more and more people who need their services. The same is true of HCH treatment programs or transitional housing with limited capacity.

Another issue related to lack of capacity within the HCH project occurs when a project becomes well-established in a fixed location, such as a clinic, and has a strong enough reputation through word-of-mouth that the waiting room is always full. Providers may then have difficulties breaking away to do outreach. They are faced with either staying in the clinic site to serve those in need who have the desire and ability to seek out services, or doing outreach to serve those in need who have neither that ability nor desire. Outreach workers who are not medical providers or mental health workers may report that those staff are desperately needed on the outreach team, but there are simply not enough staff members to go around.

The obvious solution to the lack-of-capacity dilemma is to increase the number of staff, but that is not usually possible due to funding limitations. Instead, it often becomes necessary for the project to prioritize where they put their time and resources. Are the resources better used by serving more people who have relatively fewer needs or fewer people with more complex problems? It is hoped that, with sufficient information about their community's population of people who are homeless, and with healthy dialogue among staff, Board and consumers, a workable balance can be found between these two targets. Whatever decision is reached, outreach workers need a clear understanding of their role, both in relation to the people they encounter on outreach and to their HCH colleagues.

Another obstacle in outreach work is the frustration of spending time looking for someone who can't be found, or spending months trying to engage someone, only to have them disappear, or worse yet, die. Patience and persistence often pay off, but not always. Staff involved in outreach need to share this frustration and to regain perspective by focusing on the incremental successes, using their supervisory and team relationships for support.

Outreach workers also may encounter resistance in the community stemming from anti-homeless sentiments. A common trigger for community antagonism is panhandling or signing, especially when it appears to be linked to substance abuse. Outreach workers may have to make a special effort to educate police, business people and neighbors about homeless-

ness to gain their support and cooperation in areas where panhandling is seen as a hindrance to business or tourism.

The danger inherent in outreach work is another obstacle. Outreach teams have no guarantee when going into an unknown camp, vacant building or dark alleyway that the people they encounter will be glad to see them. Whether human beings are housed or homeless, there will always be those who are involved in illicit activity, who are running from the law, or who are violent. It is essential for anyone doing outreach to stay centered, cautious and alert at all times. An outreach worker on the street alone runs a significant risk. Outreach should be done in teams of at least two people, making sure other staff know their location and keeping a cellular phone handy. Training in self-defense and de-escalation of potentially violent situations should be provided to all staff involved in outreach work.

Anyone who works with homeless persons, whether providing clothing or mental health services, requires a particular blend of personal and professional characteristics. The clients served are a low-status, non-prestige group who often are stigmatized and feared by the general population. Outreach workers may experience a sense of non-affiliation, especially when they work in a variety of host agencies. At times one must function autonomously; at other times one must shift rapidly from working with homeless persons to working with social service bureaucrats or highly placed community officials. This situation challenges the workers' adaptability and flexibility.[16]

J.Thomas Ungerleider, et al.
"Mental Health and Homelessness: The Clinician's View"
Homelessness: A National Perspective

WHO SHOULD PROVIDE OUTREACH SERVICES?

Projects may have staff who only do outreach, or they may have staff who normally work in fixed-sites accompany the outreach team either on a regularly scheduled basis or occasionally as time permits. And as indicated by the long list of potential services that can be provided through outreach, the staff involved can vary significantly – from medical providers and doctorate level professionals to masters or bachelors level counselors, social workers or case managers to paraprofessionals without degrees, including peers or consumers. People who do outreach need to meet the profession-

al criteria for whatever level of services they are providing, as well as the personal characteristics necessary to do good outreach work. Of course, all staff or volunteers involved in outreach – whether trained professionally or not – need a solid understanding of mental illness, substance abuse, community resources available and the ethics of providing services.

Most of the desired personal characteristics for staff who do outreach can be derived from the discussions above regarding what makes outreach effective. Although it could easily be said that these are the characteristics needed for anyone working with clients in an HCH project, the need for outreach workers to embody these characteristics is heightened by the settings in which they work. Staff doing outreach should be:

- flexible – able to change directions (literally or figuratively) at a moment's notice
- non-judgmental – willing to let clients define their own needs, without jumping to conclusions or diagnoses
- relaxed – easy to talk to and able to easily initiate conversation in a non-threatening manner
- patient
- respectful
- diplomatic and tactful – able to negotiate acquisition of services for clients without alienating other service providers *and* able to convince law enforcement that they are allies while still defending the rights of the clients
- resourceful and creative – both in finding ways to engage clients, as well as finding the resources they need
- centered – with a strong self-concept and clear boundaries, especially in terms of staff-client interactions
- calm and clear-headed in emergency situations
- assertive, but cautious and alert to possible danger

- able to communicate clearly and directly with clients, fellow staff or other agencies
- independent and able to take initiative, while also being a strong team player

NOTES

1 Case study from Philadelphia HCH. 1997.

2 E.B.G. Hebenstreit. Principles of the Science of Medical Police. In G. Rosen (Ed.), *From Medical Police to Social Medicine: Essays on the History of Health Care.* New York: Science History Publications, 1974, pp. 176-200.

3 G. Morse. *Conceptual Overview of Mobile Outreach for Persons Who Are Homeless and Mentally Ill* presented at the American Public Health Association in New Orleans, Louisiana, October 1987, p. 9.

4 R.K. Schutt and G.R. Garrett. Counseling and Case Management. In R.K. Schutt and G.R. Garrett (Eds.), *Responding to the Homeless: Policy and Practice.* New York: Plenum Press, 1992, pp. 46-47.

5 L. Williams. *Addiction on the Streets: Substance Abuse and Homelessness in America.* Washington, DC: National Coalition for the Homeless, 1992, p. 25.

6 D. Oakley and D.L. Dennis. Responding to the Needs of Homeless People with Alcohol, Drug, and/or Mental Disorders. In J. Baumohl (Ed.), *Homelessness in America.* Phoenix: Oryx Press, 1996, p. 182.

7 G. Morse. 1987, p. 10.

8 S.L. Wobido, et al. Outreach. In P.W. Brickner (Ed.),*Under the Safety Net: The Health and Social Welfare of the Homeless in the United States.* New York: W.W. Norton, p. 329.

9 L.M. Reyes. *Local Responses to the Needs of Homeless Mentally Ill Persons.* Washington, DC: U.S. Conference of Mayors, 1987.

10 I.S. Levine. Service Programs for the Homeless Mentally Ill. In H.R. Lamb (Ed.), *The Homeless Mentally Ill: A Task Force Report of the American Psychiatric Association.* Washington, DC: American Psychiatric Association, 1984.

11 Federal Task Force on Homelessness and Severe Mental Illness. *Outcasts on Main Street.* Washington, DC: Center for Mental Health Services, 1992, p. 37.

12 Federal Task Force on Homelessness and Severe Mental Illness. 1992, pp. 36-37.

13 B. Blackwell et al. Psychiatric and Mental Health Services. In P.W. Brickner (Ed.),*Under the Safety Net: The Health and Social Welfare of the Homeless in the United States.* New York: W.W. Norton, p. 190.

14 Memo from Alice Fletcher, Director of Programs. HCH of Milwaukee, 1997.

15 L. Williams. 1992, p. 25.

16 J.T. Ungerleider, et al. Mental Health and Homelessness: The Clinician's View. In M.J. Robertson and M. Greenblatt (Eds.), *Homelessness: A National Perspective*, New York: Plenum Press, 1992, p. 112.

"KATE"

Albuquerque, New Mexico

"Kate," a homeless woman from the south, has a multitude of health problems stemming from a chronic heart condition. A victim of child abuse, her life had been anything but easy. She arrived in Albuquerque with nothing more than her clothes, her car, and her two dogs, whom she called her most loyal companions, and a need for extensive dental care to relieve her constant oral pain.

At the dental clinic of Albuquerque Health Care for the Homeless, Kate began receiving the care she needed. Because of her heart problems, she had to take massive quantities of antibiotics before each appointment and therefore wanted as much work done as possible in a single sitting. Keeping her in the chair for three to four hours at a time, Kate endured root canals, extractions, fillings, and a partial denture replacing her front teeth.

After her appointments, the dental clinic staff gave her food that was soft and nutritious. In the meantime, Kate received a complete physical exam and an interview with a caseworker. She received a loan to acquire an ID and received crisis intervention to deal with an abusive relationship. She was also referred to a support group and to Al-Anon.

Her life still isn't easy, but there's hope. She's pain-free and says that she's been "given back her smile."[1]

A. James Liska for Comic Relief V
1992 Show Program