STREET OUTREACH TEAM: TWO YEARS IN REVIEW

Evaluation Report – November 2011 to October 2013

civitas
consulting

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Executive Summary

Background

Boyle Street Community Services' (BSCS) Street Outreach team has been operating since October 2011. The team of six Outreach Workers focus their efforts on the neighbourhoods of Boyle-McCauley, Central McDougall, Chinatown, Old Strathcona, Oliver and City Parkland areas. Outreach Workers engage with clients at locations in neighbourhoods such as bottle depots, libraries, drop-in centres, liquor stores, and parks.

Street Outreach's mandate is to connect with individuals living on the street and in the river valley to provide support and assistance in transitioning to a more stable lifestyle. This is done by building a trusting relationship with clients, helping to determine their needs and supporting them in addressing their issues.

Results

Street Outreach's clients are composed mostly of single males and like many social systems, such as foster care and justice, there exists an over-representation of Aboriginal people – 57.4%.

This program is crucial in supporting individuals experiencing homelessness to meet their immediate needs. Nearly half (47.8%) of contacts helped to meet nutritional/hydration needs of clients. About one in six contacts (17.9%) supported clients in their clothing needs and transportation needs were met by the Street Outreach team in 12.6% of contacts.

Street Outreach

By the Numbers …

November 2011 – October 2013

- Over 10,000 contacts made with 1692 unique clients.
- Clients are:
  - 76.2% Male & 23.6% Female
  - 38.7% aged 41-50 years
  - 29.6% aged 51 years and over
  - 57.4% Aboriginal
  - 72.1% Single
- Of the clients experiencing homelessness, 54.4% have been homeless for less than 1 year.
- 28.5% of contacts were made in Parkland areas.
- 84.8% of 132 clients were still successfully housed.
- 43 clients were housed through Housing First programs.

Efforts to transition and stabilize individuals revolve around three essential components: Housing, Health & Income. After 'Basic Needs', these three issues were the most common reasons for interactions between the team and its clients. This reflects the interconnectedness of these components for clients and for the systems overseeing these pieces. Quite often, subsidized housing requires proof of a stable source of income. Income supports (disability and AISH) in turn, require a medical examination and letters from a physician.

With the support of the Outreach Workers, clients show an improvement in the areas of housing, food security, income, identification and employment. However, the priority of issues requiring attention change. A second phase of issues arise including: money management, addictions and interpersonal relationships. This is indicative of the stabilization process that clients undergo with the Street Outreach team.

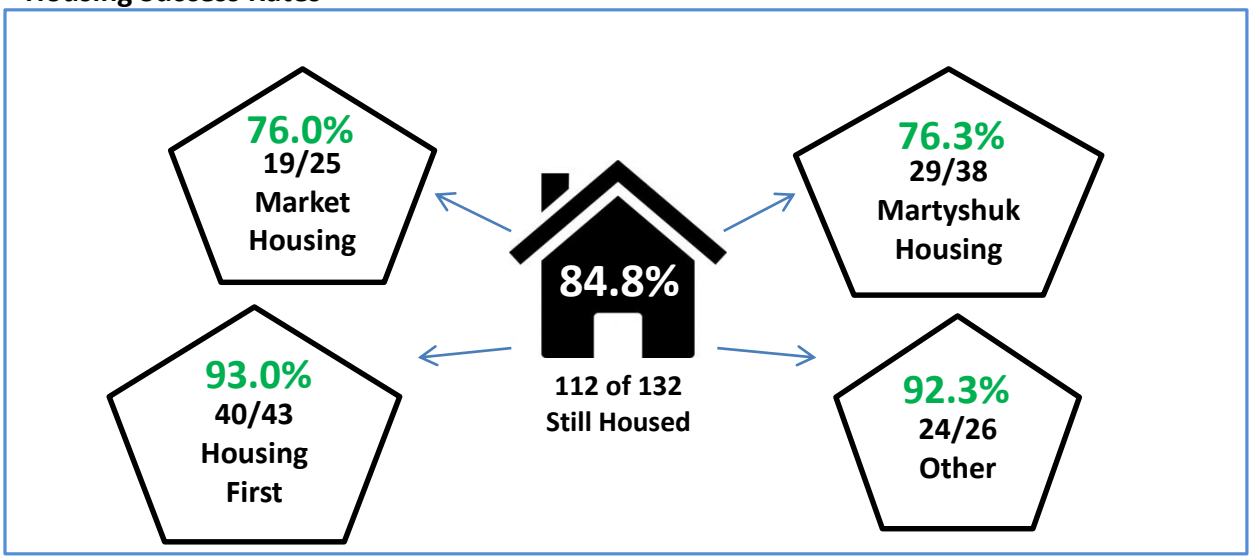
By the time that clients are dismissed from the program, generally all issues have been reduced, with the exception of parenting. Although reduced, the percentage of clients with addictions and mental health issues is still significant, 40.0% and 23.1%, respectively.

Data from dismissed clients indicate that there is a difference in the efforts required based on age and cultural background. Clients aged 51-60 years required 1.7 times more contacts compared to clients aged 41-50. Furthermore, Aboriginal clients required 1.4 times more contacts compared to Caucasian clients. If both variables are factored, being 51-60 years of age and of Aboriginal descent translates into 2.7 times more client contact than a Caucasian client of 41-50 years of age. This shows the complexity and increased support needed by aging clients and the impact of historical trauma on Aboriginal peoples.

Housing

Of the 1692 clients contacted by the Street Outreach Team, 132 were able to be housed – 7.8% of clients. Although this is a low percentage, it must be understood that housing the chronically homeless requires more time and engagement. In combination with the limited housing options available and the need to address other client issues, successfully housing individuals that may have been homeless for numerous years is incredibly difficult.

Housing Success Rates



Nearly one-third (32.6%) of the clients housed, were housed through Housing First programs. Overall, 112 clients found and sustained housing at the time of this report. Although these clients were very successful in maintaining their housing, the duration of sustained housing could not be quantified.

Stakeholder Feedback

In speaking with a range of stakeholders, it is clear that the Outreach Team has developed a strong network of connections in the community. In part, this is due to the continuity that the team has had in terms of staffing, but more so, it appears to be the result of the proactive work of the Team to nurture and develop these relationships.

Relationships are key to the interactions of the Street Outreach team with its clients and community partners. Both clients and partners appreciate the work done by this program and its staff.

"If a total stranger can care about you, why can't you care about yourself?" – Program Client

"*The Team is working with people who have given up on the system. They are re-establishing relationships with people who have become disconnected from society.*" *– Community Partner*

"If the Team hadn't gone out of their way to approach me, I would probably still be on the street or in jail now. I was stealing food from the grocery store just to survive." – Program Client

"It is obvious that the Team truly does care about their clients. It goes beyond just being a job for them and I think that the clients see that and it helps build trust. Quite simply, the patients wouldn't be where they are without the help of the Team." – Community Partner

Conclusion

Street Outreach has over the past two years been engaging others in collaborative and coordinated efforts. By doing so, the Street Outreach Team along with other service providers and government systems can collectively achieve greater impact in our communities. Together they will need to strategically address the current situation of chronic homelessness and plan for a future where the general population of homeless individuals are aging, more youth are on the streets, and the availability and use of alcohol and drugs (e.g. methamphetamine) could be on the rise.

The Street Outreach Team has built a reputation amongst its clients as being a trustworthy and supportive resource. Amongst service providers, the team has developed important connections and become an integral component of strategies, such as *Heavy Users of Service*, to serve the community better. Street Outreach continues to play an important role in the solution to homeless.

1. Background

Edmonton's homeless community is a broad spectrum of individuals with varying reasons for being homeless. This may include mental illness, drug or alcohol addictions, physical disability, unemployment and underemployment, or leaving a domestic violence situation among others. Homelessness itself can be defined as being without a fixed stable place of residence. Those who are homeless may be found staying with friends or family temporarily ("couch surfing"), utilizing emergency shelters, sleeping on the streets and in stairways or setting up encampments in park areas, such as Dawson or Mill Creek Park.

While the ultimate objective of any strategy with homeless individuals is to get them into stable permanent housing, the expectation that each individual can be housed immediately with the necessary supports leading to a successful outcome, may not be reasonable. Given the complexities of the issues that homeless individuals are dealing with, relationships often need to be developed and immediate needs addressed before housing becomes a realistic option.

Boyle Street Community Services (BSCS) has been contracted by the City of Edmonton to deliver the Relentless Outreach to the Homeless Program to help homeless individuals transition from life on the street to a more stable lifestyle. While BSCS has been doing outreach with the homeless in Old Strathcona and Parkland since 2003 and 2006 respectively, additional resources have been provided by the City of Edmonton to expand outreach services to the Central McDougall, Oliver, Boyle-McCauley and Chinatown neighbourhoods.

The BSCS Outreach Team is composed of six full-time employees that work to help homeless individuals through the utilization of five approaches:

1. Support – provide emotional support and counselling to individuals.
2. Information – provide information regarding resources and services available to individuals.
3. Supported Referrals – actively support individuals to access resources from community organizations and institutions.
4. Advocacy – educate public, systems and communities about homelessness.
5. Connecting with Stakeholders – engage potential partners such as businesses, community organizations and institutions to be a part of ending homelessness.

Each outreach worker is designated as the primary contact for an assigned neighbourhood and allocates the majority of their time in that neighbourhood. Each worker also rotates through other neighbourhoods to provide opportunities for homeless individuals to make new connections.

It is important to understand the meaning of "relentless" as it pertains to the work of the Outreach Team. The reality is that based on previous experiences, many of the individuals whom the team comes across may not initially be open to receiving support, regardless of how well-intentioned it may be. The role of the team is to continue making contact with these

individuals and attempt to find ways to engage, through something as simple as offering a granola bar, bottle of water or clean pair of socks. The hope is that over time, a degree of trust will be built that will allow the team to begin to address some of the deeper issues that the homeless individual may be experiencing. It is through this relentless approach that the vulnerability of the homeless population may be reduced and the ultimate goal of securing appropriate housing may eventually be achieved.

2. Methodology

Three main goals were identified initially for the Street Outreach Program.

1. To assist individuals in the target population make the transition from life on the street/river valley to a more stable lifestyle.
2. To increase understanding among community stakeholders about the target population and street-related challenges.
3. To identify and address service gaps and systemic barriers for people in the target population.

Data Collection

Quantitative Data

Quantitative data is collected by the Street Outreach staff. As an organization, BSCS is using Social Solution's Efforts to Outcomes (ETO) software to record information about: who is being served (key demographics), distinguishing characteristics, location of contact, client needs and referrals made by the team, and ongoing efforts and notes. Outreach staff collects this information informally during their contacts in the field and this data is later entered into the database at the office. As multiple Outreach staff may contact individuals experiencing homelessness, the team has regular conversations to eliminate duplicate entries of individuals in the database.

A list of housed clients has been kept and maintained by the Team Lead. The information included the location where the client was housed and if that client had either died or lost their housing. Unfortunately, this list did not include the duration which the client was housed.

Client Needs Assessment

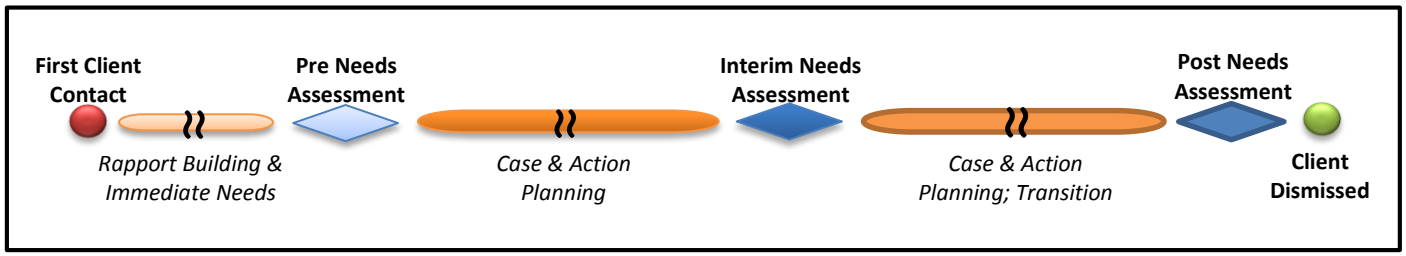
Ideally, the Street Outreach Team completes a Needs Assessment for individuals a minimum of three times over the course of the client's "enrollment" in the program. These assessments help the team members to prioritize and monitor issues for clients. Needs in the assessment include a number of issues (Table 1) and are rated as either *Priority*, *Major*, *Minor*, *Mostly Not* or *Not an Issue*. Each completed assessment results in a score based upon the number of needs and classification of priority. Scores can range from a minimum of zero to a maximum of 111.

Table 1. Identified Needs in the Street Outreach Needs Assessment

Basic Needs	Safe and Affordable Housing
	Secure Supply of Food
	Resources for Personal Care
	Access to Transportation
	Access to a Telephone
Life Skills Support	Employment
	Help with Advocating
	References
	Stable Source of Income
	Credit Rating
	Help Managing Money
	Obtain Education or Training
	Help to Access the Legal System Appropriately
	Identification
	Reintegrating After Being Institutionalized
Physical / Mental Health Support	Help to Diagnose or Deal with FASD
	Help with Recovery from Addiction
	Help to Diagnose or Deal with Mental Health Issues
	Help to Access the Health Care System Appropriately
	Help Coping with Physical Disability
	Help Coping with Brain Injury
	Help to Deal with Abuse Issues
	Help to Deal with Discrimination
	Help to Diagnose or Deal with a Developmental Disability
Family / Relationship Support	Help Dealing with Child Welfare
	Help with Interpersonal Relationship Issues
	Help with parenting Skills
	Cultural Resources
	Help as a Newcomer to Edmonton

The timing of the Needs Assessments is based on the level of relationship between the Outreach Team and client (Figure 1). After the initial contact with a client, Outreach Workers try to develop trust with the client by meeting immediate needs as required. The first Needs Assessment is completed once the Street Outreach Team has established a reasonably good relationship with the client. The Pre Needs Assessment establishes focused areas of support for the client. Subsequently, an Interim Needs Assessment can be completed after the client has had sufficient contact with the Outreach Workers that results in a change in client priorities. The timing of the Interim Needs Assessment varies based on number of contacts as well as effectiveness of each contact. It should be noted that a Street Outreach client can have more than one Interim Assessment completed if their engagement with the Outreach Workers is prolonged in duration or frequency. The Post Needs Assessment is the final assessment and is completed to ensure the client has had most of their issues addressed prior to "dismissal" from the program. Clients that are dismissed from the program have progressed through transitions and typically have been found housing. Being dismissed from the program does not exclude a client from future contact with Street Outreach.

Figure 1. Timing of Client Needs Assessments



Qualitative Data

Qualitative data was collected by BSCS Outreach staff as well as by Civitas Consulting. This qualitative data will help to document the successes of the Outreach Team as well as assist in identifying what further changes are needed in this program to address homelessness in Edmonton. Qualitative data was collected from the following sources:

1. Client Conversations – Civitas contacted past clients (chosen by the Team Lead) and engaged in a guided conversation regarding their experience with Street Outreach.
2. Street Outreach Team Focus Group – Civitas met with the Outreach Team on December 20, 2013 to gain their perspectives on the effective strategies, successes, challenges and processes. Six members of the Street Outreach Team were present.
3. Conversations with Community Stakeholders – Civitas had conversations with contacts from agencies used as referrals by individuals experiencing homelessness.

Questions used in the conversations and interviews are summarized in **Appendix I**.

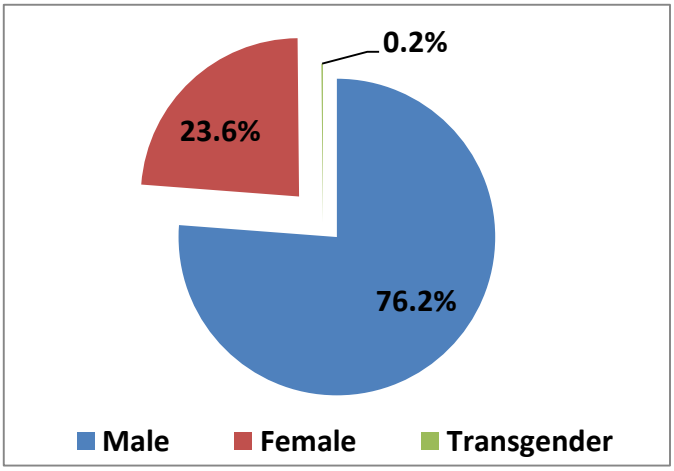
3. Results

Client Profile

Gender: Between November 2011 and October 2013, the Street Outreach Team connected with 1692 individuals experiencing homelessness. More than three quarters (76.2%) of the individuals were male (Table 2).

Table 2. Street Outreach Clients: Gender

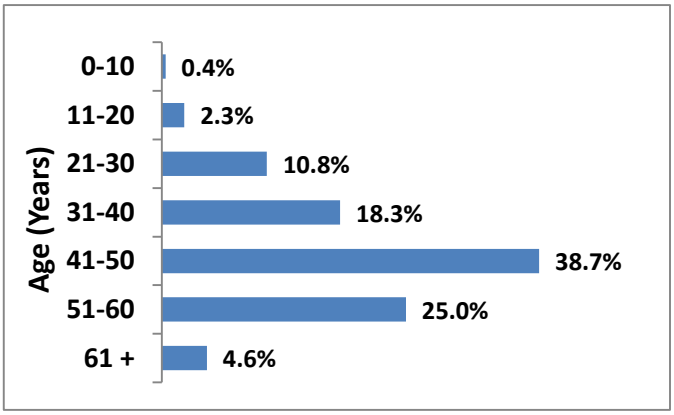
Gender	Number	Percent
Male	1012	76.2%
Female	314	23.6%
Transgender	2	0.2%
	1328	**100.0%**



Age: The age of Street Outreach clients is based solely on a date of birth being provided. This presents a bias in the data as it requires the team to build a trusting relationship with clients before gathering personal information. Only 520 of 1692 (30.7%) of clients have provided their date of birth. Furthermore, it was indicated by the Team Lead that the number younger clients are likely under-represented in the data as this group is less likely to provide their date of birth.

Table 3. Street Outreach Clients: Age

Age (Years)	Number	Percent
0-10	2	0.4%
11-20	12	2.3%
21-30	56	10.8%
31-40	95	18.3%
41-50	201	38.7%
51-60	130	25.0%
61 +	24	4.6%
Total	**520**	**100.0%**



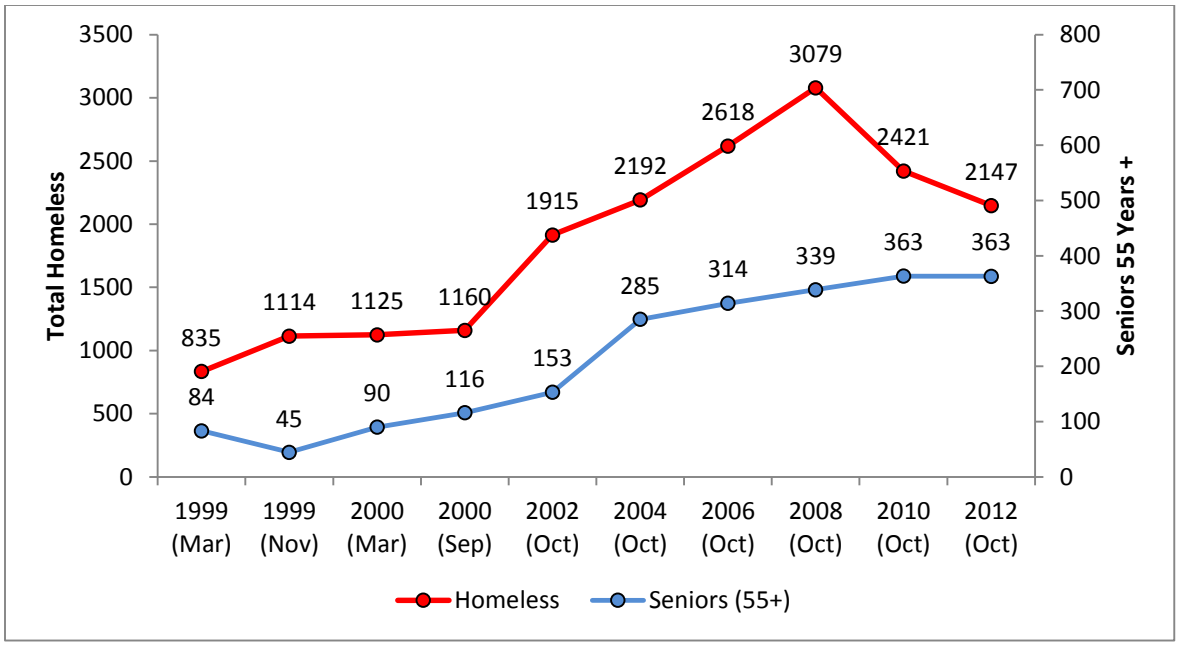
More than half (57.0%) of individuals are between 31 and 50 years of age and nearly one third (29.6%) are 51 years of age or older (Table 3). The team has noticed that there has been a shift to an older clientele over the last two years.

The growing population of seniors in the general public may be reflected in the homeless population as well. However, another explanation for the disproportionate number of older individuals may be that current strategies for reducing homelessness are effective for younger individuals (i.e. 21 to 40 years of age). This theory is further supported by data from previous Homeless Counts conducted by Homeward Trust.

The bi-annual Homeless Count conducted by Homeward Trust since 1999 showed a steady increase in the number of homeless individuals between 1999 through 2008, with the first sign of decrease occurring in 2010. From the most recent count in 2012, 2,174 individuals were identified as being homeless – an 11.3% decrease from 2010 and a 30.3% decrease from 2008.

However, of the 2,174 homeless individuals, 16.9% identified as being 55 years of age or older. This translates into 363 homeless seniors. As Figure 2 indicates, strategies to reduce homelessness in Edmonton appear to be working. However, this might not be true for homeless seniors, which has continued to show an increase in numbers since November 1999.

Figure 2. Number of Homeless Individuals and Homeless Seniors in Edmonton

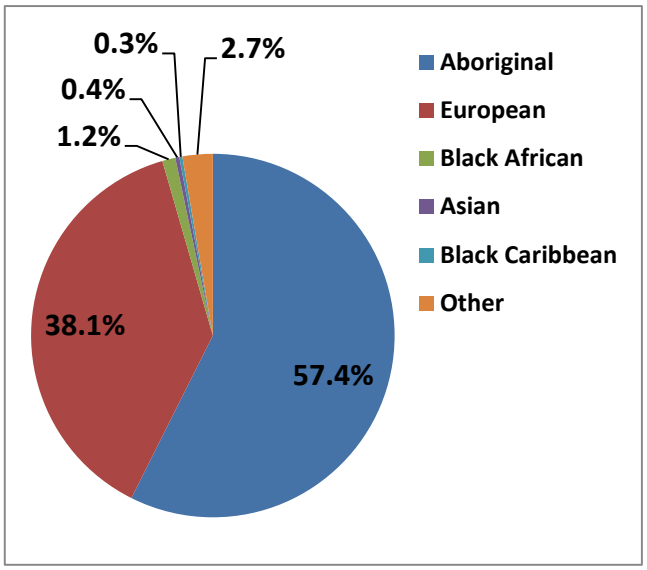


Source: Homeward Trust, Homeless Count. Data includes only data from Edmonton Homeless Counts.

Cultural Background: There was an over-representation of Aboriginals in the homeless population (Table 4). While individuals of aboriginal descent represent only 5.3% of the overall population of Edmonton[1], they comprised 57.4% of the Street Outreach's clients. The remaining clients were 38.1% European descent and a small portion (4.6%) was from other cultural backgrounds.

Table 4. Street Outreach Clients: Cultural Background

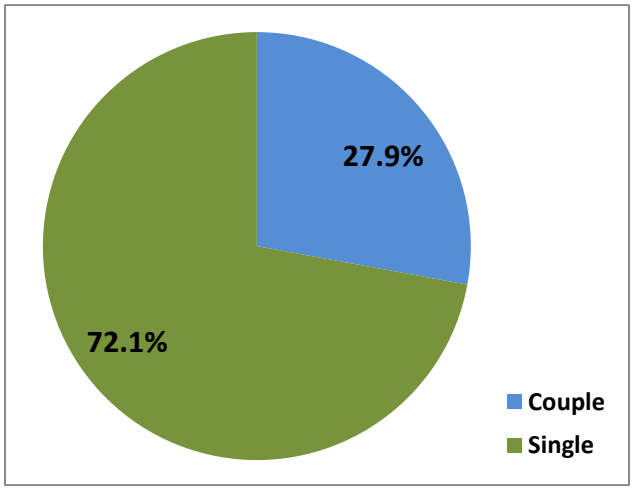
Cultural Background	Number	Percent
Aboriginal	640	57.4%
European	425	38.1%
Black African	13	1.2%
Asian	4	0.4%
Black Caribbean	3	0.3%
Other	30	2.7%
Total	**1115**	**100.0%**



Marital Status: Almost three quarters (72.1%) of clients are "single" (never married, separated, divorced or widowed). The remaining 27.9% of clients have either a partner or spouse (common law, domestic partnership or married).

Table 5. Street Outreach Clients: Marital Status

Marital Status	Number	Percent
Couple	75	27.9%
Single	194	72.1%
Total	**269**	**100.0%**

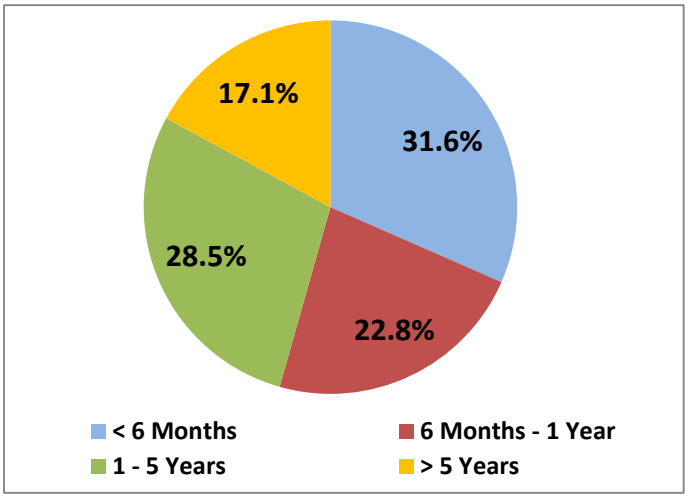


[1] Statistics Canada, 2011 National Household Survey, Statistics Canada Catalogue no. 99-011-X2011034.

Duration of Homelessness: More than half (54.4%) of individuals contacted had been without permanent housing for less than one year (Table 6). These individuals would not be eligible for the Housing First program as it requires individuals to have been homeless for at least one year or to be homeless three times in one year. It was suggested that this value is inflated as some clients might not consider themselves homeless if they were "couch surfing" or temporarily living with family and consequently consider themselves homeless for a shorter length of time than actual.

Table 6. Street Outreach Clients: Duration of Homelessness

Duration of Homeless	Number	Percent
< 6 Months	72	31.6%
6 - 12 Months	52	22.8%
1 - 5 Years	65	28.5%
> 5 Years	39	17.1%
Total	**228**	**100.0%**



Street Outreach Efforts

The Street Outreach Team made over 10,000 contacts with 1692 people experiencing homelessness over two years of operation. This translates into an average of 5.9 contacts per person and 13.7 contacts per day. The time invested in each contact can vary greatly – from minutes for a quick conversation to an entire day for a supported referral to the doctor's office, for example.

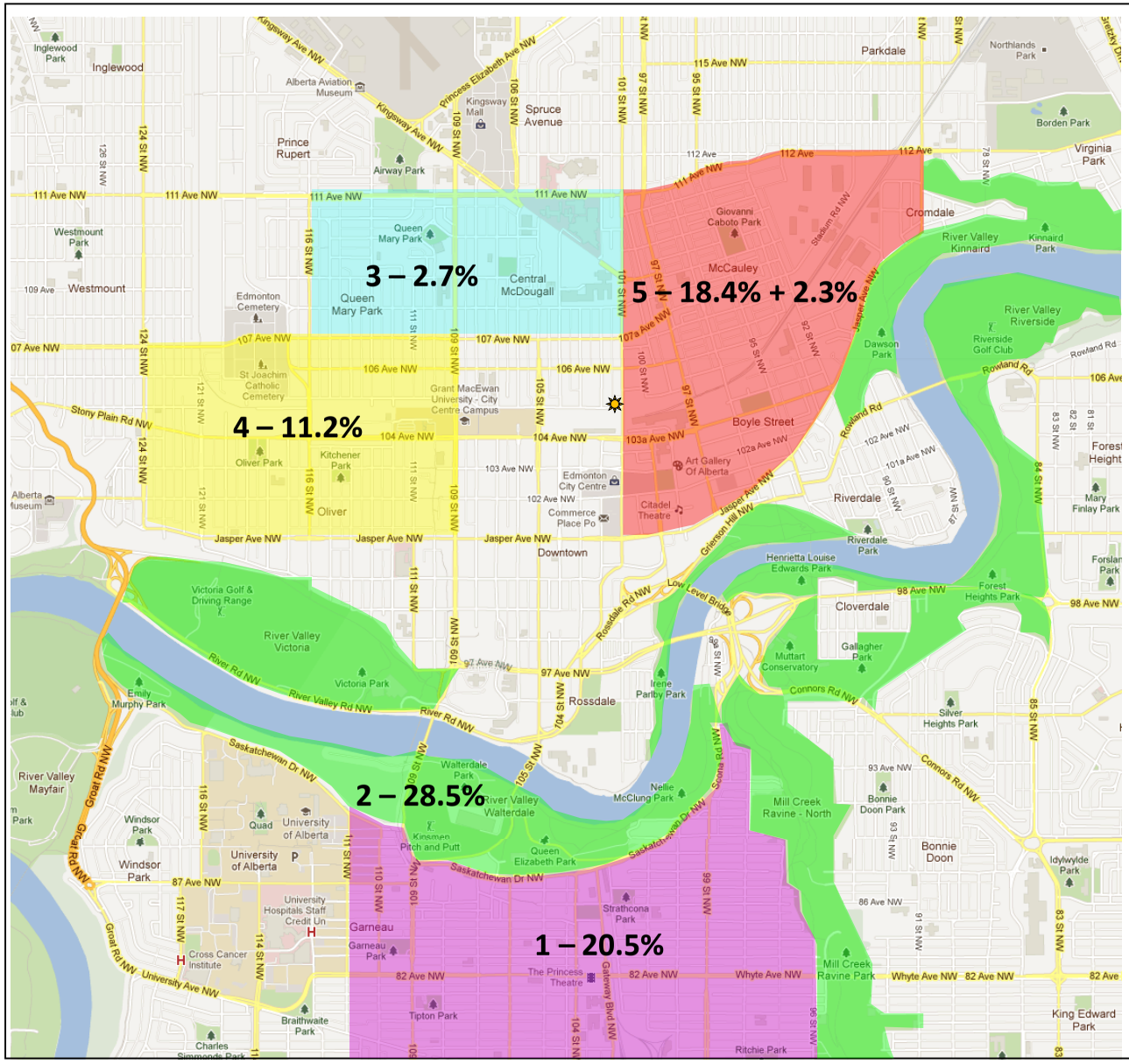
Table 7. Breakdown of Street Outreach Contacts

Point of Contact	Number	Percent
Parkland areas	2552	25.5%
Old Strathcona	1838	18.4%
Boyle McCauley	1650	16.5%
Oliver	1002	10.0%
Phone/E-mail*	747	7.5%
BSCS Offices*	301	3.0%
Central McDougall	243	2.4%
Chinatown	210	2.1%
Other**	1469	14.7%
Total	**10,012**	**100.0%**

*Contacts via Phone/Email and BSCS Office Visits were added to the database in February 2013.

**"Other" includes areas such as Callingwood, Clareview, Rundle, Argyll and hospitals/treatment centres.

Figure 2. Percentage of Contacts made by Street Outreach with Clients in Different Neighbourhoods.



1. Old Strathcona:
(Saskatchewan Drive to 76th Avenue and west edge of Mill Creek ravine to 114th Street)

2. Parkland:
(Edmonton's river valley and near-by city parks)

3. Central McDougall
(104th Avenue to 111th Avenue and 101st Street to 116th Street)

4. Oliver:
(Jasper Avenue to 107th Avenue and 109th Street to 124th Street)

5. Boyle-McCauley + Chinatown:
(Jasper Avenue to 111th Avenue and 82nd Street to 101st Street)

✸ Boyle Street Community Services Office

Over time, Street Outreach's efforts has built significant connections with their clientele and a credible reputation. So much so, that clients were reaching out to the team via telephone/email and at the offices of BSCS. Even though this was only tracked beginning in February 2013 forward (9 months of the 2 year span for this evaluation), it accounted for a tenth (10.5%) of contacts (Table 7). Phone and email contact was also used by the Street Outreach team as an additional method to check-in and follow-up with clients.

Table 8. Distribution of Street Outreach Contacts by Geographic Area

Point of Contact	July 2012	Oct 2013	Change
Parkland areas	20.0%	28.5%	↑
Old Strathcona	24.4%	20.5%	↓
Boyle McCauley	23.2%	18.4%	↓
Oliver	11.8%	11.2%	-
Central McDougall	2.7%	2.7%	-
Chinatown	2.3%	2.3%	-
Other	15.6%	16.4%	↑

Based on data for geographic distribution of contacts only, there have been some changes to the areas of contacts (Table 8) since the first evaluation in July 2012. Much of the Street Outreach team's work has been concentrated in the Parkland areas, with over one quarter (28.5%) of contacts made in this region (Figure 3). The percentage of contacts in the Parkland area has increased significantly since July 2012. Team members have indicated that there are more individuals camping in the parkland over the winter of 2013/2014 compared to previous years. Conversely, contacts in the Old Strathcona and Boyle-McCauley/Chinatown neighbourhoods has decreased by 3.9% and 4.8%, respectively.

These three locations together represent a "corridor" of movement for individuals experiencing homelessness. However, there still remains little movement of individuals between areas north and south of the North Saskatchewan River. Anecdotally, the areas south of the river tend to have more young people experiencing homelessness. This may be the result of having more youth focused agencies and resources, such as YESS (Youth Empowerment & Support Services) and Old Strathcona Youth Services, present in Old Strathcona. Whyte Avenue also attracts a "younger crowd" due to its culture, atmosphere and density of clubs and businesses.

Although Central McDougall and Oliver have fewer Street Outreach contacts, the Street Outreach team exhibits its ability to still engage in those areas. Another 16.4% of contacts were made in other neighbourhoods outside the regions defined in Figure 3. Edmonton's 2012 Homeless Count identified 46% of its 'unsheltered adults and independent youth' outside the Downtown region, which reflects the homeless population transitioning away from the inner city areas. The team members have indicated that they have had contacts with clients as far as Callingwood, Anthony Henday freeway, Clareview, Rundle and Argyll. This trend might be attributable to the growing number of developments of the downtown core and surrounding

areas. As these individuals look for ways to “stay off the grid”, they are likely to become more vulnerable, having fewer resources and social connections.

Not surprising, food and clothing were the most common immediate needs addressed (Table 9). In almost half (47.8%) of contacts, food and/or water were provided to clients. This was especially important during the heat waves of the summer months. Providing bottled water to clients isolated in the Parkland areas likely prevented dehydration and potentially serious medical emergencies. Conversely, in the winter months, providing clothing (socks, underwear, gloves, toques and blankets) was a critical support that prevents frostbite.

In only a very small fraction (2.7%) of contacts was shelter an immediate need that was addressed. Furthermore, of this fraction, very few clients’ shelter needs were resolved through permanent housing. Most clients who addressed this immediate need only found a short-term resolution (i.e. shelter at emergency accommodations, family member or intox centre).

Table 9. Immediate Needs Addressed by the Street Outreach Team

Immediate Needs Addressed	Number	Percentage of Total Contacts
Nutrition/Fluids	4787	47.8%
Clothing	1795	17.9%
Transportation	1258	12.6%
First Aid/Physician	434	4.3%
Shelter	272	2.7%
Fleeing Abuse	31	0.3%
Police/Emergency	30	0.3%
Other*	185	1.8%
Total	**8792**	

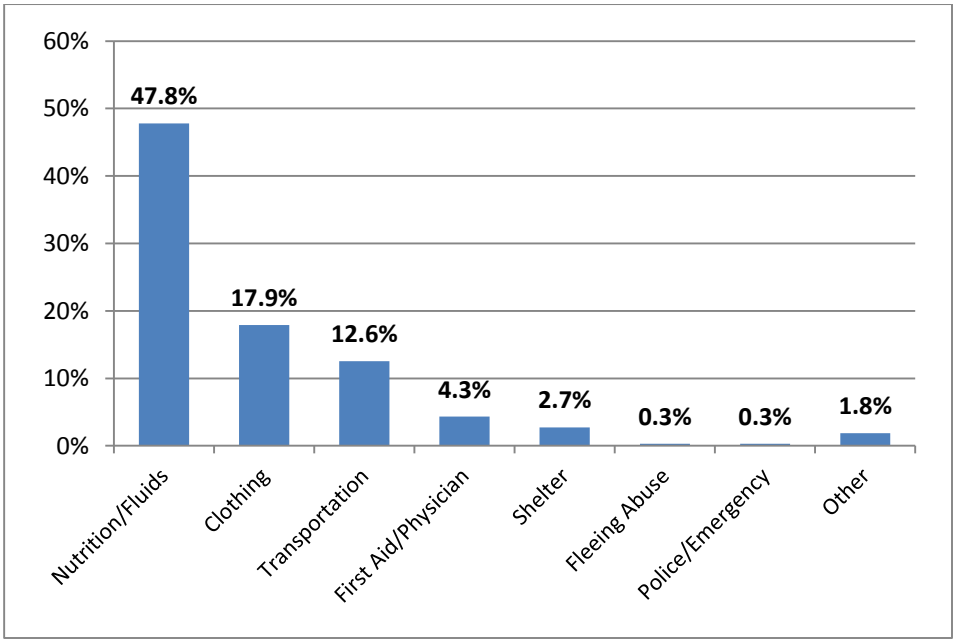


Table 10. Purpose of Contact with Street Outreach Clients

Purpose of Interaction	Percentage of Total Contacts	Frequency
Rapport Building	100.0%	10,012
Basic Needs	57.0%	5710
Housing	41.4%	4145
Health	29.8%	2985
Financial	18.9%	1891
Emotional Support	15.6%	1559
Addiction	15.2%	1523
Advocacy	10.6%	1064
Interpersonal/Family Relationships	10.0%	1003
ID Assistance	8.5%	853
Follow-up Appointment	8.1%	809
Supported Referrals	7.2%	718
Form/Application Support	6.8%	682
Meetings	6.0%	598
Employment	5.6%	559
Information	4.3%	433
Legal	3.9%	388
Bus Tickets	3.5%	349
Crisis Intervention	1.5%	152
Letters	1.4%	136
Counselling	1.2%	120
Commissioner of Oaths	0.1%	15
Other	2.1%	213

When the Street Outreach team contacts a client, the purpose of the contact is recorded by the Outreach worker. There can be multiple purposes to a contact and as a result, the total count of contact purposes has exceeded 36,400 (Table 10). Every contact made by the Outreach workers is intended to further the rapport and trust of the client. This forms the foundation from which all other work is built upon.

The Street Outreach team is required to support clients in many different ways, as evidenced by the varying purposes of contacts – from advocating to employment support to acquiring identification. The majority of efforts are focused on basic needs – ensuring the immediate safety and well-being of clients. This is also a significant method of building the client's trust.

Following that is a triad of support that is required to transition a client into more stable housing options. In many cases, housing requires a stable source of income. Applying for income supports (AISH or disability), in turn requires a medical examination and an address. This cyclical requirement of different systems creates significant barriers for homeless individuals. Often, the Outreach workers are required to coordinate all these requirements at the same time and success is most often facilitated by working with the right person in any particular system.

While the Housing First model of residential support can work, the eligibility criteria and appropriateness excludes many individuals experiencing homelessness. Individuals must have been experiencing homelessness for over one year or have had four episodes of homelessness within three years, to be considered for formal Housing First Programs. Housing First models are typically unable to meet the demands of clients requiring intensive support. Street Outreach clients often have chronic mental and physical health issues, as well as addictions issues that necessitate permanent supportive assistance – something the Housing First model programs aren't able to provide.

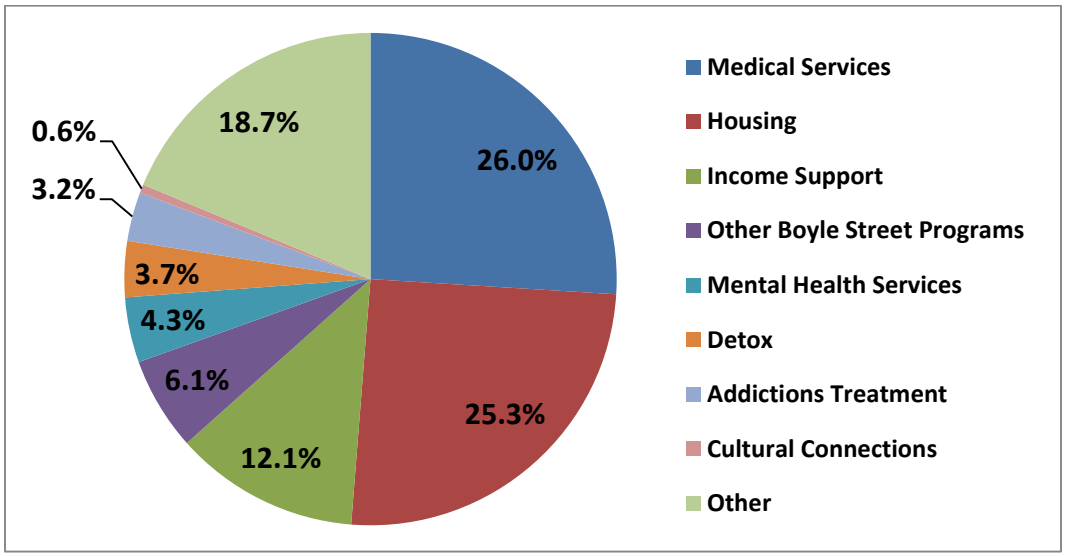
One of the guiding principles of the Outreach team is to provide supported referrals. Making a supported referral entails helping to make an appointment, providing transportation, going with the client to the appointment, assisting in filling forms/applications, advocating on their behalf and providing moral support. Nearly two thirds (63.4%) of all supported referrals relate to medical services, housing and income supports (Table 11). While many clients may need to address addictions issues, only 6.9% of supported referrals are related to detox or addictions treatment. In this instance, access to services is a major barrier. The timing and availability of resources for treatment and detox are typically not available when the "window of opportunity" presents itself with a client. Furthermore, unless there is support and stability after detox, clients returning to their previous lifestyle are highly likely to relapse. The relapse can have greater negative effects on the client.

Table 11. Supported Referrals Given to Street Outreach Clients

Supported Service Referrals	Number	Percent
Medical Services	509	26.0%
Housing	495	25.3%
Housing First	*150*	*7.7%*
*Pathways to Housing**	*74*	*3.8%*
Other Housing	*271*	*13.8%*
Income Support	238	12.1%
Other Boyle Street Programs	120	6.1%
Mental Health Services	84	4.3%
Detox	72	3.7%
Addictions Treatment	63	3.2%
Cultural Connections	11	0.6%
Other**	367	18.7%
Total	**1959**	**100.0%**

*Started tracking in May 2012

***Other* includes: Other Community-based Service Providers, Drop-in Centres, Libraries and Meals/Food, Registries (ID Acquisition)



Client Outcomes

Street Outreach was able to complete Needs Pre-assessments for 158 of their clients. These assessments are completed when Outreach Workers have established a good relationship with the client, which then allows them to identify and prioritize client issues. In many cases, team members may only have limited contacted with clients as they try to establish a good rapport. Clients may also not want to engage the team specifically to address any issues. As a result, the 158 Pre-Assessments only represent those available, ready and willing to make changes in their lives.

In the assessment, a client may identify a number of needs amongst the list of 29. Assessment were completed again months later with 145 clients to determine changes in their needs. Final assessments were completed with 28 clients when they were "dismissed" from the program. Clients that are dismissed from the program have progressed through transitions and typically have been found housing.

Aggregating scores from the pre, mid and post-assessments, the maximum, mean and median average scores (Table 12) show that over time, clients' needs and issues are generally being reduced.

Table 12. Maximum, Mean and Median Scores of Pre, Mid and Post-Assessments

	Pre (N=158)	Mid (N=145)	Post (N=28)
Maximum	75.00	57.00	29.00
Mean	28.76	24.91	7.79
Median	26.00	24.00	6.00

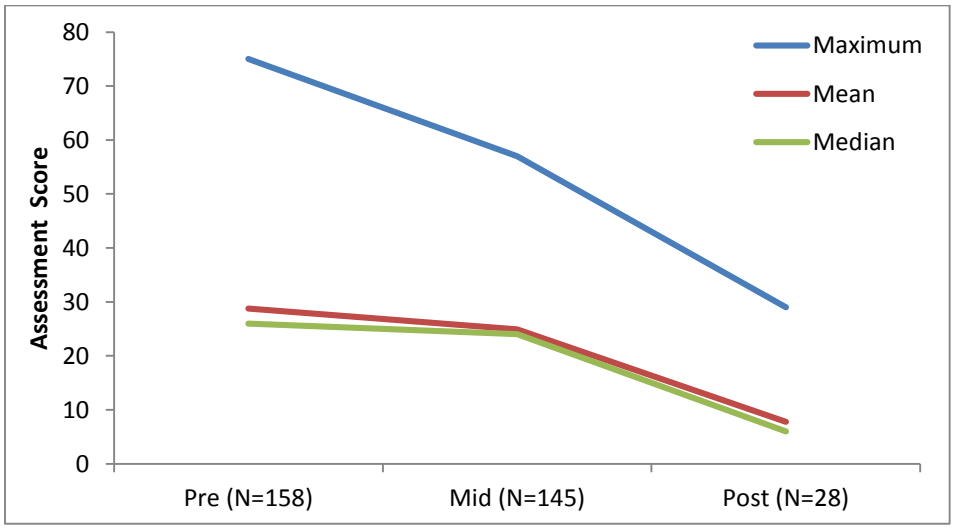


Table 13. Percentage of Assessments (Pre, Mid and Post) Identifying Issues as Either a Priority or Major Concern; Changes from Pre to Mid and Mid to Post-Assessments

	Pre (N=158)	Pre to Mid Change	Mid (N=145)	Mid to Post Change	Post (N=28)	Overall Change
Basic Needs						
Affordable Housing	92.5%	↓	62.6%	↓	14.3%	↓
Food Security	38.9%	↓	9.8%	↓	5.6%	↓
Personal Care	26.0%	↓	15.1%	↓	0.0%	↓
Transportation	23.0%	↓	9.3%	↓	0.0%	↓
Telephone Access	25.8%	↓	7.0%	↓	0.0%	↓
Life Skills Support						
Employment	32.7%	↓	17.6%	↓	0.0%	↓
Advocacy	69.0%	↓	60.9%	↓	8.3%	↓
References	22.4%	↑	30.9%	↓	10.0%	↑↓
Stable Income Source	56.4%	↓	28.9%	↓	8.3%	↓
Credit Rating	4.2%	↓	1.6%	↓	0.0%	↓
Money Management	25.5%	↑	34.5%	↓	18.2%	↑↓
Education/Training	25.6%	↓	22.4%	↓	0.0%	↓
Access to Legal System	25.3%	↑	28.2%	↓	0.0%	↑↓
Identification	48.6%	↓	21.6%	↓	11.1%	↓
Reintegration after Institutionalization	9.3%	↑	12.7%	↓	0.0%	↑↓
Physical / Mental Health						
FASD	3.8%	↑	8.5%	↓	0.0%	↑↓
Addictions	55.4%	↑	63.5%	↓	40.0%	↑↓
Mental Health Issues	38.2%	↑	39.0%	↓	23.1%	↑↓
Access to Health Care	33.9%	↓	25.9%	↓	15.4%	↓
Coping with Physical Disability	27.6%	↑	27.7%	↓	9.1%	↑↓
Coping with Brain Injury	7.8%	↑	10.2%	↓	0.0%	↑↓
Abuse Issues	14.0%	↑	14.7%	↓	9.1%	↑↓
Discrimination	4.7%	↓	3.7%	↓	0.0%	↓
Developmental Disability	2.6%	↑	6.5%	↓	0.0%	↑↓
Family/ Relationship Support						
Child Welfare	19.6%	↓	12.2%	↓	0.0%	↓
Interpersonal Relationship Issues	30.8%	↑	41.2%	↓	20.0%	↑↓
Parenting Skills	13.0%	↓	7.7%	↑	25.0%	↓↑
Cultural Resources	11.8%	↓	10.8%	↓	0.0%	↓
Newcomer to Edmonton	6.8%	↑	7.3%	↓	0.0%	↑↓

In the analysis of the assessments, issues that clients have identified as a "priority" or "major" issue were combined to be an indicator of need (Table 13). For example, 92.5% of the 158 client pre-assessments indicated that affordable housing is a priority or major issue to be addressed.

Comparison of pre and mid-assessments reflect a change in the needs and issues facing Street Outreach clients. The efforts of the Outreach Workers reduced the following barriers the most:

- ✓ Affordable housing (-29.9%)
- ✓ Food security (-29.1%)
- ✓ Stable source of income (-27.5%)
- ✓ Identification (-27.0%)
- ✓ Access to telephone (-18.7%)
- ✓ Employment (-15.1%)

Many other barriers were also reduced. However, other issues increased in priority. Generally, these included needs related to life skills support and physical/mental health. Most significant were:

- × References (+8.4%)
- × Money management (+9.1%)
- × Addictions (+8.1%)
- × Interpersonal relationships (+10.4%)

Although the sample size (N=28) for the post-assessments is small, aggregate comparisons of post-assessments can still be made with mid-assessments. Twenty-eight of the 29 issues in the assessment were reduced by the time these clients were dismissed. Only one issue showed an increase in need – parenting skills (+17.3%). It may be that as clients stabilized their lives, connections with their children (if applicable) were rebuilt and that this creates new challenges related to parenting.

Furthermore, post-assessments indicate the most pressing issue to be support for addictions. Forty percent of clients were still in need of addictions support. This reinforces the need for long-term support for some clients.

Analysis of 19 dismissed clients' files show some interesting details. This sample is comprised of 4 individuals of Aboriginal descent, 14 Caucasians, and 1 individual that did not specify cultural background. Additionally, 11 clients were aged 41-50, 7 were aged 51-60 and 1 was aged 31-40. Of the 19 clients, 11 were housed in Housing First options, 3 in market housing, 2 in Martyshuk Housing, 2 in other options, and 1 did not have housing.

The duration of client contact (first contact to program dismissal) for these clients ranged from 42 to 654 days, with an average of 308 days (10.1 months). The number of contacts with the Street Outreach Team ranged from 9 to 98, with an average of 37.3 contacts per client. It is important to note that each client contact can vary in length of time. Duration of client contact was not tracked. A 5 minute phone conversation and a 4 hour supported referral to Alberta Works are both considered a single contact.

Table 14. Average Number of Client Contacts by Age and Cultural Background

	Age: 41-50	Age: 51-60	All Ages
Caucasian	26.6 (N=7)	47.0 (N=6)	35.7 (N=14)
Aboriginal	41.7 (N=3)	73.0 (N=1)	49.5 (N=4)
All Cultural Backgrounds	29.3 (N=11)	50.7 (N=7)	37.3 (N=19)

The number of contacts was determined to vary based on both age and cultural background (Table 14). Those aged 41-50 had an average of 29.3 contacts compared to 50.7 contacts for those aged 51-60, a 1.7-fold difference. Clients who were Aboriginal had an average of 49.5 contacts compared to 35.7 contacts of Caucasian clients. This is a 1.4-fold difference. If both variables are factored, being older and of Aboriginal descent translates into 2.7 times more client contact (Table 14). This reflects the increased complexity and intensity of issues related to age and challenges/barriers facing Aboriginal clients.

Housing

Of the 1692 clients contacted by the Street Outreach Team, 132 were able to be housed – 7.8% of clients. Street Outreach contributed to these housing outcomes through supported referrals or direct assistance. Table 14 illustrates where clients were housed and if they were, to the knowledge of the team, able to maintain their housing.

Nearly one-third (32.6%) of clients housed, were housed through Housing First programs. Another 28.8% of those housed found housing in units owned by Martyshuk Housing. Market housing options were utilized by 25 (18.9%) clients and another 26 (19.7%) through other means (other community-based organizations and alternatives).

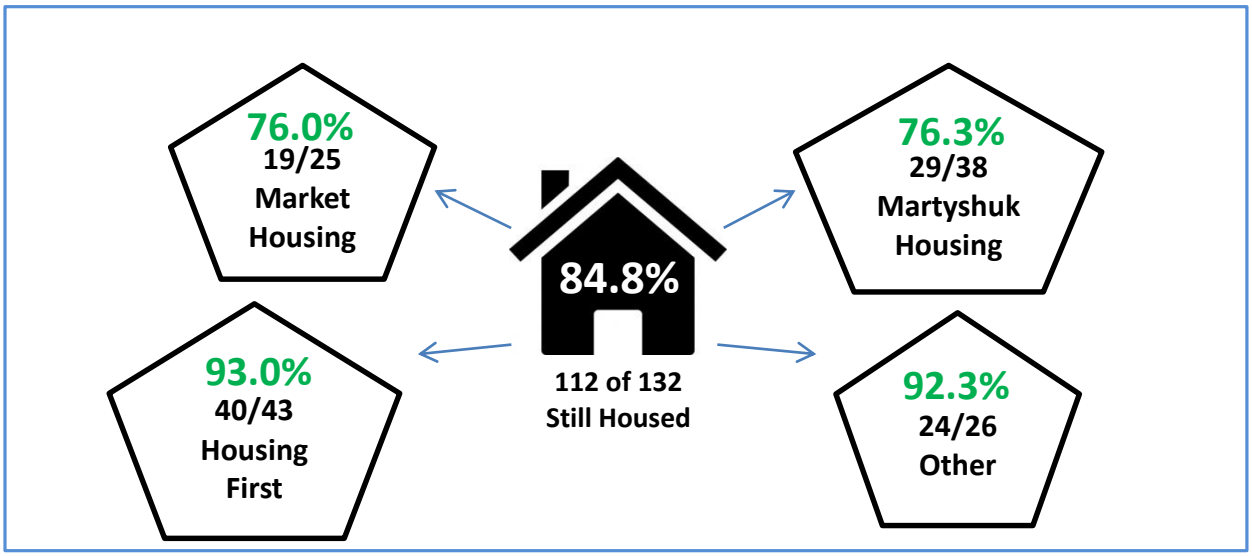
Overall, 112 clients found and sustained housing at the time of this report. This translates to an 84.8% success rate[2] (Figure 4). Of the four housing categories, Housing First options showed the greatest success with 93.0%. Other alternative housing strategies also showed similar success to Housing First programs and models at 92.3%. The success of alternatives is mainly due to understanding the client's situation and allowing clients to be empowered in choosing their housing option. Market and Martyshuk housing were slightly less effective at 76.0% and 76.3%, respectively. Martyshuk housing is typically used as transitional housing and provides shared accommodations for its residents. Tenants of Martyshuk housing also have greater needs and complexity, contributing to the lower success rate. It should be noted that these options were utilized more at the outset of the program and were perhaps not well matched for the clients. This was part of the learning curve for the Outreach Workers.

[2] Clients that had died while housed were considered successful in maintaining housing and were included the success rate calculations.

Table 15. Housing Options Utilized by Street Outreach Clients

Housing Options	Number	Percentage	Deceased	No Longer Housed
Market	25	18.9%	0	6
Martyshuk Housing	38	28.8%	2	9
Dwayne's Place	*14*	*10.6%*	*0*	*7*
Lofts	*8*	*6.1%*	*0*	*0*
Rocky	*1*	*0.8%*	*0*	*0*
Unspecified	*15*	*11.4%*	*2*	*2*
Housing First	43	32.6%	0	3
Bissell Centre	*6*	*4.5%*	*0*	*2*
Boyle Street Community Services	*13*	*9.8%*	*0*	*1*
Homeward Trust Coordinated Intake	*4*	*3.0%*	*0*	*0*
Japer Place Health & Wellness	*3*	*2.3%*	*0*	*0*
Pathways to Housing	*3*	*2.3%*	*0*	*0*
Rapid Exit	*2*	*1.5%*	*0*	*0*
SOS	*1*	*0.8%*	*0*	*0*
YMCA	*11*	*8.3%*	*0*	*0*
Other	26	19.7%	2	2
Breakout	*2*	*1.5%*	*0*	*0*
Family Members	*6*	*4.5%*	*1*	*0*
High Risk Youth	*2*	*1.5%*	*0*	*0*
Norwood Seniors	*1*	*0.8%*	*0*	*0*
Operation Friendship	*4*	*3.0%*	*0*	*0*
Rooming House	*1*	*0.8%*	*0*	*1*
Safe Housed	*1*	*0.8%*	*0*	*0*
Salvation Army	*1*	*0.8%*	*0*	*0*
Urban Manor	*7*	*5.3%*	*1*	*1*
Work Camp	*1*	*0.8%*	*0*	*0*
Total	**132**	**100.0%**	**4**	**20**

Figure 4. Breakdown of Housing Success of Street Outreach Clients



RONALD'S JOURNEY

"Ronald" had been living in Ontario with his wife of 15 years. His marriage ended suddenly and tragically one day when his wife committed suicide.

It was four years ago that Ronald moved out west to Alberta. He was searching for a new beginning – a way to start over, but it didn't happen as he had planned. As soon as he came to Alberta, he found himself homeless. Ronald ended up camping out in the woods of Dawson Park.

The Street Outreach Team had first met Ronald at his camp three years ago. His first reaction was, "Holy s**t. They do this?" It took some time for the team to gain his trust. After learning about the team's confidentiality policy and hearing about the team's good work from others, Ronald was willing to let them help.

The team assisted in getting Ronald to a medical doctor to treat his persistent infection. As things progressed, Ronald was contemplating getting a home again. With Ronald's medical condition, the Outreach Team was able to find him housing within a month – not a usual occurrence. Ronald has been living in Inner City Housing since August 2013 and is now learning to play the guitar and to use computers.

The biggest change for Ronald is his "more positive attitude." He's gone from "just existing to living again."

"If a total stranger can care about you, why can't you care about yourself?"

Stakeholder Feedback

Community Partners

A critical success factor for the Outreach Team is the ability to establish strong working relationships with various stakeholders across the community. These stakeholders include agencies who work with the same population, local businesses, Edmonton Police Services and various community groups. It is important for these stakeholders to have a solid understanding of the work be undertaken by the Team so that appropriate referrals and connections can be made.

In speaking with a range of stakeholders, it is clear that the Outreach Team has developed a strong network of connections in the community. In part, this is due to the continuity that the team has had in terms of staffing, but more so, it appears to be the result of the proactive work of the Team to nurture and develop these relationships. The Outreach Team routinely meets with stakeholders in the community to share information and trends about what they and their partners are experiencing in the community. This occurs in different venues and forums, including the Street Outreach Network and Heavy Users of Service (HUoS) committees.

Community stakeholders appear to have a solid understanding of the Outreach Team and its role in the community. As described by one community member, "*The Team is working with people who have given up on the system. They are re-establishing relationships with people who have become disconnected from society.*"

An important benefit of the partnerships that the Team has developed is the avoidance of duplicate work in the community. As described by an Outreach Worker from the Stanley Milner Library, *"Clients will often mention that they are connected to the Outreach Team. When that happens, we are able to connect and coordinate our efforts."*

Feedback that was received from the community also spoke to the ability of the Team to find resources that fit the needs of the clients. One stakeholder describe it as follows, "*A great deal has been accomplished because of the relationships that they have been able to build. Given their knowledge of the clients and the community, they can respond in creative ways."*

When asked how the work of the Outreach Team could be improved upon, the consistently heard response was that there is likely a need to increase the number of staff on this Team. While community partners greatly value the work of the Team, there appears to be a recognition that given the scope of homelessness and the intensive nature of the work of the Team, they may not have the resources to fully meet the needs in the community. As described by one organization who was interviewed, "*The challenge that exists for the Team is in finding the time they need to understand the unique needs of each client and then finding the resources in the community to meet those needs.*"

Addressing Medical Issues

One of the important activities undertaken by the Outreach Team is connecting individuals with medical assistance. Aside from being important from a health perspective, connecting with medical professionals and identifying medical issues is often an important first step in accessing financial assistance and government benefits.

Recognizing the importance of addressing medical needs, the Outreach Team has developed strong working relationships with physicians and local medical clinics. One local physician described his experience working with the Team as follows:

> *"I see the Team as an important bridge. They help a great deal with follow up. A challenge that I have faced in the past is that my clinic often can't reach many of these clients after they first come in. Our standard practice is to phone or send a letter and that isn't practical in this case. Now, I can work with the Team as they know where to find people and they can bring them in for appointments.*
>
> *It is obvious that the Team truly does care about their clients. It goes beyond just being a job for them and I think that the clients see that and it helps build trust. Quite simply, the patients wouldn't be where they are without the help of the Team."*

Street Outreach Team Perspectives

The Street Outreach Team is comprised of six Outreach Workers, of which one is also the Team Lead. Since the inception of the Street Outreach program, these six Outreach Workers have remained a part of the team, with exception to leaves of absence due to injury. This consistency in staffing translates into consistent contact with clients and community partners. Consistent staffing also lends itself to team cohesion. As one Outreach Worker put it, "*we are also friends outside of work*."

Team members are motivated by the meaningful work they do. They face new challenges and people, build relationships, and feel they make a difference in people's lives. This in conjunction with the culture fostered by the leadership of the Team Lead and Program Manager helps to maintain zero turnover.

The team operates on two basic principles. The first principle is "relationship". In their interactions with clients, community partners and each other, developing a good, credible relationship is critical. For Outreach Workers, this translates into following through with actions, contributing creative solutions to problems, and checking one's ego to support mutual responsibility to clients. The second principle is "communication". Each morning, before heading out, the team meets collectively to share their day's plan and client contact notes, and ensure their supplies are refreshed. They also communicate with other services to determine most effective and efficient use of resources to support their clients.

The Street Outreach Team recognizes that they have limited resources and capacity to assist their clients. To that end, they "bring other resources to be more successful." Street Outreach connects with other groups and programs, but the key is to find "the right person in that system that is helpful and understands."

MIKE'S STORY

Mike, a 51-year-old male, had been living outside for around four years when he first came into contact with the Team. In the winter he would go to McDonald's to warm up. While there one day, a member of the Team introduced himself to Mike and bought him breakfast. They talked about Mike's situation and explained how they might be able to support him. After a few connections, Mike was ready to work with the Team, "I asked around and everyone on the South Side knows those guys, they're pretty street smart."

The Team was able to take Mike to see a doctor to address some serious issues with his back. They also helped him secure identification and, most importantly, a place to live. Currently, he is living on Calgary Trail renting a room from a friend. He has been housed for over a year and the Team still checks in on him from time to time to see how he is doing.

When asked about the changes that the Team has helped in with in his life, he offered the following thoughts:

> *"The first couple nights I had my place, I started walking back to my campsite before remembering that I had a place, it was kind of overwhelming. I would like to get back to work but I am still trying to get my back sorted out. I'm now going to the Glen Sather Sports Medicine Clinic which I never could have done before.*
>
> *If the Team hadn't gone out of their way to approach me, I would probably still be on the street or in jail now. I was stealing food from the grocery store just to survive. I'm a proud Irishman and am not someone who would ask for help. Those guys [Outreach Team] are pretty cool, people on the street trust them. They have helped so many people, I just wish there were more people like them out there."*

4. Conclusion

Over the course of two years, the Street Outreach Team has served Edmonton's community of homeless individuals with incredible passion and commitment. The work that the Outreach Workers do is highly complex and requires great investment of time and energy. The people who are being helped by Street Outreach are people who have been marginalized so much and so often that trust has become a major barrier. Showing them the relentless nature of the Street Outreach Team is key to gaining that trust.

Nearly 160 clients have been supported by these Outreach Workers to address their personal needs and find safer housing options. Considering that nearly half of the population being served by this program have been experiencing homelessness for more than one year, being able to get clients stabilized and to maintain their housing is quite an accomplishment.

Although the Street Outreach Team has been able to make an impact in many people's lives, there remains many who could use the same intense support provided by this team. Furthermore, other clients and the Street Outreach could make further gains if they could overcome a number of barriers.

- Shortage of Housing – There are fewer affordable housing units available, including market housing units. More transitional housing facilities and facilities with "harm reduction" policies would help provide safer environments for homeless individuals.
- Detox & Treatment – The limited capacity and availability to detox and treatment centres is a significant barrier. For individuals who are ready to get treatment, the window of opportunity is small. Accessibility and demand are therefore incongruent.
- Income & Income Supports – The process for applying and receiving benefits and income supports is often not well understood and the requirements are difficult for homeless individuals to meet. However, having a stable source of income is necessary to finding and maintaining housing.

Street Outreach has over the past two years been engaging others in collaborative and coordinated efforts. By doing so, the Street Outreach Team along with other service providers and government systems can collectively achieve greater impact in our communities. Together they will need to strategically address the current situation of chronic homelessness and plan for a future where the general population of homeless individuals are aging, more youth are on the streets, and the availability and use of alcohol and drugs (e.g. methamphetamine) could be on the rise.

The Street Outreach Team has built a reputation amongst its clients as being a trustworthy and supportive resource. Amongst service providers, the team has developed important connections and become an integral component of strategies, such as HUoS, to serve the community better. Street Outreach continues to play an important role in the solution to homeless.

5. Appendix

Appendix I - Street Outreach Evaluation - Conversations/Focus Groups Questions

1) Questions for Assisted Clients

1. Tell me about your connection to the Team?
2. How did you first come in contact with the Team?
3. What allowed you to connect with the Team/build trust?
4. How long without a stable home?
5. Where living now?
6. How has your life changed as a result of your contact with the Team?
7. Where would you be now if it weren't for the Team?
8. Is there anything you would change about the Team?

2) Focus Groups with Outreach Workers

1. What makes the Street Outreach Team wor?
2. How would you describe your interactions with the homeless?
3. Describe a situation where you were able to help an individual?
4. What's working well? What's not?
5. What do you feel is the key contributor to effectively assisting people experiencing homelessness?
6. What would help you do your work better?
7. What trends are you noticing in the homeless population?

3) Conversations with Community Stakeholders

1. Tell me about your connection to the Street Outreach Team.
2. What is working well with the Street Outreach Team?
3. What could be improved/services enhanced with the Street Outreach Team?
4. What suggestions do you have for improving services to homeless individuals in our community?
5. Any additional feedback regarding the Street Outreach Team that you would like to share?