Lowcountry
Continuum of Care

STREET OUTREACH

Contents

"Street outreach is planned, strategic, and organized. It is not an activity of driving or walking around aimlessly happening upon homeless persons by chance. In a coordinated entry system, street outreach should know exactly which people they aim to connect with daily, for what purpose, and with a strong housing orientation. Three quarters or more of every shift should be spent with existing contacts and moving the housing process forward. Only about a quarter should be spent with new contacts. Everyone on the priority list is known by name, acuity level, and location of where most commonly located."

What Makes Good Street Outreach in the Era of Coordinated Entry? By Iain De Jong

OVERVIEW

Street Outreach can assist clients in breaking the cycle of homelessness by moving from the street to permanent housing by providing client support and helping each client develop a plan to address their barriers to sustaining housing; this can include, assisting with getting documents such as ID and social security card and applying to mainstream services and benefits. As part of the plan, Street Outreach (SO) will identify areas in which clients will need assistance to accomplish the goals and objectives to obtain permanent housing.

Street Outreach should be principally focused on one goal: that of supporting persons experiencing homelessness in achieving some form of permanent, sustainable housing. Street Outreach provides "essential services necessary to reach out to unsheltered homeless people; connect them with emergency shelter, housing, or critical services; and provide urgent, non-facility-based care to unsheltered homeless people who are unwilling or unable to access emergency shelter, housing, or an appropriate health facility (24 CFR 576.101)."

Outreach should cover all seven (7) counties within the CoC; unless funding dictates differently. During natural disaster events (like inclement weather from hurricanes or winter storms) outreach workers will make special efforts to let people know expanded sheltering available. Outreach teams will also work with other agencies such as City Police, Sheriff's Dept., and other outreach workers to discuss coordination and engagement; specifically, regarding large encampment areas. Outreach workers will assist with identifying people who are socially isolated (lacking internet, phone, and transportation) as a special population; this includes those people camping in wooded settings and are sometimes difficult to locate and initially resist engagement.

Street outreach polices will continue to be updated and evaluated.

HOUSING FIRST

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

TARGET POPULATION

Providers of Street Outreach services shall target unsheltered homeless individuals and families, meaning those with a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground.

Most of the day should be spent with existing contacts and moving the housing process forward and include:

- Diversion and Housing Problem Solving
- Linking to community resources

- Addressing any barriers that could help shorten their length of time homeless
  - ✓ ID
  - ✓ SS card
  - ✓ Disability benefits
  - ✓ Employment income
  - ✓ Bank account or savings
  - ✓ DD214

ACCESS POINT

The Lowcountry Continuum of Care is committed to ensuring that all households have access to services and are provided the same assessment approach at each access point: Street Outreach and the Housing Crisis Line are considered the main access points to CES in the Lowcountry.

The same assessment approach is provided at all access points that are usable by all people who may be experiencing homelessness or at risk of homelessness with as few barriers as possible.

All Street Outreach members are trained in outreach, assessment and referral. The process can flexibly navigate to reach homeless persons wherever they reside and has a primary goal to reach and engage the unsheltered populations. Outreach efforts are a combination of designated outreach staff, programs, services and other staff likely to encounter persons who are experiencing a housing crisis.

STANDARD ASSESSMENT

All individuals and families served through street outreach programs will be assessed using a comprehensive, universal assessment survey called the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) to assist with making an informed and objective referral regarding the level of need, recommended housing intervention of each family, and streamline eligibility determinations.

1. The VISPDAT should only be completed once and only updated if the situation changes.

2. Before conducting VISPDAT assessments, staff must complete a training video and meet with CoC staff to review

- All VI-SPDAT assessments should be done face to face
- Written consent must be completed. The only time a verbal consent can be done is during initial phone contact (i.e. Housing Crisis Line)

- The VI-SPDAT should only be completed once if the client is not housed, or situation changes
- Answers to the questions should be the client's response; not the assessor's interpretation or feeling. If the assessor would like to add notes regarding the assessment, that can be done in the Client Notes section in HMIS.
- If the individual is currently in an institutional setting (e.g. jail, substance abuse treatment facility, hospital, etc.), the VI-SPDAT may be administered if their current stay is less than 90 days AND they met the definition of literally homeless immediately before their stay in the institution began.
- Whether the VI-SPDAT is first conducted on paper or directly input into HMIS, all VI-SPDAT assessments must be recorded in HMIS within 48 hours of when the information was first collected.
- The VI-SPDAT is a different tool than the full SPDAT: do not use these terms interchangeable as they are different. The VI-SPDAT is the common assessment survey or triage tool used, the Full SDPAT can be used as an ongoing case management tool.
- Detailed information can also be found in the Coordinated Entry Written Standards

Please remember, the VI-SPDAT score is used as a guide. Persons are prioritized for referrals based on their length of time homeless and the severity of their needs. Manipulating a score will not place the person higher on the prioritization list.

At this time, the Lowcountry CoC is re-evaluating the current assessment tool.

HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)

All CoC, ESG and SSVF funded Street Outreach programs are required to enter clients in the Homeless Management Information System (HMIS) at first contact (ESG and CoC Interim Rule 24 CFR 576 and 578). This helps to ensure coordination between service providers through the Coordinated Entry System (CES) while avoiding duplication of services and client data, as well as, provides an opportunity to document homelessness.

All Outreach Staff will utilize their designated Outreach entry/exit provider in HMIS; this will assist when documenting homeless history for those being referred to housing programs such as PSH, as well as outreach outcomes.

Performance Measure 7: Successful Placement from Street Outreach
System Performance Measure 7 requires communities to analyze where people exit to when they exit the system. For street outreach projects, nearly every exit is considered a positive exit because it means a person has left the street and has moved to some form of shelter.

HUD HMIS Project Types:	SO
Type: Temporary	Positive Outcome

- Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- Foster care home or foster care group home
- Hotel or motel paid for without emergency shelter voucher
- Moved from one HOPWA funded project to HOPWA TH
- Psychiatric hospital or other psychiatric facility
- Staying or living with family, temporary tenure (e.g., room, apartment or house)
- Staying or living with friends, temporary tenure (e.g., room apartment or house)
- Substance abuse treatment facility or detox center
- Transitional housing for homeless persons (including homeless youth)

HUD HMIS Project Types:	SO
Type: Temporary	Negative Outcome

- Jail, prison or juvenile detention facility
- Place not meant for human habitation

HUD HMIS Project Types:	SO
Type: Permanent	Positive Outcome

- Long-term care facility or nursing home
- Moved from one HOPWA funded project to HOPWA PH
- Owned by client, no ongoing housing subsidy
- Owned by client, with ongoing housing subsidy
- Permanent housing for formerly homeless persons
- Rental by client, no ongoing housing subsidy
- Rental by client, with GPD housing subsidy
- Rental by client, with other ongoing housing subsidy
- Rental by client, with VASH housing subsidy
- Staying or living with family, permanent tenure
- Staying or living with friends, permanent tenure

HUD HMIS Project Types:	SO
Type: Other	Negative Outcome

- Deceased
- Client Doesn’t know
- Client refused
- Data not collected
- No exit interview completed

COORDINATED ENTRY SYSTEM (CES)

To help ensure those experiencing homelessness receive housing and minimize barriers to access, all individuals and families assessed through street outreach will be entered into HMIS. CES is a CoC-wide process for facilitating access for all resources designated for homeless individuals and families. This system ensures that every homeless individual or family is known by name, provides assistance based on the individual or family's unique needs, and matches them to the most appropriate service strategy or housing intervention when available. In doing so, CES ensures that the limited resources in the Lowcountry are allocated to achieve the most effective results.

ENGAGEMENT

Unsheltered persons are engaged for the purpose of providing immediate support, intervention, and connections with homeless assistance programs and/or mainstream social services and housing programs. It is important to meet the client where they congregate or reside, develop a relationship based on trust and honesty, and work with them in the field to end their cycle of homelessness. Use a variety of best practice engagement strategies to build genuine relationships with clients over time. As a general rule, do not initiate housing conversations, unless preempted by client request, until the third client contact when a rapport has been established. At that point, initiate a strategy of Phased Engagement.

> Phased Engagement is a strategic process by which the Outreach Team explores each client's strengths and opportunities for non-subsidized housing prior to discussing or assessing a person for subsidized housing. In doing so, the initial conversation empowers the client and promotes self-agency rather than creating an unrealistic expectation that a subsidized housing option will be provided forthwith. Also, it helps the Outreach Team reserve the very limited stock of subsidized housing for people who are the most vulnerable and do not have any appropriate alternatives to leaving the street.

Engagement activities include:

- Providing crisis assistance and referrals
- Addressing urgent physical needs
- Actively connecting and providing information and referrals to programs targeted to those experiencing homelessness to housing programs, including emergency shelter, transitional housing, community-based services, permanent supportive housing, and rapid re-housing programs.
- Making an initial assessment of needs and eligibility (VI-SPDAT)

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

CLIENT SERVICE COORDINATION

This includes assessing housing and service needs, arranging, coordinating and monitoring the delivery of individualized services to meet the needs of the program participant. Eligible services and activities are as follows:

- Using the Coordinated Entry System (CES)
- Conducting the initial VI-SPDAT
- Verifying and documenting program eligibility
- Developing, securing and coordinating services
- Assisting client with obtaining Federal, State, and local benefits
- Providing information and referrals to other providers
- Assisting household with developing a path to permanent housing stability

Professional and Ethical Guidelines for Outreach and Engagement

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 those experiencing homelessness but, also with coworkers, 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.

• 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.

• Refrain from giving personal gifts or cash to clients.

• 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

APPENDIX A: Housing Documents

From social security cards to proof of military service, people experiencing homelessness must secure a variety of documents to move into housing; these documents can often be difficult to acquire for those without the contacts or system knowledge to know how to get what they need. Experienced, well connected outreach staff can fast track the process by maintaining an updated list of local agency contacts and key documents required for each local housing and service offering.

To expedite the referral process for those experiencing homelessness in our community, please upload the following as file attachments in HMIS. Clearly label the name and description to enable easy location of required documents (Ex: Chronic Homeless Cert, Disability Verification, SSI, Income, etc.)

RRH	PSH
○ **ID** ○ **SOCIAL SECURITY CARD** ○ **PROOF OF INCOME** ○ **ZERO INCOME FORM** ○ **DD214 (if applicable)**	○ **ID** ○ **SOCIAL SECURITY CARD** ○ **PROOF OF INCOME** ○ **ZERO INCOME FORM** ○ **CHRONIC HOMELESS CERTIFICATION** ○ **DISABILITY CERTIFICATION**

All information should be uploaded to the File Attachments in HMIS within 24 hours of receipt of the documents.