O U T R E A C H: attitude - method - practice

1. INTRODUCTION

Institutions and associations have, for centuries, offered basic help – food, shelter, clothing - to people living on the streets. But, in the past, such poverty was seen as an unavoidable condition of life. Homeless people were seen as unfortunate examples of extreme but individual poverty, not as the consequence of specific deficits in health or social provision.

Today, poverty is increasing everywhere in Europe. More than 22.5% of the European population is at risk of poverty or social exclusion (Eurostat 2018), and more than 4 million European citizens are homeless (FEANTSA estimation). Homelessness has become a political priority, even if only at the level of rhetoric rather than concrete actions which require the allocation of specific resources.

Studies in England, Germany and other EU countries have demonstrated the excessive prevalence of mental disorders in homeless people.

Apart from the increasing numbers of people affected by homelessness and mental illness, there are major problems for such people in accessing appropriate services. These can be administrative, a result of mental illness, or arise from personal experiences of helping services.

Outreach initiatives in the past were focused on providing for basic needs, distributing food and blankets to those living on the streets. Such volunteers had often had no specific training in the social or health sector, just a desire to make themselves useful. However, faced with the particular challenges faced in doing this sort of work, during the 1980s many of these organisations reorganised and offered a range of increasingly professional and skilled services – sometimes within NGOs but also existing health, housing and social services.

Originally it was thought that such services could significantly impact the number of homeless people on the street (1) – and for a while, they did. The principles of outreach have also been found to be effective with people who have a home to live in but are « cut off » from other people, for whatever reason.

However, the era of austerity has fostered the recent increases in homelessness. So, instead of becoming less necessary, such services have become more essential than ever. Hence the importance of this Erasmus project – to enhance the skills and experiences of people engaged in providing service to homeless people.

The following proposals are grounded in practical experience and intended to clarify the skills and practices needed to meet homeless people, to hear their voices, and to understand their situation – so that they can, as much as possible, gain access to their fundamental rights - to social and health services, to a home, and to the support to live there.

OUTREACH - description

- *The idea of Outreach is used to describe programmes and schemes that **locate people** who need help or advice, rather than waiting for those people to come and ask for help. (Dictionary Collins)*

- *Bringing medical or other services to people at home or to where they spend time (Dict. Cambridge)*

- *It is to **provide** **services** to any group of people **who might not otherwise have access to those services**. Such services go to meet those in need of their services where they are, rather than expecting them to come to an office or clinic. (Wikipedia encyclopaedia)*

Outreach is more than a specific pillar in our scheme – it is the *common element* that links the other service pillars and creates a pathway from exclusion on the streets to social inclusion and connection with health and social services.

Different definitions of outreach share some ideas:

1. **To find, to meet, and engage with people** *who need help*
2. **To identify and provide assistance** *for basic needs.*
3. **To build bridges** *with social & health services to facilitate both access to services and continuing contact with them.*

It's not easy to find an exact literal translation of the word '*outreach*' in other languages. For example, in French, we find '*aller vers*'… (to tend towards) and '*aller à la rencontre*' (to go meeting).

In the past, outreach initiatives were focused on providing for basic needs, such as the distribution of food and blankets. The new element in outreach is the involvement of those with professional skills and specialist knowledge – doctors, nurse, psychologists, social workers – going out beyond their usual professional setting to meet people where they are.

2. MAIN IDEAS

a. **Outreach is an attitude***:* More than a method, and it requires that the practitioner is:

- **Open**
- **Attentive**
- **Accessible**

to people who do not have access to health and social services.

b. **A good outreach service is**:

- Offered **where** the person lives or spends their time - streets, shelters, squats, *the home* - whether or not the location is familiar to, or comfortable for, the worker.
- Offered if **accessibility** is a problem.
- **Open** to the client, without any request necessary from the client.
- **Open** to the client, without needing a **referral** from any other service.
- **Informal,** offered within the context of a personal relationship.
- The worker's position is more **alongside** the client, rather than looking at the client — a non-hierarchical and relationship-based approach.
- **Partnership** based, where the client and service work together**.**
- **Normal** - outreach work is seen as an integral part of work rather than as an exception.
- **Accessible** - this is seen as more important than specialisation.
- The first priority is to establish a person-to-person helping **relationship** – and where time and resources are allocated for this.
- Offered purely **for the benefit of the patient**, to facilitate their progress towards social inclusion - not to satisfy political or bureaucratic aims.
- **Respectful** of the client's dignity, their right to be different, their right to be heard, of their space and their time.

- Able to **consider all possibilities,** both in terms of the individual, but also in terms of other significant actors and service providers.

c. Changing practice to an outreach model

We, as service providers, are used to predictable, organised (perhaps comfortable) environments that, in some sense, we feel we "own". However, effective outreach work takes place in less-planned, more spontaneous ways in other people's space.

Greater emphasis is placed on establishing a helpful relationship with a client than on making a diagnosis or gathering information.

Outreach work requires that a worker can listen to a person's concerns, be attentive to their body language, be flexible enough to accommodate their feelings and desires and can respect their voice before acting.
This is characteristic of good mental health practice anywhere but can make extra demands in less conventional, less private and (possibly) more hazardous surroundings such as the street.

Homeless people tend to have needs in multiple domains at a single point of time, which reinforce each other – so no one service can act effectively. This applies to all homeless people who live on the street. So, collaboration and coordination are absolutely essential for an outreach model to work effectively. In order to avoid competition between services, or clients "falling between" services, this needs to be mandated at managerial level by service providers.

SOCIAL AND HEALTH OUTREACH

A. Phases of outreach work:

- **Identification of a person in need**:

  You, or a member of your outreach team, may see someone on the street who seems to need assistance. But you may equally be told about such a person by a family member, the police, private persons, or a shopkeeper in the neighbourhood.

- **Establishing contact**:

Introduce yourself – as yourself, saying who you are and why you are there and asking permission to talk to the person. You can then sit down with them and start to work out how much they are willing to talk – if at all.

It may be that you don't need to talk much at first but can just spend time with the person, perhaps over a coffee or a cigarette, allowing both of you to become comfortable with the other. If he or she tells you that they don't want to talk, or moves away, just try another day again, don't take it personally. It can take some time, and it can be lonely to work on your own with clients. Working in pairs has some advantages, but can be perceived as threatening by a homeless person.
You may want to establish informal contacts with other people involved with the client, perhaps even their family.

Clarification: *Getting to know the person*

Meeting someone several times, even if only for a short time, can create the basis for establishing trust and mutual understanding.

These meetings can be as short as your client wants, on a bench, in a park, in a café. You can sit together and chat or smoke a cigarette and drink a cup of coffee. After some time, you can clarify what kind of help the person needs.

This can elicit conflicting thoughts and feelings in the worker. Any homeless person with severe mental illness will want to live as good a life as possible, even given their difficult circumstances. It may seem, sometimes, that this way of life has been freely chosen, and so one does not want to interfere. But, at the same time, we know that a person can be trapped in their homelessness by symptoms of mental disorder.

- **Interventions**: *Establishing the right form of help*

This can start with an offer of the simplest form of help that will be accepted. This will often be practical, such as supplying clothing, food, or a sleeping bag. Or it could be a physical health problem, where a worker can offer simple treatment for skin sores.

Gradually, more substantial issues can be addressed, such as obtaining welfare payments, a health insurance card obtained, or housing applied for.

If mental health problems are evident, these can now be discussed. You can ask for permission to contact the welfare office, psychiatric hospital, family, or other help organisations. A comprehensive plan can be made, preferably involving both the individual concerned and the responsible institutions and organisations.

- **Support:** *maintaining support and contact*

  As the person comes off the street and moves into more settled and appropriate accommodation, their support needs will change.

  The conditions of deficit or conflict that first contributed to social exclusion can easily happen again – and need to be addressed, if possible. It's important to maintain contact to ensure early intervention if problems should arise.

- **Conclusion:**

  The art of ending the helping relationship at the right time. This needs to take account of the fact that the relationship with the client may be the only substantial relationship they have had in many years. So, the ending of contact with the client needs to be planned well-ahead, giving the client time to get used to the idea, to grieve (perhaps) and to adjust to their new situation.

  A good ending can help to ensure that what has been gained from this contact and work will not be lost.

  Contact may, for some, need to continue at a lower level of intensity for many years. For example, in the form of visits a couple of times a year or the possibility to contact the team by telephone.

  The team should try to slowly phase out support and interventions while others take over.

B. Roles of healthcare workers in street work:

- All those working with people on the street must be aware of the principles of outreach work and engagement, and be familiar with the practical ways of developing a positive, helping relationship with a client.

- **Nurses:**

- Can work directly with a person's hygiene, care, motivation, evaluation of any medical problems, assessment of capacity and vulnerability.
- Can work as intermediaries between the person and medical staff (hospital, GP- medical doctor), particularly to clarify/translate medical language" for the patient.
- Can support follow-up treatments and medical appointments, by both accompanying and by helping to negotiate bureaucratic processes.
- Will meet with the person regularly.

- **Mental health nurses**:
  - Will meet the person regularly
  - In addition to the role of generalist nurses, MH nurses work in a specialist role with people experiencing and/or affected by mental disorder, in whatever setting they may be (street, shelter, etc.)
  - Bridge-building for health care services through the mutual trust relationship established with the person
  - The guidelines are to follow the person's demands, desires and needs (with no preconceived objectives and no time limit), using a proactive approach and trying to deliver holistic attention and sense of dignity.

- **Medical doctor** (GP): Will meet the person on the street, to:
  - Enhance the person's engagement with the whole service
  - To break down any barriers of mistrust that exist due to previous bad experiences with medical services.
  - Give clinical advice in non-urgent cases.
- **Psychiatrist:** Will meet the person on the street to:
  - Enhance the person's engagement with the whole service.
  - Establish a psychiatric diagnosis and formulation.
  - Provide non-urgent and urgent (compulsory) interventions, where possible.

    - Facilitate access to psychiatric resources, whether in hospital or not.
- **Psychologist**: Will meet the person on the street to:
    - Help to establish a working relationship with the patient.
    - To establish a psychological diagnosis and formulation
    - Support and advise the team in the psychological aspects of their daily work with the patient.
- **Social workers:** Like nurses, will often function as case coordinators and will see the person regularly to:
    - Provide social work interventions
    - Facilitate access to healthcare and social services.

Issues to address in re-housing:

- To be proactive in maintaining contact with clients.
- To be aware of the paradoxical dangers of moving into fixed accommodation – e.g., lower levels of activity can make thrombosis more likely.
- Increased risk of overdoses (alcohol or other drugs) because of:
    - The ability to stock drugs or alcohol.
    - Increased privacy (desirable in most senses) making overdoses less visible, and so reducing the possibility of intervention.
- Loneliness at home.
- To create, inform and support a network of health professionals from the "normal system" that are able to follow these patients and provide both continuing and urgent help when needed.

3. DIFFICULTIES:

In relation to homeless people:

a. **Fire-fighting:** It is common for services to focus on immediate and urgent need, without tackling underlying issues. The danger is that the homeless person merely becomes dependent on the service, without any change in their underlying situation.

b. **Repeated** social or health emergencies without any resolution of the underlying causes for the individual.

c. **Refusal of service** by people sleeping in the street - even a refusal to meet or to speak.

d. **"Urban hygiene":** Interventions, usually by police or cleaning services, to remove homeless people from certain areas without improving their predicament.

e. **Widespread fear and distrust** (of homeless people) towards those in any kind of authority.

In relation to workers :

f. **Discouragement**: In spite of great efforts, the homeless person disappears or dies.

g. **Institutional barriers to access:** - clinic opening hours, physical accessibility etc.

h. **Competition and individualism of NGOs and statutory services**: tendering culture discourages collaboration and encourages organisational self-aggrandisement

i. **Lack of reciprocity** in giving and receiving.

j. **Time, urgency and lack of resources** limit options for more permanent solutions.

k. **The stigmatisation of homeless people on the street:** they can be seen as unhelpable – or as not deserving of help.

B. **Co-working and Coordination:**

Networking and cooperation are essential, both at an organisational level and in each individual case. Unfortunately, funding is organised in such a way that agencies that should be working together are, instead, competing with each other.

Competition **Collaboration** **Coordination**

- **COMPETITION:**

This is the “natural” state of organisations, competing for funding and customers/clients. It can lead to improvements in standards, particularly where professional standards are involved.

However, most of the issues surrounding homelessness are not susceptible to effective intervention by one organisation or team, and so competition has the potential to limit the effectiveness of help given by excluding other, potentially helpful, sources of assistance.

- **COLLABORATION**

  Collaboration is the most rational response to complex problems, such as those generated by homelessness and mental illness. Ideally, a collaboration between two or more entities (people, departments, associations, institutions) both public and private, will produce joint working which can achieve results that individual agencies would be unable to accomplish on their own.

  Good collaboration produces better quality, facilitates project execution, improves team efficiency, creates better work environments, and makes organisations grow.

  By collaborating, people share skills, knowledge, talent, information and resources to achieve a common goal.

  Given that collaboration will go against normal organisational instincts, it cannot be assumed to be happening. It needs to be formally acknowledged and valued at the highest level in any organisation. Collaboration needs to be planned, well-structured and monitored – and focused on results.

  - **COORDINATION:**

    Coordinating the actions of different agencies can focus attention, avoid needless duplication of effort, and achieve complementarity. It allows the deployment of diverse approaches to a common problem.

4. Good practices

Specific outreach practices

Phases of outreach

1. **Preparation** *(prior to meeting with someone on the street)*
    - The collection of as much information as possible before planning any intervention or first contact.
    - The use of a multidisciplinary team composed of (at least) a coordinator, health and social workers, with both salaried & volunteer workers.
    - To plan a “program” of interventions.
    - To assign the ' *case* ' to a member of the team who will take continuing responsibility for the person concerned. It can be helpful to have two people allocated in this way, to allow for sickness, leave etc.

2. **Planning the first meeting on the street:**
    - A meeting should be held to assess risks, opportunities and the objective of the proposed meeting with a potential client.

3. **Continuing recovery:** Regular meetings to monitor and plan the progress of social and/or health reintegration.

Good practices in outreach work

- **Time:** One may need to manage time differently from that used when working within more structured systems. In more formal systems you may be able to plan to get a job done within a specific time, to make and keep appointments, and "use" time optimally (or, in the eyes of the organisation, “efficiently”. In outreach work on the street, time is far less under your control – most often, the needs of the person will determine how long a particular task or intervention will take.
- **Patience:** It can take weeks and months to get close to another person - quick results can be achieved, but usually take a while. Again, it is important to make any timetable contingent on your client’s needs and, as far as possible, let the other person decide the tempo. A rejection does not need to be a rejection – if you can wait and allow the person to establish trust with you over time.
- **Recognise** and respect the client’s needs and desires.
- **Trust/credibility:** must be earned. It is not enough to work on the streets with good intentions alone. People living in the streets have met many well-meaning people in their lives – in institutions, from social work departments, NGOs, etc. – and yet, they are still on the street.
- For someone who has suffered a great loss the process of developing trust in others can take a much longer time than in mainstream health or social work. You need to demonstrate that you are punctual, reliable, honest, can act effectively and that you are a safe person to be with.

- **Timing:** The right time to make contact is when the homeless person wishes it; the right time to apply for a pension is when the person wants it. One must have provisional plans, but these need to be adjusted according to the ability of the client to tolerate them – one often needs to wait until the client is ready.
- **Resilience:** You may have to do uncomfortable things – such as approaching, several times, a person who rejects your attempts to establish contact with them.
- **Reject hierarchy:** To lay aside any professional status and to relate to the client, first and foremost, as a person, to create as equal a relationship as is possible.
- **Curiosity:** Be curious, genuinely want to understand another person's world.
- **Team working:** Roles and functions are clear, but workers are flexible enough to share assignments and to work beyond their roles where necessary.

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- **Supervision:** Street work is demanding. It can be lonely, and it can easily leave the worker without the collegial support that is usually part of working together. Therefore, no street-level project carrying out work with homeless mentally ill people living on the street should be without a well-organised structure for regular supervision.

5. CASE PROFILE

Context: This happened during a winter period of municipal emergency cold alert (November- March). This increases the number of night beds available for homeless people, and the number of mobile units for street outreach.

Report: The urban police reported to the municipality's social service the presence of a woman of a certain age and under ' pitiful ' conditions, who rejected any form of contact and dialogue

Mobile Unit : The Coop Soc X mobile unit, composed of a volunteer (driver), social worker and educator, was sent to evaluate the situation,

First meeting: The social assistant discreetly tried to establish a contact, a few words. The woman was in a visible state of self-neglect, with an infected leg wound. She refused to talk, did not acknowledge their

greeting and gave no reply to any questions. She did not respond to the offer of a hot drink, so it was just left next to her. The team said good night and that they would come again tomorrow.

Evaluation and brief report

Observations from this first contact suggested that her predicament needed to be dealt with urgently. She was without money or appropriate clothing or accommodation, she was in poor health and not receiving proper treatment (leg infection), she had not been able to keep herself clean and was not equipped to be sleeping out on a cold night. This information was shared with other night services that operated mainly in the central station, an area frequented by the homeless.

Team meeting at the shelter, with the participation of a physician. The case was classified as urgent and was allocated to the social worker. The immediate objective was agreed to be to create enough of a relationship with this lady to try to convince her to come off the street and accept treatment for her leg.

Plan: A frequency for subsequent meetings was proposed, to enable the social worker to gain the trust of the lady, and hopefully to help her to accept dressings for her leg from the hostel infirmary, to avoid gangrene and possible amputation.

Results & Synthesis: After the next meeting she accepted dressings from the hostel infirmary – and then stayed to sleep in a chair. She then moved to a four-bedded room – and, ironically, complained that the other guests weren't clean enough.

So, in spite of her original indifference to the outreach team at their first meeting with her, the lady was subsequently able to accept medical treatment for her leg and accommodation in the hostel after roughly ten weekly visits.

Conclusion The primary process of outreach and engagement – meeting, listening, taking care, providing basic help (the hot drink) – enabled an alienated woman to re-engage with helping services.

Questions:

- What strengths and risk factors do you identify in the intervention described?
- What could be the critical moments in the process?
- Starting from your experience can you imagine a different intervention? If yes can you describe it?

1. **GLOSSARY** :

- **Client:** a person who makes use of supportive services, whether professional or voluntary. Other phrases used to describe clients are, in different settings, patients or service users.
- **Home:** a place where a person feels they belong and that they have a right to be there. A place of affections and emotions, protection and security, where a person feels welcomed, recognised and supported,
- **Housing:** a place where people can live in quietly.
- **Homeless and mentally ill people**: people who are homeless who also have a mental disorder which may have precipitated the homelessness, but almost certainly serves to perpetuate homelessness and social exclusion.
- **Institutionalisation:** The process by which an individual becomes dependent on an institution, to the detriment of their independence and ability to make decisions for themselves.
- **Psychiatric deinstitutionalisation**: A cultural and scientific process that recognised that mental illness and psychological suffering is not best helped prolonged isolation in psychiatric closed institutions. The alternative is community-based treatment, which involves a substantial investment in personnel and services.

De-hospitalization The closure of hospital beds. Although carried out under the guise of "constructive" deinstitutionalisation, it is often carried out for financial reasons rather than therapeutic ones.

Compulsory health treatment: If a person's mental disorder means that they become a risk to themselves or others, or just cannot look after themselves adequately, they may be detained in hospital against their will (or, at least, without their expressed permission), using the laws applicable in that particular country.

Undocumented migrant: A foreign-born person who does not have a ***legal*** right to be or remain in one specific country, but who has – as a human person – the basic entitlements recognised by the Declaration of fundamental human rights.

OutREACH : → **go outside** *to meet people*

InREACH : ← **welcome inside** *to access services*

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APPENDIX 1. *(if useful) about two outreach practices :*

Project UDENFOR does outreach work on the local and regional plan in Copenhagen and other parts of Denmark in the following fields: homelessness, drug abuse and mentally ill people together with other marginalised groups in Denmark. It is a non-profit organisation registered in the City of Copenhagen, Denmark in 1999.

Our objects are :

- an improvement in the conditions of the socially rejected in our society by identifying and documenting factors which result in social rejection in order to prevent any further effects. her of (*delete)*
- to spread knowledge of such factors and spreading knowledge of preventing people from being rejected and ways improving conditions for those already rejected.
- to develop new methods for working with severely excluded persons.
- to try directly, through practical work to improve the conditions of the people already socially rejected.

The activities of Project UDENFOR shall reflect the view that there have always been many different approaches by professionals depending on their educational and professional background.

Infirmiers de rue (Street nurses).

- A medical non-profit working on outreach to and rehousing of the most vulnerable homeless people of the streets of Brussels.
- The organisation has developed a specific approach based mainly on hygiene, medical care, and the valuing of the resources and the talent of people.
- Teams of two nurses, go in the street to meet homeless people, raise awareness of the importance of hygiene for well-being and inclusion, and help them, step by step, in the process to recover good health and self-care.
- At the same time, they respond to demands around medical care, treating people on the spot when needed, but trying as much as possible to bring them back to « normal » medical structures, and helping them to get enough confidence to get back by themselves.
- During their contacts with the people, a lot of attention is paid to actively discover their talents, resources and wishes, in order to promote self-esteem.

- Training is given regularly to professionals, around the importance to work on health and self-care, how to speak about it, and how to do it. Basically, the training aim at having the professionals see health as a useful tool, in their work, rather than as an obstacle.