Homeless Outreach Practises in BC Communities

Volume 2: Outreach Program Profiles

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Community Profile

CMHA Port Alberni Homeless Outreach Program is included in this study as an example of an outreach program operating in a small urban area.

Community: Port Alberni (City) located on the west coast of Vancouver Island has a population of less than 18,000 persons. It is in the traditional ancestral lands of the Nuu-chah-nulth First Nations. It was incorporated in 1912, becoming a service centre for the forest and fishing industries surrounding it. It is the largest municipality of the Alberni-Clayoquot Regional District. Nearby are the municipalities of Tofino and Ucluelet and the lands of the Nuu-Chah-Nulth Tribal Council.

Population Growth and Migration: The City of Port Alberni saw a slight population drop between 2001 and 2006, of 1.1%, from 17,743 to 17,548. Net migration to the region between 2000-2001 and 2008-09 saw a loss of 95 individuals, largely to intraprovincial out-migration.

Key Statistic	City of Port Alberni	British Columbia
Population Growth 2001-06[1]	-1.1%	5.3%
Proportion of population 45 and over	49.6%	43%
Population with a university certificate, diploma or degree (above or below Bachelor's degree)[2]	12.7%	30.2%
Unemployment Rate by development region, 2009 (Vancouver Island/Coast)	7.2%	7.6%
Households in core housing need, 2006 and 1996 (Port Alberni CA)	9.4% in 2006 (965 households)	14.6% in 2006 (221,475 households)
	14.1% in 1996 (1,385 households)	17.4% in 1996 (228,970 households)
Number of rented dwellings (units)	2,110 (2006)	
	2,330 (2001)	493,995
Vacancy Rates, October, 2010[3] (Port Alberni CA)	5.4%	2.8%
Median cost for rent, October, 2010 (Port Alberni CA)	$568	$752
# homeless 2008	112	

Population characteristics: The age profile of the population was largely comparable to provincial averages, with about 50% of the population age 45 and over in comparison with the BC average of 43%. 13% of individuals within the Census Agglomeration identified as Aboriginal and 11.4% were immigrants.

Economy: According to BC Statistics, "The main economic activities of this regional district are forestry and tourism. The forestry industry has been important for the area historically. It is home to several lumber mills and a pulp and paper production facility. Some lumber mills have announced closures or output reductions as a result of the high dollar and lower demand from the U.S. The Arrowsmith TSA, located partially in this region, had its annual allowable cut increased in 2004. The area has a growing tourism industry that is helping reduce its reliance on resource extraction. The

[1] The City of Port Alberni is used over Census Agglomeration due to changes in the geographical boundaries of the CA between 2001 and 2006.
[2] Between 25 and 64 years of age.
[3] For privately initiated rental row and apartment structures of three units and over

area is well known for its outdoor activities and coastal communities. Both Tofino and Ucluelet have recently been undergoing development with several resort expansions either proposed or underway. The area has both a commercial and sport fishery and both shell fish and fin fish farming exist along its western coast.

Education and Employment: The City of Port Alberni has a significantly lower proportion of university-educated individuals than BC, with 12.7% of individuals between 25 and 64 having some form of university certificate, diploma or degree, compared with the BC average, 30%. However, there is a much higher proportion of those apprenticeship or trades training (18%) than the rest of the province (11.9%). The unemployment rate in the CMA in 2009 was slightly above the provincial average, at 7.6%, up significantly since 2008, when it was 4.4%.

Housing Profile: Vacancy rates for Port Alberni in 2010 were almost double the provincial average of 2.8%, at 5.4%. Additionally as of 2006, median rent costs were lower than the BC average, at $520 for the City of Port Alberni. However, the region also saw a decline in the number of rented dwellings of 9.4%, or 120 units, between 2001 and 2006. While the number of households in core housing need in Port Alberni improved between 1996 and 2006, the increased unemployment rate indicates that the situation may have changed since 2006.

Low-Income, Dependence on the Safety Net and Homelessness: Median family income in Port Alberni was lower than the BC median income in both 2001 and 2006. The prevalence of low income in Port Alberni (13.4%) was about the same as the provincial rate. Between September 2008 and September 2010 the dependence on the social safety net rose slightly, with recipients of Basic Income Assistance rising from 1.2% to 1.6%. In 2008, 112 homeless individuals were counted in Port Alberni.

Case Study

Delivering Agency

The Canadian Mental Health Association Port Alberni (CMHA PA). The agency's primary mission is to serve those living with a mental illness. Among the programs offered are peer support, public education, and the New Horizons Clubhouse, a community-based rehabilitation program, focusing on a work-ordered day and including a lunch program, employment opportunities, and social and recreational activities. As well, CMHA PA operates a number of housing facilities for those with a mental illness, including crisis and transitional beds, and supported housing. CMHA PA also offers programs that are open to anyone in the community: advocacy for such matters as disability applications and appeals and landlord-tenancy issues; and the Roger Street Apartments, a 42-unit single room occupancy (SRO) facility of transitional units with support services.

Impetus

Homelessness had already been identified as a serious issue in Port Alberni. In June 2006, CMHA BC Division initiated a year long pilot Homeless Outreach Project in partnership with the then BC Ministry of Employment and Income Assistance. Port Alberni was one of eight locations around the province where CMHA divisions delivered the outreach services. The current program began in 2007 and is funded by BC Housing's Homeless Outreach Program (HOP) program.

Goals and Objectives

The Port Alberni outreach Program seeks to address issues that contributed to the homelessness of a client and to address the client's current needs, and to do so through a single access point, the outreach worker. For the first two years outreach workers sought to engage with those who are homeless without income, those who are homeless with income and those who are homeless with income but who choose to remain outdoors. Now they have expanded to include those who are housed but cannot make ends meet. The program's goals are also to assist homeless individuals not receiving income assistance to access financial assistance and then to secure and maintain housing.

Client group

Clients are generally 30-50 years old, and can be single individuals, couples, or families, mostly single parents. In the last two years, 55% of clients were male and 20% were families. Many clients have mental health and/or addiction issues, many are victims of the economy, and many have poor educations. About one-third are Aboriginal, a higher proportion than in the general population. Lately, the team is seeing more women leaving abusive relationships. This may be related to the downturn in the city's economy.

Some clients merely need a small monetary assistance to make ends meets. Others, such as those with an unmedicated serious and persistent mental illness, need more complicated service and attempts are made to meet their needs. 50% of the clients are successfully housed and 50% are in cycle between some form of housing and the street. A number are seriously drug addicted and have a difficult time maintaining their housing. They typically move from low to zero barrier housing, and then will couch surf. When the weather gets better a number will camp. Occasionally, if a client has burned all housing and resource bridges, they will move to a different community and contact is lost. Some of the low to zero barrier housing landlords will accept a client back after a period of time.

Staffing

The CMHA PA Homeless Outreach Program has two full-time workers. Though they have separate caseloads the workers keep up-to-date with all cases for a time when one worker is unavailable. They generally work separately to cover more ground, except if there is the potential for danger. Staff requirements are a minimum of a community college diploma in mental health plus 2 years experience, or a 1-year college certificate plus 4 years experience. Training is on the job. As well, staff have taken courses in case management and interviewing skills. Generally staff work between 0830 and 1630, but remain flexible and will work on weekends if needed.

Qualities identified for a good outreach worker: Possessing the skills to engage with the client, being non-judgemental and empathetic, and able to advocate and meet the clients' needs. Clients of HOP added that the worker was down to earth, easy to talk to and didn't know it all out of a book, liked to joke around, was willing to listen to what the client needed to talk about, and was personable. One mentioned that it helped that the worker had had a similar experience.

Outreach description and activities

The outreach workers serve Port Alberni as well as going three times a month to the small west coast towns of Tofino and Ucluelet, where clients are generally those with an income source who do not want to come inside.

a) Engagement

Initially the workers spent time introducing the program to the community and going out to the street and camps to explain it to potential clients. Currently, because the program is so well known, clients come largely through referrals. They come from the shelter, corrections, referring agencies and the food line, as well as those living rough on the street or in camps. The team receives a call from or about client and will go to where that client is. They can also perform intake over the phone.

b) Housing

If the client already has an income, housing is the first step. The client is asked to phone the worker daily until accommodation is found. When a place has been identified the worker and client go together for a viewing. Once the person is housed the worker will engage with the client as needed. CMHA PA receives $3,600/month in rent supplements, which is used to top up rent and for food vouchers. Funds are allocated at the discretion of the outreach worker.

The team has built relationships with certain landlords and property managers and are extremely careful to maintain these relationships by assessing the appropriability of each client for the type of housing supplied, whether it be low or higher barrier. As well, CMHA PA operates a 42-unit transitional housing facility where clients can be housed until they are ready for more permanent, independent housing.

c) Income assistance

If the clients need to apply for income assistance (IA), the worker completes an online form, makes an appointment with the ministry office, and goes with the client to advocate for them. Once the client has an income, the worker will attempt to find housing.

d) Mental Health and Addictions

The team will refer and support them through and after treatment.

e) Physical Health Care

There is no walk-in clinic in Port Alberni and a lack of general practitioners (GPs) taking on new patients. Clients are forced to use the hospital emergency department if they do not have a GP.

f) Other services

Will refer to lifeskills programs, though service is very limited. People need life skills to take advantage of employment and training and life skills opportunities are lacking, but outreach workers will refer. The local MLA has provided a legal advocate who takes clients from both the outreach program and CMHA.

g) Follow-up

The outreach workers are the first to be called when a client is having housing or income issues. There is a program-mandated six- month follow-up with the client, and the worker will continue to contact a client at least every three months for however long it is needed. Occasionally a client whose mental illness goes untreated or who has a personality disorder will refuse follow-up. Also some clients have died, some move on to other locations and others just disappear. If a client cannot be found the workers will look for them, but they do not bother a client once they no longer need support. However, a client is always welcome back into the program should the need arise.

Definition of success

A number of definitions were put forward. Central was that the client is housed and supported in their housing and at least beginning to stabilize, if not working toward self-sufficiency. Another measure of success was that being with the program resulted in harm reduction. A third indicator of success is when the program moves away from merely finding housing to being concerned mainly with helping the clients maintain their housing.

Clients' opinions about the program: One felt that the time the worker spent with the client was sufficient. The other said it was sometimes sufficient. One had no problems contacting the worker; the other did, but only due to the lack of access to a telephone. Both liked the worker, describing the worker as really caring and as loving the job. Both thought the worker's personality fit the job well. Neither could think of anything they would change with the delivery of services. One listed housing as the most important assistance the program offered, the other advocacy.

Outcomes

In spite of a serious/severe housing shortage, outreach workers and the community interviewees believe the program has been successful in achieving at least some (or all) goals with each client. In a six-month follow-up in 2010, 314 clients were housed a total of 345 times (some were housed a multiple of times). 80% of clients were housed after 6 months.[4] Clients who receive disability allowances (usually clients with a serious and persistent mental illness) generally are still receiving financial support after 6 months. The program has greatly helped to lesson the burden on other, often over-stretched, community resources.

[4] Bob Hargreaves. Executive Director, PA CMHA. Personal communication. Jan. 25, 2011.

Challenges

- The depressed economic climate.
- A shortage of housing: supported, transitional and affordable, as well as accommodation for those with limited mobility. As well, the Single Room Occupancy accommodation available to those on a government housing allowance is substandard, and the shelter is too small. [5]
- A shortage of addiction treatment and recovery beds and facilities, and a shortage of GPs.
- Limited life skills training opportunities. (Having an outreach worker who could offer life skills would be of great benefit.)
- A transient population.
- Unsafe weather and driving conditions can limit service to Ucluelet and Tofino.
- The inability to access a client's record at various agencies due to privacy issues
- The lack of formal agreements with landlords.
- Improving the relationship with the First Nations.
- Reporting to the BC Housing data base is time-consuming and eats into the available time to serve clients.
- There are few dry accommodation options in the town for a person on IA who was leaving a recovery house. This could have a detrimental effect on the person being able maintain both their sobriety and the housing they had accessed through the program.

Community Linkages

Outreach workers are aware of all services that could be accessed by their clients depending on need. The relationships to agencies are largely informal, but services are coordinated so as to avoid duplication. The program has linkages with the Ministry of Social Development (Income Assistance), Mental Health and Addictions, detox, treatment and recovery facilities, the School Board, Women's Centre, RCMP, the MLA, Corrections, the Bread for Life food program, social workers, home support, Ministry of Children and Family Development, the New Horizon's Club House, Garnet Recovery House, municipal bylaw officers and landlords and property managers. Landlords rely on the workers' judgment the suitability of clients as potential tenants. Outreach program workers sit on the Alberni Valley Community Stakeholders Initiative to End Homelessness with other community agencies.

Community Impact

While the program itself may not be well known in the general community, this is unlikely to effect the program's efficacy because stakeholders in the community are well aware of the program and not only support it but rely on it. It was mentioned that when one worker goes on holiday the gap in services is noticeable.

Effective Outreach Practices

1. Thoroughly introducing a newly established program to the community and potential clients to gain community cooperation for - and use of - the program. Gaining most of their clients through agency referral or self-referral, as now happens, can be a more efficient use of the outreach workers' time. Instead of having to go out on the street and search for clients, as well as take time to engage on the street, the workers can spend more time assisting the client.
2. The Homeless Outreach Program has a special protocol with the local office of the Ministry of Social Development, which operates the income assistance program. Clients are not required to

[5] The city, BC Housing and the health authority are currently involved in the development of a replacement for the shelter and its transitional housing.)

meet normal qualifications such as the three-week job search and a ministry worker is assigned just to outreach program clients. This has proven to be a most helpful arrangement for quick delivery. The quicker the delivery the sooner the person can gain housing and the sooner they can work on the issues that lead to their homelessness.

3. Developing close working relationships with five local landlords and maintaining it through:
   - Taking care to place clients in accommodation suitable to their situation;
   - Providing support to the clients and being available to respond to a crisis; and
   - Not taking sides in disputes between the landlord and a outreach program tenant but referring the dispute to other sources for mediation so as not to alienate the landlord by being the tenant's advocate. Defending one client can cost housing for dozens down the road if, because of it, the landlord decides to terminate his support for the program's clients.
4. A staff that is non-judgemental, friendly and calming, able to listen to the client and support his needs.
5. There are no "former clients." Clients remain with the program until they no longer need the support, for however long that turns out to be.

Importance of Outreach Practices Identified in the Literature

Interviewees rated most of the effective outreach practices identified in the literature as important or very important. The exceptions were "assisting the client with transportation" and "hiring formerly homeless clients as outreach workers." These were viewed as somewhat important and not important respectively.

Community Factors affecting Outreach

The following were rated as very important factors in the community that contribute to successful outreach.

- Rents in Port Alberni can be lower than are experienced in other areas of the province due to factors such as economic decline. This can allow those who move from homelessness to a place where their income is higher than the $375 provincial shelter allowance to find suitable accommodation.
- Availability/connections with other support services in community.
- Adequate, ongoing funding for program operation.
- Being a small town makes it easier to follow-up with clients because the clients are often linked to other services that partner with the program and because people know one another.

Prince George Native Friendship Centre: A Small Town Homeless Outreach Program

Prince George Community Profile

The Prince George Native Friendship Centre Homeless Outreach Program (HOP)/Aboriginal Homeless Outreach Program (AHOP) is included in this study as a sample of an outreach program operating in a small urban area.

Community: Prince George, population 83,000, is located in the centre of the province and is a regional government, transportation and trade hub. It is the largest city in northern British Columbia and is located in the Fraser-Fort George Regional District. It sits in the traditional territory of the Carrier Sekani First Nations. There are four reserves in the surrounding area.

Population Growth and Migration: Prince George has seen significant a population decline in recent years, with a loss of 2.1% of the City's population between 2001 and 2006, or about 1800 individuals. The Fraser-Fort George Regional District saw a net loss of 8,571 individuals to intraprovincial and interprovincial migration between 2000-2001 and 2008-09. International in-migration mitigated loss slightly, contributing 857 new residents to the area.

Key Statistic	Prince George CA	British Columbia
Population Growth 2001-06	-2.1%	5.3%
Proportion of population 0-14	19.2%	16.5%
Population with a university certificate, diploma or degree (above or below Bachelor's degree)[6]	18.5%	30.2%
Unemployment Rates (by development region) 2009	12.0% (Cariboo) 10.4% (North Coast and Nechako	7.6%
Households in core housing need, 2006 and 1996	8.7% in 2006 (2,760 households) 12.8% in 1996 (3,270 households)	14.6% in 2006 (221,475 households) 17.4% in 1996 (228,970 households)
Number of rented dwellings	8,745 units (2006) 8,905 units (2001)	493,995 units
Vacancy rate, October, 2010[7]	7.5%	2.7%
Average rent, October, 2010	$666	$752
# homeless, 2008 and 2010	375 in 2008 361 in 2010	

Population characteristics: At the 2006 Census the total population of the Prince George CA was 83,225. The median age was 37.3, below the provincial median of 41 years. Prince George also has a high proportion of children, with those aged 0-14 years composing 19.2% of the population. 10.7% of the population of Prince George claims Aboriginal identity, and 9.4% were immigrants.

Economy: According to BC Statistics, "Forestry has been the main economic activity for this area historically, however recent efforts to diversify the local economy have resulted in growth in mining, high-tech and tourism industries. This area is home to many large lumber and pulp and paper mills, some of which have announced closures or output reductions. Its economy was once dominated by

[6] Between 25 and 64 years of age.
[7] For privately initiated rental row and apartment structures of three units and over

resource industries, largely forest-based, but is now more diversified, with employment coming from the Northern Health Authority and educational institutions such as the University of Northern BC.

Education and Employment: Prince George has a significantly lower proportion of the population, with any form of post-secondary education, compared with the BC average. For example, only 18.5% of the population has some form of university education, well below with the provincial average of 30.2%. The unemployment rate in the development regions around Prince George increased significantly between 2008 and 2009, from 6.5% to 12.0% in Cariboo and from 7.7% to 10.4% in North Coast & Nechako.

Housing Profile: Vacancy rates in Prince George for 2009 were 7.5%, well above the provincial average of 2.8%, indicating greater housing availability although not necessarily for lower cost units. Additionally, as of 2010, average rent of $666 was significantly lower than median rental costs for all of BC. However, the number of rented dwellings also dropped between 2001 and 2006. Core housing need in Prince George improved between 1996 and 2006. While 12.8% of households faced core housing need in 1996, this declined to 8.7% in 2006, a reduction of over 500 households. However, much of this data is dated, and with the economic downturn core housing need statistics may have worsened.

Low-Income, Dependence on the Safety Net and Homelessness: Median after tax income for households and families for Prince George was higher that the provincial median income in 2006. 14.7% of economic families live below the low-income cut off, and between September 2008 and September 2010 the dependence on the social safety net in the Fraser-Fort George Regional District increased, with recipients of Basic Income Assistance rising from 2.9% to 4.0% of the population. 6% of children under 19 were reliant on income assistance. The 2010 Homeless Count surveyed 361 people, a slight decrease from 2008.

Case study

Delivering Agency

The Prince George Native Friendship Centre (PGNFC) is a non-profit, non-sectarian organization offering a wide variety of programs and services specifically designed and delivered to meet the needs of urban Aboriginal people. However, in keeping with their mission statement to serve the needs of all people regardless of race, creed, culture, gender, or age, non-Aboriginal people are also welcome to access programs and services. These include social and health programs, education and employment programs, and economic development. More than 20,000 people seek their services annually.

Impetus

Homelessness had been reported as very visible in the city. The PGNFC had already tested an approach through their youth outreach program and their Homeless Outreach Program (funded by BC Housing's Homeless Outreach Program (HOP) and Aboriginal Homeless Outreach Program (AHOP) was an opportunity to shift the service to adults.

Goals and Objectives

The Prince George HOP/AHOP teams engage individuals deemed at risk where they find them. The philosophy is Housing First plus supports, with the program aimed at helping the homeless and those at risk of homelessness to secure housing and access to needed social services and life skills. One interviewee stated that the Prince George outreach program was broad enough to help people even if they did not want to be housed.

Client Group

The PGNFC describes the outreach population as Aboriginal and non-Aboriginal people from 18 to 82 years, more males than females, with addiction, mental health and health issues. The community interviewees saw the client group as broader, as including individuals in need of assistance, both the homeless and those at risk, such as those who may have housing but not enough money for food and other essentials.

Staffing

Four outreach workers, working in teams of two for safety, are employed 25 hrs per week each (2.5 FTEs). Requirements are first aid, Suicide Prevention, Therapeutic Crisis Intervention, Class 4 drivers license, and a minimum of grade 12. Team members receive further training in mental health first aid and concurrent disorders, and safety precautions when addressing the needs of people with Hep C and HIV. Staff does not necessarily have to have been homeless themselves, but have to know and understand about homelessness.

Qualities identified by clients for a good outreach worker were: Respectful, able to listen, friendly, flexible, funny, easygoing, possessing empathy (i.e. knowing what it is like to be on the streets), camaraderie, easy to ask help from, and an ability not to let negative attitudes or actions from the clients affect their approach.

Outreach Description and Activities

The programs are delivered from Ketso Yoh, a PGNFC facility offering a 21-bed low barrier emergency shelter, 10 alcohol and drug supportive recovery beds, 15 supported living beds, drop-in services, lifeskills training, case planning, and cultural supports. The program operates 7 days a week with two shifts: Sun-Thurs. 10-3 PM, Tues.-Sat 3-8 PM. Teams use a van to travel about the downtown core, to go to shelters and into camps. The teams provide clients with the opportunity to connect with services they might have trouble accessing on their own.

a) Engagement

The approach is always with respect and is one of harm reduction. The teams make sure the person has eaten that day, is warm enough and has a place to sleep. In winter they bring hot drinks and blankets to the streets and leave their card with the person for contact. In the camps, if the person is not there, they leave items as gifts to announce that they came and will return. Clients also come to the outreach program through referrals and now that the program is well known and the van recognizable through self-referral. As the program has become more known on the streets, it has become easier to build relationships with potential clients. Time spent with the client depends solely on the client and their needs. Clients interviewed found it easy to contact the worker by telephone and felt that the time the worker spent with them was satisfactory.

b) Housing

The teams also connect and build relationships with landlords. Each team receives $1,200 a month in rent supplements for distribution to clients. Guidelines for the supplements are strict and it is time consuming to determine eligibility. However, filling out the long eligibility form has the advantage of giving the outreach worker an insight into the client's abilities to manage money and their other needs, leading the worker to offer further services.

c) Income assistance

The teams bring clients to shelters, take them to drop-in centres where they can shower and access toiletries, assist the client with housing, and receiving income assistance, and will refer those who need and wish to mental health or addictions services, physical health services, life skills training, employment training and legal aid services. The client's level of comfort will determine if an outreach worker accompanies the client to an appointment.

d) Health care

As well as referring to clinics and the hospital, clients can receive care for certain minor problems, like foot care, from the Needle Exchange nurses.

e) Follow-up

There is no determined cut-off time for support. Clients who stabilize will stop contacting the worker. Sometimes a stabilized client will fall back into homelessness and contact will be rekindled. One interviewed client stated that they had been connected to the program on and off for 4-5 years.

Definition of Success

PGNFC defined success as: As little as someone asking for help, as much as getting the person housed. Success, they said, is by what the client defines as success.

Outcomes

After 6 months 40-50% of the clients are ready to and do obtain independent housing. Ninety five percent of clients are receiving Income Assistance. In addition, approximately 10% of clients become eligible for a Disability Allowance (DA) after working with the outreach team for six months where they have been receiving supports such as obtaining a doctor and getting the assessments they need for DA eligibility. Approximately 30% will stabilize and access the necessary supports and resources to be employable. [8]

Challenges

Certain gaps or challenges have added work pressure on the outreach teams. Examples are:

- The lack of decent, suitable and affordable housing in the area and that the housing available at $375/month is often substandard. Also lacking are transitional housing beds. This means that people cycle through the shelters because there is nowhere else to go.
- Interviewees stated that the new combined Mental Health /Addictions model is working in Prince George. However, treatment centers deal only with one or the other, either mental health concerns or addictions, and this can be problematic for those who are concurrently disordered.
- The lack of adequate addiction treatment. Facilities in other locations remove the person from the setting of their addiction, but also remove them from the support of family and friends.
- There is only winter funding available for certain services delivered by Mental Health and Addictions, as well as certain services delivered by the shelters.
- There is a lack of GPs who are willing to go into the shelters to provide medical service.

Clients felt the most important assistance the outreach program offered was housing, advice, transportation, and the method of engagement – regarding the person as human (not the usual response they experienced when on the street).

PGNFC identified the following gaps and challenges:

- Difficulty recruiting and training outreach staff who work only part-time due to available funding and the need to work in teams of two;
- Funding for bus fares for clients;
- Required paper work for HOP/AHOP is onerous and takes time from serving the client; and
- Due to privacy issues, it is difficult to share information between service organizations.

Others identified:

- It was suggested that there is need for either round the clock service or at least a 24-hour crisis line. Clients felt that service hours should be expanded in the coldest times of the year.
- Having to go any distance to access services is a challenge in Prince George winters.
- Because Prince George is a service centre, people come into town for a variety of reasons, including medical. Some find that upon release they do not have the funds to return home. This is also true of some people released from the local correctional institution.

[8] Jennifer Harrington, Director of Supportive Housing. PG Native Friendship Centre. Personal communication. Feb. 17th, 2011.

- There is a need to educate the general community on the issues of homelessness and to involve other sectors, such as the business community, in addressing homelessness.
- Many people who are at risk of homelessness live in sections of the city that are not served by the program.
- It was suggested that having a liaison position to connect all the services for a continuity of care would be helpful to delivering the program.

Community Linkages

The outreach team has largely informal linkages to:

- Ministry of Social Development (IA)
- Mental Health and Addictions of Northern Health
- Community Response Unit, Northern Health[9].
- Assertive Community Treatment (ACT) team, Northern Health
- Addictions treatment facilities
- Walk-in clinic and Central Interior Native Health Centre
- Hospital
- Programs offered through the NFC
- Life Skills programs: NFC, Firepit (cultural resource centre), Carrier Sekani Family Services
- Employment training opportunities
- Probation officers and legal aid
- 4 or 5 specific landlords
- Beyond Homeless Standing Committee of City Council
- Homeless Intervention Table (HIP) - Participants share information weekly in a triage approach to finding sustainable housing.

Community Impact

While some Interviewees felt that the program was generally supported and not contentious, others felt it wasn't well enough known. The suggestion was made to publicize the program both to gain community support and because seeing how others have come through adversity could help those on the street to be more positive about their own abilities to do so.

Effective Outreach Practices

1. Passionate, dedicated staff
2. The one-stop-shop approach of being able to offer a large number and variety of programs by the host operating agency. Examples include transitional housing, life skills training and employment programs. As well, there are many other community services available.
3. The teams have established relationships with certain landlords who will call with a vacancy. They will also contact the outreach teams if there is a problem with a housed client, enabling supports to be increased to prevent eviction.
4. The teams communicate with the different shelters and this can allow people who were banned at one shelter to be housed at another.
5. The PGNFC takes a holistic approach to all its services including outreach, and works to ensure that a broad range of community services are available not only to clients of HOP and AHOP, but

[9] In the Prince George area, the Community Response Unit (CRU) acts as the primary point of entry for all adult community mental health and addiction services and provides support to the hospital emergency department in assessing/ stabilizing/identifying appropriate services for those who present at Emergency with mental health and addictions concerns.

to their families as well. The NFC finds this multidisciplinary approach beneficial, as it assists the client by meeting a variety of needs.

6. It takes time to develop relationships with a client and it may take a number of visits to engage. The team's approach is, "Let us take you somewhere safe." It could be a café for something to eat or a shelter. The engagement process and the time required for each visit depends on the person and his/her specific needs.
7. For those with mental health or addiction concerns, the approach is to establish a relationship and to build trust so that the client knows they are safe with self-disclosure. Then the team refers.
8. The PGNFC has funding for a program for up to thirty (30) people who are on IA, but who are restricted from accessing the ministry office due to previous behaviour problems. The PGNFC serves as a third party and assists these people to help them obtain the needed financial supports
9. The team works hard to ensure that it is always empowering the client to do things for himself.
10. The close relationship between an employee of the Community Response Unit of Mental Health and Addiction Services and the outreach team has led, among other benefits of his position, to cementing linkages between the shelters and forensics.
11. It benefits the program to have an active municipal strategy like that of the City of Prince George that recognizes the need for affordable housing in the community and addresses the need, as well as recognizing a Housing First approach to eliminating homelessness.

Importance of Outreach Practices Identified in the Literature

Interviewees rated all effective outreach practices identified in the literature as important or very important. However the lowest rating was provided for "taking a team approach to staffing i.e. outreach workers share a caseload" and "Hiring formerly homeless clients as outreach workers." The former practice, a team approach to staffing, was rated highly by workers, but was viewed as less important by clients, who would prefer to have a relationship with a single outreach worker as opposed to a team.

Community Factors Affecting Outreach

Prince George is a tight knit community with good linkages between various organizations. It was reported that services do not overlap and it is possible to make appropriate referrals, rather than "passing the client off" to someone else. Working together has meant that agencies have been able to do things they couldn't do alone.

CMHA North Shore: A Suburban Homeless Outreach Program

Community Profile

Community: CMHA North Shore Homeless Outreach Program is included as an example of homeless outreach operating in a suburban community. The North Shore is composed of three largely suburban municipalities: the District of North Vancouver, the City of North Vancouver and the District of West Vancouver, as well as lands of the Squamish First Nation. The Districts of North Vancouver and West Vancouver are suburban in nature, while the City of North Vancouver is more urban, with dense development in the Lonsdale area.

Population Growth and Migration: The North Shore has seen little population growth in recent years, with a population gain of only 1.1% between 2001 and 2006, making the combined population of the three municipalities 169,858. Net in-migration to the region between 2000-2001 and 2008-09 was largely dependent on international immigration, and interprovincial in-migration also contributing to population growth.

Key Statistic	North Shore Municipalities	British Columbia
Population Growth 2001-06	1.1%	5.3%
Proportion of population 45 and older	46.2%	43%
Population with a university certificate, diploma or degree[10]	26.8%	30.2%
Unemployment Rate 2009 (Vancouver CMA)	7.1%	7.6%
Households in core housing need, 2006 and 1996 (Vancouver CMA)	17.0% in 2006 (129,145 households)	14.6% in 2006 (221,475 households)
	19.0% in 1996 (122,350 households)	17.4% in 1996 (228,970 households)
Number of rented dwellings	19,215 units (2006)	493,995 units
	20,685 units (2001)	
Vacancy Rates, October, 2010[11]	1.9%	2.8%
Average rent, October, 2010	$1,462(District of WV)	
	$973 (City of NV)	
	$1,058 (District of NV)	$752
# homeless, 2005 and 2008	128 (2008)	
	85 (2005)	

Population Characteristics: The age composition was largely comparable to provincial averages, with a slightly greater proportion of individuals 45 and older (46.2%). This varies according to municipality, with a significant proportion of seniors in West Vancouver. All North Shore municipalities have a small Aboriginal population, with 2.1% of the population identifying as Aboriginal in the District of North Vancouver and 0.9% and 0.4% in the City of North Vancouver and the District of West Vancouver respectively. All North Shore municipalities had significant immigrant populations, of 37.1%, 36.5% and 31.7% for the District of West Vancouver, City of North Vancouver and District of North Vancouver respectively.

[10] Between 25 and 64 years of age.
[11] For privately initiated rental row and apartment structures of three units and over

Economy: The North Shore is a largely residential area, with some density and commercial development in several areas, notably Lonsdale. Many residents commute to jobs in other cities in Metro. The North Shore economy is heavily tourism-dependent. The service industry, entertainment industry and some manufacturing and transportation also contribute significantly to employment.

Education and Employment: The North Shore has a slightly lower proportion of university-educated individuals, with 26.8% of individuals between 25 and 64 having some form of university certificate, diploma or degree, compared with the BC average, 30.2%. The unemployment rate in the CMA in 2009 was slightly below the provincial average, at 7.0%, though it increased significantly since 2008, when it was 4.3%.

Housing Profile: Vacancy rates for the North Shore communities were very low. The District and City of North Vancouver both had a vacancy rate of 0.9%, while the vacancy rate for West Vancouver was 1.4% in 2010. Additionally, as of 2006, median rent costs for the North Shore were much higher than the BC average, with median rent in West Vancouver being highest, at $1,123. The region also saw a decline of 1,470 rented dwellings between 2001 and 2006. While the incidence of core housing need in Metro Vancouver improved slightly between 1996 and 2006, from 19% to 17%, there was an actual increase of nearly 7,000 households in core housing need.

Low-Income, Dependence on the Safety Net and Homelessness: Median income for households and families in the City of North Vancouver are comparable with the provincial median income; however, household incomes in the Districts of North and West Vancouver was significantly higher. In the City of North Vancouver 21.2% of economic families live below the low-income cut off, while 11.7% of families were below the low-income cut off in both district municipalities. Between September 2008 and September 2010 the dependence on the social safety net in the Metro Vancouver Region rose slightly, with recipients of Basic Income Assistance rising from 1.2% to 1.6%. An increase of nearly 43 homeless individuals was recorded between 2005 and 2008, making the total 128.

Case study

Delivering Agency

The Canadian Mental Health Association North and West Vancouver Branch (CMHA NWV). Established in 1958, the agency's vision is "Mentally Healthy People in a Healthy Society." Their mission is to support recovery and resiliency through four streams: advocacy, community-based research, services and education. This branch provides a range of individual and group support, including grief counselling, support group, a telephone coaching service called Bounce Back, and counselling for people with chronic disease. CMHA NWV also operates four different housing sites: a five-bed transitional house for men in recovery from mental health/ addiction and three facilities targeted at individuals with persistent and serious mental illness. This branch also operates two employment programs targeted at different populations and broader community education and health promotion. Finally, until January, 2011, the CMHA NWV had a Community Navigator, a life skills program that operated in close partnership with the Homeless Outreach Program to help provide opportunities for community integration to clients.

Impetus

CMHA North and West Vancouver was one location selected for the 2006 CMHA Homeless Outreach pilot projects, which were implemented in eight BC communities, in partnership with the then BC Ministry of Employment and Income Assistance. A need for the program had become apparent through the branch's employment programs, as clients faced challenges maintaining employment while homeless or trying to find and maintain housing. Funding from the BC Housing Homeless Outreach Program (HOP) for a permanent part-time outreach worker started on August 1, 2007; the position was expanded from part-time to a full-time staff member at the beginning of 2008.

Goals and Objectives

The work of the North Shore outreach program is largely focused on two objectives: helping homeless individuals connect to and maintain safe and affordable housing and assisting homeless individuals access income assistance or other financial assistance. As such, engagement with the homeless population provides an important basis, building relationships and trust. The program also provides connection with health services through a nurse practitioner and until recently connected homeless individuals to life skills services through the in-house Community Navigator program, now discontinued. Finally, the program also provides individuals who have been housed the supports they need once housed.

Client Group

The nature of the client group has changed significantly in the last three years of the program. In 2008 the client base was almost entirely Caucasian males between 35 and 45. In 2009, 79% of clients identified having a mental health issue, while 77% struggled with addictions. While this group still forms a majority, the spectrum of clients has recently broadened. Two demographics that have increased in particular are older individuals (50+) with alcohol addictions and single mothers with children.

Staffing

The CMHA North and West Vancouver has one full-time outreach worker who handles the entire program caseload. There is a supervisory role with the Executive Director, but the outreach worker

manages her own time and caseload. However, she works closely with other services provided in house, as well as other outreach workers at the North Shore Lookout Shelter. Because there is only one long-serving staff member there are no established standards for the outreach worker. While the worker's educational background is business, she brings street mission experience from another country, as well as professional experience from working with both the Harvest Project and North Shore Lookout Shelter for several years.

Outreach Description and Activities

The outreach program serves the North Shore community, actively connecting to homeless individuals and those at risk of homelessness who need services and support.

a) Engagement

In early stages of the program clients were contacted through outreach and engagement in parks, malls, camps and the broader community. While still a part of the program, most clients access the program because of word-of-mouth awareness about the program amongst the homeless population or referrals from other community services and supports, such as the Lookout Shelter or women's services.

Clients noted the importance of a number of qualities in an effective outreach worker. These included honesty and openness allowing clients to trust the worker. Compassion, understanding of a clients' experiences, and a non-judgmental perspective were also key qualities. These qualities provide the important emotional support that allows clients to build a long-term relationship with an outreach worker. One client noted that it was particularly useful having an outreach worker who was straightforward with him, allowing him to take the same approach. Both clients emphasized the importance of being respected by a worker, which is not an approach they received from all service providers.

The program engages with clients through booked appointments or a once-a-week drop-in (Tuesdays), where clients do not need an appointment. The length of time dedicated to clients varies according to their needs from brief weekly meetings to all-day support for clients with special needs. Typically, the outreach worker will work with clients to connect them to income supports and help create a long-term housing strategy, that continues to provide a client with the supports they need once housed. However, the worker may also provide additional support or referral, particularly to health services and/or other programs provided by CMHA.

b) Housing

The worker helps fill out housing applications (for BC Housing, Co-op applications, non-profits). The worker also provides a weekly housing list every Monday of shared or more affordable accommodations in Vancouver or the North Shore. The worker will also provide support for clients seeking housing.. While the outreach worker does not usually meet landlords, in order to encourage independence in clients and reduce potential stigma associate with being homeless, the worker will coach clients before interviews. In some cases the worker contacts landlords if mediation is necessary. The worker also makes referrals to Lookout Shelter, where a bed is made available to North Shore outreach workers.

c) Income assistance

The worker is able to fast track applications for homeless individuals seeking income assistance once a week. The worker will fill out part of the Persons With Disabilities application and work with doctors. Finally, the worker will advocate to both social assistance and health providers, including providing support at income assistance reconsideration and tribunals when necessary.

d) Addictions

The worker will provide referrals to detox or rehabilitation facilities and can sometimes fast-track rehabilitation applications. The worker has created a strong relationship with an addictions specialist on the North Shore and will transport clients to the first 2-3 appointments at his office. Later clients can talk to the specialist using Skype from the CMHA office.

e) Mental health care

The worker can provide referrals for Rapid Access Psychiatric Services, offered by Vancouver Coastal Health Mental Health Teams. The CMHA offers grief counselling for mild depression in house and the worker will provide follow up with doctors regarding mental health issues with clients (73% of people on the North Shore with mental health issues are served by a GP).

f) Physical health care

A nurse practitioner works at CMHA on a weekly basis; the worker can refer clients to the nurse practitioner to start a file, providing a case background for future referrals to physicians.

g) Life skills

In addition to services provided by CMHA, the worker provides referrals to Family Services of the North Shore North Shore Crisis Services Society or other community organizations.

h) Employment and training

There are a number of employment services at CMHA, including Open Door, ACHIEVE and BC Employment Services.

i) Other services

Younger clients may be referred to Hollyburn Family Services, which has a youth safe house; some clients may be referred to the Food Bank. After housing is secured the worker may help clients with rent (through rent supplements), with budgeting, other community resources (clothes, furnishing, etc.) as necessary. The worker will refer clients to one of three community resources: North Shore Community Resources' legal advocate, UBC Law Students or Pivot Legal Society.

j) Follow-up

The worker will continue to support individuals as long as they need services. Outcomes for clients are recorded at 6 months. Because of the range of services available at CMHA, the worker will often maintain informal links with individuals who are accessing employment or mental health services. Other follow up occurs through telephone calls or appointments. The worker will sometimes look for clients who have stopped accessing services. In some cases if clients have moved on it may be impossible to monitor them. Additionally, some clients who have found stable employment and housing may no longer wish to have contact with the program. Client files are only closed when an individual has died, and clients are welcome to return to the program at any time.

Definition of Success

Several definitions of success were proposed. A primary long-term definition of success is access to safe and affordable housing and access to income and community supports. However, a more immediate definition of success was simply a program in which every interaction helps create more stability and functionality for the client, and in which the client's life is improved, even if only slightly. Finally, an element of success was the development of a community network of support in which multiple partners can work together to provide services that an individual needs at a given moment in time.

Clients' views of the program: Both clients felt that the program was sufficient at the time when they had used it. However, one noted that the outreach worker is significantly busier with the current caseload. Both individuals were able to access the worker on a regular basis, and both clients felt that the outreach worker had a respectful, non-judgmental and compassionate approach to them. Both clients suggested that the program would benefit from an additional staff member to support the outreach worker. One client noted that access to secure housing was an important service offered by the program. The other said that the role played by an outreach worker in the community, providing someone for homeless individuals to talk to who's sober and respects them was vitally important.

Outcomes

Despite a lack of affordable housing across the housing continuum, outreach workers and community partners believe the program is successful. Since its beginning in 2006, the program has worked with 520 clients. Of these 82% were able to maintain housing for more than six months. In 2010, 216 clients were housed; 33 individuals were housed more than twice, usually due to challenges associated with acquired brain injuries. Additionally, the outreach worker was able to connect a significant number of clients to income assistance, although only two accessed the Rental Assistance Program (RAP) a provincial government rent supplement program for families. Clients who receive disability allowances or basic income assistance were generally able still receiving support after six months.

Challenges

Outreach workers and community partners cited a number of challenges in program delivery. These included:

- Lack of community awareness and denial of homelessness on the North Shore.
- With a concentration of services in the urban centre of Vancouver there are few services on the North Shore; a lack of health options for clients, particularly doctors/dentists willing to treat the homeless population; a lack of resources around mental health and addictions; pressure on other services for seniors and women. In particular a drop-in centre providing a range of services (from showers/laundry to outreach) was cited as a useful potential resource.
- A lack of emergency and transitional housing. Both are in high demand and heavily used, as well as accessed by clients from around Metro Vancouver.
- Cost of rental housing. With rents of minimum $500/month (more likely $750-800) it is very difficult to find affordable housing for clients, particularly those on basic income assistance or disability allowances.
- Volume of forested area in the region makes it difficult to locate/identify camps for outreach.

- Difficulty integrating the outreach program into other programs offered by CMHA. A variety of services means a diverse client group, which can lead to conflict with other building tenants or between clients who have varied backgrounds.
- Workload is significant and can be a significant burden on the well-being of staff.

Community Linkages

The outreach worker has a strong relationship with a range of other community services. Relationships to other agencies are largely informal. However, the CMHA sits on the North Shore Homelessness Task Force. This task force links local governments and service agencies by providing a formal planning and policy network. Links to other organizations are largely informal, although the outreach worker maintains close links with other frontline organizations. These include the North Shore Lookout Shelter and Motivation, Power and Achievement Society. Staff members from these organizations take a team approach to working with the homeless population. In some cases (where appropriate and with clients' permission) case information may be shared to provide advocacy or other support for clients. CMHA also partners with Vancouver Coastal Health to provide direct health services to clients once a week, while maintaining links with the broader health care community. Additionally the outreach program refers clients to a large number of other community services (see above). While the outreach worker maintains some relationships with landlords, this is not a core focus of partnership building within the program. One client was referred both to a shelter and then transitional housing due to the close relationship between the outreach worker and Lookout Shelter. The other client said the outreach worker was able to fast track his entry to a rehabilitation program.

Community Impact

The program itself is not widely known about in the community. However, the program itself is well connected to all community stakeholders, who are supportive of the program's work and rely on it. A continuing challenge is an ongoing lack of awareness about the broader issue of homelessness on the North Shore. Community partners noted that the outreach program has resulted in or contributed to several visible community outcomes, including a reduced work load for other service workers, less visible homelessness on the North Shore, greater cooperation between organizations and agencies and a stronger policy response from local governments. Additionally, the program has significant positive impacts on clients themselves.

Effective Outreach Practices

1. Developing strong partnerships with other organizations serving the homeless. By taking a team approach to working with organizations like Motivation Power and Achievement society and Lookout Shelter, the program is able to ensure that the needs of a client are met as quickly as possible. This collaboration also ensures that services are not duplicated and helps build awareness of the issue.
2. Empowering clients to get involved in the service. Clients often refer new clients, and this builds a reputation of trust within the program. The outreach worker supports this by showing consistency with individuals, building relationships and working with clients over the long term to try to give them a better life.
3. Clarity and consistency in working with the client. Showing respect and providing whatever services possible, but not promising something that can't be delivered. Instead, focusing on small efforts to improve clients' lives. This creates an open honest relationship where clients can trust the worker as someone to go to for help.

4. Thinking outside the box to ensure that clients receive the services they need, both in the short and long term. This means looking for alternative arrangements that meet clients' needs as they arise.
5. Working in partnership with the Community Navigator to provide support and community connections to clients who are housed. This long-term support basis allowed clients to move from outreach services to the development of life skills. This program is no longer funded, though there are efforts to re-establish the position in coming months. This work is still somewhat supported by the long-term relationship between the worker and clients; however, the worker's caseload is too large to support significant life skills supports to clients.

Importance of Practices Identified in Literature

All of the outreach practices received a rating of "very important" or "important" from the interviewees. However, former clients viewed "accompanying client to appointments" as either not important or somewhat important. In addition, agency, community and former clients all thought that "hiring formerly homeless persons as outreach workers" was less important than "hiring staff with special knowledge of homeless people and the problems they face". Providing mediation with employers and/or landlords was also rated as somewhat less important.

Community Factors affecting Outreach

One of the most important factors cited in the success of the outreach program was the availability of and connections with other support services. From the perspective of outreach workers, community partners and clients, being able to provide or immediately refer clients to a range of available services is vital to any outreach program. There are several reasons for this:

- From a client perspective being able to access many services builds the reputation of the outreach worker as someone who can actually help. Being able to link clients to other services and advocate on their behalf means clients are more likely to trust the worker and make use of the program.
- From a community partner perspective the availability and connections with other support services helps to link responses to homelessness in the community, building a network (often informal) of services and resources that partner agencies can make use of with their own clients. Additionally, it prevents duplication of services.
- From an outreach worker's perspective a strong network of community services reduces the burden of trying to provide all services to a client. It also allows outreach workers to provide a difference to a client's life.

The availability of affordable housing was cited as another key factor in the success of the program. While community partners and outreach workers felt there was inadequate affordable housing on the North Shore, being able to provide access to *some* affordable housing made a significant difference in the effectiveness of service delivery to clients. However, these interview participants felt that the lack of affordable housing represents a major barrier to further outreach success.

Another major community factor was awareness of the issue of homelessness. While outreach workers and community partners noted the lack of awareness of homelessness as an issue on the North Shore, several felt that awareness was growing. One example of this growing awareness is the North Shore Homelessness Task Force, connecting local governments with community services to coordinate planning and policy responses to homelessness. However, it was noted that a greater

awareness of the issue, particularly from organizations indirectly linked to homelessness (e.g. health care providers) would further benefit the organization.

Finally, interviewees all ranked adequate ongoing funding for the program as a key factor for success.

Alouette Home Start Society: A Suburban Homeless Outreach Program

Community Profile

Community: The Alouette Home Start Society Community Outreach Program is an example of a homeless outreach program operating in a suburban community. Maple Ridge is a small suburban municipality on the periphery of Metro Vancouver, separated from adjacent communities by the Pitt and Fraser Rivers. It maintains a large agricultural land base; however, rapid development in the last 15 years has significantly changed its composition.

Population Growth and Migration: Maple Ridge has seen significant growth in recent years, with the District growing by over 5,780 people, or 9.2%, between 2001 and 2006, a significantly higher rate of growth than BC's.

Population characteristics: As of the latest Census (2006), the population of Maple Ridge was 68,949 persons. Maple Ridge has a greater proportion of young residents under age 14 (20.3%), likely indicating a large number of young families. 2.6% of the population claimed Aboriginal identity, while immigrants composed 17.7% of the population.

Key Statistic	District of Maple Ridge	British Columbia
Population Growth 2001-06	9.2%	5.3%
Share population 0-14 yrs	20.3%	16.5%
Population with university certificate, diploma or degree [12]	18.8%	30.2%
Unemployment rates 2009	7.0% (Vancouver CMA)	7.6%
	7.2% (Mainland/Southwest)	
Households in core housing need 2006 and 1996 (Vancouver CMA)	17.0% in 2006 (129,145 households)	14.6% in 2006 (221,475 households)
	19.0% in 1996 (122,350 households)	17.4% in 1996 (228,970 households)
Number of rented dwellings, 2006	4,800 units (2006)	493,995 units
	5070 units (2001)	
Vacancy Rates, October 2010 [13]	3.2%	2.7%
Average rent, October 2010	$750	$752
# homeless 2004 and 2008 (Maple Ridge/Pitt Meadows)	42 in 2005	
	90 in 2008	

Economy: Maple Ridge is traditionally agricultural, with nurseries, greenhouse operations and berry growing continuing to play important economic roles. The area has some industrial activity, including boat building, metal fabrication, battery manufacturing, plastics and printing/publishing. A majority of Maple Ridge residents commute to work in other cities throughout the region.

Education and Employment: The City of Maple Ridge has a significantly lower proportion of the population, with some form of post-secondary education (42.4)%, compared with the BC average, 61.8%. Additionally, about 19% of the population has some form of university education, compared with the provincial average of 30.2%. The unemployment rate in the CMA rose significantly between 2008 and 2009, from 4.3% to 7.0%,

[12] Between 25 and 64 years of age.

[13] For privately initiated rental row and apartment structures of three units and over.

slightly above the provincial rate, with a comparable rise in the Mainland/Southwest economic development region of 4.2% to 7.2%.

Housing Profile: Vacancy rates in Maple Ridge/Pitt Meadows in October 2010 were 3.2%, slightly above the provincial average. As of 2006 median rental rates in Maple Ridge were about the same as for all of BC. The incidence of core housing need in the Vancouver CMA improved between 1996 and 2006, but the actual number in core need increased by nearly 7,000 households. In the five years between 2001 and 2006, the rental housing stock declined by almost 300 units.

Low-Income, Dependence on the Safety Net and Homelessness: Median family income for households and families in Maple Ridge are well above with the provincial median income. As of 2006 14.5% of economic families lived below the low-income cut off, a decline of 0.6%. The dependence on the social safety net in the Metro Vancouver Region rose slightly, with recipients of Basic Income Assistance rising from 1.2% to 1.6% of the population between September 2008 and September 2010. The homeless population also more than doubled in the period between 2005 and 2008 in the Maple Ridge/Pitt Meadows area, from 42 to 90.

Case Study

Delivering Agency

Alouette Home Start Society (AHSS). The Society was established in 2003 by six Maple Ridge agencies that recognized the need for an organization focused on housing and homelessness to work with the community to find solutions to address the lack of affordable housing and homelessness. Its mission: using a holistic approach, to advocate for the provision of creative, innovative housing solutions with affordable choices. Founding members were Alouette Addictions, Bowman Employment Services, Cythera Transition House Society, Katzie First Nation, Salvation Army Caring Place and Virtues R Reality. The society operates a youth safe house, the Community Outreach Program and is in the process of building a 46-unit supportive housing project with the Province and District of Maple Ridge.

Impetus

A broad community consultation process determined that AHSS would have three priorities: a youth safe house, outreach and supportive housing.

Goals and Objectives

The objectives of the Community Outreach Program (COP) are to act as a bridge between services and the homeless community by engaging with homeless people, and assisting them to access financial assistance, to secure and maintain housing and to connect them with health and life skills services as appropriate. The program is funded by both BC Housing HOP and HRSDC.

Client Group

The program serves youth and adults who are homeless or at risk of homelessness. They serve a broad range of clients, although the majority is in the 35-44 year age range. Outreach workers have seen more seniors in last of couple years. This population faces one or more problems including a lack of income or savings, loss of housing (from eviction or fire damage) or the loss of a spouse, and consequent emotional issues. To address this issue outreach workers teamed up with RCMP and Senior Services.

Staffing

The program has two outreach workers (2 FTE each working 35 hrs per week), working in the daytime hours. There may be an opportunity to hire an additional .5 FTE part-time outreach worker. For the outreach position, experience is viewed as valuable, but attitude and ability to connect with people are the most important qualities. AHSS doesn't insist on certification.

Clients' views of outreach work: The Worker's ability to deal with paperwork was the best quality, the one he appreciated. They would also need to be able to deal with the outdoors, mud, hiking to get to camps. Self defense would be good skill to have, and he though all outreach workers should experience homelessness for a few days to see what its like.

AHSS tries to strike a balance between coverage and team outreach work. They presently offer service Monday to Friday with some extra hours on Sat. One outreach worker works Monday to Thursday and the second works Tuesday to Friday, so that they overlap on some days. This helps ensure safety, flexibility, and the ability to support one another. AHSS sees a benefit to having a male and female outreach worker with different personal styles. For safety reasons, workers check in before going to the bush or driving a client somewhere.

Outreach Description and Activities

Workers promote independence by providing clients with tools they can use for the rest of their life, recognizing that outreach is a temporary service. Outreach activities vary according to the client. Some clients need help with specific tasks, for example, finding a home, so the process might take only a week or month. Others might benefit from a longer-term relationship. There are some clients whom workers have supported for years. Or it may be a short intensive relationship - 20 days per month. On average, the workers see ten people a day, and connect with each client once per week. Former clients interviewed were satisfied with the amount of attention they received from their workers.

a) Engagement

Clients call or they obtain referrals from other services such Employment Assistance and the hospital. About half of the time initial engagement is a result of workers looking for the street entrenched or those who are camping. They find homeless people by looking at area maps, networking with other clients, and building relationships with those who might know where other homeless people may be found. COP workers will provide basic necessities like warm clothing and food to people living in the bush as a way of initial engagement

b) Housing

Workers assist clients with their housing search by updating a housing list once per week, using online sources. Originally it just included Maple Ridge but now it has expanded to include other communities like Port Coquitlam, Surrey and Abbotsford. Other agencies also use the list.

Workers assess client needs by reviewing their situation, and collecting information on income source, previous housing history, locational and housing preferences. They also contact other agency workers to get insight about a client to help make a better choice. Workers show the client the list and help them connect with landlords. In addition to immediate assistance into housing, workers also provide assistance with applications for social housing. They have the ability to do some priority referrals to BC Housing and will use their discretion to do so.

Outreach workers try to avoid driving clients from place to place, as they want to promote independence. However workers will assist with transport to view housing options if there are mobility issues. They also liaise with landlords, and advocate for clients if there is a likely eviction.

Workers communicate frequently with landlords, particularly shared accommodation landlords, who have high turnover rates. It is difficult to find housing for $375/month as the typical room costs $500 to $550. Workers try to educate landlords about the services available, how income assistance operates, what clients are entitled to and required to do. Landlords will call the outreach worker if anything goes wrong to give them a chance to address the issues. Workers don't provide references for clients for liability reasons.

c) Income assistance

Outreach workers assist clients mainly through the fast track process where a worker accompanies the client to the income assistance office, and provides assistance with necessary forms. The original agreement with IA was for same day service for referral. This has changed and there has been a level of frustration as outreach workers wish to provide clients with accurate information about what services they can provide and how quickly.

Clients sign a release of information permitting COP workers to access their information with IA. Former clients value this assistance with IA paperwork and the bureaucracy. Workers have relationships with staff to facilitate the process. Workers have also been able to assist clients who are third partied (clients who must pick up their cheque from another agency).

AHSS COP wishes to acquire a laptop and internet stick to enable workers to assist clients outside of the IA office.

d) Addictions

If a client discloses addiction, the outreach worker will encourage the client to agree to treatment and if they are willing, assist them to find an appropriate treatment program. Many clients need detox and workers will refer but note there is little detox capacity available. They work with Alouette Addictions in Maple Ridge to pair client with the appropriate style of treatment. For clients with both mental health and addiction issues or concurrent disorder, finding suitable treatment is a challenge.

e) Mental health care

Outreach workers provide referrals to Fraser Health Mental Health or Alouette Addictions. If a client is apprehensive about attending an appointment, the worker will accompany them, if desired.

f) Physical health care

Workers have a kit and first aid certification to attend to immediate first aid issues. Otherwise, they advise clients to get medical attention, and will help them with transportation hospital if needed, or refer to a list of doctors accepting new patients. For clients without a family doctor, the COP works with the public health unit and needle exchange.

g) Other services

AHSS COP refers clients to other agencies offering lifeskills programs, employment and training and legal services. Outreach works closely with the RCMP and will advocate with the legal system to get a client the appropriate service. They work closely with Community Services, who provide basic legal advice.

h) Follow-up

Workers follow up with clients after 6 months in housing as mandated by BC Housing, but after that, follow up is more limited. Workers support clients upon request, and monitor clients through connections with other services. Clients know they can call their workers at any time if they need assistance. Little time is spent on follow-up because there are so many new clients. Most clients are referred to other services in the community, including clients with addiction or mental health issues.

Some clients do not want to continue the relationship with their worker once they are settled. They feel outreach is there to help people to find housing or they may carry shame and guilt about their situation. If a client changes their phone number the worker may assume that the client has achieved the necessary independence.

Definition of Success

Individual client needs determine what is success. Each service provided suggests someone's life is a little better than before and any small progress is viewed as success.

Relationships are harder to measure, but if clients have someone beside them, supporting them, and have a connection, that is viewed as success. The AHSS COP has achieved a good success rate in housing homeless clients as showed by the high housing retention rate. Staff would like to see less visible homelessness in the community and they are not yet sure if that has been achieved. The organization's vision is to work towards the root causes of homelessness, which is a lack of affordable housing.

Outcomes

The outreach team helped 31 people secure housing in 2009/2010, and 89% of clients remained housed at 6 months.[14] According to the BC Housing Support Services Review, this one was of the highest rates in the Fraser Region. AHSS does not track outcomes for income assistance or other forms of assistance.

According to staff interviewees it is challenging to measure outreach outcomes as someone might attempt treatment three times and fail twice, but the fact that they tried is progress. The goal of relationship building and connection is also difficult to measure.

Challenges

- The society and COP operate out of a safe house with no publicly accessible office space. As a result Workers need to find places to meet clients in the community such as coffee shops, making privacy an issue.
- More staff coverage, for example, 7 days/wk.
- The gap between shelter component and rents in Maple Ridge. The minimum rent is $500, and the shelter component is $375. Unscrupulous landlords rent 'blanket rooms' where several people share a small space with blanket draped for privacy.
- Finding drug free housing. People who are trying to be clean don't want to live with others with addictions.
- There is a shortage of services for people with concurrent disorders.
- Recording statistics takes time away from clients.
- Inadequate supply of affordable housing and services like detox.
- Recovery houses will accommodate the homeless, but then if there is an issue, evict them, and their money is not returned.

Community Linkages

AHSS has strong linkages with the Salvation Army Caring Place in Maple Ridge, which offers emergency shelter, extreme weather space, transitional housing, a meal program and Community Advocates. COP outreach workers and Community Advocates work closely together. COP workers often meet their clients there. AHSS is currently trying to formalize its relationship with Caring Place.

The COP has linkages with other community agencies as well, including both formal and informal relationships with the local Employment Assistance office, CMHA, RCMP, Alouette Addictions,

[14] BC Housing Support Services Review for Alouette Home Start Society. Dec 16, 2010.

Bylaws (who will accompany outreach workers to bush and also provides referrals), Health Services, Bowman Employment Services, the hospital, and Friends in Need Foodbank. In the case of IA, the office maintains some appointments for COP workers that they are able to fill at short notice. While the Employment Assistance linkage is formal, other connections are informal.

Other community agencies like IA, police and Bylaws depend on the COP workers, and will call them to assist with certain matters. The COP program assists other agencies to carry out their responsibilities.

The COP takes an integrated case management approach to addressing homelessness. It participates in the Community Network which meets monthly to plan service provision in the community and includes a variety of service providers. A smaller group meets every two weeks, called the Holistic Meeting. It consists of front line staff that gather to discuss common clients. The goal of the meetings is to share information on client progress with each agency in a confidential setting, and is helpful in delivering appropriate services to clients. There are no formal agreements, but the organizations share common goals.

Community Impact

Community awareness about homelessness is growing. AHSS holds a Homelessness Awareness Week every year and interviewees think it has borne fruit. The new supportive housing project has received little community opposition. However, a segment of the population feels that if new service is introduced into the community, it will attract homeless people. One community stakeholder thought that the COP practice of going into the bush to find homeless people has in fact increased the visibility of homelessness in the community.

Effective Outreach Practices

1. Employing staff with the personal qualities to build relationships with homeless and with stakeholders, and with compassion and empathy.
2. Collaborating with other community stakeholders. Being part of a community network.
3. Seeking out homeless people where they are.
4. Offering services as long as the client requests it and this may include repeat services. Even if a client entered treatment 5 times and relapsed 4 times, workers will continue to work them.
5. Demonstrating respect for the client through outreach worker conduct, speech, body language, demeanor, and attitude.
6. Consistency in dealing with clients. Outreach workers have to be there for client, even if the client is unreliable or doesn't show up. Clients must know they can count on their outreach worker at all times.
7. Connecting clients with services in the community and helping them with navigating the bureaucracy and paperwork.
8. Providing basic necessities like warm clothing and food to people living in the bush as a way of initial engagement.
9. Assistance with maintaining housing, for example, talking to landlords in the event of an eviction or bed bug infestation.
10. Ensuring worker self-care. Workers need to take care of their own physical, mental, and emotional well being to be able to work successfully in this environment, including outdoors.

11. Promote worker safety. Practices include constant communication with each other, supervisors and other services, and employing a tactical approach to dealing with certain clients by, for example, meeting in public places, not visiting camps alone.

Important Outreach Practices Identified in the Literature

Most outreach practices identified in the literature were rated as "very important" by interviewees, although two were rated less positively. All interviewee types rated "Hiring formerly homeless people as outreach workers" as not important. As one interviewee noted, this is because the organization must ensure there was no previous direct client relationship with a formerly homeless person seeking employment as an outreach worker, as this would blur boundaries. In a small community like Maple Ridge, even if no direct client relationship existed, this could be a problem as all homeless persons and outreach workers typically know one another.

Several interviewees also viewed assisting clients with their transportation needs as less important. They wished to avoid creating a dependency situation. However, one former client viewed it as a very important outreach practice because the homeless population has challenges with reading, social interaction and directions, and so have difficulty using public transit.

Community Factors Affecting Outreach

The integrated case management made possible by the Community Network and Holistic Meetings are key local factors contributing to the successful operation of AHSS COP.

Maple Ridge, although a suburb, is like a small town with a strong sense of community. Because of its size, agencies serving homeless know each other and can work together. One interviewee thought it might be more challenging to maintain those connections in larger centres.

One interviewee also noted that because of the small town character, clients might worry that their personal information would be shared.

There is a perception that Maple Ridge has a higher incidence of homelessness than other small communities and that housing is more expensive than in some other suburban communities.

Maple Ridge is a large municipality, many people camp outdoors, they are a challenge to find and camps move frequently. Finding individuals in the bush requires workers to be outdoors and do more walking compared to outreach workers in urban areas.

All interviewees rated the following factors as important for successful outreach:

- Availability of housing that is affordable in community;
- Availability of/connections with other support services in community; and
- Adequate, ongoing funding for program operation.

Ki-Low-Na Friendship Society: A Large Urban Area Homeless Outreach Program

Community Profile

Community: Ki-Low-Na Friendship Society Homeless Outreach Program is located in Kelowna, BC. Kelowna is a rapidly developing urban area in the interior of BC, and consists of the City of Kelowna, Lake Country District Municipality, Peachland District Municipality, and West Kelowna District Municipality, the lands of the Westbank First Nation and the Central Okanagan Regional District.

Population Growth and Migration: Kelowna has been one of the fastest growing areas in the province. Between 2001 and 2006 the City of Kelowna grew by over 10,000 people, an increase of about 11% and well over BC's rate of growth (5.3%). Much of the growth throughout the Central Okanagan Regional District comes from in-migration. Between 2000-01 and 2008-09 in-migration accounted for 27,660 new residents. Intra-provincial migration contributed the most (50.0%) to this population growth. In contrast, about 90% of all in-migrants to BC were from outside the country.

Population characteristics: As of the latest Census (2006), the total population of the Kelowna CMA was 162,275. The median age in the CMA was 43.4, with 84.3% of the population age 15 or over. 3.8% of the population claimed Aboriginal identity, while 14.8% of the population were immigrants.

Key Statistic	City of Kelowna (CMA where indicated)	British Columbia
Population Growth 2001-06	10.8%	5.3%
Population share of individuals 65 and over	19.4%	14.6%
Population with a university certificate, diploma or degree (including Bachelor's degree)[15]	22.7%	30.2%
Unemployment Rates (by development region) 2009	8.7% (Thompson-Okanagan)	7.6%
	12.0% (Cariboo)	
Households in core housing need, 2006 and 1996 (Kelowna CMA)	11.1% in 2006 (6,615 households)	14.6% in 2006 (221,475 households)
	15.2% in 1996 (7,290 households)	17.4% in 1996 (228,970 households)
Number of rented dwellings, 2006 (Kelowna CMA)	15,225 units[16]	493,995 units
Vacancy Rates, October 2010 (Kelowna CMA)[17]	3.4%	2.8%
Average rent, October 2010 (Kelowna CMA)	$822	$752
# homeless 2004	400	

Economy: According to BC Statistics, "The improved transportation links to the Lower Mainland have made the Central Okanagan [including Kelowna] a desirable place to locate secondary and tertiary manufacturing. The University of British Columbia Okanagan continues to grow. Agriculture and the

[15] Between 25 and 64 years of age.
[16] Comparison data not available from 2001 due to change in census geography from Census Agglomeration to Census Metropolitan Area between 2001 and 2006.
[17] For privately initiated rental row and apartment structures of three units and over.

popularity of the region for tourism and as a retirement centre should ensure continued growth for this region. Residential construction has risen rapidly recently. Agricultural activities include fruit tree and wine grape growing as well as horse and cattle ranching."

Education and Employment: Although the Kelowna and BC labour force have comparable levels of post-secondary education, the composition and type of post-secondary education in Kelowna differs from the provincial rates. In Kelowna 22.7% of the labour force has a university diploma or degree, compared to over 30.2% in BC. The unemployment rate in the economic development region around Kelowna was high in 2009, above 2008 levels and the BC average.

Housing Profile: Vacancy rates in Kelowna for 2010 were 3.4%, above the provincial average.[1] However, rental costs are also above the provincial average. The incidence of core housing need in Kelowna improved between 1996 and 2006. While 15.2% of households were in core housing need in 1996, this declined to 11.1% in 2006. Both are slightly lower than provincial rate. Despite these improvements, a significant number of households remain in core housing need 6,615 households.

Low-Income, Dependence on the Safety Net and Homelessness: Median after tax income for households and families in Kelowna are comparable with the provincial median income. 9.5% of all persons were below the low-income cut off in 2005. Dependence on the social safety net in Kelowna rose significantly, with recipients of Basic Income Assistance rising from 1.3% to 2.6% of the population between September 2008 and September 2010. The 2004 Census of Homeless Individuals counted more than 400 homeless persons in the City, with an average length of 31 months spent homeless.

Case study

Delivering Agency

The *Ki-Low-Na Friendship Society* (KFS). KFS is a multi-service agency in downtown Kelowna that serves several roles. It is the centre of urban Aboriginal culture in Kelowna and celebrates Aboriginal culture. However, it also plays a role delivering social services to all community members. In addition to its Aboriginal Homeless Outreach Program KFS operates two transitional housing facilities, targeted at youth and families respectively, and housing support related to homelessness. KFS also provides family and children's services, youth programming, health and wellness programs, legal advocacy, employment services and contracted English language services for newcomers to Canada. Additionally the Friendship Centre hosts smaller programs, such as a diabetes prevention program and cultural programming (e.g. for National Aboriginal Day).

Impetus

Homelessness had been identified as a serious issue in the downtown core. In 2006, a four pillars program was developed to address homelessness leveraging federal, provincial and local government resources to address it. The Kelowna Friendship Society was at the frontline of providing many services to the homeless population, as approximately 30% of the homeless population is Aboriginal. KFS found that although there were limited services available throughout the community for the homeless population, there was limited expertise, particularly in providing services to the Aboriginal homeless population. The Aboriginal Homeless Outreach Program at KFS was developed and implemented in 2006.

Goals and Objectives

The outreach program at KFS provides an important single point of contact for the homeless population in downtown Kelowna. The long-term objective of the program is to get clients into stable long-term housing and provide ongoing support once clients are housed. However, an important immediate objective of the program is to connect clients to appropriate community resources and services (e.g. health services, income security), establishing relationships with other agencies and organizations and advocate for clients in order to improve their lives in the short and medium-term.

Client Group

The client group has changed over time and it is highly dependent on the time of year, due to the large migrant worker populations associated with agricultural work in the region. The majority of clients have addiction and/or mental health issues and are at high risk or have multiple barriers. While in the past the majority of clients were Aboriginal (approximately 60%), there is currently a relatively balanced proportion of Aboriginal and non-Aboriginal clients. The majority of clients (approximately 70%) are male and most clients are single. However, there are some single parents and occasionally two-parent families at risk of homelessness who use the program.

Staffing

There are a total of 2.8 full-time equivalent outreach positions. One full-time equivalent position is funded through the AHOP program and a 1.8 full-time equivalent position is funded through the Homeless Partnering Strategy of HRSDC. Three staff members share responsibility for the outreach program. While individual staff have separate caseloads to build individual relationships and trust with clients, they share information on clients to ensure coverage should one staff member be unavailable. The backgrounds of the outreach workers vary, bringing a combination of

educational experience (e.g. graduate of the Human Service Worker Program and a Bachelor of Social Work), lived experience of homelessness and professional experience working with the homeless and people with disabilities.

Outreach Description and Activities

The outreach workers serve residents of the city of Kelowna, with a main focus on homelessness in the downtown core.

a) Engagement

Initially staff members were conducting outreach in the community, partnering with staff from other agencies and meeting the homeless population where they congregate. The approach was modeled on street nurses and allowed staff to get to know homeless individuals and build relationships and trust.

While this is still a program activity, most clients access the program through the Friendship Centre. The initial engagement, combined with the store-front nature of the program and its proximity (across the street) from Interior Health's Outreach Urban Health unit provides an excellent basis for knowledge of the program among the urban homeless population. Outreach workers try to accommodate drop-in clients, but out of necessity rely on appointments and the team tries to balance flexibility with caseload. New clients are usually walk-in referrals. In some cases clients are referred to the program through a cooperative network of service agencies called Partners in Community Collaboration (PICC).

Intake processes vary depending on the needs of the client: in some cases the workers help locate housing, while in other cases they may work with clients to access income assistance or connect them to community services.

b) Housing

In some cases the program provides referrals to one of many places, usually transitional housing; in other cases the outreach staff work with a client and landlord in assisting client in getting housing in an apartment. The program will refer clients to White Buffalo Lodge transitional housing if clients fit the criteria for the facility. Willowbridge, run by CMHA, also provides transitional housing with life skills services. In some cases the outreach program can subsidize rent for 3 to 4 months.

c) Income assistance

Outreach staff may accompany clients to the Ministry of Social Development office and provide case referrals to one of two MSD workers who work outside the office. Workers will assist with IA applications, particularly through the online system. If there is an appeal process the KFS legal advocate can assist clients.

d) Addictions

Depending on the client, there could be a referral to an addiction program at KFS or to Outreach Urban Health. In some cases the program will refer clients addictions counsellors based at other facilities like Cardington.

e) Mental health care

The outreach worker will provide a referral to Outreach Urban Health or the in-house mental health services. In some cases the worker refers them to Okanagan Advocacy and Resources

Society (OARS). However, this program used to be more directly focused on advocacy for people with mental health issues than they currently are.

f) Physical health care

The worker will provide referrals to Outreach Urban Health.

g) Life skills

Life skills referrals are handled through a variety of different resources, depending on a client's circumstances. An Aboriginal person ready for employment upgrading or training could use KFS employment services. KFS also has in-house facilities such as a community kitchen and informal stuff. There is a range of services from informal, day to day living (like budgeting, cleaning, etc.) to more formal like employment services that are provided at the Friendship Centre, though in some cases workers will refer clients to partner organizations (e.g. Willowbridge transitional housing provides life skills).

h) Employment and training

In-house employment services are available for Aboriginal clients. For non-Aboriginal clients referrals are made to Gospel Mission employment program and others in the community. However, many employment programs are not focused on homeless clients.

i) Legal services

KFS legal advocacy program (focused on poverty law) is available to clients. For criminal issues the outreach worker would refer clients to Duty Council.

j) Other services

Outreach workers will provide referrals to Brain Trust for people with acquired brain injuries. The two organizations will partner in finding housing, detox, supported living or other services the client may require.

k) Follow-up

Outreach workers continue to have contact with clients long after they are housed, providing referrals to health services, addictions services, mediation with landlords, nutritional education and more. While the outreach staff follows up at 6 months, in many cases clients will continue to access services at the Friendship Centre and maintain an informal relationship with outreach workers. There is no limit to when clients can stop accessing the outreach program, although clients are encouraged to build positive community networks to reduce their reliance on the outreach program over time. In some cases if clients move away or are still struggling with an addiction, outreach workers may not be able to locate or follow up with them.

Definition of Success

Agency members and community partners proposed several definitions for the program. A primary definition includes finding stable housing for clients that allows them to address other issues in their life, such as addiction and mental health issues, and develop positive community networks. An important dimension of this definition is connecting to individuals who may have barriers to accessing services and working with them to navigate services and resources in the community. While interview participants recognized that in some cases long-term, permanent housing may be the ultimate goal, success was defined more by allowing clients to make some "movement forward," allowing them to feel that they are not stuck, and that they are consequently improving (even if only incrementally) their health and well-being.

Client opinion of Outreach Program:
The client interviewed was very satisfied with the program. She felt that the approach of the outreach workers and their willingness and ability to help with a range of problems (health services, housing, employment) made this a valuable service. The client referred to KFS as 'home,' noting that beyond the delivery of outreach services, she had been able to find a community kitchen program, a compassionate ear, help with life skills and ultimately employment.

A second key determinant of success was the clients' view on the program. There was a sense that the program is widely accessed because outreach workers take seriously and respect the situation in which clients may find themselves. This allows the workers to help clients navigate barriers and services and provide them some greater measure of independence. A final proposed definition of success was community-based: that the outreach program's work improve broader community service delivery to Aboriginal people, by stronger awareness of sensitivity toward and respect of cultural differences between Aboriginal and non-Aboriginal people in Kelowna.

Outcomes

Despite significant limitations in terms of affordable housing in the community agency members and community partners believe the program has been successful in its goals. Since starting the program KFS has developed and received funding for the White Buffalo Lodge, a low-income transitional housing facility. It was noted that clients may cycle in and out of housing, depending on their step in the healing process, thereby affecting the percentages of clients in long-term, stable housing. However, by providing continuous support to clients wherever they might be in a cycle, agency staff felt that they could help an individual address some of their long-term, underlying challenges. Agency staff and community partners felt that the outreach program had been very successful in developing relationships with homeless individuals. Agency members felt that outreach workers were able to build long-lasting relationships with clients and even when they couldn't provide everything that was needed they were able to improve the lives of clients and provide a compassionate ear. With regards to building relationships with other community members, including landlords and other service providers, agency members and community partners felt that the outreach staff had been very successful. One staff member noted that awareness of issues specific to the Aboriginal community and Aboriginal homeless has improved significantly in recent years, with culturally-sensitive service delivery much more available to Aboriginal homeless individuals. He noted that while there remains work to do in the community raising awareness, there have nonetheless been significant changes in the last several years.

Challenges

- Much of Kelowna's housing is built for a tourist market, which increases affordability pressures in the community. There is also ongoing prejudice against Aboriginals in the community increasing the difficulty of finding housing.
- Long-term housing with supports is still lacking in the community and is vital to many of the program's clients.
- Workload is a significant issue. The number of clients accessing the program means that outreach workers may not have enough time to follow up fully with clients that have been housed.
- Because of sprawl in the region the outreach program is only able to serve the downtown core, while increasingly other areas need services (particularly because of the nature of transient farm worker population in the surrounding region). Transportation links are moderate, but not as strong as the could be to address this issue.
- Tracking data is a challenge because it is time consuming and cuts into time with clients. Data collection could be improved by staff, but that would detract from services.
- The Food bank requires clients accessing their service to have an address, making it inaccessible to many homeless individuals.
- Service cutbacks have impacted clients and service delivery (e.g. legal services were cited as a key area where cutbacks have been made).

Community Linkages

Outreach workers are aware of and have strong relationships with a number of service agencies in the community. KFS is also the hosting member of an innovative community-wide network for service delivery to disenfranchised individuals: Partners in Community Collaboration (PICC), composed of 25 organizations or government agencies that work with homeless and at-risk populations who meet once weekly for an hour to collectively address clients' needs (see below for full description). In addition to the PICC partnership, outreach workers are involved in a number of other community efforts to address homelessness. These include the Mayor's Committee to End Homelessness in Kelowna, the Kelowna Homeless Networking Group, a stakeholder network involving service non-profits and the faith-based community, Partners for a Healthy Downtown, consisting of downtown stakeholders (RCMP, local businesses, service agencies) and acting a vehicle for communication and cooperation in developing a healthy downtown environment, and the Homeless Intervention Project, a provincially-funded initiative to integrate care planning for chronic or episodic homeless individuals. KFS also has long-standing relationships with other service organizations such as Outreach Urban Health, CMHA, Gospel Mission, Now Canada and the Salvation Army.

Community Impact

KFS staff and community partners who participated in the interviews felt that while the program itself may not be known about in the wider community, it is well known to stakeholders and established as a key community agency in addressing homelessness in downtown Kelowna. Since the program's beginning there have been a number of noticeable community shifts regarding homelessness:

- More homeless individuals are able to access market housing.
- Individuals are able to access services appropriately; services are able to respond appropriately to their needs.
- The program has acted as one catalyst among several for the development of transitional housing (Recent transitional housing developments include: Cardington Apartments is 30

units of 1st/2nd-stage transitional; Willowbridge provides 40 units of 2nd-stage transitional; White Buffalo Lodge provides 39 transition units for youth, families, elders and those at risk of homelessness).

- The development of the PICC program has significantly improved service delivery and the service network in Kelowna.
- Increased safety and health in the downtown core.
- Visible homelessness has been reduced.
- Local governments and the broader community have become more aware of homelessness and other social services required to address homelessness.

Effective Outreach Practices

1. Development of PICC: Partners in Community Collaboration (PICC), composed of 25 organizations or government agencies that work with homeless and at-risk populations who meet once weekly for an hour. PICC follows a formal client engagement process in which: (a) workers engage clients, (b) workers and clients discuss the client's needs and potential resources in the community, (c) the worker brings forward the client's needs to the PICC meeting with a case management plan and (d) case management of "PICC'd" clients occurs throughout the week. This process was developed to "remove barriers impacting health, increase continuum of care for clients and decrease the number of disenfranchised and homeless individuals in Kelowna. The partnership is instrumental in connecting clients to appropriate services, developing relationships between agencies and built capacity and accountability within the community.
2. Workers who understand Aboriginal experience and culture are a vital component of the outreach program. Staff that have experience and understand urban Aboriginals' needs and struggles is an important element of the program, as 30% of Kelowna's homeless population is Aboriginal. The client base of the outreach program at KFS is approximately 50% Aboriginal. Helping Aboriginal clients navigate services and educating service providers about their needs develops a respectful, culturally sensitive environment, improving access to services for many clients.
3. The Kelowna Friendship Society provides a range of services, allowing outreach workers multiple points of contact with a client. This provides several benefits. For example the Saturday morning breakfast hosted at the Friendship Centre allows relationship building with potential clients in an informal, friendly atmosphere. KFS also provides a number of services to Aboriginal and non-Aboriginal individuals. This means outreach workers may come into contact with homeless individuals seeking employment or legal services. It also allows outreach workers to conveniently refer clients to in-house services.

A flexible approach to meeting with clients is also vital. While appointments are sometimes necessary, being able to respond to crisis immediately is a vital component of outreach work. Having several staff members increases opportunities for flexibility without staff burn out.

Importance of Outreach Practices Identified in the Literature

Most of the outreach practices in the literature received a rating of "very important" from the interviewees. However, the former client viewed "assisting clients with transportation" as very important, while outreach workers and community partners only viewed it as moderately important. In addition, agency, community and former clients all thought that "hiring formerly homeless persons as outreach workers" was less important than "hiring staff with special knowledge of homeless people and the problems they face".

Community Factors affecting Outreach

A key factor for the success of an outreach program is relationship building between service agencies. One community partner noted, "no community can address homeless issues without having a community response." The success of the PICC program is dependent on a model of collaboration, communication and transparency among agencies that increases the quality and quantity of services delivered to clients. Developing a common language, goals and visions contributes to this collaborative effort.

Relationships among service agencies also helps develop a second factor for success: respectful and appropriate services. By ensuring that services are culturally sensitive and respectful of the needs and backgrounds of individuals (both Aboriginal and non-Aboriginal), clients are able to access services that concretely improve their lives. Cultural barriers that arise can make the work of outreach workers significantly more difficult. One community partner noted that a key element of a successful program consists of being able to meet clients where they are. While this was intended as a physical statement, it also applies to emotional and cultural needs of clients.

A third factor of success is the importance of community champions and leaders. One community partner noted the leadership role that KFS has played in addressing homelessness in Kelowna. As one of many organizations that has provided positive leadership in the community, KFS has increased the awareness of the issue, helped build networks and improved the lives of clients in the community.

One other success factor that an agency staff member discussed was the importance of public transportation. This allows individuals across the community to access services in the downtown core. It also allows clients looking for housing to expand their search beyond what is immediately available in the downtown community.

Finally, while affordable and long-term supportive housing is an ongoing challenge in Kelowna, it was nonetheless cited as a key factor for success. Only by ensuring that clients have access to a range of affordable housing options can the issue of homeless, and any underlying issues (e.g. physical, mental health, addictions) be meaningfully addressed.

RainCity: A Large Urban Area Homeless Outreach Program

Community Profile

Community: The RainCIty Homeless Outreach Program is included in this study as a sample of homeless outreach operating in large urban area. Metro Vancouver is the largest urban area in British Columbia and forms the primary economic hub for the province.

Population Growth and Migration: Vancouver has seen significant a population increase in recent years, with a population gain of 5.9% between 2001 and 2006, making the City's population 578,041. Regionally, there has been a 6.5% population increase in this time period. Net migration to the region between 2000-2001 and 2008-09 totalled 283,310 individuals, with 317,801 international immigrants to the City in this time period. Interprovincial in-migration also contributed somewhat to the City's growth, with intraprovincial out-migration resulting in a loss of 42,696 individuals.

Key Statistic	Vancouver	British Columbia
Population Growth 2001-06	5.9%	5.3%
Proportion of population 25-44	30.1%	27.4%
Population with a university certificate, diploma or degree (above or below Bachelor's degree)[18]	37.8%	30.2%
Unemployment Rate 2009	7.1%	7.6%
Households in core housing need, 2006 and 1996	17.0% in 2006 (129,145 households)	14.6% in 2006 (221,475 households)
	19.0% in 1996 (122,350 households)	17.4% in 1996 (228,970 households)
Number of rented dwellings	131,535 units (2006)	493,995 units
	132,755 (2001)	
Vacancy Rates, October, 2010[19]	1.3%	2.8%
Average rent, October, 2010	$1059 (City)	$752
# homeless, 2005 and 2008, City of Vancouver	1,291 in 2005	
	1,576 in 2008	

Population characteristics: As of the 2006 Census, the City's population was 578,041. The proportion of age groups was largely comparable to provincial averages, with a slightly greater proportion of individuals 25-44 (30.1%). 1.9% of the population identified as Aboriginal, while 39.6% of the regional population were immigrants.

Economy: Its location on the delta of the Fraser River and ocean access means this area is home to the largest population in the province. The main economic activities in this region are agriculture, manufacturing, business services, and tourism. Areas in the region outside of Vancouver are mainly residential and industrial suburbs. The municipalities of the Greater Vancouver Regional District (GVRD) have come to an agreement on a *Liveable Region Strategic Plan*, which designates a "Growth Concentration Area" where infrastructure, such as rapid transit, will be put into place to accommodate increased growth.

Education and Employment: Vancouver CMA has a high proportion university-educated individuals, with 37.4% of individuals between 25 and 64 having some form of university certificate, diploma or degree, compared with the BC average, 30.2%. The unemployment rate in the CMA in 2009 was

[18] Between 25 and 64 years of age.
[19] For privately initiated rental row and apartment structures of three units and over

slightly below the provincial average, at 7.0%, though it increased significantly since 2008, when it was 4.3%.

Housing Profile: Vacancy rates for the Vancouver CMA were very low, at 1.3%, compared with a provincial average of 2.8%, indicating a possible rental housing shortage. Additionally as of 2006 median rent costs were higher than the BC average, at $1,059 for the City of Vancouver. The City also saw a decline of 1,220 rented dwellings between 2001 and 2006. While core housing need in Vancouver improved slightly between 1996 and 2006, from 19.0% to 17.0%, there was an actual increase of nearly 7,000 households in core housing need.

Low-Income, Dependence on the Safety Net and Homelessness: Median income for households and families in Vancouver are comparable with the provincial median income. However, 26.6% of economic families live below the low-income cut off, well above the 17.3% provincial average. Between September 2008 and September 2010 the dependence on the social safety net in the Metro Vancouver Region rose slightly, with recipients of Basic Income Assistance rising from 1.2% to 1.6%. An increase of nearly 300 homeless individuals was recorded between 2005 and 2008, making the total 1,576.

Case study

Delivering Agency

RainCity Housing and Support Society: Originally Triage Emergency Services & Care Society, RainCity has been delivering housing and support solutions for people living with mental illness, addictions and other challenges since 1982. It operates an emergency shelter, transitional and supported housing, a meal program, life skills services, harm reduction services in the Downtown Eastside (DTES), and two additional teams other than the Homeless Outreach Program, the Concurrent Disorders Outreach and a Housing First ACT[20] team. This Homeless Outreach program is funded by BC Housing.

Impetus

The impetus for the outreach program was the high number of homeless in the DTES. The RainCity Homeless Outreach Program began in 2006 as a pilot project. While the DTES has many services for the homeless, this program provided services not available to other outreach programs, such as fast tracking to Income Assistance (IA), which provided almost immediate funds for housing. Providing housing right away gave the worker a better opportunity for contact than if the person's only option was to be housed in a shelter. As well, having an outreach worker gives a person a better chance to stay employed than if he was alone on street.

Goals and Objectives

- Being able to meet people where they are and building trust with them. With trust you have a greater chance of the person succeeding.
- Assisting the person to obtain IA, to obtain and maintain housing and referring them to needed services.

Client Group

The client groups go through cycles. Sometimes the team will see a large number of women with children. Other times, female sex trade workers. Word of mouth brings certain populations to the program. Currently they are seeing male labourers.

Because of their ability to offer a $300 rent supplement, (see below under Outreach Activities) many RainCity clients are those not requiring large amounts of support. While approximately 60% of current RainCity HOP clients have addiction issues, many are able to function well with their addictions. Clients whose addiction or other issues provide a serious barrier to finding and maintaining market housing will not be selected to receive the rent supplement, but will be accommodated in other forms of housing.

As the rental market has worsened, teams are now getting more calls from people have been evicted from their homes and are living in cars or a family shelter or who are about to be evicted. As a result, they began to serve less and less of the street entrenched and began more re-housing clients, especially with the ability of the team to use the rent supplement. Rather than moving people from the street to housing, the outreach team found themselves moving people from non-stable to more stable housing. (There are other outreach programs in the DTES that can look after the more street entrenched homeless population.)

[20] Assertive Community Treatment

Staffing

The outreach team has 3.6 FTEs. The .6 FTE is provided through Vancouver's Downtown Community Court.

Attempts are made to find staff with previous outreach experience, although this is not often possible. Most staff had been employed in other services of RainCity and have worked with homeless people. The program looks for a two-year college certificate in mental health and addictions or previous experience as a mental health worker.

Qualities identified for a good outreach worker: Respectful, accommodating, flexible, soothing, able to listen, and maintaining confidentiality.

When teams go out on the street on intake days, they work in pairs for safety, and if possible consist of one male and one female. If only one person is available, he will not go out alone, but will work in the office with clients who come there. The case load is a pool and involves all staff. While an attempt is made to ensure that the client does not get into a dependent relationship with any one worker, it was noted by the client interviewed that having to repeat his situation to a new worker was uncomfortable.

Outreach Description and Activities

The team works weekdays from 830 to 1700, except for those who go out on the streets Tuesday and Thursday for intake. They may work from 0700- 1930 depending on the daylight hours.

a) Engagement

During the pilot program, RainCity would typically find its clients on the street. Now clients come to the outreach teams by self-referral through word of mouth, by referrals from other agencies, or through outreach on the streets. An appointment is made for intake. While the initial street contact is done in pairs, subsequent meetings with a client can occur singly, but always either at the outreach offices or in a public place, like a coffee shop. If something more private is required the workers go in pairs

b) Housing

The RainCity outreach program is a unique program. In the last year and a half it has had access to a rent supplement of $300 per person for 39 people provided through the Downtown Community Court. Added to the housing allowance of IA, the total allows individuals and families to be housed in market units, primarily outside the DTES, where the majority would like to live. The rent supplement has a one-year time limit (although there is some flexibility) and by one year the person or family is expected to be able to keep stable housing on their own either through employment, a disability pension, or by moving to a rent geared to income building. When seeking a market rental suite, outreach staff will have clients phone a landlord themselves, both to encourage independence and because some landlords do not want to rent to people who have an outreach worker.

Once the person or family are housed and a plan is in place, meetings might take place once a week for two or three weeks and then at least once a month when the person picks up their rent supplement cheques from the outreach office. Workers see six new clients per week (24/month) and approximately 2-4 of these 24 are rent supplement clients who are taking over from clients who have come off the supplement. However, approximately 85% of the workers' time is taken up with these 39 rent supplement clients, leaving little time to do more than house and refer

other clients. The client interviewed for this case study, who did receive a rent supplement, stated that he never had trouble contacting the team and that they always went "above and beyond" for him

c) Income Assistance

During the pilot, the team would help most clients to obtain Income Assistance (IA), find a place in a Single Room Occupancy (SRO) hotel using BC Housing's Supportive Housing Registry (it includes a specific number of buildings largely in the DTES), and would give them home start kits. With other more high functioning clients, staff assisted them to move into a BC Housing directly-managed unit and provided support while they waited for stable housing. Slowly over the years there has been less of a need to connect the client to IA because most clients were already receiving.

d) Addictions

The RainCity Outreach Program considers the most difficult to house are those who are addicted and in wheelchairs. Having disabilities severely limits a persons ability to find suitable housing. Clients with addictions require case by case assistance. If they are looking for help, the team will refer to other agencies. If the addiction is conflicting with the ability to provide services, the team will work with that person wherever he is. If the person starts using again after a period of sobriety they usually disengage from outreach, but the team will continue to try to re-engage. The main focus of the program is finding stable housing. That is what the team has time for and they must rely on other agencies to supply the supports they cannot offer.

e) Other services

Now that they are working with clients with lower-needs, staff have time for some life skills training for those receiving the rent supplement to enable the client to advocate for himself.

f) Follow-up

The team supplies ongoing support to those in the rent supplement program, helping them work on their plan, so as to become independent. Once the person is no longer on the rent supplement program, once he is on his own and housed, the team no longer supports him. However, they always tell people to get in touch with them if the housing does not work out. The RainCity outreach program must supply tax receipts to the rent supplement recipients, which the recipient picks up at the office, and this provides at least one follow-up at tax time, but the team does not have the time for more than this. For those not on rent supplements, the team will refer to other agencies for client support but will step in if the housing is in jeopardy.

Definition of Success

The RainCity team sees success as getting a homeless person into appropriate housing where they have a real sense that they will do well there, where they have an income to live on and their life is relatively stable. Having said that, just having people want to come to the outreach team and work with them is a success in itself.

Outcomes

After 6 months 80-90% of clients have maintained their housing. The ones that end up in a shelter again or on the street usually have complex issues and are referred by RainCity to other teams. In addition:

- 75-80% are still receiving IA;
- 99% of those eligible are receiving the disability allowance; and

- 25-30% are employed.[21]

RainCity's main focus is to find their clients stable housing and in this they feel they have succeeded. One community interviewee stated that people are definitely getting housing quicker and leaving the shelters. However, another interviewee felt that while the outreach program did a great job with accessing housing, they did not go further, but left the client to work on their own issues.

Challenges

Raincity identified the following challenges:

- With only 3.6 FTEs, the program is almost entirely about housing. Those who are not eligible for the rent supplement program can be complex clients with a number of issues and in need of high support.
- There is a stigma to receiving IA when trying to access market housing.
- IA is now more difficult to access. Previously a client would have a specific Ministry worker. Now the client calls a general number and is assigned to any worker available and must repeat their case history to each new worker.
- Only a small percentage of the clients are housed in the DTES. It can be a challenge to keep in contact with those whose housing is far from the program office. The travel time and expense can pose a problem.
- Having the $300 rent supplement has made the RainCity outreach program unique, but has been a burden as well. The supplement requires much follow-up and financial accountability. It requires the issuance of cheques and income tax forms. A higher IA rate would alleviate the need for the supplement. This would also shift the team's focus back to working with the harder to house street entrenched individuals. However, this has problems as well as the program's funders have an expectation that a certain number of clients are to be served by the team. To serve more street-entrenched people, RainCity's outreach team would need for this expectation to be lowered because street-entrenched people take more time.
- Currently the DTES is a magnet for homeless people because everything the person needs is available in a 2-block radius. The creation of a one-stop shop of services in another city or area of Vancouver would relieve this.

A possible challenge to the program would be losing either or both the Current Disorders Outreach team and the $300 rent supplement. The loss would severely impact the ability of RainCity Outreach Program to deliver its program as currently designed.

Other challenges identified:

- The inability to access or find a service needed by a client.
- The high cost of housing and the lack of affordable housing.
- A lack of capacity in mental health services, creating a population that is not connected or poorly connected leading to this population being harder to serve.
- The program does not have enough capacity to serve all the clients who need the program nor enough time to support clients fully. It was suggested that the program could be enhanced by adding a person who could teach life skills or someone who could provide legal services.

[21] Christoph Hofmeister. RainCity Housing. Personal communication. Feb. 16th, 2011.

Community Linkages

The Team refers to many community agencies, and receives clients from a number, such as shelters and transitional housing programs. The client base is quite varied so that the team does not speak to many agencies on a regular basis. The Team mainly deals with the Ministry of Housing and Social Development (for IA) and BC Housing. Community interviewees stated that their agencies will refer their own clients to services required, one of which is the RainCIty Homeless Outreach Program. They see this program as the service to provide housing.

The program does not have relationships with landlords. This was tried but did not prove successful.

The extra rent supplement is a factor in stakeholder support for the RainCity outreach program because it has allowed this team to house clients who come from other agencies, thereby assisting these agencies in delivering services to their own clients. However, interviews indicated that it was important to the success of the program for the team to explain the program thoroughly to referring agencies and to inform them when changes to the program take place, such as the change in target population undergone by the RainCity program with the advent of the $300 rent supplement program. There is a need for agencies to thoroughly understand the program and the specific target population served so that they can refer appropriately.

Community Impact

Within the service sector the program is well known. While initially there was some publicity about the "new" outreach program, its advent and the increase in emergency beds in Vancouver, such as those provided by the HEAT shelters, has made homelessness less visible and this may have lessened community awareness about homelessness and therefore about the program itself.

Effective Outreach Practices

1. The $300 rent supplement allowing the team to adapt the program for a less marginalized population and allowed clients to find market housing in areas outside the DTES. The additional funding provides clients with a housing allowance much closer to actual rent costs
2. Having a number of agencies to refer to for supports allows the team to concentrate on housing the client.
3. Putting the client in the driver's seat; giving them the skills to advocate for themselves.
4. Maintaining a non-judgmental attitude, always siding with the client and hearing them out. Not going behind a client's back to another agency that also serves the client.
5. RainCity's unique position with three outreach teams under its management, allowing for the HOP team to refer clients who are too complex for them to the Concurrent Disorders Team (CDO) team or the ACT Team.
6. That BC Housing allows the program to have five priority placements per year to BC Housing's directly managed housing. This enables outreach workers to quickly house clients who can function in a non supported/limited support environment.
7. The collaborative approach with other service providers and shared values, allowing for non-judgemental support to clients and an understanding of their issues.

Community Factors Affecting Outreach

Vancouver is large enough to have several Homeless Outreach Program (HOP) teams. This could allow for specialization and perhaps greater efficiency in addressing the needs of the homeless population. Teams can serve clients with different functioning levels and gear their support to the level that they serve rather than having to support a wide range of client issues and needs.

Importance of Outreach Practices Identified in Literature

When asked to rate the importance of some effective outreach practices identified in the literature, interviewees thought that most listed were very important. However, hiring formerly homeless clients as outreach workers was generally viewed as not important. Although only one client was interviewed there were some differences in their perspective on the importance of the worker making numerous contacts (not important), taking a team approach to staffing (not important) and accompanying client to appointments (very important).

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