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STREET OUTREACH PROGRAMS FOR HOMELESS AND UNDERHOUSED PEOPLE: A GROUNDED THEORY STUDY

A Thesis Submitted to

The School of Social Work
Faculty of Graduate Studies and Research

In Partial Fulfillment of the Requirements

for

The Master's Degree in Social Work

By

© Alan Gordon Tanner

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Abstract

As extreme poverty and homelessness continue to increase and become more visible in urban centres throughout Canada, it is increasingly more important to develop and critique interventions within the field. This grounded theory study provides and overview of one type of intervention - street outreach programs. It is informed by interviews with front line street outreach workers in Vancouver, Toronto and Montreal. It includes an outline of the academic literature on homelessness and street outreach programs and stresses the importance of viewing this social phenomenon through a structural lens. It describes in detail the main aspects of street outreach work, as well as evaluates the greater the political significance of this type of work. Conclusions demonstrate the importance of establishing trusting relationships with clients and working from a structural approach that satisfy peoples immediate needs while addressing the root causes of extreme poverty and oppression.

Résumé

Comme la pauvreté et le fait d'être sans-abri extrêmes continuent à augmenter et devenir plus visible dans les centres urbains par le Canada, c'est de plus en plus plus important de développer et critiquer des interventions dans le champs. Cette étude mise à terre de théorie fournit et l'aperçu général d'un type d'intervention - les programmes d'assistance de rue. Il est informé par les entretiens avec la rue de front ouvriers d'assistance dans Vancouver, Toronto et Montreal. Il inclut un schéma de la littérature académique sur le fait d'être sans-abri et les programmes d'assistance de rue et accentue l'importance de vue de ce phénomène social par une lentille structurale. Il décrit en détail les aspects principaux de rue travail d'assistance, de même qu'évalue le plus grand la signification politique de ce type de travail. Les conclusions démontrent l'importance d'établir de fier les rapports avec les clients et le fonctionnement d'une approche structurale qui satisfait des gens les besoins immédiats en adressant les causes de racine de pauvreté et l'oppression extrême.

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1.0 Introduction

Extreme poverty and homelessness are becoming more visible throughout large urban centres in Canada. There is a growing volume of literature on the subject, both in academic journals, and in the pages of many national and local newspapers. This increasing visibility has developed over the last decade, at a time of unprecedented economic growth in private and corporate sectors. Fueled by trends in public life and political discourse driven by dominant liberal capitalism, including massive cut backs in government spending and the privatization of public services, these changes have placed greater responsibility on families and individuals to care for and satisfy their own needs. Structural theory provides an important lens to both, understand the root causes of this social phenomenon and construct far-reaching and transformative solutions. It clearly views homelessness and increasing poverty as a socio-political consequence and dismisses pathological claims that blame poor people for their problems and social location. Structural theory also provides a framework for explaining why some people with less power in society based on their gender, class, age, sexual orientation, ability, race and ethnicity are more likely to find themselves in positions of extreme poverty than others.

Social workers and other health and social service professionals play an important role in the social reality of homelessness and extreme poverty. These professionals are directly involved, not only in assisting marginalized people that experience homelessness, but also help shape how this social phenomenon and its root causes are constructed. Front line workers have a role to play in either perpetuating or counter acting this dominant ideology. Workers do not practice in a in a vacuum away from the powerful

forces that dominate and oppress people, and as such, must confront liberal capitalist ideology (McQuaig, 2001) within their own professions that reinforce the status quo and locates the root causes of poverty within the individual. Practice models are needed that embrace a structural approach and propose far reaching, transformative, social change.

This research paper explores and provides an overview of one type of practice model, street outreach, which is gaining popularity in urban centres throughout Canada. Street outreach programs were developed to respond to the increasing number of people who find themselves in situations of extreme poverty and homelessness. This model is important because, as this research paper finds, it provides an alternative framework for interacting with people who experience homelessness. Instead of limiting entitlements and restricting access, street outreach programs take care to people where they are located both geographically and emotionally. It can be consistent with a structural approach in that it attempts to reduce the power differential inherent between worker and client, based upon dialogical relationships that are established on the client's terms. Street outreach workers are employed to provide for the immediate needs of homeless people, and to connect them to a variety of services that address the broad determinants of health. They are also in a unique position to advocate along side their clients for long-term solutions that address the root causes of extreme poverty. In addition, if programs are integrated within larger health and social services, as will be argued, they have the potential to have an emancipatory influence on the practices of these social institutions and be a precursor to transformative social change.

This study explores the field of street outreach services for homeless and underhoused people in three large Canadian urban centres. It attempts to highlight the

main goals and objectives of this work and further investigate its main components including, relationship building, advocacy, working with community partners and organizational requirements that support successful outcomes. In addition, street outreach programs are examined ideologically to assess their impact on the root causes of homelessness and extreme poverty. Two central questions of the research were: (1) What are the main goals and objectives of street outreach work and what are some of the essential elements of a successful outreach program, and; (2) What is the ability of street outreach programs to address the underlying structural root causes of homelessness and extreme poverty. A grounded theory approach (Glaser & Strauss, 1967), is used during interviews with street outreach workers in three large Canadian urban centres – Vancouver, Toronto and Montreal. This theory generating approach is useful as there is very limited research presently on this practice model within the Canadian literature. Grounded theory is helpful because it begins with a field of study and allows theory to emerge from the data collected throughout the research process. This study collects data from interviews with front line street outreach workers and direct observations of street outreach work. Research was conducted over a three month period, between April and June of 2002. This document is a culmination of this research endeavor.

After this brief introduction, Chapter 2 provides an overview of the literature in relation to: defining homelessness; its prevalence in Vancouver, Toronto and Montreal; homelessness and its impact on health; street outreach programs; and structural social work as a lens for understanding homelessness. It concludes by providing a working definition of homelessness for this study. Chapter 3, explains the methodology used for this study including: the research questions; design; reflexivity; sampling procedures and

description of the sample; data collection methods; and analysis. Chapter 4, presents the research findings and organizes them into sections that represent the some of the major categories that emerged from the study including: the goals of outreach; the importance of relationship building; the role of advocacy; working in community partnerships; implementing peer support programs; supportive organizational settings; recruiting staff; measuring program success; and integrating programs within larger health and social services. It concludes with current trends related to homeless reported by outreach workers in their communities. Finally, Chapter 5 provides further discussion on: the key findings; limitations of the study; implications for the field of street outreach; implications of future research; and recommendations and conclusions.

2.0 Literature Review

2.1 Defining Homelessness

There are a variety of definitions found in the literature to describe homelessness. Hwang (2001), places the state of homelessness on a continuum between relative and absolute measures. Relative homelessness refers to the condition of those who have a physical shelter but one which is deemed inadequate in terms of health and safety. This includes lack of protection from the elements, access to safe water and sanitation, security of tenure, personal safety and affordability. Absolute homelessness refers to those in a condition without physical shelter and could include those sleeping outside, in vehicles, abandoned buildings or other places not intended for human habitation.

A special committee set up in Montreal in 1987, defined a homeless person as, "an individual who does not have an address or a decent and safe home for the next 60 days, who has little or no revenue and no social network, and is therefore isolated and excluded," (Thibaudeau & Denoncourt, 1998). The US congress also uses the aspect of time in their definition. They define homelessness in terms of spending more than 7 consecutive nights in a non-dwelling (Weinreb, Goldberg, & Perloff, 1998).

Hopper & Baumohl (1996), state that homelessness is at best an "odd-job" word used to impose some order on a hodgepodge of social dislocation, extreme poverty, seasonal or itinerant work and unconventional ways of life. Burt (1996) uses the terms "literally homeless" and those "at imminent risk of literal homelessness". The literally homeless refers to people that sleep outdoors, in emergency shelters or in state institutions. Those at imminent risk of literal homelessness include people whose current housing is precarious and if lost would lack the prospects and resources to keep themselves from

literal homelessness. Similarly, a task force on homelessness in Toronto defined the term to include those who are absolutely, periodically or temporarily without shelter and those that are at substantial risk of being on the street in the immediate future. In studying homelessness in Toronto, the task force found this definition was, "broad enough to include people most in need and most at risk but, at the same time, not too broad and unmanageable to hinder the possibility of finding solutions," (Report of the Mayor's Homelessness Action Task Force, 1999).

Blasi (1994), states the problem of homelessness has been socially constructed. He argues homeless advocates have redefined extreme poverty in terms of homelessness and, in doing so, have paid inadequate attention to questions of race and other issues that leave some groups of people much more susceptible to homelessness than others. Further, he states that the effect of this shift in terminology has actually prolonged poverty by diverting attention and resources away from the wider issues of poverty to create and institutionalize the emergency shelter system. Clarke (1996) constructs homelessness as the extreme expression of a "poverty agenda" and the homeless as collateral damage in the drive to wipe out income support programs such as unemployment insurance and welfare. Societal stakeholders, he argues, do not have a common interest in eliminating poverty but rather a vested interest in being globally competitive. As such, homelessness and poverty cannot be presented as the products of any mistake or even willful ignorance but rather must be seen as a clear-cut linchpin of capital's push for cheap labour (Clarke, 1996). Boes & van Wormer (1997), pick up on the political ideology at play in the term homeless and state that the way homelessness is defined will reflect the political orientations of the writer. They suggest that a biopsychosocial framework is ideally

suited to understanding the multidimensional nature of homelessness, especially for women.

Finally Layton (2000), within his broad discussion on defining homelessness, includes the notion that homelessness is perhaps best understood as the opposite of homefulness. He lists a variety of features describing home life that are completely absent for someone who is homeless or at risk of becoming homeless. These features include: centrality, rootedness and place attachments; continuity, unity and order; privacy, refuge, security and ownership; self-identity; social and family relations; and community.

2.2 Cities Under Study

2.2.1 Vancouver

The situation of homelessness in British Columbia has been studied extensively as of late by the outgoing provincial NDP government. This research culminated in a four-volume report published in April 2001, titled "Homelessness – Causes and Effects." One of the research tools used to gather information was a "snapshot" taken on November 19, 1999, in which all emergency shelters in the province including youth safe houses were asked to complete a simple survey of their clients on that night. The snapshot counted 363 individuals in the lower mainland of British Columbia that were staying in emergency shelters. They were predominantly male (81%), between the ages of 25 – 44 (51%), single (90%) and Caucasian (70%). The most frequent reasons given for admission to emergency shelter were out of funds (31%), eviction (17%), just moved to city or visiting (10%), family breakdown (9%), and substance use (9%) (Government of British Columbia, Volume 2, 2001).

The City of Vancouver estimates that on any given night, there are between 300 and 600 people living literally without shelter and an additional 300 – 400 staying in emergency shelters for a total of between 600 – 1000 homeless people per night (Government of British Columbia, Volume 2, 2001). Vancouver area shelters indicated that the number of people they were turning away from their facilities, due to over capacity, grew by 86% between 1994 and 1999. Youth shelters alone had seen an increase of 36% between 1998 and 1999. Structural causes of these increases were identified by the huge reduction in the number of people receiving government benefits, due to tightening eligibility requirements, from 82% in 1991 to just 53% in 1999 (Government of British Columbia, Volume 2, 2001).

Hwang (2000) reports that First Nations peoples are over-represented in the homeless population. They made up 11% of the shelter residents in Vancouver, whereas they represent only 1.7% of the Vancouver's total population. He states that theses numbers are probably far higher because First Nations peoples are less likely to access services that do not reflect a First Nations value system and thus many that were sleeping outside were missed in the count. An ethnically mixed advocacy centre, the Downtown Eastside Resident's Association states that homelessness is most common among First Nations males over the age of 30 – 35 years (Klos, 1997). Along with presenting the data on the shelter count, the Government of British Columbia Report (2001), also acknowledges it's shortcomings. Counting people only in shelters is misleading as it misses those sleeping outside and underestimates the numbers of specific sub-groups such as women, youth, and First Nations people for whom there are few suitable shelters. The report adds that women and children are often the invisible homeless, as they will

avoid the street and shelters by doubling up with other families living in inadequate accommodation.

A unique situation in Vancouver is the presence in the downtown east side of many run down hotels offering accommodation in single room occupancy units (SRO's). The availability of these relatively cheap rooms has the effect of perhaps masking what would otherwise be a larger population relying on the emergency shelter system (Layton, 2000). SRO's are popular because they are located close to services and because the average rent of $325 can be covered by those eligible to receive social assistance. Unfortunately, most hotels and rooms are places of despair and violence. Sexual harassment, racial discrimination and homophobia are extensive and make the rooms a very dangerous place to be (Allen, 2000).

2.2.2 Toronto

A number of structural changes brought about in Ontario during the mid 1990's by the Progressive Conservative provincial government have had a multiplier effect on the number of people living in poverty and in situations of homelessness throughout the province. In Toronto specifically, three policy changes seem to have had devastating effects (Government of British Columbia, Volume 4, 2001; Layton, 2000). First, was the decision in 1995 to drastically reduce income assistance to those receiving benefits. For single adults receiving social assistance this cut amounted to a 21.6% reduction in benefits. The impact of welfare cuts meant that many receiving benefits could no longer afford increasing rental prices for apartments in a market being squeezed by a record low vacancy rate. Second, immediately upon their election to office, the Progressive Conservative government abruptly ended non-profit and co-op housing supply programs.

Approximately 17,000 units of affordable housing slated to be built for families and individuals who otherwise would be unable to compete in the private housing market were cancelled. The impact of this policy decision has meant there is virtually no new rental housing being built in Toronto. Third, the introduction of the *Tenant Protection Act* in 1998 gave new power to landowners in the sense that they were now unrestricted in their ability to raise rental prices once apartments are vacated. Also increased, is the incentive to evict long-term existing tenants. Those particularly at risk under this new legislation were seniors and those whose first language was not English and/or French, the language in which eviction papers are written.

The City of Toronto has been proactive in monitoring increasing homelessness in the city. A Task Force on Homelessness was created in 1998 to address the unprecedented levels of homelessness visible throughout the city. The Task Force Report entitled "*Taking Responsibility for Homelessness: An Action Plan*," was released in January of 1999 and made 105 recommendations to council to address both short-term needs and long-term solutions. One recommendation that has been implemented is the publication of a yearly report card on homelessness in Toronto meant to determine if the problem is getting better or worse. Results from this latest report card in 2001, give us a backdrop to understand the present situation of homelessness in the city. Report findings indicate that: between 1988 and 1999 the number of people staying in emergency shelters during a one-year period increased from 22,000 to 30,000 respectively; the fastest growing group of homeless in Toronto is two parent families and couples; the number of children staying in emergency shelters continues to rise, from 2,700 in 1988 to 6,200 in 1999; people of all groups are staying in the emergency shelter system for longer

periods of time; more people are moving in and out of homelessness; the number of people living outside and thus not counted by emergency shelter statistics remains high; mortality of homeless people is also increasing from a total of 27 deaths in 1999 to 37 deaths in 2000; the waiting list for social housing increased to 63,110 households with an average of only 348 households placed per month; street outreach staff report increased contact with women, pregnant women, gay, lesbian, bisexual and transgendered people (City of Toronto, 2001).

2.2.3 Montreal

1996 census data for the Montreal area show that more citizens were paying over 50% of their income on rent; an increase of 41% compared to 1991. Changes in the labour market over this time show an average drop in income for renters, a drop in full-time employment and increase in those receiving social assistance (Government of British Columbia, Volume 4, 2001). A count of individuals using the emergency shelter system in Montreal between 1996 and 1997 established 8,253 users during this one-year period (Fournier, 1998). Although this figure seems to indicate a slight drop in homelessness since 1991 (Fournier, 1991), authors suggest that methodological differences make comparisons limited. Layton (2000), reports those at greatest risk of becoming homeless in Montreal include women, young people, the pre-retired and seniors.

A recent study in Montreal (1998) on homeless youth, *Le Defi de l'acces pour les jeunes de la rue,* by the Regie regionale de la sante et des services sociaux de Montreal-Centre reveals that homeless young people face multiple barriers to survival. The study followed 479 youth (14-25) who had been without a place to sleep at least once or had

regularly used street youth resources over the last 2 years. Study results indicated that: over one third of the youth had been sexually abused (63% of girls and 15% of boys); 59% reported using drugs more than 2 times per week and 39% had used intravenous drugs; 1.4% were HIV positive; and 13 youth had died over the course of the study representing a mortality rate 13 times higher than for Quebec youth of the same age (Regie regionale de la sante et des services sociaux de Montreal-Centre, 1998).

2.3 Health and Homelessness

The realities of homelessness, which can include inadequate diet, the lack of clothing and shelter, decreased opportunities for personal hygiene and inability to access health care contributes to many unmet health needs in this population (Drapkin, 1990; Gillis & Singer, 1997; Jezewski, 1995; Sachs-Ericsson, Wise, Debrody, & Paniucki, 1999). Homeless persons are at a much higher risk for infectious disease, premature death, acute illness, chronic health problems, suicide, mental health problems and drug or alcohol addiction than the general population (Report of the Mayor's Homelessness Action Task Force, 1999). Severity of illness can also be more intense due to factors such as extreme poverty, delays in seeking care, non-adherence to therapy and cognitive impairment (Hwang, 2001). A study of emergency shelter users in Vancouver showed that 43.5% of respondents reported that they currently had a health problem that needed the attention of a physician (Acorn, 1993). Dental health problems requiring the attention of a dentist were reported by 58% (ibid).

Medical problems that are particularly prevalent in the homeless population include seizures, chronic obstructive pulmonary disease, muscular skeletal disorders, respiratory tract infections, skin problems, sexually transmitted diseases, HIV infection

and oral and dental health problems (Hwang, 2001). Foot disorders are common and the result of walking for miles in inadequate foot wear, prolonged exposure to moisture, and long periods of walking and standing (Boes, 1997; Hwang, 2001). Homeless people are also at increased risk of contracting tuberculosis given the overcrowded conditions of shelters with poor ventilation (Hwang, 2001). Violence is also a constant threat to people that are street involved. A report issued by a community-nursing agency in Toronto called Street Health, revealed that 40% of homeless individuals interviewed reported they had been assaulted and 21% of homeless women reported they had been raped in the previous year. Further, 10% of the 458 homeless respondents reported a physical attack by police officers in the last year, 35.6% of this group had been assaulted more than once (Ambrosio, et. al., 1992). In addition homeless men are 9 times more likely to be murdered than their counterparts in the general population (Hwang, 2000).

Mortality rates among people that are street involved are much higher than the general population. Compared to the their peers, mortality rates among street youth in Montreal are 9 times higher for males and 31 times higher for females (Hwang, 2001). In Toronto among men using homeless shelters mortality rates are 8.3 times higher than the mean for 18 – 24 year olds, 3.7 times higher than the mean for 25 – 44 year olds and 2.3 times higher than for 45 – 64 year olds (Hwang 2000). The leading identified causes of death among men 18 – 24 were accidents, poisonings (unintended overdose of opiates, other drugs or alcohol) and suicides; among men 25 – 44 were AIDS, accidents, poisonings and suicide; and among men 45 – 64 were cancer, heart disease and cerebrovascular disease (ibid). Homeless women have been found to have higher rates of

health problems than do men and face a greater risk of sexual and physical violence (Boes & van Wormer, 1997).

Barriers that homeless people face in relation to accessing health care are described in the literature as those that are structural and those that are individual (Sachs-Ericsson, 1999; Thibaudeau & Denoncourt, 1998; Tommasello, Myers, Gillis, Treherne & Plumhoff, 1999). Structural barriers include lack of transportation to and from appointments (Gillis & Singer, 1997; Jezewski, 1995; Plescia, M., Watts, G. R., Neibacher, S., & Strelnick, H., 1997; Tommasello et al., 1999), cultural differences between patient and providers (Jezewski, 1995), clinic hours that do not meet the needs of homeless persons (Gillis & Singer, 1997; Jezewski, 1995; Report of the Mayor's Homelessness Action Task Force, 1999), negative and discriminatory attitudes of health care workers (Gillis & Singer, 1997; Jezewski, 1995; Report of the Mayor's Homelessness Action Task Force, 1999; Sachs-Ericsson, 1999), lack of proper identification including a health card (Hwang, 2001; Jezewski, 1995; Mayor's Homelessness Action Task Force, 1999; Thibaudeau & Denoncourt, 1998), trouble accessing prescription medication (Hwang, 2001; Mayor's Homelessness Action Task Force, 1999) and no access to dental care (Mayor's Homelessness Action Task Force, 1999). Individual barriers include the reality that many homeless people fear and avoid bureaucratic institutions and procedures because of prior negative experiences (Gillis & Singer, 1997; Jezewski, 1995; Tommasello et al., 1999) and have competing basic priorities such as securing food and shelter to attend to (Gillis & Singer, 1997; Hwang, 2001; Jezewski, 1995). If a person who is homeless achieves appropriate access to health care, they then face the dilemma of having no safe and secure place to recover from

illness or infection (Hwang, 2001; Report of the Mayor's Homelessness Action Task Force, 1999).

Several studies have found that in the face of multiple barriers to access, homeless people often rely on local hospital emergency rooms to address their health needs (Hwang, 2001; Leslie, 1997; Mayor's Homelessness Action Task Force, 1999; Sachs-Ericsson, 1999). Apart from being one of the most expensive points of access to the health care system, emergency rooms also tend to provide fragmented care and do not provide preventive medical care (Plescia et. al., 1997; Mayor's Homelessness Action Task Force, 1999; Sachs-Ericsson, 1999). The medicalized focus of emergency departments have the impact of what Boes and van Wormer (1997) call a "treat'em and street'em" approach to care, a band-aid approach that does not address the multidimensional and unique needs of homeless and underhoused people. Hwang (2001) also reports that homeless people are admitted to hospital up to five times more often than the general population and stay in hospital longer than other low income patients. These longer hospital stays result in significant excess health care costs. At the same time lower rates of service utilization have been noted for medical specialists, sophisticated treatments and other services such as dental, pharmacology and eye care by people living in extreme poverty (Leslie, 1997).

2.4 Street Outreach Programs

Street outreach programs are one way that community agencies have begun to respond to gaps in service for homeless people. Outreach can be defined as services that help people to survive on the street or to get them off the streets. Outreach workers facilitate access to basic supports and offer services including food distribution, clothing,

blankets, transportation, health care services including disease prevention, information and referral (Mayor's Homelessness Action Task Force, 1999). Erickson & Page (1998), consider outreach as the initial and most important step in connecting or reconnecting homeless people to needed health, mental health, recovery, social welfare and housing services.

The goals of outreach referred to most often in the literature include: to bring services to places where homeless people congregate (Drapkin, 1990; Weinreb & Bassuk, 1990); to provide for the immediate needs identified by the client (Erickson & Page, 1998; Plescia et al., 1997; Mayor's Homelessness Action Task Force, 1999; Rowe, 1999; Tommasello et al., 1999; Warnes & Crane, 2000); to establish a trusting relationship between worker and client (Erickson & Page, 1998; Gillis, 1997; Plescia et al., 1997; Report of the Mayor's Homelessness Action Task Force, 1999; Rowe, 1999; Tommasello et al., 1999); to link homeless people with appropriate mainstream services in the community (Erickson & Page, 1998; Gillis, 1997; Plescia et al., 1997; Report of the Mayor's Homelessness Action Task Force, 1999; Rowe, 1999; Tommasello et al., 1999; Warnes & Crane, 2000); and to identify people as quickly as possible when they first become homeless in order to link them to services (Warnes & Crane, 2000).

Outreach programs cannot serve all potential clients. Exemplary programs have clearly defined program goals and objectives (Erickson & Page, 1998). Some programs target a subset of the population, including persons with mental illnesses (Fisk, 2000; Lam, 1999; Levy, 2000; Rosenheck, 2000; Rowe, 1999), those with substance use problems (Tommasello et al., 1999), seniors (Warnes & Crane, 2000), and homeless families (Weinreb & Bassuk, 1990). Others provide specific services such as access to

primary health care and work with all sub groups of the homeless population restricted within a certain geographic catchment area (Gillis, 1997; Jezewski, 1995; Plescia et al., 1997; Thibaudeau & Denoncourt, 1998; Wilk, 1999).

The literature suggests that successful outreach programs must be based on a core set of values and principles that drive interventions and which set the stage for developing realistic goals in an arena of limited resources and potentially slow progress (Erickson & Page, 1998). Exemplary programs possess a philosophy that aims to restore the dignity of homeless persons, dealing with clients as people (Axelroad & Toff, 1987; Wobido, 1990). This includes recognition of the strengths, uniqueness and survival skills of the person, support for empowerment and self-determination by presenting options and potential consequences rather than solutions, and by listening to homeless persons rather than "doing" for them to ensure a balance of power between homeless individuals and outreach workers (Rosnow, 1988). Respect for the difficulty of the recovery process and recognition of small successes, such as any activity deemed safer or healthier, are also highlighted as necessary components of successful programs. Outreach work that instills a sense of hope in clients while helping them maintain positive and realistic expectations are considered essential (Erickson & Page, 1998). The literature suggests that clients who define their own goals and set the time frame for which they will be achieved are more successful (Winarski, 1994). Outreach workers that show their respect for client's territory and culture when visiting them on outreach shifts and take care not to interrupt the lifestyle of the people they are trying to help, support the empowerment process. In fact, Lopez (1996) makes the point that clients don't lose the right to be left alone in the privacy of their own home, even when that home might be located in a public space.

In addition to these important program elements, staff also must possess certain characteristics to engage in successful street outreach. These include demonstrating a non-judgmental attitude when working with people, having realistic expectations of the people they are working with (Erickson & Page, 1998; Wilk, 1999), showing flexibility in reassessing daily work priorities, being creative and resourceful when working with people (Rosnow, 1988; Thibaudeau & Denoncourt, 1998), and exhibiting good judgement, intuition and street sense including providing for safety for themselves and clients (Rowe, 1999). Strategies include conducting outreach with a partner, perhaps from another agency, avoiding closed, remote or dangerous areas, assessing situations before acting, dressing appropriately, carrying a cell phone and establishing relationships with local police (Erickson & Page, 1998). Consistency and persistence is important when dealing with clients that may engage only after repeated contacts. Outreach workers need to be very knowledgeable of community resources and should only make promises that they know they can keep. Unfulfilled promises may jeopardize the trust involved in building relationships with people that have been oppressed and let down numerable times (Rowe, 1999). Finally, the literature supports that staff must appreciate the diversity found in the homeless population and demonstrate cultural competency working across ethnicity, gender, transgender, lifestyle and age spectrums (Erickson & Page, 1998; Wilk, 1999).

Outreach workers with a team approach, who know when to ask for help, or a second opinion in developing clinical assessments are more effective (Axelroad & Toff, 1987; Wobido et al., 1990). Street outreach work must prioritize the capacity for an emergency response and medical and psychiatric support when access to involuntary

treatment is needed (Warnes & Crane, 2000). Providing outreach as part of a team allows clients to establish trust with several other people that may span several agencies or professions, including; social workers, nurses, nurse practitioners, harm reduction workers, medical and psychiatric consultants and other outreach specialists (Erickson & Page, 1998). The team approach can also aid in combating; burnout, increasing client needs, and the inherent sense of isolation individual workers can feel (Axelroad & Toff, 1987).

Outreach workers are both advocates and gatekeepers who operate under the supervision of institutional rules and processes. They witness the deep social needs on the streets while at the same time seeing the bureaucratic requirements that undermine individual care (Rowe, 1999). Specific programs may have eligibility requirements for service and offer care only to those diagnosed with mental illness or addictions as opposed to all those in need. Therefore, workers must be resilient and patient in a work environment marked by high turnover, difficulty tracking clients, high stress, lack of resources, and lack of immediate improvement in the clients they serve. Effective workers are able to continue working despite the difficulties endured by their clients, without personalizing them (Erickson & Page, 1998). To do outreach work is to make a political and professional statement, aligning oneself with the poor and against "soulless bureaucrats" (Rowe, 1999).

Erickson & Page (1998), identify two distinct ways of classifying outreach models. The first is the Linkage Model vs. Continuous Relationship Model. Linkage programs serve to refer clients to mainstream health and social service providers. They do not provide formal follow-up tracking and have been determined ineffective for some

marginalized groups because of barriers that prevent access to referral services (Erickson & Page, 1998). In continuous relationship models, workers perform outreach and continue on as a person's case manager. Drawbacks to this model are the small, recommended caseloads, 10:1, which may be unrealistic for many agencies and may restrict capacity to conduct outreach to new clients (Morse et al., 1996; Warnes & Crane, 2000). Continuous relationship models have been shown to be effective at maintaining contact with clients and housing retention (Erickson & Page, 1998).

The second classification of outreach programs is between Mobile Programs vs. Fixed Site Programs (Erickson & Page, 1998). Mobile programs take services to the streets as well as in shelters, drop-in centres, emergency rooms, hospitals and jails (Axelrooad & Toff, 1987). The mobile model requires that projects be "equipment heavy," including agency vehicles, employee cars and communication systems such as pagers, cellular phones and walkie-talkies (Erickson & Page, 1998). Vehicles enable teams to cover large areas and can be useful for transporting clients to shelter, drop-ins and to clinics and hospitals (Warnes & Crane, 2000). Mobile programs may be more successful with substance users for several reasons. There is less stigma and community opposition when outreach workers meet clients individually on the street rather then having them come to a centralized location. Also clients who are high or intoxicated are often asked to leave fixed service sites (Warnes & Crane, 2000).

Fixed Site outreach programs such as drop-in centres, soup kitchens, churches or day programs for those with mental health problems, usually located in high density homeless areas, can be easily accessed by a greater number of clients (Erickson & Page, 1998). Services offered at fixed site programs vary widely. Some may include food,

clothing, and showers and depend heavily on volunteers. Others may have salaried and trained staff and deliver rehabilitation, group therapies, health care and resettlement programs (Warnes & Crane, 2000). A rising number of users at many day centres has brought overcrowding and increased violence to some sites. These conditions create significant barriers for people who dislike crowded conditions and wish to avoid violence (Warnes& Crane, 2000).

Outreach work is based on the assumption that homeless people can attain a better quality of life. However, engaging with outreach workers does not translate into an immediate improvement in quality of life for homeless clients. Rowe (1999) identifies 8 potential consequences to homeless people of making a connection with outreach workers. They include: a) linking with even the most basic of services often requires clients to disclose personal information and thus suffer a loss of privacy. Information collected by agencies for funders is as basic as name, age and gender but could also include more personal information such sexual abuse history; b) giving up ones homeless identity and a known routine in order to make a transition back into the mainstream; c) clients may have to conform to certain rules of behaviour to please workers and remain eligible for assistance; d) street outreach workers show respect to their clients which is a contradictory message and contrary to others given by society towards homeless people – it implies there is an expectation of getting better; e) giving up ones freedom and independence to take the risk of trusting a worker to help. If one is not successful the worker may react negatively or punish the client; f) the sense of mainstream time can be a barrier. Instead of managing ones own time it is managed for you by work schedules, bill payments, rent and so on; g) the change of having to be around material things increases

responsibility and can have both physical and psychological affects; h) social isolation often comes with accepting help, severing ties with the homeless community and ending up isolated in an apartment with no sense of community only to worry about failing and ending up back on the street.

It is important to be aware that there is a fine line between outreach work that encourages a person to accept help as a preliminary to leaving the street and that which enables continued street living (Warnes & Crane, 2000). Warnes & Crane (2000), also caution of outreach fatigue – the duplication of work and conflicting and confusing care plans from several different outreach workers with the same client. For both these reasons it is essential for services to be better coordinated and to be connected to longer-term solutions to homelessness (Mayor's Homelessness Action Task Force, 1999).

Studies have shown that outreach and engagement strategies, while initially time-consuming and slow-moving, are successful because they reach more severely impaired persons who are less motivated to seek out services (Lam and Rosenheck, 1998). It successfully engages the most troubled in this group and is associated with substantial improvement (Tommasello et al., 1999). Results from an evaluation of a large multi-site mental health outreach program in the United States called the Access to Community Care and Effective Services and Supports (ACCESS) program, showed that clients reached in outreach on the streets experienced improvement on nearly all outcome measures equivalent to clients who were contacted in other services, agencies and shelters. Outreach clients did equally well in areas of housing outcomes, quality of housing, improved mental health and decrease of psychiatric admissions, substance

abuse, employment, social support, reduced victimization, and quality of life (Lam and Rosenheck, 1998).

Without accessible and effective programs in the community, the isolated efforts of outreach workers will not succeed. In order to increase the accessibility of community-based agencies, the integration of service delivery with community education and policy advocacy must occur (Gillis & Singer, 1997). The multiple and complex problems of homeless persons cannot be resolved by a single agency. Therefore, agencies and workers involved in outreach activities must attempt to participate in coalitions, educational opportunities and formal instruction with other agencies and health and social service professionals to share insights and make the services more accessible (Gillis & Singer, 1997). Agencies and workers must also participate in public policy advocacy. Educating policy makers and the general public about issues related to homelessness may result in more productive decision-making. Educating clients, staff and board members enhances participation in the democratic process (Gillis & Singer, 1997).

In conclusion, the literature that does exist on street outreach programming is fairly consistent in its description the work. It informs us that street outreach work must have clearly defined goals and objectives, should focus on serving specific sub-populations within the homeless or work within limited geographic areas, must embrace a core set of values with which staff approach their work and that interventions be team driven. Erickson and Page (1998), assist in presenting and contrasting Linkage versus Continuous, and Mobile versus Fixed models to organize street outreach work, while Rowe (1999), presents the price homeless people play in engaging with street outreach

workers. Several authors also raise the importance of coordinating and integrating street outreach services. Unfortunately, there is a lack of literature that raises the greater political significance of street outreach work in relation to homelessness. In addition, there is also limited research on the effectiveness of outreach models in addressing the long-term root causes of extreme poverty and homelessness. This suggests the need to evaluate programs through the lens of structural approach.

2.5 Structural Approaches as a Lens for Understanding Homelessness

The theoretical perspective that will accompany this research project is that of a structural approach. The structural approach to social work can be helpful to inform all health fields and will be used to understand homelessness and inform the essential components of street outreach programming. The central objective within a structural approach is to empower clients – to render them freer and more powerful in relation to those who oppress and dominate them (Moreau, 1990). Mullaly (1993), states the guiding principle for structural social work practice is that all work should contribute in some way to the goal of social transformation. This two-pronged approach allows workers to address the immediate needs of their clients while at the same time working to transform social relations to attack the root causes of oppression and inequality.

The structural approach stands in contrast to many contemporary schools of thought that advocate and teach students cognitive behavioural methods, systems theory or ecological approaches to working with people and understanding their problems (Mullaly, 1993). These approaches most often define social problems as having root within the individual, family or community (Mullaly, 1993). The structural approach condemns individualism that works against notions of community and interdependence

and that breed competition, greed and dominant capitalism (Mullaly, 1993). At the same time it places a high value on recognizing the individuality that makes each person unique and allows for our social diversity. In opposition to the narrow focus taken by mainstream theories, structural social workers understand that social problems are most often the result of powerful interactions in the social environment, interactions that maintain societies power in the hands of a privileged few who oppress others based on issues of class, gender, race, ethnicity, ability/disability, age and sexual orientation. Moreau (1989) states,

> "Social problems are not caused by deficits in communication between individuals and systems as both ecology and systems theory posit. Differential access to power and conflict between systems are the problem and not a lack of mutual fit, reciprocity, interdependence and balance between individuals and systems. (p.23)

As a result, the main distinction between the structural approach and contemporary liberal social theory is that the later reflects and perpetuates the present social order whereas the former attempts to transform it along socialist lines (Mullaly, 1993).

Structural work is political action that workers carry out on a daily basis. The personal problems clients present with are not seen as the fault of the individual but as a result of the social environment in which they survive. It recognizes personal problems as a manifestation of powerful and oppressive structures that exist in liberal capitalist society (McQuaig, 2001). These structures allow some dominant groups to oppress others based on the their membership in a particular group or category of people and thereby protect their power, privilege and wealth. Oppression can be defined as a mode of human relations involving domination and exploitation – economic, social and

psychological that can occur interpersonally, or between groups, classes and societies (Weil, 2000).

Carniol (1992), identifies six activities that the structural social worker should be engaged in to attain the full measure of client empowerment. Empowerment refers to the process through which people reduce their powerlessness and isolation and gain greater control over all aspects of their lives and social environment (Mullaly, 1993). The first activity is "defense," and maintains that the client's basic need for resources is the workers first priority. Part of the workers role during this activity is to address and push back barriers to access that the client may be facing and to ensure they are fully aware of the all the resources they might be entitled to. The worker tries to include clients in accessing services and resources as opposed to just doing for the client.

The second activity addresses "client – worker power," and aims to reduce the power differential between client and worker (Carniol, 1992). In contrast to conventional practice where the worker is portrayed as expert, this activity recognizes that the client is the expert in regards to their life situation. A strengths-focused approach that acknowledges and supports client resiliency in the face of oppressive societal structures should be adopted (Carniol, 1992). Workers will attempt to demystify techniques and agency jargon and be prepared to share assessments and records with the client. Developing a relationship between worker and client based on the sharing of power and maximizing client choice is essential. Mullaly (1993) introduces the concept of establishing a dialogical relationship with service users. This relationship based in meaningful dialogue between the worker and service user represents a horizontal

exchange rather than a vertical imposition. This exchange of ideas occurs with each participant acting as equals, each learning from the other and teaching the other.

The third activity is "unmasking structures" and involves workers sharing their insights of how the primary structures of oppression – sexism, racism, classism, ableism, ageism, and heterosexism - create social problems and marginalize people (Carniol, 1992). By focusing on root causes of oppression based in systemic inequalities, workers avoid blaming the client for their problems. The use of appropriate self-disclosure by the worker to exemplify how primary structures marginalize people may be helpful. For example a queer worker may share how they have been emotionally and physically affected by homophobia, highlighting how the state laws that fail to recognize same-sex marriage and family assists in perpetuating hateful bigotry and violence against queer people everywhere.

The fourth activity addresses "personal change" and recognizes that oppressed people are socialized to "internalize their identities as devalued persons" (Carniol, 1992). Time must be taken to unmask, confront and reclaim feelings of fear, hurt and anger. Feelings must be validated and connected to their true source in the social environment as opposed to within oneself. For workers to actively engage clients in this activity requires them to have an adequate structural and ideological analysis. In addition, workers should have an adequate understanding of how they have played the role as oppressor and oppressed. Two techniques that can assist in personal change include normalization and redefining (Mullaly, 1993). The purpose of normalization is to assist clients to see that their problems are not unique. It helps service users put situations and problems in their proper political, economic and social context and see that there are many others around

them struggling with similar issues. Being exposed to others who are oppressed by the same societal structures can reduce internalized oppression, guilt, shame and help build self-esteem. Linked to normalization is redefining, a consciousness raising activity in which personal troubles are redefined in political terms (Mullaly, 1993). Personal pathology is deconstructed to reveal the many ways groups of people are oppressed based on their sexual orientation, age, ability/disability, ethnicity, class, race and gender.

The fifth activity is "collective consciousness" whereby workers support a client's examination of the limits of individualism (Carniol, 1992). Workers may assist clients identifying opportunities to link with others that with are similarly oppressed. These may include support groups, social action groups, community collectives and the like. Disclosure by the worker in regards to personal experiences they have had in organizing collectively may also prove helpful. The idea here is to encourage liberation over one's self blame and to join with others to work collectively for social change.

The sixth and final activity described by Carniol (1992), is "political change." He describes this activity as ongoing rather than a one-shot event and, as such, it weaves itself throughout interactions between client and worker. It encourages clients to get actively involved in social movements and to become politically active. Political change is what must be achieved on a large scale if socialist values are to become the norm. While political change in this regard is large and far reaching, Carniol (ibid) also suggests that it can support personal change and smaller victories. He also recognizes that political change can be regressive, thus widening the gaps between rich and poor and worsening exploitation. Workers that participate in all of the listed activities in their work can assist in maximizing client empowerment.

This approach is vital if we wish to transform society along more equitable and socialist lines. In the field of homelessness the difference between mainstream liberal approaches to work with homeless and underhoused people and those that reflect a structural approach are clearly visible. The growing homeless industry that satisfies people's immediate and basic needs without addressing the longer term and root causes of poverty reflect the liberal mainstream approach. This industry is meant to provide basic care while at the same time controlling oppressed groups that pose a threat to the status quo. Programs that provide for immediate and basic needs while at the same time working on long-term solutions and societal transformations to prevent extreme poverty reflect a structural approach. Concretely, these programs might provide assistance in securing basis needs such as food, shelter, health care and clothing while at the same time supporting income redistribution and programming that promote justice and equality for women, queer people, ethno racial minorities including First Nations people, those with differing abilities, seniors and young people.

Liberal workers are content to work within a system that provides the very basic necessities to people living in poverty and hence maintain the status quo. They adhere to the rhetoric given by the state which implies that all people have equal access to opportunities within our liberal capitalist society (McQuaig, 2001). They personalize the problems of individuals and families and encourage changing what they deem to be negative behaviours that they believe will limit the ability to compete for survival in the free market. They may provide programming with a cognitive behavioural basis such as anger management, life skills training, and drug and alcohol relapse prevention. This programming may have an impact on one individual's behaviour it but does nothing to

address the root causes and meanings of people's anger, poor life skills and drug and alcohol use. Structural work does not preclude intervention at the individual and family levels, but instead of dealing with each of these levels by itself, connections are made between private troubles and the structural source of homelessness in every case (Mullaly, 1993).

A structural approach to understanding people's social problems is needed now more then ever to critique the widening gap between rich and poor both, nationally and internationally. Social science literature exists in a broader culture in which virtually all social phenomenon – particularly those associated with poverty – are seen as reflecting personal characteristics, choice and failings (Blasi, 1994). The absence within research literature of references to structural inequality or oppression usually goes in hand with a discussion of the individual shortcomings of people who find themselves homeless or underhoused. Focus is given to things such as the high prevalence of mental illness, substance use, free choice and or deviance. The prevalence of mental illness, alcohol abuse and substance abuse in homeless literature is pathological and ranged as high as 90%, 86% and 70% respectively (Tommasello et al, 1999). Rates of mental illness reported within women living in homeless and underhoused conditions are medicalized even more than for men (Boes, 1997). In instances where high rates of mental illness are associated with homeless populations in the literature, very few authors investigate its relation to the unstable, violent environment that people are living in. Is it surprising that these environments are likely to cause depression, anxiety and paranoia in people? Substance use and misuse is put forth as a deviant behaviour rather than acknowledged as a coping mechanism used for survival. While substance use may pose a barrier for

accessing services and securing stable housing, it does not exist in a vacuum apart from powerful oppressive societal structures.

The result of narrowly defining the complexities of homelessness in the individual is a service system that upholds a class division between those deserving of support and service from those that are undeserving. Moore (1994), defines the deserving as those, "...[t]hat have through no fault of their own have fallen to circumstances that have left them with nowhere to go. They are responsible and appreciate ... assistance." He defines the undeserving as those "...[I]ndividuals or families who are believed to be homeless by virtue of their own attitudes, beliefs, and irresponsibility... They are unappreciative of ... assistance and viewed as manipulative in their attempts to obtain support and service." These class divisions are supported by agency staff and policy and internalized by homeless people themselves. In the author's experience some homeless and underhoused service users make attempts to clearly indicate they are not like those other "junkies, hookers or crazies." This internalized oppression (Mullaly, 1993),has the effect of making people believe the only realistic way to end their poverty is to change themselves, leading to self blame and self governing rather than collective organizing against structural violence (Lyon-Callon, 2000).

Associated with the tendency to individualize the causes of poverty is the process of medicalizing homelessness. Many outreach programs are very focused on the physical health aspects of homelessness and therefore tend to reinforce the medical model upon their clients. Instead of relegating responsibility, the disease model advocates for individual empathy and support. In the process persons affected by trauma, childhood sexual and physical abuse, depression, schizophrenia, alcoholism, substance abuse,

domestic abuse, and other ailments are thought to be in need of medical treatment, most notably psychiatric treatment. Medicalizing these individuals plays the ideological function of legitimizing class relations and serves to depoliticize what are intrinsically political problems and suggest individual responses to what are collective problems (Lyon-Callo, 2000).

Lyon-Callo (2000) is critical of approaches that provide a continuum of care. Under this model he suggests that communities develop programs and services to treat the myriad of symptoms thought to create homelessness, for example those that assist people affected by traumatic episodes in their youth, a poorly functioning foster care system, depression or schizophrenia, alcoholism, substance abuse, domestic violence or other ailments that restrict their capacity to remain employed and housed. The result, he suggests, is a caring approach to people who are homeless, one that embraces the disease model and does not fundamentally address questions of access to and distribution of resources in the community. He argues:

> "...that the focus on "disease" within the discourses of helping actually obliterates discussion of alternative explanations and thus hinders developments aimed at resolving homelessness through altering class, race, or gender dynamics."

Medicalizing people who live in extreme poverty has the impact of defining the root causes of homelessness within the individual. However, assuming that providing a continuum of care and services to people on the street upholds and reinforces the disease model is inaccurate. Research shows that many homeless women have a history of domestic violence (Boes & van Wormer, 1997), and that many homeless First Nations people have a history of childhood physical and sexual abuse caused by residential schooling (Klos, 1997). Thus, homeless women and homeless First Nations people

require a continuum of services that are available to address their unique needs. These services must not solely reflect a psychiatric approach but should embrace a range of alternative supportive techniques including for example, those grounded in First Nations values and culture. Offering a continuum of care does not necessitate that services be enmeshed in the medical profession. Instead they must embrace the broad determinants of health including programs that provide access to housing, income, employment, education, social and cultural supports, as well as physical and emotional health.

Authors that do include a discussion of wider societal structures and values, to a varying degree, make links to; globalization, the changing labour market and the growing gap between the classes (Clarke, 1996; Lyon-Callo, 2000; Mathieu, 1993); capitalism and right wing ideology that has led to the deterioration of social programs and the welfare state (Baptist et al, 1999; Clarke, 1996; Lyon-Callo, 2000; Mathieu, 1993); institutionalized racism and the over representation of ethnic minorities that are homeless or underhoused (Baptist et al, 1999; Blasi, 1994); sexism, patriarchy and the incidence of male sexual and physical violence against women (Boes & van Wormer, 1997); queerphobia and oppression driven on the basis of sexual identity and orientation (Leifer & Young, 1997; Rew, 2000); deinstitutionalization and lack of resources to provide service to those with mental health issues in the community (Mathieu, 1993); and ageism and the isolation felt by seniors deemed incapable of contributing to society (Warnes & Crane, 2000).

The multitude of oppressions that exist to make homelessness a reality for people, require solutions that are wide reaching and transformative. Front line workers, homeless advocates, the poor and their allies must continue the struggle for programming and

policy that is structural in nature. Until a fundamental change is realized in the way wealth and resources are distributed in society, we are left to work with the tools at our disposal. Within the helping professions working in the field of homelessness, we always need to understand the greater significance of our work. It is the author's experience that work is often done in crisis mode and service or treatment is only short term in nature. Reliance on these short-term interventions without focused work on the root causes of oppression and poverty has led to the creation of what some authors have termed the homeless industry (Blasi, 1994; Hambrick & Johnson, 1998; Lyon-Callow, 2000; Moore, 1994).

The homeless industry that exists in large urban centres is made up of a host of services including, emergency hostels, shelters, day programs, drop-in centres, soup kitchens, clothing rooms, crisis centres, health programs and street outreach services. They play an important role in meeting the basic and often immediate needs of homeless and underhoused people. These needs include shelter, facilities that prevent exposure to the elements, opportunities for social support, food, clothing and health care. However, the continued reliance of the state on these services to provide basic needs without focusing on the structural roots of homelessness has led to their institutionalization. The consequences of these well intentioned efforts include; reproducing and reinforcing the image of homelessness as a social problem with origins in the individual (Lyon-Callow, 2000), allowing liberal communities to think they are solving the problem of extreme poverty and homelessness by simply providing mass shelters (Blasi, 1994), forcing workers to spend more time on organizational needs that on helping the people they are employed to assist (Moore, 1994), and introducing competition between basic needs

services for dwindling resources and increasing resistance to shift resources away from emergency shelters to permanent housing (Hambrick & Johnson, 1998).

The homeless industry is well established in the research sites of Vancouver, Toronto and Montreal. The budgets of agencies providing services in each of these communities total millions of dollars that could otherwise be redistributed more equitably among those that are homeless and underhoused. The goal of services in the community should be to work themselves out of existence. The reality is that many agencies provide employment to middle class workers and thus resistance to this goal is enmeshed in powerful class dynamics. The abrupt transfer of homeless industry funds for redistribution to individuals or to projects such as permanent housing would create a gap in meeting many people's immediate and basic needs. The question for the author then is, how do we ensure that services for homeless and underhoused people continue to meet immediate and basic needs but at the same time work to address the structural issues that are at the root of homelessness and extreme poverty? The author's hypothesis is that services must not be ghettoized so as to allow the homeless industry to grow. Instead all services should be integrated within mainstream state funding envelopes. In the example of street outreach services, of which this paper will focus, the author will argue that they should be part of a "continuum of care" that is infused by a structural analysis so as not to become enmeshed in the medical model, and be integrated within larger more mainstream health and social service systems.

Providing this continuum of care for homeless and underhoused is not enough by itself. Both workers and clients must actively be engaged in the larger struggle for social change to address issues of access to and distribution of resources in the community.

Therefore we must take care to provide a range of appropriate services for those that are homeless and underhoused today, while at the same time participating in social action that will prevent future generations from the same social phenomenon. A structural approach within the field will assist in this regard, guiding workers to address the immediate and unique needs of the individuals they are working with, while at the same time unmasking oppressive societal structures and encouraging political change. This combination of theory and practice can be consistent with street outreach work, provides for the people living in extreme poverty today and works to support social change for tomorrow. A structural approach therefore must be used to provide a theoretical framework for such a study as this one. This approach will be used to show its compatibility with the working style, values and political objectives of street outreach work as investigated in three large Canadian cities.

2.6 Finding a Definition

The literature identified multiple definitions rooted in competing ideological positions as exemplified by liberal and structural approaches. For the purpose of this study, two concepts will be defined; homeless and underhoused. Both are not meant to be mutually exclusive and are imagined to exist on the farthest continuum of extreme poverty. Homeless may refer to situations in which people are residing outside in parks, recreational areas, tents, store alcoves, parking garages, under bridges, in make shift accommodations, emergency shelters, and church basements to name a few. Implied here is the absence of tenure, stability and safety. Underhoused may refer to situations in which people have tenure but imply a minimum in physical standards such as sanitation, security, access to cleaning and cooking facilities, overcrowding and affordability. It

might include people renting rooms in buildings that are dilapidated and in need of renovation. A good example of such conditions are prevalent in Vancouver's east side, where single room occupancy units (SRO's), exist in many run down hotels and provide underhoused conditions to many people living in extreme poverty.

These definitions are meant to be fluid in the sense that people do not necessarily occupy these spaces for indefinite periods of time. People move between categories and depending on their ability to negotiate oppressive structures may at some periods move towards and secure more stable housing. Also implied in these loose definitions is that people living in these extreme situations display enormous strengths and innovation in order to survive. In the author's experience some who might be labeled as homeless, might define their housing status as otherwise. They may have a place they consider to be a home that in many ways could potentially be safer, more stable and sanitary than what city shelters might be able to offer. In Toronto, a community of homeless people congregated on port lands and established what was known as "Tent City." This abandoned industrial land became home to approximately 100 permanent residents. Housing on the site consisted of tents, trailers, shelters built from donated construction material by hand and also pre-fabricated housing units donated by local community activists. Individuals at this site took pride in their homes and community and did not necessarily identify as homeless. Unfortunately, police in riot gear evicted residents of tent city en masse in the fall of 2002, through a deal brokered between the City of Toronto officials and the landowner. They have since been forced to find new accommodation either in the few affordable housing units available in the city, the overcrowded shelter system or are literally living on the street.

The creation and existence of Tent City is an example of homeless people's resistance to oppression and extreme poverty and is consistent with structural theory. This alternative community created a self-described home for many people that otherwise would have been more reliant on state resources. Their eviction by riot police highlights the state's response to this challenge to the status quo. While it is important to support the strengths and innovative ways people have responded to extreme poverty, homeless and underhoused individuals do deserve better housing conditions than the likes of Tent City or those that are presently available in urban centres across the country. Access to safe, affordable and sanitary housing must be viewed as a basic human right. This refocuses the definition of homeless, from one centred on the faults of individuals, to one which asserts that the root causes of homelessness lie in oppressive societal structures and inadequate responses from all levels of government to provide the continuum of housing necessary to accommodate all its citizens.

3.0 Methodology

3.1 Research Question

This study explores the field of street outreach services for homeless and underhoused people in three large Canadian urban centres. It attempts to highlight the main goals and objectives of this work and further investigate its main components including, relationship building, advocacy, working with community partners and organizational requirements that support successful outcomes. In addition, street outreach programs are examined ideologically to assess their impact on the root causes of homelessness and extreme poverty. Three central questions of the research were: (1) What are the main goals and objectives of street outreach work? (2) What are some of the essential components of street outreach work? (3) How do street outreach workers address underlying structural root causes of homelessness and extreme poverty?

Although there is a growing literature in North America on the issue of homelessness specifically related to prevalence and root causes, there continues to be a limited amount of work documenting models of practice in the field. Initially it was my intention to focus specifically on the question of integration of street outreach programs. By integration I refer to how well linked programs that serve homeless people are to a continuum of other services in the community. Central features to this inquiry were how well programs are funded and if they were organized and situated within larger health and social service systems ie. community health centres, hospitals, social welfare services etc. After completing a literature review, it was discovered that there lacked a documentation of what street outreach services presently existed in urban Canadian centres and how these services were organized. Wanting to provide a Canadian perspective on this issue, I

chose to investigate street outreach programs serving homeless and underhoused people in Canada's three largest urban centres; Toronto, Montreal and Vancouver. Research was conducted in these cities as they represent urban areas where a lot of street outreach programming is occurring. Data collected from these three urban centres are combined to provide an overview of outreach programs and are not meant to serve as a comparative analysis. Therefore, no distinction is made between cities in the research findings, in addition no comparative analysis was undertaken because of the restricted sample size and the wish to protect the confidentiality of respondents. Interview questions were developed and used as a guide in each of ten separate interviews (See Appendix A for Interview Guide).

3.2 Design

The methodology of this study is informed by a Grounded Theory approach, developed by Glaser and Strauss (1967). Grounded theory is a qualitative research approach developed as a model to generate theory. It begins with a field of study and allows theory to emerge from data collected throughout the research process. Data can include interviews, observational field notes, videos, journals, memos, manuals, catalogs and other forms of written or pictoral materials (Silverman, 1993). Conceptual ordering, or an organization of the data into categories according to their properties and dimensions, is a precursor to theorizing. The development of theory relies on not only on conceiving or intuiting ideas, but also requires that they be formulated into a "logical, systematic and explanatory scheme," (Strauss & Corbin, 1998). Ideas are explored fully and considered from many different angles or perspectives. As grounded research

proceeds, any developing hypothesis must be continuously compared against incoming data and adjusted, further developed or discarded as necessary (Strauss & Corbin, 1998).

As data is collected, it undergoes close scrutiny by the researcher. This is called microanalysis. Microanalysis includes two major components, the first being the data itself and the second being the researcher's interpretations of the data (Strauss & Corbin, 1998). Grounded theory techniques such as open and axial coding are used to assist with microanalysis. Open coding is the first analytical step in opening up the data to expose the thoughts, ideas and meanings contained within (Strauss & Corbin, 1998). Data is broken down, closely examined and compared for similarities and differences. Similar or related concepts are grouped under more abstract categories. Axial coding is then used to relate categories to sub-categories along the lines of their properties and dimensions (Strauss & Corbin, 1998). As research is collected a continuous process of collecting, coding and analyzing data is undertaken. Data collection ends when the researcher feels that information and new themes or categories have been exhausted.

3.3 Reflexivity

Reflexivity is an important component of qualitative work. Since the researcher's interpretation is central to a grounded theory method, the researcher has an ethical responsibility to make explicit his or her values, assumptions and perspectives. Therefore, this discussion requires a brief description of how my own social location and life experience has informed my topic choice and methodology. I have been working in the field of homelessness as a social worker for several years, first as an employee of a street outreach program providing an entry to health care for homeless and underhoused people in South East Toronto and later as the coordinator of this project. During this

time, political restructuring under the Progressive Conservative Government in Ontario led to strict cutbacks in the area of health and social services. As a result, I witnessed over the course of the late 1990's, a significant increase in the number of people living in poverty in Toronto and accessing the street outreach program I worked for.

While long term funding in health and social services seemed to evaporate, money has been made available for a variety of short-term programming. As the number of people living in homeless and underhoused conditions increased in South East Toronto money began to be directed at a variety of community based social services agencies working with people on the streets. I witnessed the number of so-called outreach workers increase dramatically at a host of local Toronto based agencies. While the demand for services continued to increase I began to question the larger political implications of street outreach work. Having been on the front line for some time I recognized that the nature and style of work was much different than my limited past social work experience in large publicly funded institutions. I found a positive fit with the values inherent in my own program and approach but remained frustrated by the inability and lack of time to work on some of the structural roots of poverty that so frequently were related to me first hand by the people I was working with. For these reasons I wanted to take a step back and explore in greater detail the theory behind my work and explore my political interpretations with others engaged in similar work in Toronto and other urban locations outside of the political landscape shaped by the Ontario Provincial Government.

In relation to my social location as a gay white middle class male, I understand and have experienced first hand the impacts of homophobia and exclusion. These experiences have influenced my career choices and desire to work with others who

experience oppression. Witnessing the way others have been marginalized based on their gender, ethnicity, race, ability/disability, age, class and sexual orientation strengthens my resolve to stand in solidarity with them in our struggle for social justice and change. At the same time I need to be critical of my privilege in relation to the people I work with. A quick glance at many working in the social services reveals a very white middle class reflection. Having what I believe to be a structural approach to my practice I wanted to evaluate the ways my privilege and that of my colleagues was perpetuating and controlling those that use street outreach services in the name of care and best intentions. I felt the need to question the large growth in the number of services for the homeless around me and wonder how they would lead to transformative societal change along socialist lines. I have continued to ask these questions of myself during this research process and hope they are reflected throughout this body of this work.

3.4 Sampling Procedures and Description of the Sample

The data sources included: individual and group interviews with front line street outreach workers; and direct observations of street outreach programs in the field. These different and yet complimentary data collection sources provide triangulation in order to enhance research credibility. An ethics review board at McGill University granted a certificate of Ethical Acceptability of Research Involving Humans before data collection commenced (see appendix B). Five agencies were chosen and invited to participate in the study in each city and interviews were conducted over the course of three months; Toronto – April 2002, Montreal – May 2002 and Vancouver – June 2002.

Based on my connections and familiarity in Toronto, convenience sampling was used to contact other colleagues working in the field. Snowball sampling and a review of

community based directories, The Vancouver Red Book and The Directory of Community Services for Homeless People in the Greater Montreal area, was used to establish research contacts in other cities. Letters were initially sent to all 15 contacts identified and 10 agreed to participate in the study (See Appendix C for the letter of invitation to participate). Executive Directors were contacted who then asked their front line workers if they were interested in participating. All participant agencies and staff were given an overview of the research aims and were assured that all results would be confidential and not identify by name, agency or city, those who participated. Five were located in Toronto, two in Montreal and three in Vancouver. Other agencies either did not respond to the initial letter or were unable to schedule time to participate in the study. The reasons for those agencies that did not respond is not known although in Montreal the issue of language may have been a barrier. Unfortunately, due to time and budget constraints, all correspondence was conducted in English and as such did not necessarily reflect the linguistic realities of agency workers in the Montreal area.

Ten separate interviews were conducted with nine different community based agencies and one retired front line worker and researcher in the field of homeless outreach programs. Two of these separate interviews involved two or more staff members of the same agency bringing the total number of participant to 13. Of the 13 participants involved in the study 8 were women and 5 were men. The ethno racial backgrounds of participants were varied with 9 white, 2 visible minority workers and 2 First Nation's workers participating. In terms of professional background or training, 5 had a background in nursing, 5 were social workers or social service workers, 2 had the title of harm reduction worker and 1 the title of mental health worker. Of the nine

agencies that participated, 3 were community based agencies in the sense that they received funding from a variety of sources and were relatively small in size, 3 were based out of community health centres and funded by provincial health ministries, 2 were solely municipally funded programs and 1 was funded by a provincial centre for disease control.

3.5 Data Collection Methods

Based on my front line work experience and information gleaned from the literature, a semi-structured interview guide was developed. This guide was shared with a colleague in the field to ensure its relevance and clarity. Feedback from this colleague was incorporated into the guide accordingly. All interviews were audio taped and used consent procedures (See Appendix D for Consent form for Interviews). Each interview lasted between 60 and 90 minutes. Research was initiated in Toronto with local front line workers. Data collection and coding and analysis was undertaken simultaneously in accordance with the Grounded Theory Approach and as such audiotapes were transcribed and coded after each interview. The interview guide was adjusted to incorporate new questions and eliminate others based on data analysis and the repetition or exhaustion of particular themes as the research unfolded. Therefore the interview guide used subsequently in Montreal and then in Vancouver was slightly different than in Toronto. The creation of an audit trail in combination with extensive note taking assisted in evaluating and editing the interview guide and in the development of the coding for data analysis.

In addition to the interviews conducted I did request of each agency a chance to directly observe their work by accompanying them on an outreach shift. In each instance I stressed the importance of not being too intrusive to clients served by their programs.

Of the nine agencies involved in the study, 6 agreed to have me accompany them on an outreach shift – 3 in Toronto, 1 in Montreal and 2 in Vancouver. Scheduling and time constraints proved to be the only barrier for the other three.

3.6 Analysis

All interviews were audio-recorded and transcribed by the author. Notes were taken during the interviews and memos were written throughout the transcribing process to capture the researcher's interpretation of respondent's feedback. Extensive notes were taken after each direct observation in the community and these proved helpful to compare and contrast with the information given during individual and group interviews. Open coding was used to expose the thoughts, ideas and meanings contained in the transcribed text. Similar or related ideas and concepts were cut and pasted under more abstract categories. Collecting, coding and analyzing the data occurred simultaneously throughout the research process.

Axial coding was used to further develop categories and identify sub-categories and relate them to each other along lines of their properties and dimensions. For example, the category of advocacy was further developed in the sub-categories of individual, internal and external advocacy. These were contrasted and examined in their relation to their role within street outreach and their ability to achieve structural change. These coding techniques are consistent with the grounded theory approach developed by Glaser and Strauss (1967).

4.0 Research Findings

Many themes were developed throughout this research project. The following sections are organized to capture the main aspects of street outreach work as mentioned by respondents. This section starts with a discussion on why street outreach programs have been developed, the goals of these programs and the significance of taking care of people where they are located geographically and emotionally. Some significant time is used to describe the process of relationship building, as it emerged as one of the core categories around which all outreach work is aimed. The role of advocacy is examined and discussed in its relation to addressing some of the root causes of poverty and homelessness. The main organizational requirements that support street outreach including the importance of community partnerships, agency setting, staff recruitment and peer support programs are reviewed. Respondents give their feedback on how successful street outreach is measured and contrast this in relation to funders. The importance of integrating street outreach programs within larger more mainstream services is evaluated based on feedback from respondents. Finally, street outreach workers give their thoughts on current trends and some predictions for what the future will bring.

4.1 Why Street Outreach?

Street outreach programs exist and function to provide marginalized populations – homeless and underhoused people including but not limited to women, street youth, seniors, First Nations peoples, ethno-racial communities, newcomers to Canada, refugees, those with varying abilities, gays, lesbians, bisexuals, transgendered and transsexual people - access to a range of health related services. Health services can be broadly

defined to include a range of basic needs related to the determinants of health framework including; food, shelter, social supports, primary health care, housing, employment, education and income. Programs are designed to address the barriers that exist to many mainstream services and try to provide care in a way that is accepting and non-judgemental to the client. Street Outreach workers realize that the structure of the mainstream universal health care system does not provide access to people that are economically and socially disadvantaged.

> Universal health care is not accessible and so our clients are lost right there. I think the system works against the population that we see or it is not embracing to the population that we see and that is difficult. - (365-367) Susan, *Harm Reduction Worker*

> Our mandate from the Health Ministry is to provide access to homeless people for health care and social services from a community health facility. – (29-30) Karen, *Street Nurse*

Barriers mentioned by outreach workers relate mainly to structural inadequacies of institutions to meet the needs of homeless and underhoused people; needs that are often more immediate in nature and require a system that provides access on demand. One harm reduction worker who works with street involved drug users comments that,

> Coming here, I think coming through any door is a barrier and it represents a lot of things to people. When you are working with street based addicts its now, immediate, their needs are primarily around their addiction. To set it up with a system that says you have to come to see us doesn't work out with most people. Making an appointment doesn't work out. – (56-60) Susan, *Harm Reduction Worker*

Homeless and underhoused people have a hierarchy of needs that places emphasis on survival and securing shelter food and clothing on a daily basis. This reality means that health needs are often ignored or attended to only when they reach chronic or acute stages.

Other barriers to health care that homeless and underhoused people face include the inability to present a health identification card. Homeless people do not have a safe place to store their personal belongings and therefore important items including identification are often lost or stolen and are not easily replaced. Mainstream health services often operate on fixed hours during the week and leave service gaps on evenings and weekends. When clinics are open they may require long waiting times before people are seen. Long waiting times further interfere with the need to secure food, clothing and shelter on a daily basis. Transportation can pose a barrier for those that lack the ability to pay for transport to and from health services. Attitudes of health care workers may be discriminatory towards people living in extreme poverty and thus translate into negative experiences for those who try to access services. Finally there is a lack of services available that address the unique needs of people living in extreme poverty including; those from different ethno-cultural populations including First Nations Peoples, women, queer people, youth, seniors, people with differing abilities, drug users and those with mental health problems.

> ...the big number one major component is that by and large it is a population that does not seek out health care. So they are not just marginalized economically and socially, they are also marginalized from a health care perspective. They are more at risk for disease, from contracting disease and they are more apt to get sicker before they seek out help. Because most clinics that exist and most health services in the City are not really geared to them. They are not patient. They have got sort of an assembly line approach to how they provide health care. There is a real mismatch between the population and the service and what ends up happening is these people don't get serviced. – (80-88) Alexander, *Street Nurse*

The result of these structural inadequacies is a large gap in service provision for people that are often the most vulnerable. This service gap often results in no access to services.

Negative past experiences with health and social services create fear and mistrust of the system and serve as a barrier to access. Instead of providing care, too often health and social services provide control measures over the marginalized people they are meant to assist. Overcrowded shelters are often violent places with staff that focus not on the unique needs of individuals but respond with control measures such as barring policies and mandatory mental health assessments for clients.

> They know the resources but they don't want them, there is nothing there for them. They don't want to go to the drop-in, they don't want to go to the shelter because they are afraid. So we have folks that sleep on the street and will never go anywhere else because of their experiences. – (91-95) Jean Luc, *Mental Health Worker*

Although a person might be very familiar with local service providers they may be unable to satisfy their health needs based on their fear, mistrust and past negative experiences.

A variety of community-based agencies have tried to respond to these barriers by providing a range of health services through Street Outreach Programs. These programs provide an alternative form of care and, as outreach suggests, take services to people where they are located both physically and emotionally - in the community. They aim to have an effect on the structural barriers that exist in accessing larger more mainstream institutions and services. In addition to providing the opportunity to access a range of services related to the determinants of health, Street Outreach Programs also provide a place where marginalized people can feel safe in their surroundings and free from the violence that is present on the streets.

> And that is really what it is about, safety. When you are out here and there is nothing safe out here, there is nothing safe about the drugs you use or the way you use them you need to have some element available to you and say okay I am going to stay here for ten minutes. I am not going to get robbed. I am not going to get raped. No one is going to expect anything from me in return. – (99-103) Alexander, *Street Nurse*

Providing a safe environment to marginalized people with mainly previously negative experiences when dealing with health care professionals allows for the development of trust. Satisfying immediate and presenting needs leads to the development of a relationship, which in time can begin to address other issues such as chronic illness, mental health problems and the unmasking of larger societal structures that oppress and marginalize people. One community nurse share's her experience of working with a man whose needs were not being met by mainstream services.

> I was thinking about the man that we used to do outreach to that lived in his car … That went on for two years and he had a terrible mental health problem. He thought he had an implant in his tooth that was sending him voices. Then he got a place and wasn't around for a while and then he came back and needed shoes and while he was talking to Robert about shoes he said he was so thirsty and his mouth was so dry that he couldn't talk so Robert sent him to me. I checked his blood sugar and sure enough it was right off the chart and it turns out he has diabetes. So for about two years now I have seen him at least twice a week. He reports to me his blood sugar level and he has no mental health complaints to speak of right now. Just having Robert and I to come to with that trust. His lifestyle is pretty bizarre but he knows that he can say anything to us. It is the kind of thing where if you tried to tell him you know you can't do this and there are no voices in your head… Jean Luc actually took him to a dentist to have the transmitter removed. … he keeps his appointments and is taking care of himself but it is impossible to work with a guy like that within the structured medical health system. He would have to be taking some kind of medication because for them it is definite schizophrenia. – (164-175; 179-181; 202-205) Kate, *Street Nurse*

This example highlights an important contrast between this street outreach service and what the interviewee refers to as the structured medical system. Workers here did not pathologize this client with mental health diagnoses but worked with him creatively to establish trust and a relationship and therefore satisfy his emotional and physical needs.

4.2 Goals of Street Outreach

There are several interconnected goals associated with street outreach. These include providing basic and immediate needs, establishing relationships with marginalized people and connecting or linking people to services. The goals could be defined on a continuum as in Figure 1 with satisfying immediate needs as the initial goal followed by establishing trust and a relationship and ultimately leading to connecting people with appropriate services.

Figure 1 **– Continuum of goals**

Immediate Needs **Trust & Relationship Building** **Connecting to Services**

Depending on the range of programming offered by the agency, street outreach programs can be used as a tool to "hook" people on the street up with services that are offered at a fixed site location.

> And so my job is if there are women working the street I get them to stop the van and go over to talk to them to see if they have enough condoms, as simple as that. Usually what happens is after I have seen them a few times, they ask me questions about what I do and why I give them condoms. That is sort of the hook to try and get them to come in. – (23-28) Charlene, *Social Worker*

> So outreach is important, I refer people back at outreach sites to physicians in house sometimes to chiropody, dental, those services. People also use the ground floor which is set up for laundry and showers. That is an important outreach component of the health centre because it draws homeless people into the building and gives them a reason to come here and get familiar with the folks on the ground floor. – (121-126) Loretta, *Street Nurse*

> We just deal with people in terms of what they want, if they want toothpaste, if they want to see a nurse. The nurse part is easier for them because it is not too intimidating so if they have a wound on their foot or something and you can tell them where they can come to a clinic, you don't need a health card. So we have

> people that are really isolated that are coming, some of them are connected to the nurses and they come regularly so their basic health is kind of taken care of. – (72-77) Jean Luc, *Mental Health Worker*

These workers illustrate how basic necessities such as condoms, food, access to laundry and shower facilities and toothpaste help to establish contact with people on the streets, build relationships and can lead to accessing a range of health services. The goal of relationship building, which emerged as a major theme of street outreach activities, will be examined in more detail shortly.

One respondent mentioned that there is a time limit to outreach activities and that ultimately the goal is to have a person establish a relationship with a regular health care provider in the mainstream system.

> The other thing with outreach is that it is not for an eternity. She will not provide outreach to them all their lives. Eventually she will attempt to stream them to the regular health care so that they can establish a relationship with a doctor... - (96-98) Karen, *Street Nurse*

It is important to emphasize that the long-term goal is to connect people with services. Street Outreach is not meant to replace mainstream services but to assist in providing access to them. If this long-term goal is not pursued or recognized then we risk establishing a second tier of programs and services for those living in extreme poverty. An accessible nursing clinic operated in a homeless drop-in centre may provide some basic health care service but it does not compare to, and cannot replace the range of services available in the mainstream health system.

Two workers interviewed identified the need to prevent people from becoming homeless and or to connect with homeless and underhoused people before they became entrenched in the street lifestyle.

> We try to connect with them at the shelter level … so if we can help to connect people before they become chronic street, then that is a bonus for us. – (300; 304-305) Frank, *Social Worker*

> We need more preventative homelessness programs to help people at risk of losing their housing. Also to connect people that are new before they become entrenched in street life. – (184-186) Anna, *Street Nurse*

This suggests that another goal is to connect with people who have become recently homeless. Workers state it is perhaps easier to connect with people new to the streets and easier to reintegrate them at this early stage into social systems before the situation of homelessness and the coping and survival mechanisms that go with it become normalized.

One goal that might seem at odds with this caring approach to street outreach programs that emphasizes free choice and non-judgemental values is mandating help for those deemed incapable of caring for themselves. One respondent mentioned the importance of placing someone in non-voluntary services in extreme circumstances.

> Part of what we do is if someone is in danger, if we see person that is refusing services but health wise is okay then there is nothing we can do according to the law. But if someone is not eating and is looking unhealthy then we can contact a network here that goes around with the police and they can take people in if they are really bad, but that is in extreme situations. – (59-63) Jean Luc, *Mental Health Worker*

What is left unsaid is how such determinations of extreme situations are made. Given that some public attitudes towards homelessness are less than compassionate, the ability to determine extreme situations leaves room for an abuse of power over very isolated and marginalized people. What also is unclear from this response is what services are provided when a person is "taken in." This point reminds us that regardless of the values and trust inherent in relationships built between outreach workers and homeless and underhoused people; a large differential of power still exists between staff and client.

4.3 Taking Care to People Where They Are "At"

The term outreach by its definition reflects an action that denotes movement away from something to touch or come in contact with something else. When respondents were asked to define outreach all referred in some way to leaving the agency or institution and physically relocating to places where homeless and underhoused people live or congregate.

> Leaving the office and going to them as opposed to an expectation that the clients always come to us. Sometimes they do, but most times they do not. – (10-13) Charlene, *Social Worker*

> … we start the week on the street. We have a list of people that are sleeping completely outdoors and people who have no contact with the shelter or the drop-in. – (78-80) Karen, *Street Nurse*

> We do have a fixed route in the community but it is open to change at anytime. Right now that team is looking for re-connect youth … mainly those in the sex trade, survival sex trade. But while they are out there they will also be servicing the community. – (148-150) Lisa, *Social Worker*

Street outreach can happen on foot, on bicycle or with the assistance of a vehicle. In other instances outreach workers will set up a space to work in local drop-in centres or homeless shelters. Often outreach shifts are coordinated with a fixed weekly schedule allowing homeless and underhoused people to become familiar with where and when to find an outreach team.

> There are four full time nurses here and we take turns doing outreach on Friday mornings teaming up with another agency … because they have a van. That is one aspect of the outreach going to people that are hard to reach in the ravines and under bridges that we could not get to on foot normally. Then we do outreach every Wednesday night teaming up with the AIDS outreach and prevention team … and that is on foot and we do a smaller circumference doing outreach. Again just connecting with people that would not for whatever reason come to our … regularly scheduled clinics in the drop-ins. So it is doing outreach to people that are hard to reach and that might be hesitant to come in or don't like to come to the corner where we will be for various reasons. Then we do casual outreach throughout the week just hanging out on corners and the drop-ins that are not

> scheduled clinics and just see if anyone needs anything. – (13-26) Kate, *Street Nurse*

One community nurse added that street outreach is not much different than homecare services for people that are housed.

> I visit clients in detox and in treatment and help them to able to stay there. So I do a lot of that kind of one to one outreach kind of work. It is really similar to home visiting, they don't have homes so I go where they are. I visit people in jail and all those kind of things to stay connected to folks. – (16-20) Loretta, *Street Nurse*

Respondents stated that in taking "care" to where people are at in the community you are going into another's personal space. Even if that space is located in a public setting such as a park or church basement it is important to respect that you are in a sense crossing a boundary into a place lived in by others.

Again workers recognized the fact that, for a variety of reasons, homeless and underhoused people face barriers to coming to them. But in addition to outreach in the physical sense, workers also referred to reaching out to meet people where they were at emotionally. Allowing them to define their own needs and pace of working or connecting with outreach staff.

> I think that we have to go to where clients are at and that is geographically as well as them identifying what their needs are. – (64-65) Susan, *Harm Reduction worker*

> So the outreach is going where the people are and responding to their needs. Not what you think are their needs, that is very important. – (50-51) Anna, *Street Nurse*

> So the big component for us is really being there setting our speed, setting our agenda, setting our pace to that of the client and then being available to do what we need to do from a health care perspective. – (92-94) Alexander, *Street Nurse*

Meeting people where they are at might not be initially consistent with an agencies mandate of reducing HIV or STD transmission, connecting people with services or taking

care of health related issues but it does lay the groundwork of establishing relationships and trust with people that are isolated and weary of helping professionals. Workers talked of having to balance their own work and agency agenda's with that of the client.

> I have a certain approach with homeless people that usually starts with where they are at and what they really want to get out of why they are here. I have my own mental agenda that might be screening for Hep C or TB in my head, but if what they want is socks and a token then that is what we do. We just talk about what it is that we can maybe do and then I will gently insert other agendas...
> - (241-246) Loretta, *Street Nurse*

> ...you cannot go there with a fixed idea, this person has to see a psychiatrist or has to go on medication because it is not going to work. But if you deal with them at their level and they tell you, "you know what if you can get me a shirt, or get me some pants or get me some shoes," that is fine for the day. And in time if they trust you enough to know that this guy is not some maniac who wants to take me to some crazy place then they start telling you, you know "I used to have doctor, or I used to see someone," so the story doesn't come straight you have to piece it together. So what we do is we accept people where they are.
> - (111-118) Jean Luc, *Mental Health Worker*

Living in poverty and working for survival on a daily basis translates into having needs that are very concrete in nature and address the very basics of existence including shelter, food and clothing. Two of the street outreach vans observed in this study carried a variety of food or sandwiches with them on shift. One program operated a detox for youth, while another owned and managed its own apartments. Almost all of the street outreach workers carried a variety of clothing with them including clean socks and blankets. If the staff did not have direct access to these basic needs they had thorough knowledge of resources in the community where they were distributed.

One consequence of leaving the privacy of the office or agency is giving up your privacy as a professional. Others witness many of the contacts and interactions made on the street or drop-ins and this visibility can have an impact on more than just the person you are working with at any given time. One community nurse mentioned the

importance of being aware that you are always presenting yourself to others and that you are always being watched.

> If I talk to someone who is very, very unwell, you know "crazy," I am very conscious that everyone is watching to see how I have that conversa tion. Nothing is unnoticed, you are always sort of presenting yourself to the community at large. So visibility is important. – (66-69) Loretta, *Street Nurse*

Observers could easily be influenced to identify themselves to outreach workers for service or remain anonymous depending on their interpretation of the events they witness. Another community nurse cautioned that doing too much outreach can be intrusive to people.

> And outreach is good but it can also be very intrusive. ... We do outreach where they sleep, where they eat, where they have a shower and we do outreach in the bars. Sometimes social workers and nurses can be like the police. We can be everywhere. I think we have to be critical about that too. – (520-525) Karen, *Street Nurse*

This concern of being too intrusive was exemplified during a direct observation with two community nurses doing outreach to a community of homeless people.

> We approached an abandoned grain silo that the nurses knew was inhabited by three homeless men. One of the nurses called out several times as we entered the structure. When asked she informed me that they took great care to announce their arrival as opposed to intruding on the home of these men. (114-117) *Direct Observation Monday, April 22, 2002*

Being critical about the amount of outreach one does and where one does it implies that community agencies that offer street outreach services must coordinate amongst themselves on where and when they work so as not to duplicate and overlap services.

4.4 Relationship Building

Based on the contents of interviews with street outreach workers one central theme that emerged from the data was the importance of relationship building with homeless and underhoused people. A good relationship with people was seen as key to

conducting successful street outreach work. Once a relationship is built workers can begin to explore and address any number of health related issues including primary health care, treatment for chronic illness, safer drug use, safer sexual practices, mental health issues, housing, income, employment, education and social supports. Workers can also advocate, addressing individual and systemic causes of homelessness and poverty.

> I think being flexible and understanding that relationship building is the most important part of outreach work. You can't say okay, today I am going to do five things with this person because really relationship building is the core. Once you have made a good relationship with someone, where they trust you and see you as someone who is potentially helpful to them, the sky is the limit, anything can happen. – (44-49) Loretta, *Street Nurse*

> I think the most important part of my job doing outreach is to establish relationships with people. Establishing relationships with people that might not normally go out and seek services. – (41-43) Peter, *Harm Reduction Worker*

The only exception to this consensus was one street outreach worker that primarily worked with youth under the age of 19. She commented that her team purposely tries not to build long-term relationships with young people.

> We do not form long term relationships with the street kids here because that is not how we see ourselves in the community. We pretty much try to get them re-connected with family and out of the community and not be the catalyst that brings them back. We suggest for them to give us a call if they start to feel like they are going to slip and they miss the community or the life style. Give us a call and we will give them a tune up of all the things that they are not missing. – (42-49) Lisa, *Social Worker*

This exception suggests that the relationships built with youth are somehow different than with the adult population. Underlying this idea may be the fact that workers recognize they may have a greater influence on younger people that are more vulnerable than the adult population. Workers may feel a greater responsibility to intervene in young people's lives and establish or re-establish support mechanisms in extended families or home communities as opposed to replacing them. When the respondent was further

questioned about this issue they explained that it had more to do with the physical location of the agency's services - in a very low-income, high drug using part of the city with high mortality rates.

> I think it has a lot to do with our community. If we were more uptown or on the west side we could afford to have those kind of relationships. But because of our backyard we don't want this to be anyone's destination if it doesn't have to be. – (467-469) Lisa, *Social Worker*

Another explanation could be that the worker specifies long-term relationships. In all other interviews no specification was made about the duration of relationships that were established with people. In fact as will be discussed later, relationships for the most part are developed to provide and or link people to services. Depending on how long it takes for trust to develop, a relationship could be short or long term in nature.

According to participants the key to relationship building is the establishment of trust with people, many of whom have lost faith in the ability of the society to help them. Two things appear to be central to this process. They are: 1) the worker's ability to satisfy the concrete and immediate needs of the homeless and underhoused people they encounter; and 2) the values with which workers approach their work. As mentioned, the immediate needs of people living on the street can include any number of different things. During a direct observation of an encampment of homeless people in one of the three cities under study, community nurses used the distribution of basic supplies to stimulate conversation and check in with people.

> During the course of our visit, we approached each dwelling with our carts full of supplies. The nurses knocked on doors announcing that K and C were there. Most of the residents had established relationships with the nurses and expected them for their regular Monday afternoon visit. ... Each person we encountered was initially asked if they needed any of the supplies we had on hand. All residents accepted the ration of one roll of toilet paper, one bottle of water, one package of tea light candles. Others asked for vitamins, throat lozenges,

> bandages, and tampons. These informal conversations about the supplies we had on hand led into a check-in with people about how they were coping. (41-48) *Direct Observation Tuesday, April 23, 2002*

When interviewed one of the community nurses mentioned how important it is to have something concrete to offer people that are struggling for survival.

> I think meeting immediate needs is really important. So when you came with me on outreach you saw that we give people toilet paper, that is a pretty immediate need, water, toilet paper, sources of light, band-aids. I give out socks, lozenges, transit tokens. When I smoked I gave people cigarettes. Just those kind of things. Not expecting that anyone would want to talk to me if I have nothing to offer them. I am a nice gal and all, but quite frankly people have survival on their minds and there is no reason for them to give me the time of day unless I can do something. ... then, people size you up and feel that you are worth talking to perhaps and they begin to see you as someone who can help them. – (71-79) Loretta, *Street Nurse*

Homeless and underhoused people are quite used to having agency workers tell them what they cannot have. Whether it is welfare benefits, housing, employment opportunities, or basic survival items the norm is that people do not qualify, conform to rules or are just too difficult to deal with. This usual practice lies in contrast to street outreach workers that travel to where homeless people are located in the community and offer concrete resources. Satisfying client's immediate needs is also consistent with Carniol's (1992) defense activity whereby the structural social worker's first priority is resource allocation.

The second key to establishing trust with clients relates to the values with which workers approach outreach. The values most often referred to by outreach workers include working from a non-judgemental, respectful approach that understands the realities of life on the street.

> The values are just the non-judgement and the understanding the chaotic lifestyle of most drug users. That they might identify something today and it might change tomorrow and that is okay. – (89-91) Susan, *Harm Reduction Worker*

> The ultimate thing that I think it boils down to and this is based on our teachings is respect. Because when I have respect for someone else, regardless of the life or choices that they have made, I become non-judgemental about what they are doing. – (53-55) Charlene, *Social Worker*

> It is just a completely non-judgemental approach. …we have to accept people for who they are and what they are doing. …we are not going there to tell them it is right or wrong, we are going there to help them with whatever it is that they need. … - (132-133) Kate, *Street Nurse*

Other workers talked about the importance of having a harm reduction approach incorporated in the work that they do. A working definition of harm reduction given by Riley &O'Hare (1998) in relation to drug use is, "…an attempt to ameliorate the adverse health, social and economic consequences of mood-altering substances without necessarily requiring a reduction in the consumption of these substances." Common examples of harm reduction programs include needle exchange, methadone programs and drinking and driving awareness campaigns.

> We are not judgemental at all. We work from the harm reduction model and try to the greatest risk out of any given situation. … We take it from, if you are going to use, use safely. If you have to do what you are doing do it as safely as possible. How you choose to live your life is entirely up to you but always choose life. … If you are going to go dating make sure you have someone that is looking out for you. So that is a huge part for us. What ever you do, do wisely, do safely. – (66-67; 69-73) Lisa, *Social Worker*

> I just say okay if this is what you are doing this is how you can do it safer or more safely. And you know people will come to me and say listen you know I am getting too heavy into crack I really need to stop or something and then I can go to the next step and say come to talk to me. Maybe you can try this or try that. But that trust and that rapport and relationship has to be there before anything else happens. These people are so used to hiding from people, hiding from psychiatrists or police or security guards or property managers or whatever its like we come on the scene and it is just us and they know that. – (132-133; 137-138; 140-147) Peter, *Harm Reduction Worker*

Harm reduction strategies offer a concrete approach to street outreach workers. It can be argued that they are also congruent with a structural social work approach in that they

challenge the status quo and the state's historical criminal approach to people who use illicit drugs. These strategies recognize that this historical approach has marginalized and oppressed illicit drug users making them more susceptible to conditions of extreme poverty and of contracting health complications including HIV and hepatitis. In practice, harm reduction demands a non-judgemental approach from workers and supports a dialogical relationship with clients based on trust and mutual sharing of information.

Many agencies and institutions involved in work with marginalized populations espouse to work from a non-judgemental approach. However these values sometimes fail to make it from mission statements to direct practice. During direct observations with street outreach programs most worked from a non-judgemental approach in my presence.

> Interactions with service users were on very equal terms – between outreach staff and homeless people. In one case it seemed as if there might be some familial relationship between one of the outreach staff and one of the homeless people served. Interactions were mostly jovial and filled with humour. This was the case with all clients served even those that presented very intoxicated and at times more demanding than others. (56-60) *Direct Observation, Monday, April 22, 2000*

However during one ride along with a street outreach program these values were interrupted by the frustrations of a worker.

> The second caller agreed to meet us at a local variety store. We said we would meet them in 5 minutes. When the person was maybe only a minute late one of the workers was visibly annoyed when working with the person. This considering the fact that we were not at all busy during the evening. (37-40) *Direct Observation, Friday, April 19, 2002*

This observation stands in contrast to other data collected in interviews and during direct observations. It should be noted that this worker's frustrations could be due to numerous other factors most notably the overwhelming and growing number of people living in extreme poverty that outreach workers must interact with on a daily basis. Frustration and burn out in the field is a reality for many and demands that agencies provide a

continuum of supports to workers on the front line. This issue will be discussed in more depth in a later section on organizational settings.

Part of a non-judgemental approach is absolute acceptance of another's lifestyle. It means seeing the people you are working with as equals and just as deserving of care and support as any other person. This is where more mainstream institutions start to waver in their acceptance of people with strict policies on eligibility and behaviour requirements. A mental health outreach worker highlighted the difference between his agency's approach to street outreach work and the policies of local hostels.

> ...some people will really be tough with you like come in and refuse to leave or some people are verbally aggressive because that is their way of affirming their self. So what we do is we don't have like in the hostels, like you have to go, if we did that we would have no clients. So we really have to accept people, we will still set basic things that we have to accommodate each other on but we don't have strict rules like you do this or you don't do this or that kind of thing. – (122-127) Jean Luc, *Mental Health Worker*

Another community nurse contrasted the difference between her approach now versus when she previously worked in a hospital.

> I have an older gentlemen in his 70's who was having some health problems and I made an appointment for him. Normally he is very independent. And I sent him to the doctor and he reported back what he was supposed to do and everything and it turns out that he had not gone at all. And I think if I was still working in the hospital I would have been you know, I can't help you if you are not going to blah, blah, blah. But it turned he was just not able to walk too well lately and so I took him to the doctor this week and stayed with him and he kind of laughed about the fact that he had been a brat you know. – (153-159) Kate, *Street Nurse*

Some workers directly referred to the notion of equality when referring to important values in street outreach work.

> I think that maybe a starting place might be that everyone is worthy of appropriate accessible health care including people who are homeless, people who use drugs and alcohol and people who are mentally unwell. That is the essence of the work. I think everyone deserves health care. – (34-37) Loretta, *Street Nurse*

> Mainly it is a question of equality between citizens. We talk more about people than about homeless people. We still have and I hope we will keep public health services so at least for now we should provide the same equity to every body. - (138-141) Karen, *Street Nurse*

Although relationship building was seen as essential, workers acknowledged that it often takes a long time for isolated and marginalized people to engage with them. Given that many homeless and underhoused people have had negative experiences with service providers in the past, being skeptical of street outreach workers is a rational survival mechanism on the streets.

> They might just want you to nod in their direction the first ten times you walk past them in the park, and after that it might be "Hey, what's up" and after that it might lead into something else. – (174-176) Susan, *Harm Reduction Worker*

> I have seen that over the last year, we had a guy that wouldn't speak, he would take our food but not say anything and now he will carry on a conversation with one of our drivers. It took a year to get to that place. – (94-96) Charlene, *Social Worker*

One can imagine how important the first encounter is with someone who has taken the risk to connect with a worker. After perhaps only previous negative interactions with the system of which street outreach workers are a part, it is essential that workers strive to actively listen and maintain their non-judgemental approach at all times. Another negative experience with a worker could translate into further isolation for the client.

Other important aspects of relationship building mentioned by street outreach workers were to be visible in the community over time and to be accessible. In many community-based agencies low paying jobs are the norm, which translates into high staff turnover. High staff turnover works against the time it takes to build relationships with clients and results in a lack of trust with the multitude of different worker faces on the streets, shelters and drop-ins.

> I think being out there in the community on a really consistent basis and being visible is important. ... You are recognized and because you don't just pop in and leave and you are here day in day out year in year out. It communicates to people that you are not fly by night, you are in for the long haul and you are maybe worth having a look at. – (57-58; 61-64) Loretta, *Street Nurse*

Being reachable to people that you are working with is also very important. After someone receives a referral to welfare or the hospital, it is essential to either follow up or provide a number to call if there are any problems.

> It is really important to say to someone here is how you can reach me. I give out all kinds of my cards and tell people to call me. If I send someone to welfare, I sent someone from the shelter to welfare on Tuesday night, I can't call welfare because it is night time so I send someone to welfare, but what I do is I leave a message for the welfare worker. I give my card to the client and I say call me tomorrow the instant you run into a snag. – (276-281) Loretta, *Street Nurse*

Finally, one worker mentioned that it is important to be available in crisis situations when and where they happen.

> They have an outreach cell phone with them so a member from the community could call them up and say I am in crisis and someone is coming after me. Can you guys get me out of the community? So yeah our phone will be open and we will respond. – (163-166) Lisa, *Social Worker*

If someone finally does call out for help, and if immediate service is available, it can have a significant positive impact on a worker client relationship.

As it became clear that relationships were seen as a key part of street outreach work, the interview guide was adjusted to include a question on how a worker knows when a relationship has been established with someone they are working with. How do workers know when they can move beyond satisfying immediate needs to insert some of their own working agenda? The two respondents that answered this question mentioned that it required a certain amount of life and work experience combined with active listening skills and a little intuition.

> I have children of my own so I can't speak for other people that I work with but I have my own mother's intuition. So when I am working with kids I am thinking of how are they feeling, body language reaction so I can intuit maybe now is a good time for me to say, so I see you are fidgeting a lot, I am kind of concerned that you are having some health concerns that you are not really looking at. How have you been feeling, or you are really itchy oh you are really itchy where? I know a doctor, I can just drop you off there and you can go and see him. So I can introduce some things that they are now feeling comfortable about just by watching their body language. ... You can't just give one of our new workers a book and say okay. ... You just pick up on those things after awhile. The longer you are doing it the better your skills are. – (311-320; 329-330; 337-338; 343-344) Lisa, *Social Worker*

> I think my quick answer would be that it is intuitive. Although that is not a very good answer, it is not one of those good empirical answers where you have collected the data, analyzed it and realized that this is when we know. It is so individual with the client that I don't think we can set a hard and fast rule as to when it has happened and when we know. ...the answer for any of us is that person is not resisting you anymore. That they are starting to access you, they are starting to come to you to seek out answers to questions they have or seek help for situations that they are engaged in. And once you are there with them and they are paying attention to you, and you are not having to work to get their attention. And they are starting to seek you out, then you know that you can start to introduce your own thing, stuff that you are meant to be doing.
> - (106-110; 115-120) Alexander, *Street Nurse*

Workers monitor their relationships with clients to know when they can introduce issues related to more than just immediate needs. The situation will vary with each individual so the importance of active listening and picking up on non-verbal cues is important. Sometimes workers misread the signs from their clients and move too fast.

> Occasionally there are individual strategies that do not work with individuals. I have tried and true ways of connecting to people that mostly work. Occasionally they don't work and you realize I moved too quickly with that person or sometimes there are those things that you realize - I should have realized that person was too paranoid to ask to sign a form that day and you realize that you have put sort of a glitch or bump in your relationship building. – (139; 144-148) Loretta, *Street Nurse*

If a worker moves too quickly with a client it can threaten to jeopardize their developing relationship and trust.

The central task of developing relationships with clients is one aspect that sets street outreach work apart from other modes of service delivery in the health and social services sector. Some workers referred to their relationships with clients as similar to that of friendship or family.

> That relationship can become that support kind of like a friendship. You need to go to the hospital, okay I will go with you. You want to go to detox I will go with you. It is not as scary because you are going with a friend, you are going with someone that you trust, somebody that you have established that relationship with. – (234-237) Peter, *Harm Reduction Worker*

> And you can tell them that you love them too. Like where else would you be able to say that you know. There is a lot of that that goes on, a lot of almost like family. You would probably be condemned for that in other agencies but people say that they love you and you can truly mean it. I mean I really love my clients… - (486-489) Kate, *Street Nurse*

> It is about building up the trust and the friendship before hand so that you are there when they need you to be there. – (241-243) George, Social Worker

Comparing relationships with clients to friendships or family relationships brings up the issue of professional boundaries. While it might feel good to relate to people you are working with as friends or family it threatens to mask the reality of a large power imbalance between worker and client. It also calls into question what behaviour is appropriate to engage in with people you are being paid to help. Furthermore, it potentially disregards the consequences to the client who may interpret friendly behaviour from an outreach worker as being true friendship. Imagine the consequence of realizing that one of your best friends only listens to your problems and offers support because they are paid to do so.

One worker shares an experience of being new to the field and facing the blurry line of worker and friend.

> I used to do a lot of work with street youth and there had been this one client that I had been working with for some time and basically the work that I had done with him was just sitting down and chatting about stuff. Going places, wherever he wanted to go and I reached that point where I thought okay we are good now. We have established a relationship. I can start interjecting here. I can bring up my agenda. And I brought up the whole issue of sexually transmitted diseases and HIV and testing and getting into that whole angle of dialogue and he said, "James, I can't talk about that stuff with you. You are my friend." And I thought oh fuck I have blown it. Like this is not where it is supposed to go. – (305-314) Alexander, *Street Nurse*

This example suggests that relationship and trust building with clients should not be pursued blindly. Workers are employed and on the street for a reason – most frequently to satisfy people's immediate needs, offer support and increase access to a range of health related services. It also suggests that workers that are new to the field may lack the experience to recognize boundary issues as they arise. Another community worker draws attention to this fact by his comments,

> Everybody's boundaries are going to be a little bit different so again you have to be a little bit flexible. Nobody starts off with really straightforward rock solid boundaries and leaks out the other way to where they have none. They usually work the other way. So it is not a problem that gets worse as time goes on, it usually gets better. - (514-517) George, *Social Worker*

Although workers may improve their skills over time as they relate to boundary issues, abuses of power should be of primary concern, particularly at the beginning. The issue of boundaries should be open for discussion in the staff rooms of street outreach programs. Feedback from people living on the street could be canvassed to broaden the perspective on this issue. In addition it is essential to include boundary issues in the training for new employees so as to prevent a trial and error working style that disregards the impact on the homeless and underhoused people they are working with.

Workers agreed that the boundary issues within their working relationships with clients are not as clear-cut as they might be in an institutional setting. Outreach by nature

requires that workers leave their agencies and work in the environment they find their clients. It also requires that work take place at a pace dictated by clients. One community nurse highlights the potential consequences of this working style.

> It creates a real catch 22 though. It does because in a lot of cases we have to be willing to sit down with people with where they are at. And our philosophy is that we go into the community and work with people where they are at. And once you sit down at the community agency that they pick or the drop-in centre that they pick that is their hangout and you are sitting with them and you are having that chat. There is the implication that you are hanging with them. You are being a bud. You are not being a street nurse you are being a bud. – (330-340) Alexander, *Street Nurse*

This dilemma requires workers to be upfront about their work agendas. A structural approach requires that workers unmask agency practices, jargon and goals. As such workers must be clear about who they work for and what services and resources they have to offer. This same community nurse shares an example of how they are upfront and clear about the nature and goals of their work.

> I have found it necessary to just be very clear with people that even though I am getting into life and death and core issues with them and they are really going places where their heart is, I am working. And this is a profession for me. While I am prepared to go further than most health care providers are prepared to go with you in advocating for you. It is about advocacy. It is about your health. It is about disease prevention and that is where I am coming from. And if the suggestion that we do cross those boundaries ever comes up, I am very solid that that's not a place we can go. – (321-328) Alexander, *Street Nurse*

This participant affirms that it is important to be upfront and open with clients about work objectives. Workers need to clear about boundary issues when and if they arise.

Street outreach workers are on the front line of extreme poverty and experience on a daily basis the human suffering that is a result of it. Workers have a kinship with their clients in that they share this space and witness the impact of oppressive societal attitudes and structures. Workers may relate personally to oppression based on their own

social location by gender, race, ethnicity, ability/disability, age, sexual orientation or class and be drawn to street outreach work for this very reason. For workers that belong to smaller communities such as the First Nations, workers may have familial ties to clients, as was the case during one direct observation during this study (Direct Observation, Tuesday, April 23, 2002). This closeness can assist workers in developing empathy and a non-judgemental approach to their work but it also has the potential to harm clients, particularly if assumptions about friendship and emotional ties are not shared. In the end, it exposes clients to disappointment and masks privilege. Being upfront about the differences in power between worker and client and the unequal perceptions and definitions of friendship is essential. Practicing from a structural approach that unmasks agency goals and aims to reduce power differentials between worker and client can assist workers in avoiding boundary conflicts with their clients.

4.5 Advocacy

Working with homeless and underhoused people gives workers an inside view of the barriers marginalized people face when accessing services. After a relationship has been established with a client, workers are better able to assess needs and appropriately match people with services available in the community. Referrals made may address a host of issues related to the determinants of health including; income support, housing, employment, physical health problems, mental health problems, treatment for drug and alcohol use, education and social support. Referrals in the community must take into account the unique needs of individual clients and therefore appropriate matches will take into consideration issues of sexual orientation, ability/disability, race, age, ethnicity, class and gender. Often giving someone the name, location and intake information of a

community agency is not enough to get them access to the services they need. For this reason street outreach workers spend a lot of time advocating on behalf of individual clients to facilitate access to a particular service or resource. When asked about advocacy generally, workers explained that it is an integral part of their work responsibilities.

> I think that advocacy is just part of the work that we do. Whether it be picking up the phone on someone's behalf to hook them with something or walking them down to the hospital to make sure they are seen by someone in emergency or sitting on different coalitions that are fighting for more rights for a population that doesn't have a voice. – (270-273) Susan, *Harm Reduction Worker*

> ...we do a lot of advocacy with other hospitals, other health services and welfare. So we do political work somehow on a daily basis.- (263-267) Karen, *Street Nurse*

> There is huge amount of insider information required to make the system work for people, be that welfare, shelter, housing the whole system is set up to deter people and it mostly does that. So in order to make it work, ... you have to share that insider information with people, that is really helpful. – (87-89; 90-91) Loretta, *Street Nurse*

Workers distinguish here that there are different forms of advocacy that they are involved with. They include individual advocacy with clients, internal advocacy within community agencies and external advocacy aimed at challenging the status quo and bringing about social change.

Workers advocate on behalf of individuals on a daily basis trying to secure them access to services. Through this work street outreach workers see first hand the impact of agency policies that are punitive and inhumane.

> ...we have a few people that are very well known in the city. They are noisy, they are loud, they are tough. So their reputations precede them. I have one guy that is banned from all the hostels in the city. – (432-435) Jean Luc, *Mental Health Worker*

> We have a core group of youth who are the most resistant, most non-compliant. ... Many of them have burned bridges because of poor behaviour, poor life skills. Just to get a youth who has been down here more than a year into a safe place can

> be the hardest struggle because they told some worker to fuck-off. … And the reason that this kid is going to be exposed to greater violence is because she verbally assaulted someone who has all the power, gets to make all the decisions and may lord forbid have some of their own issues taking place on that day and this kid is going to pay the price for telling this worker to fuck-off. Within a couple of months that worker has forgotten that child but for the rest of the child's youth she is not going to get into that place. We do hours and hours of advocacy just to get kids in doors. – (212-229) Lisa, *Social Worker*

Advocacy on behalf of individuals is needed to overcome common restrictions to services such as barring practices at shelters. It challenges the need for social service workers to hold power over those who are often the most marginalized. Advocacy such as this is even more important when there is already a lack of services available for certain groups. Safe and supportive shelter services for transgendered and transsexual homeless people are sorely lacking, if available at all in Canadian urban centres. Barring a transgendered or transsexual person from a shelter may eliminate the only option for shelter that person has. Similar services are lacking for women, those with disabilities, First Nations peoples, refugees, newcomers, youth, those with mental health issues and drug users.

Other practices of individual advocacy workers talked of included accompanying clients to appointments or waiting with them in the likes of an emergency department.

> …if they are referred somewhere we go with them and stay with them until another worker takes over and stays with the person throughout the process that they are in. It is usually more of an appointment sort of situation or taking someone to the emergency department. That is what they need, support. – (200-206) Jane, *Social Worker*

By being physically present workers can advocate in person and ensure that their clients receive the care they deserve in a respectful and timely fashion. This direct support can also have a positive effect on the relationship between worker and client.

> Advocacy is huge from a client to professional perspective because if a client comes here and says, "I got this god damned form that needs to get filled out. My worker is not going to give me my money until this health form is filled out." It is

> confusing and they have been going to place after place after place to get it done. It is around health so it is appropriate. So you sit down with them and you make the phone calls and you are golden in their eyes. So that is a big piece of work that helps me get in with clients. It is key from a social determinants of health perspective.- (388-396) Alexander, *Street Nurse*

Individual advocacy assists people in gaining access to services that meet their unique needs, unmasks the restrictive and oppressive policies of agencies and has a positive impact on relationships between outreach workers and clients.

In addition to individual advocacy, one worker described what she called "internal advocacy" that she was involved with at the community health centre where she worked. She talked at length about the importance of communicating to colleagues and managers the significance of outreach work and of conditions of homelessness and poverty that she bears witness to.

> I see that as such a fundamental part of my nursing role to be a witness to what I see, to be witness to the truth. Internally in my organization, I am constantly the person who raises the issue of homelessness during staff meetings. I am always updating people on the conditions in the shelters and what is happening out there because I really see it as part of my role to educate my colleagues about stuff. So I think that is one thing - internal advocacy – with my managers. – (190-195) Loretta, *Street Nurse*

This worker describes internal advocacy as an essential part of her work. There seem to be three separate but related goals of this internal advocacy. The first is to ensure that street outreach work remains a priority for the organization and to make professional colleagues aware of its objectives and goals.

> I am a pretty strong advocate for myself and the for the outreach components of the work. I think that if I were not so stubborn and strong an advocate the outreach component could be easily lost and that happens in many organizations because outreach is mysterious and people don't necessarily know what it is. - (157-161) Loretta, *Street Nurse*

This worker is advocating for her own job as an outreach worker in a larger organization that has many different programs and serves a variety of populations.

The second goal of internal advocacy is to educate other staff about how to work more appropriately with homeless and underhoused people. If successful, this goal may reduce the barriers that homeless and underhoused people face when trying to access services at this health centre. In addition to educating staff about the realities of life on the street, this worker also talked of modeling behaviour and values that will build trust with people and make the organization more accessible and welcoming for marginalized clients.

> Sometimes it can be unsettling for a health provider to figure out where to start with someone who … is really unwell who may not want to talk about medication or a TB test or have blood taken or any of those things. I think part of what is a useful role for myself is modeling how you talk to someone like that and how you get from A to B with folks and I think that colleagues learn from that, I hope so. – (250-255) Loretta, *Street Nurse*

Street outreach workers should focus some energy on their own agencies policies and practices in relation to marginalized clients as opposed to solely addressing the barriers and inadequacies of other community services.

The third and final goal of internal advocacy is to create an environment in the organization so that it is willing and committed to speak out and participate in external or systemic advocacy. This worker shares a specific example of how energy spent inside the organization led it to adding its voice to very important health issue.

> Recently we had a TB outbreak and there are positions that I would like the organizations that I work for to state publicly, but in order to do that I realize that I have to update and brief the management team here on the ins and outs of the issues. I asked for a meeting with the managers and said I want to spend a little bit of time talking to you about TB and why we should be speaking out about this. That allows the organization to add its voice to the bigger struggle, but you have to do that internal work. You can't just say, I am going to go and do this, you

> have to do that work. It then gives me the opportunities and the flexibility to add our voice to the bigger picture so that I am able to talk to the media, I am able to do deputations at City Hall or wherever they are needed. I am able to do that work, that broader advocacy work because I have negotiated an agreement internally that allows me to do that. – (195-206) Loretta, *Street Nurse*

This worker adds that she does not always get the approval of management to speak on behalf of the organization.

> Where people are a bit more nervous are around issues that would appear to criticize the funder, the province, so that is dicey, not for me personally but for the organization that has bigger responsibilities to think about than I do. So we negotiate that stuff and it doesn't mean that I don't speak out, but it may mean that I speak as a street nurse and not a staff member and that is okay. – (215-219) Loretta, *Street Nurse*

Internal advocacy is important and perhaps even more so in larger organizations or institutions that are involved in outreach work. It can ensure that street outreach programs are valued as an integral work strategy, provide education and modeling for other staff not involved in outreach work and ultimately can lead to the organization taking part in external advocacy aimed at addressing structural roots of poverty and homelessness.

External advocacy is aimed at changing government policy and practices, challenging oppressive attitudes and ultimately transforming societal institutions so that they no longer are a root cause of poverty, oppression and homelessness. During interviews workers talked of and gave examples of external advocacy or political work that either they were involved in as individuals or that their organization was a part of.

> Nursing week is in two weeks so the street nurses network is going to hold a press conference and try and address some of those issues that the root causes exist and nothing is being done about them. – (536-538) Kate, *Street Nurse*

> Once in a while we write an article in the newspaper or for a health magazine and it is always a reflection about a health or social problem we encounter in our work. – (279-281) Karen, *Street Nurse*

> We have an executive director who is well spoken in the political arena and he goes and represents us. If we have a concern we take it to our director and our director will run with that ball. – (275-277) Lisa, *Social Worker*

> From the broader perspective of things and the bigger picture of advocacy there is something we have been involved in. You can see the pictures back there, we are advocating for the establishment of safe injection sites for injection drug users. – (411-414) Alexander, *Street Nurse*

One worker commented that the nature of street outreach work gives them an opportunity to see up close the larger structures that affect clients they work with.

> But one thing that we find is that, doing the work we do, we really have an inside snapshot into the lives and the issues of the population. And sometimes you are the only one that has a position that some people in the community respect enough to listen to because they certainly don't listen to the clients. And you can stand up and say either alongside the clients or in lieu of the clients these are things that we feel really need to be addressed and this directly impacts their health. So yeah advocacy is huge. – (416-421)Alexander, *Street Nurse*

Workers at a smaller community based agency were asked about the consequences of participating in a large protest that occurred at a provincial legislature in the summer of 2000. Protesters included a number of homeless and underhoused people who were demanding an increase in the number of affordable housing units available to them. This agency was visible at the protest providing nursing care to demonstrators that were assaulted by the police. A community nurse comments on the aftermath of the protest.

> We don't ever feel kind of paranoid although the two year anniversary is coming up for June 15 ... after June 15 the police, like at least one of our staff were in jail after that. The police were so diligent and so horrible that we felt the place could be bugged. Like we were really scared but it wasn't really so much related to funding as it was about being persecuted. – (631-636) Kate, *Street Nurse*

Another outreach worker at the same agency suggested that they have a responsibility to be involved with campaigns that involve their clients around unequal access to services and resources.

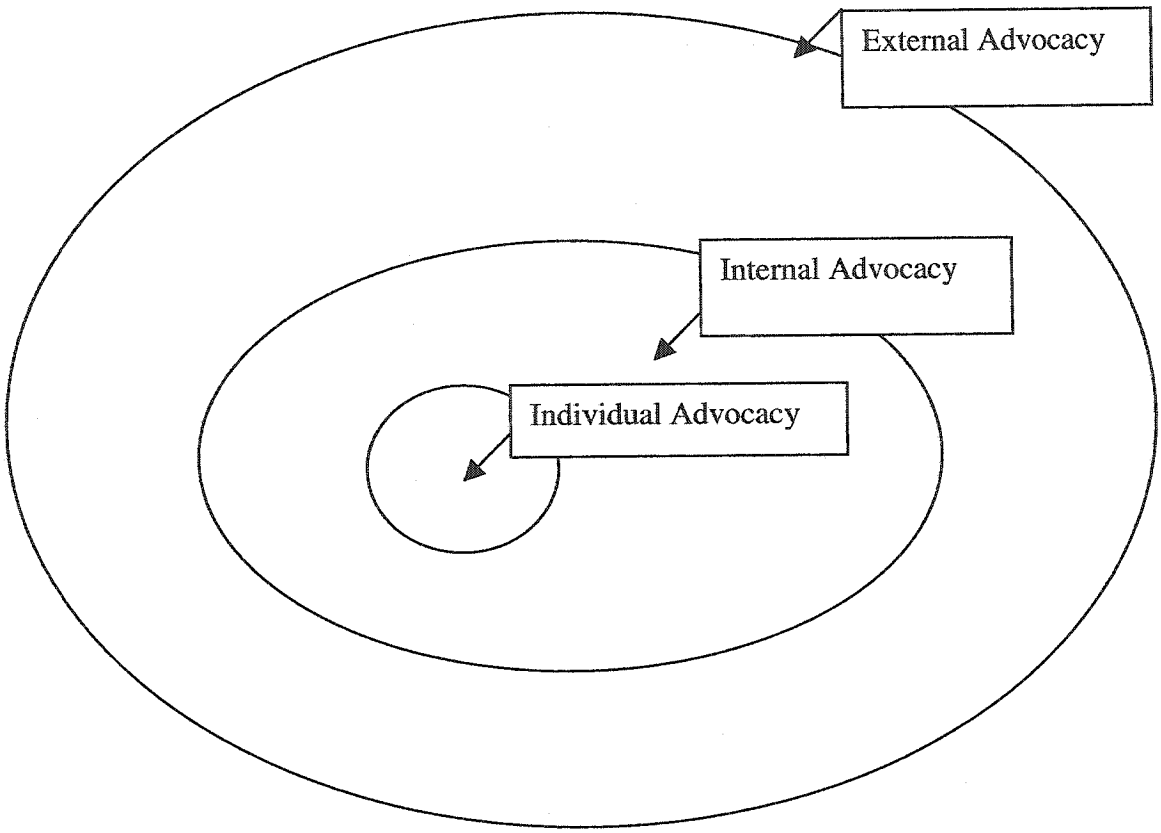
> We are saying these are the people we are dealing with on a daily basis and these things are very important to them. Housing is important to them, the health issues, so when there is an issue that is about not accessing health we think it is our responsibility to go out there and make this a public issue. – (651-654) Jean Luc, *Mental Health Worker*

The large demonstration referred to above shows workers and clients standing side by side demanding a change to the status quo and encouraging social transformation. It also highlights an example of where workers are not always doing for their clients, but instead standing in solidarity as homeless and underhoused people themselves demanded state action and increased investment in affordable housing.

Advocacy proves to be a large part of street outreach work. With individuals, within organizations and to change oppressive societal structures – all street outreach workers are involved to a greater or lesser degree. These three types of advocacy can be conceptualized as shown in Figure 2. Street outreach workers use Individual Advocacy to address barriers and exclusionary policies they encounter with individual clients. Although the same policies may negatively affect many other people the chance for significant structural change is limited. Internal Advocacy is used by workers to address systemic barriers and policies within the agency that prevent clients from accessing services. Change within the agency can have an impact on the people that come into contact with it and as such structural change can occur within this one organization. In addition it can create an environment for which the agency can engage in External Advocacy. External Advocacy is aimed at changing government policy and practices and

challenging oppressive attitudes, as such its potential for structural change that impacts the most people is the greatest.

Figure Two – **Advocacy within street outreach programs**



Given that outreach work requires relationship building with clients and is based on a foundation of trust, advocacy as it is described above is a natural extension of work on the streets. This is another characteristic of outreach work that sets it apart from other types of work in the helping professions and demonstrates its compatibility with structural approach that aims to bring about social change.

4.6 Community Partnerships

Street outreach workers mentioned that it was important to work closely with other local community agencies. In doing so workers mentioned that it provided better coordinated services to the marginalized populations they are working with, made available a broader range of services and expertise and provided solidarity with which to conduct external advocacy. Informal partnerships are established between workers at various agencies to assist with referral between services.

> I think it is really useful to have local working partnerships and be able to work with your neighbour agencies. I work in a heavily serviced neighbourhood so it is useful to link with shelters, the other drop-in centres, to sort of work together around client care but also to call on each other for lobbying purposes. Having a network of people that you know. It improves care to clients if you work with other folks in the neighbourhood. It certainly improves care to clients if you have a working knowledge of what else is out there. – (496-502) Loretta, *Street Nurse*

> On the front line our workers have wonderful relationships with their counterparts in other agencies. … And we all work very hard on this level together to provide the best services we can for people we work with. – (750-756) Lisa, *Social Worker*

One worker mentioned that it was essential to have contacts with professionals working in a variety of different areas because one street outreach worker cannot be an expert in all the social problems a client might present with.

> …any worker who believes that they are the answer to someone's needs is pretty egocentric in the sense that you don't work in a vacuum … you have to rely on other people to help that individual out. You can't be an expert in housing, health care, trauma, and abuse because we are not, we are just not. We can build a relationship with someone if they identify something like abuse, but it is not my forte, it is not my expertise. I can listen to you, but if you want to work on something around that than lets try to hook you up with someone who has more experience in that area. And if you can trust me to make that link for you then we can go from here. – (209-217) Susan, *Harm Reduction Worker*

Just as a worker cannot be an expert on all social issues they also cannot attempt to understand how a single social issue may impact differently on a number of diverse

people, for example, women, youth, First Nations people, members of other ethno-racial minorities, transgendered and transsexual people, seniors, and those with differing abilities. For this reason, it is essential to build community contacts with workers in a multitude of social service agencies that are specifically designed to meet the diverse needs of a variety of population groups.

Partnerships are developed between agencies in more formal ways within the realm of service delivery. Many of the workers interviewed talked of going out on the streets with workers from other agencies during their outreach shifts.

> We pair up with nurses. We pair up with the hepatitis C support program. We pair up with an outreach worker from Agency W, with a housing worker from Agency X, with an occupational health worker from Agency Y and we pair up with a sex trade worker from Agency Z. ... If it wasn't for partnerships I know specifically my program couldn't operate. – (997-1002) Peter, *Harm Reduction Worker*

> We would call out to an outlying municipality and say we are going to be out in your neighbourhood. Do you want to hook up? We are looking for these kids in particular. We would then go and meet with one of their workers and share our information and let them show us around. Where they are finding kids and the trouble spots so we can add that information to what we have and so it is just an extra set of eyes out there looking. – (134-140) Lisa, *Social Worker*

> ...our solution has been to ally ourselves with service providers who do attend to those other needs, the social determinants of health that are sort of outstanding and not attended to. And in working with them we can also tag along and say ahah here is this other issue that we have we would really like to sit down and talk to you about. We really take advantage of that trust relationship that we have built to create that agenda. – (140-145) Alexander, *Street Nurse*

In pairing up, agencies can share resources, allow staff to learn about other agency services and develop working relationships with other workers in the field. Clients benefit from coming into contact with all the services offered through these partnerships.

While partnerships were seen as an important part of providing access to services for marginalized people in the community, workers identified that there were barriers in

establishing partnerships. These barriers related to different value bases between agencies, the diversity of community populations and services and the intense competition for dwindling funding sources.

> Agency X doesn't believe in safe injection sites, you know okay what are you going to do, but wait a minute they are in the needle exchange business. So would a safe site put them out of business. So you have to wonder about this sort of thing. ...the most difficult thing is the infighting between organizations. It is the hardest. – (113-115) George, *Social Worker*

> This community is often times at odds with itself. You have a number of populations down here. You have a large South East Asian community, ...You have the First Nations community, ... You have lower economic social classes, ... And you have the drug using community ... So how do you work with a community that is that diverse? – (586-595) Lisa, *Social Worker*

> We all have to work together. Unfortunately the way that the government has structured their funding dollars is everyone is sort of fighting for the same pot of money to do the same work, so it just becomes almost territorial. But I think we can accomplish a lot if we do work in partnership. – (227-230) Susan, *Harm Reduction Worker*

Even with these barriers present all street outreach workers mentioned that they were in some way involved in working partnerships with other community based agencies. One community nurse in Montreal talked of her agencies membership in a coalition of more than 50 local community groups that fight for affordable housing and social justice issues related to poverty and homelessness. She mentions that membership in this group allows for workers to develop relationships with each other that assist in service delivery, as well as to join together to participate in external advocacy.

In addition to working in partnership with local community agencies, street outreach workers were also asked if they had any contacts or partnerships provincially or nationally. One worker mentioned that they had traveled or toured other community-based agencies outside of the local area to become familiar with referral processes.

> We do a lot of referrals to treatment outside of the city. ... Our workers went to Agency X for an information session to learn to do an effective referral and all that stuff so we can better serve our clients and get them in easier. – (516; 519-521) Lisa, *Social Worker*

Another worker mentioned that they had professional contacts at agencies across the country.

> So we were in communication more informally than formally. But a lot of it has to do informally not as an agency to agency but around professional issues. – (742-744) Alexander, *Street Nurse*

> I think it is useful to have allies across the province and across the country. The street nurses for example have an email list that has folks from Vancouver, Toronto and Montreal. It is one way to get connected and link and network. – (504-506) Loretta, *Street Nurse*

Others mentioned that it would be beneficial to work more closely with other agencies and community groups involved in street outreach at the national level.

> ...I think it would be a good thing. I don't exactly know how because it is a big country but the population is traveling from one province to another. ... I think it would be an excellent thing if we could because when we exchange with people in the United States it is not the same thing. They don't have the public health services and it is very different. And the notion of individual rights is very strange. They don't have the same notion of the community. And I think all over Canada it is something we have in common this community vision. – (805-807; 810; 818-822) Karen, *Street Nurse*

> We don't have as many connections across the country that we would hope to have. We have connected with a few researchers here and there and other shelters throughout the country, partly through our partnership with Agency X and with people that have brought others to see what is going on here. I have done a bit on the net but not much. – (276-280) Frank, *Social Worker*

While workers stated that finding allies and partners on a national scale would be helpful they did not offer concrete suggestions on how this might occur. Increasing numbers of people affected by extreme poverty and homelessness in all areas of Canada mean that street outreach workers are overworked as it is. This growing volume of work combined with the lack of resources to meet and communicate nationally pose barriers to the

sharing of ideas. However, even the small scope of this research project allowed for a brief overview of resources and services available that would be of great benefit to others working in the field of street outreach services and suggest that further investigation in this regard might be fruitful.

4.7 Peer Support

While investigating some of the important components of street outreach programs with workers, one aspect that was mentioned on several occasions was that of integrating clients into employment opportunities at the agency. Referred to as a peer support element of their programs, workers talked about how powerful a tool this was to build self-esteem, earn an income, learn new skills and in a general sense foster community leadership.

> Our agency likes to hire from its own community. We have a requirement that you have to have a minimum of 18 – 24 months of clean time. But we welcome all past clients to definitely come in and put in an application and a resume. In the past we have hired from our client pool and we have had some really spectacular success stories. In some branches of our agency like our needle exchange … in the neighbourhood of 70-80% of our staff are in recovery. … Lots of people from the community, Aboriginal and non-Aboriginal, so they have deep roots in the community and really care about people in the neighbourhood. And it is an incredible shot in the arm for these people that think that life is hopeless and never going to change and then they see one of their old cronies driving by in a van making pretty decent money. Some of them are "Oh my god you are the last person I would ever expect to turn it around." So that helps in the community. – (350-363) Lisa, *Social Worker*

> It is a training program so the majority of the people that apply are street involved. … we give them a job, we teach them how to be an outreach worker, how to case manage. We teach them about our programs and services, what they mean. … We bring in the hostel-training program, plus we get them their CPR, first aid and crisis intervention training. Some of them have lower literacy skill so we bring in tutors to upgrade their skills. – (221-228) Charlene, *Social Worker*

One worker talked of the positive impact peer support can have on a person's self-esteem but also commented that peer support workers can gain access to very isolated populations.

> It is really important because you are giving people an income which is really the most important health intervention short of housing. Self-esteem is good plus you connect, learn things and connect with populations that you otherwise would not connect with so it is really important. – (525-528) Loretta, *Street Nurse*

Another worker referred to a longer-term goal, that of giving ownership of the program back to people who have been users of the service.

> Now he is one of our volunteers. … There is no one he doesn't know and he understands what a person is going to go through before they ask to quit. What a person needs while they are out there. You know to me if I can find somebody who is not in danger of falling back into it when they have got a couple of bucks then that is who I want to use. You know I mean ultimately you want to get rid of us and you want peers to run this thing. That is who you want to do it. – (288-289; 290-295) George, *Social Worker*

In this sense the aim of peer support really becomes to build capacity in the community so that it can ultimately become self-sufficient and take care of its self.

While workers were generally supportive of peer support elements in their programming they did indicate some hurdles in implementing it. One worker suggested that there are complications related to the boundary transition from client to worker.

> It is a hard transition for some of our staff and for me. To have someone that I have been working with for a year and now they are my peer, now they are my co-worker. Sometimes it is difficult because they still see the relationship as outreach worker and client and now they are actually staff and sometimes it takes a little more boundaries. – (239-242) Charlene, *Social Worker*

Another worker mentioned that implementing peer support elements in outreach programs required an investment in time and staff resources.

> It is very labour intensive and it is a huge commitment of work and support. - (525-526) Loretta, *Street Nurse*

Given that a peer support work program could be the first employment in a formal work setting for many people in some time, agencies that undertake this initiative should ensure that they have the time and resources to support and adequately train peer support workers. Peer workers may be more vulnerable to workplace stress and at increased risk of the affects of poverty and homelessness. Care should be taken to provide ongoing support to peer workers that may not be successful in agency initiatives. Having unrealistic expectations of peer workers may bring failure and add to their internalized guilt, shame and oppression leaving them more isolated and less likely to access the agencies programs and services. Peer worker elements of outreach programs as described by workers clearly addresses some of the root structural problems to poverty and homelessness including as mentioned; increased self-esteem, employment, income, education and community development. For these reasons peer support programs if properly developed and implemented are an essential component of any outreach program.

4.8 Organizational Setting

Street outreach workers were asked to describe what was important organizationally in their work environments to support the work they do. Responses included discussion of management structure and qualities that were helpful in executive directors or supervisors. Two respondents talked about how their organizations operated more as collectives than a traditional hierarchy.

> To me the biggest thing is that we are a flat organization. It is not layered, it is not bureaucratic and the ED that we have had for seven or eight years sets the tone of the organization… she doesn't judge and she is very accepting of our different styles and never questions and yet lends support at the same time. Without that I could not work. – (334-336; 342-344) Kate, *Street Nurse*

> I have worked here as a street nurse for ten years and what we discovered way back at the beginning was that the people out there on the streets doing the work really know what is needed. So we don't have a top down management structure at all. – (160-162) Alexander, *Street Nurse*

Allowing workers to share power within the organization is consistent with the values that street outreach workers strive to use in their interactions with clients. An environment is created that in a sense is non-judgemental and respectful of workers where the contribution of each staff member is valued. As one harm reduction worker comments,

> Being the drug guy is just as important as being a nurse. ... or just as important as being the mental health outreach worker or just as important as the sleeping bag exchange person or just as important as whoever. – (347-354) Peter, *Harm Reduction Worker*

In organizations that reflected a more traditional reporting structure, workers still stressed the importance of having management that is supportive, flexible and accepting and willing to fight for the rights of the population they work with.

> We needed a certain latitude to start this program and after that we needed them (management) to be very fair with the population. Because of course when you have a population of homeless people who come sometimes they are drunk, sometimes they are intoxicated, sometimes they are psychotic and they come with the rest of the population. You can have a reaction from other citizens, you can have a reaction from other employees... So you need your coordinator to be very fair and point out that we deserve this population and they deserve the same services and draw the line there. – (198-202; 203-205) Karen, *Street Nurse*

> My executive director comes from the streets. He has been in recovery for 26 years and he used narcotics so his heart is here with the people and the community. He is very supportive of the work that we do here and that goes unquestioned. He supports us 110%. That helps us keep going. He is willing to fight, the supervisors here are willing to fight for us to do the good work and that is what we are going to do. – (579-583) Lisa, *Social Worker*

> ...validation of the work they do is really important. It is not like you are painting a house and you are done. Everything is in progress and we went through a long period of time where you would go home and it just feels like you are pissing it

> away and its like god I am not doing anything. – (380-383) George, *Social Worker*

In short, workers need to feel supported on the front line but also need their agencies and management to support and engage in external advocacy.

Street outreach work involves bearing witness to the impact of extreme poverty. Workers observe situations of human suffering on a daily basis and require working environments that promote self-care. Management must understand and respect the toll these life and death situations can take on staff. Respondents talked of the importance of having a variety of work experiences and debriefing mechanisms in place to prevent the workload from becoming overwhelming.

> I think it is very difficult to just do outreach with no break in that, sometimes it gets a little overwhelming. You need to go out with other staff, in pairs. You need a space where you can just come in and talk about what is going on. – (192-194) Susan, *Harm Reduction Worker*

> There has to be variety and if a person comes up with an idea you know the normal supervisory thing is to say oh we don't do that. So I have got to say well lets look at this how could we do this you know just tell me what it is and I will try to support it. – (421-424) George, *Social Worker*

> There is a lot of HIV related death. A lot of overdose related death. Deaths. We knew most of the women that disappeared and that is hard. That is a pretty heavy thing to carry around and I think we really as a program have to take a good hard look at what kind of coordinated organized response we provide our staff with and I think a good program of critical incident debriefing and care has to be in place. Beyond just you know we are tight with each other, we meet regularly, and we make sure that we have a chance to debrief. – (346-352) Alexander, *Street Nurse*

Several respondents repeated the importance of providing a variety of work experiences to staff. Practically this might mean splitting up front line work with some administrative duties, community work or staff training and development. Providing a variety of work experiences to staff may have budget and programming implications, for example it may

limit the amount of time outreach workers spend on the street each week. Management must understand and support these implications. Most workers interviewed seemed satisfied with the support they receive in their work environments.

Workers raised three other organizational issues. These included having clear agency goals and objectives, allowing these goals and objectives to be responsive to the changing trends and needs on the streets and creating work environments that are culturally representative and supportive of both workers and clients. Participants in the current study mentioned that,

> ...you need to identify very clearly what is your objective in working with people. ... maybe one of your objectives is to identify which ones will need help a little bit, which ones will need a lot of help and which ones will need help for ever. – (286-290) Anna, *Street Nurse*

> Come up with a plan and lay out what you are doing. Why are we doing this? The corporate mentality, why do we do things the way that we do? You have got to remember or otherwise you can't justify what you are doing. – (167-170) George, *Social Worker*

Having clear goals and objectives can keep the agency and workers focused. It may also prevent getting overwhelmed by the life situations and presenting needs of clients. While these goals and objectives should be clearly stated and comprehensible to all agency staff, clients and the community at large, workers also mentioned that they should be responsive to changing trends and needs of people living on the street.

> The program has to continue to grow and change because then people can move with it. If we stay the same then how can we expect our clients to make the choice to leave the street because we are not offering them anything better. It is hard enough what we offer them anyways, we are asking them to leave their friends and their family, for what, a clean life. It doesn't sound that good actually. – (337-341) Charlene, *Social Worker*

> Issues change, particularly around HIV. We have watched it turn from primarily a MSM disease to an IDU disease or a mix of the two. And how we approach

> men who have sex with men is completely different than how we approach injection drug users. We had to be able to make those switches on the ground. – (171-175) Alexander, Street Nurse

One harm reduction outreach worker talked of the impact when their agency was unable to meet the changing needs of drugs users in the community.

> The onset of crack use has slowed our business down because people are smoking crack as opposed to injecting it and we do not hand out crack pipes so people are less likely to call us now. Other outreach programs are allowed to give out crack pipes. So the shift in the drug movement has affected us because we have not been able to make that shift with it. – (330-335) Susan, *Harm Reduction Worker*

The final organizational issue that was mentioned repeatedly was that of ensuring the agency was culturally supportive of the diversity reflected in clients and staff. Homeless people are a diverse group that face a multitude of oppressions based on age, ability/disability, race, gender, sexual orientation, ethnicity and class. Staff make -up must strive to reflect the diversity found among homeless people and agency programming must recognize that each individual's experience of homelessness and extreme poverty will differ based on their social location. One community nurse gave examples of the diverse programming that exist at the community health centre where she works.

> We have community gardens for people who cannot afford to buy fresh fruit and vegetables. We have ESL classes and high-risk youth workers and an East African homeless outreach worker and Caribbean mental health case manager. - (324-327) Loretta, Street Nurse

Language was also identified as a barrier to accessing agency services. One worker listed all the languages their staff was collectively able to speak.

> Many of our workers have a second language. I think we have Mandarin, Cantonese, Japanese, Spanish, French, Zulu and German. We are able to do effective outreach. – (370-373) Lisa, *Street Nurse*

Smaller agencies may not be able to provide as diverse programming as the likes of a community health centre and therefore must work in partnership with other community-based agencies that understand and meet the unique needs of individuals. One participant in this study provides outreach services through an First Nations agency and describes the diverse programming that is offered there,

> We offer healing circles, Ojibwa language classes. These are all things that we feel are missing and that is why there are so many people on the street that are aboriginal because when you don't know where you have come from you don't know where to go. So when we put that base down around what our traditions mean, our teachings around respect and our grandfathers and all of that, then people start to feel more centred and more grounded to who they are because that is part of who we are. – (167-173) Charlene, *Social Worker*

First Nation's peoples are over represented among the homeless people found on Canadian streets. They share a history of oppression based on colonial and racist practices that continue to this day. The needs of this community are unique and as such need to be understood and addressed in their historical and cultural context. Street outreach workers need to work in partnership with First Nation's Community and Social Services to provide appropriate and culturally sensitive services for their First Nation's clients. Finally this same First Nation's worker talked of the importance of having the agency incorporate and support her culture within the workplace and how it had a positive affect on most staff.

> That is ultimately what the best thing about working here is and that is what I think make the majority of us all really good workers. ... Having the opportunity to practice my spirituality in my place of employment, I couldn't ask for anything more. It is 24 hours a day; it is always with me, not just when I go home. If I wanted to smudge at any time I could do it here. So you can't do that at a non-native agency. ... I mean there is politics that go on in any agency, but they are easier to overlook when you are offered a place that you can be something that for a lot of us was denied while we were growing up or as young adults. So now within the work place I can be who I am supposed to be, who I was born as. I

> couldn't ask for anything more. – (189-192; 194-198; 203-206) Charlene, *Social Worker*

While this example highlights some of the challenges in meeting the needs of First Nation's peoples, agencies must also be able to respond to the diverse needs of all their clients including; women, those with differing abilities, seniors, youth, diverse ethno - racial communities, refugees, gays, lesbians, bisexuals, transgendered and transsexual people and drug users. In practice this might mean that different agencies with an expertise in working with different sub-groups of the homeless population establish outreach programs within their own communities. Such an approach is consistent with a structural approach and allows the social problems people experience with poverty and homelessness to be seen in their proper political and social context as opposed to having root in the individual.

4.9 Staff Recruitment

Another important aspect of the organizational environment is the make up and qualities of the staff. Participants in the present study talked about the need for competent staff that were willing and motivated to engage in street outreach work.

> I think you would need to have staff that are willing to do it. And that is I think a big thing. They get excited about it. There are people here that don't like doing outreach, so why send them out. It is not going to be a pleasant experience for anybody, especially for the people they encounter. – (154-157) Susan, *Harm Reduction Worker*

> For the staff we ask them to be competent and to have a little experience. They need to be very organized because we are dealing with people who are in disorganization and present with many problems and who will probably say no I don't need anything even though their needs are obvious. So you need to be able to evaluate people correctly and to be competent and patient too and be open to the needs of the client instead of your needs as a worker. – (164-170) Karen, *Street Nurse*

> A high level of skill and a high level of motivation among the staff are other key factors that have to be in place. We need nurses working here who have to be given a very small number of instructions and then have the motivation and the wherewithal to put together something that works with a group of people they are working with. We can't script it in any way. – (182-186) Alexander, *Street Nurse*

Experience and skill were mentioned as an important pre-requisite of the work but educational background and professional qualifications were not. It may be worth noting that requiring professional training and post-secondary education can act as a barrier for people who are economically marginalized and thus negatively affect the implementation of a peer support model in some programs. It is unclear from the data collected how workers conceptualize the tensions between educational prerequisites and life experience and recent moves to professionalize fields such as social work. What was evident from two respondents was a desire to avoid acquiring staff that held very altruistic views of helping others.

> ...they used to send us people that were like big peace and love, with no experience, not competent and disorganized. They would dress like the client and everything. I think it is disrespectful for the people we work with. With anybody else in the population you will try to be professional. – (172-175) Karen, *Street Nurse*

> ...our screening process is very, very careful. If we get the sense that somebody wants to save the world and that their mission is to go out there and do everything that they can to satisfy some need within themselves to work then we say maybe this isn't the place for you. – (265-271) Alexander, *Street Nurse*

One other important skill that respondents raised in relation to staff was that of being non-judgemental of other staff working in the field and of being well documented.

> There is always a certain amount of skepticism with people that are unfamiliar with you, but again it is almost as important for our non-judgemental sensitivity framed approach to deal with other professionals as it is when we deal with our clients. – (215-218) Frank, *Social Worker*

When advocating for client access to services workers need to respect others in the field. This can be challenging sometimes when working with other agencies that have restrictive policies or value systems different than our own. One participant mentions that being able to clearly explain situations, give examples of interventions and be well documented can assist in this process.

> ...we have be able to explain our point of view and that it is why I said before that you need to be competent because you need to be able to explain why you think this person is in danger. Why you think this person needs care now. Give examples of what they can do. ... We try to be well documented and when they see that they are speaking to someone who is competent, who has an idea, who is able to see if they will make a mistake, usually they will listen to you. – (672-679) Karen, *Street Nurse*

4.10 Measuring Success

In the face of worsening poverty and homelessness in Canada street outreach workers were asked how they measured the success of their work with people. By success, the author means to capture the way that workers know their efforts are supporting client empowerment. Participants in the study consistently answered they measured success qualitatively.

> Qualitatively, for sure. In terms of individuals being in a better place than they were a year ago, individuals maintaining a relationship with the organization, I think that is successful, someone who was a total care avoider now comes here once a month. I think that is amazing right. They are still sick and still have all the same health problems they had, but they come here, like tiny little bits of incremental success is how I measure success. – (387-392) Loretta, *Street Nurse*

> I guess the way that I have learned to look at it is to look at the small things, like the fact that I invited that person and three weeks later they showed up. So I make a point of saying I am glad you came or come and sit over here and start introducing them to other people and then leave them alone and see what happens. If they show up again, I say wow, it is great to see you again and just work from that. That to me is change. – (112-117) Charlene, *Social Worker*

One worker mentioned increased coping skills in clients and remaining healthy as successful measures of street outreach.

> ...with us it would be when a client is not so needy on you to help them with the day to day crisis, that coping mechanisms have been learned and taught and that the client doesn't need you on such a constant basis and it is not always based just on crisis. That you are not just reacting to a client in crisis mode, I think that is a good thing. As long as someone stays healthy and stays HIV negative and Hep C negative then something is going on that is right. – (290-295) Susan, *Harm Reduction Worker*

Finally, two different respondents equated success with keeping people alive in life threatening circumstances on the streets.

> Just being is a success. Some of the young women that I work with, that I spend a great deal of time with every day, say that they want to end their life. Seeing them the next day is a measurable success to me. Feeling desperate but passing by on a date that is a success. She is giving a little more attention to her own well being so she is not going with that guy again because he beat the living hell out of her the last time. That is a measurable success. Suffering all day without going out to fix, that is a success. Using so they want to be alive the next day for me is a success. Anything that allows someone to have the desire to live, I don't care how they do it, is always successful. – (524-531) Lisa, *Social Worker*

> Like the guy I was telling you I found who thought he had the microchip or whatever in his mouth. I am happy he is alive now because he was able to come to us and we were able to find out that he has something like that which he didn't know he had (diabetes). This guy probably would have drifted into down there to Lakeshore and probably would have died there. So just that he is alive is good news. - (728-732) Jean Luc, *Mental Health Worker*

These reflections on how workers measure success suggest small changes are important. They are also despairing remarks that suggest workers do not have a great deal of confidence in the social service system as it currently operates to support people out of poverty and homelessness.

The way workers measured success differed significantly from the way funders of outreach programs measured success. Workers stated that funders required and focused

on quantitative measures to evaluate programs. Specifically, funders were interested in how many people were accessing each outreach service.

> With funding bodies its reporting and they are all quantitative reporting, so it is all about numbers. – (286-287) Susan, *Harm Reduction Worker*

> ...they want to see how many people we are servicing and how many people are accessing our programs. We go up to 300 – 310 people per night in the height of the summer. That is not a success to me, not a success at all. – (288-290) Charlene, *Social Worker*

> They are looking for numbers. They want to see that their money was well spent. That she not only recovered and was welcomed back into the family but now that the family too seek family counseling and you know they want the fairy tale ending. They don't want the sad details of their lives. We look at the sad details and we work with that. – (551-554) Lisa, *Social Worker*

One worker elaborates on the tension that this discrepancy creates.

> Most funders equate success with the number of encounters. We have tried really without success to articulate the complexity of our work and the needs of our clients and we have not been able to do that. We will say or list all the ways in which our clients really have multi complex needs and the funder will say we don't want to know about that we just want to know how many people you saw this week. That is a huge tension because the folks that I look after require a lot of time. – (363-368) Loretta, *Street Nurse*

The increased time required by workers to establish trusting relationships with isolated and marginalized clients, works against the quantitative measures that funders impose. Two workers further explain this conflict.

> It takes me two hours perhaps to provide care to a person, and so it looks like what is that nurse doing with one person for two hours, what is she doing, how is that efficient? So it is very difficult if not impossible to actually communicate to funders the complexity of the work. – (373-376) Loretta, *Street Nurse*

> ...that has been a point of some conflict over the years. Because we have always believed that the only way that we are going to start to get anywhere with this population is by spending time with them and if we don't spend the time with the clients we are not going to be able to do the things that we need to do to meet their objectives. There has been a conflict all the way along. – (464-468) Alexander, *Street Nurse*

These comments suggest that funders do not understand the complex nature of outreach work – relationship building with very isolated and marginalized people. By not accommodating a process that is flexible in relation to the amount of time workers spend with individual clients; funders are perhaps indicating their unease and/or unwillingness to commit to this unique style of working.

The discrepancy between how success is measured in street outreach programs between workers and funders hints at the ideological differences between the two. Workers take part in advocacy; individual, internal and external in an attempt to transform societal conditions and ultimately reduce people's reliance on programs that provide access to care and satisfy basic needs. Their aim is to see the numbers of their clients drop. This is in distinct conflict with governmental funding bodies that equate successful outreach programs with higher client ratios. This pressure on higher numbers and efficiency disregards the complex realities of street outreach work. The focus on numbers by funders puts pressure on agencies receiving money to increase their client base over time. In doing so funders seem to have lost sight of the significance of evaluating success by quantitative methods alone. If higher numbers of people are coming into contact with street outreach workers, it means one thing – there are more and more people living in situations of extreme poverty. In addition, quantitative measures do not allow funders to recognize the diversity that is reflected in the populations who are using outreach programs. Numbers alone mask the primary sources of oppression and do not explicate the many ways that diverse groups of people are experiencing poverty and homelessness. As such, quantitative measures should not solely determine successful street outreach programs.

4.11 Integrated Programs

In order to assess the ability of a program to address the structural roots of poverty and homelessness it was thought important to evaluate street outreach programs for their ability to provide a continuum of care and services to clients. Providing basic and immediate needs on the street serves a purpose but does not expose complex underlying issues. Providing a continuum of accessible services that meet unique individual needs and address the determinants of health including food, shelter, social supports, primary health care, housing, employment, education and income might allow for permanent and measured change to occur. Unfortunately the situation of homelessness has reached crisis proportions in many Canadian urban centers and as such the pressure to provide emergency relief has intensified. Without long term and permanent solutions that address the root and structural causes of homelessness and poverty, services that provide emergency relief are becoming institutionalized in all three cities under study. One worker commented on the danger of outreach programs only becoming emergency relief providers.

> Well I think the danger is the institutionalization of homelessness, so we don't treat it as an emergency short-term response that it should be and that it means that we don't have to build housing. It means that governments don't have to create housing because we create this infrastructure that basically keeps people alive until they die their early death. ...it provides a safety valve to let governments off the hook because the problem remains hidden. ... I think that the danger is, and more specifically to outreach is, that you are funding outreach positions to link people with what, not housing just with emergency relief. There is a role for that but it diffuses energy and resources from upstream solutions like housing and I think that is problematic. That is a huge danger for sure. – (449-452; 458-464; 467-468) Loretta, *Street Nurse*

In this sense outreach programs and providing emergency relief serve a very conservative agenda, that of masking poverty and homelessness and avoiding long term public

investments in social infrastructure. Another participant shared an experience of being invited to a municipal meeting called by the Mayor,

> ...he asked everybody to go to City hall and he said, "How many more beds do we need? How many more soup kitchens?" And people were saying we don't need this, maybe a little but this is not the problem we need more lodging, more permanent solutions, permanency. Because we will not solve the situation of homelessness if we don't do that. – (529-537) Karen, *Street Nurse*

This response underscores the need to provide a continuum of services that support people in moving out of situations of poverty and homelessness.

Another worker disagreed on the permanency of institutionalized services for the homeless and underhoused by reflecting on the unstable funding situation most agencies find themselves in.

> ...the critics say that there is this growing industry and it is fixed, but in reality it could all change very quickly. For instance if it was made illegal to be homeless, you could imagine depending on the infrastructure that was built to deal with that by the powers that be, the situation could change radically. For instance all these people like us, that have to apply every year for funding could find themselves reduced, reduced or eliminated. The winds of change could come along and decide that outreach is not the solution and the vast majority of outreach could be eliminated in a matter of months. – (24-31) Frank, *Social Worker*

In this sense outreach programs and emergency relief measures might only be an interim stop in a political transformation of a society based on social values of collective rights and responsibilities to one based on individual worth and merit. As growing numbers of homeless people become more visible, politicians face increasing pressure to find solutions. Criminalizing poverty and detaining homeless and underhoused people has its history in large American cities like New York (Mathieu, 1993). Recent comments by the Mayor Lastman of Toronto, who suggested sweeping the streets of homeless people before a visit by the Pope (Toronto Star, July 19, 2002) and Jim Flaherty a candidate in

the leadership race for the Premier of Ontario who suggested a get tough approach with homeless people, threatening to lock them all up (Toronto Star, February 15, 2002) imply that this political transformation is well under way in Canada.

Several respondents commented that they felt some of the money and resources going to fund new outreach programs and homeless services could be better spent on long term interventions.

> You just wonder too, if you put all the salaries together if you could build a shack or something. Something to say, this is what we are doing, but it is not happening. – (53-55) Jane, *Social Worker*

> How many more inter shelter workers do we need. There isn't enough beds. So we could have 50 workers trying to get people off the street, but if we have no place to put them then what is the point. It is easier to fund a position for $50K a year than to spend half a million to build affordable housing. So that is why there are doing it, then they will eventually just cut the program. – (416-422) Charlene, *Social Worker*

Participants at one community-based agency noted the conflict between their expanding services and the lack of money funding affordable housing.

> The money is going to the wrong place. The money shouldn't be coming to agencies like us the money should be going to building the housing. – (1103-1104) Jean Luc, *Mental Health Worker*

> We shouldn't be expanding our staff we should be eliminating our jobs. – (1107) Peter, *Harm Reduction Worker*

> We should be getting smaller, like the purpose of our job is to make our jobs obsolete right, the money is not going to the right places. – (1110-1111) Kate, *Street Nurse*

These statements raise the issue of just how much agencies involved in the provision of services for the homeless and underhoused perpetuate the funding of emergency relief programming.

Participants in this study were asked to describe how integrated they thought their programs were within more mainstream health and social services and how important they thought this issue was. The hypothesis being the more integrated a program the more access it would have to other services and programs within the system and thus the more it could address the structural causes of poverty and homelessness. Respondents were also asked to comment on funding for programs. The idea being that the more stable funding was for a program the more integrated that program would be in the system. In relation to funding, participants gave mixed responses.

> (our funding) is ... more stable than most outreach funded positions. We are with the Ministry of Health and the Health Centre has been here for a really long time so it is fairly stable. Most small grass roots community based organizations have terribly insecure funding and are not paid well so this is I think different than most. – (484-487) Loretta, *Street Nurse*

> We are all over the place; the City...; Public Health; the Homeless Initiatives Fund; the United Way; the Trillium Foundation... We are continuously writing reports, continuously reporting what we are doing. – (389-393) Charlene, *Social Worker*

> Our funding could be reduced or entirely eliminated. ... the money is partially city, provincial and federal as well. The feds and the province gave the money to the city on the condition that da de da de da but those conditions could change. – (239-243) Frank, *Social Worker*

> The nursing funding seems to be stable and the mental health but the other funding is not. We don't have funding for the receptionist so we just have to find money. I don't know how we get it we find it. We have a fundraiser for instance. Your funding (to the harm reduction worker) is not stable at all in fact they have no funding now. – (1017-1020) Kate, *Street Nurse*

Funding instability requires management to be consistently searching for new sources of revenue. This may prevent organizations from long-term planning and can lead to job insecurity for workers with low wages and lack of benefits.

When commenting on the integration of outreach programs most workers referred to the continuum of services their outreach programs provided.

> We also do a treatment program, it is four weeks out of the city, it is a fly in camp. We take ten clients and fly in and we spend four weeks up there with ten clients offering them traditional ways of life. Ceremonies, healing circles, sweats, stuff like that. – (121-124) Charlene, *Social Worker*

> And I was telling you that this work site here, this is our office front, upstairs we have a residential detox program for youth. We also have an off site location for detox for youth that are not downtown kids. – (108-110) Lisa, *Social Worker*

> So there is a chain of things for me that is useful. I think if you were just to have a mental health there at the back and we remove all the others it would be completely ineffective. – (294-296) Jean Luc, *Mental Health Worker*

One participant stated specifically the problems associated with outreach programs that are not connected or integrated with other programs or services.

> I think that there are outreach programs that are not connected to anything that are less useful. They are useful because in the moment a homeless person can get connected to a health service lets say, that is good and they can get things that they need which is good. … But the health service is not connected to anyone, they cannot say to the person, meet me tomorrow and we will do that together. And so I think those isolated little parachuted programs, I don't personally like. Although I don't underestimate the value of being able to get a pair of socks at night, like that is useful but I don't think that it is very good care, I don't like it as a model. – (260-263; 269-274) Loretta, *Street Nurse*

Furthermore, this worker mentioned how the overuse of volunteers can compromise care and lead to the development of a parallel system of care for marginalized people.

> Also I think there is some problem with an over reliance on volunteerism. … with some programs you might volunteer every two months and so you are actually not going to be able to build that relationship with people over time. So that heavy reliance on volunteerism it minimizes the value of outreach. … It is a parallel system somehow unlinked to the mainstream health care system which everyone is entitled to. – (288; 291-294; 304) Loretta, Street Nurse

One community health nurse in an established health care facility talked of not wanting to ghettoize services for homeless and underhoused people.

> We have two aspects of this work; we do outreach and outreach for us means going where the population is so shelters, drop-ins and on the street. And we have, we give services in the building too because we want to facilitate the accessibility, we want them to receive the same quality of services as any other people in the society. ...it is very important for us not to ghettoize the services and ghettoize the population. – (37-40; 48) Karen, *Street Nurse*

The issue of program integration is important in relation to street outreach programs for three reasons. First, street outreach programs that are well integrated within larger systems can provide a continuum of services that move beyond just emergency relief measures to address some of the structural roots of poverty and homelessness. They avoid becoming a vehicle for the state to mask the symptoms of extreme poverty and offer a range of services that meet the unique needs of the diverse homeless population. Second, integrating street outreach services within a continuum of care avoids ghettoizing services for the poor and marginalized. By incorporating street outreach programs with the likes of community health centres provides access to the same quality of care that the general population receives. Finally, funding for integrated programming may be more stable and therefore can lead to long term program planning and development and provide more supportive working conditions for staff.

4.12 Current Trends

Given that street outreach workers are on the front line bearing witness to the impacts of poverty and homelessness, they are also in a unique position to evaluate trends and determine if the situation is improving or deteriorating. Workers interviewed in all three cities were asked to comment on how the needs or trends on the street have changed in their communities in the last five years. There was consensus in all three locations that the situation of homelessness is getting worse.

> I used to house people. I don't do that anymore because there is no housing for people. I used to help people move into housing and I haven't done that in a really long time. For the first time in my career, I have been doing this for fourteen years now, I have more people outside than inside shelters. ... We used to house people, then we used to get them into shelters, now we buy them sleeping bags. It is just phenomenal and what is normal now would have been unthinkable even five years ago ... It has changed quite dramatically that is for sure and much, much for the worse. – (420-423; 425-427; 437) Loretta, *Street Nurse*

> Early on with street youth they were using acid, crystal meth, smoking pot now they are injecting. ... It seems now that I am seeing a lot more youth sleeping in doorways and they are on the needle. So I think in some ways it is not getting better I think things with youth that are not improving. – (628-629; 632-634) Alexander, *Street Nurse*

> They are getting younger; the people on the street are getting younger. We serviced a lot of youth last summer. ... But they are getting younger, we see 14 year olds, 15 year olds. I see a 14 year old on the corner selling herself and there is more of that than there was before. People are forced to that method of making money to survive. That is what I have seen. – (309-310; 313-316) Charlene, *Social Worker*

> The framework has not gotten better. Supportive housing, affordable housing, stuff like that it hasn't gotten better. In fact over the last eight to ten years it has gotten so much worse. So agencies like ours, to do just what we do we are treading water. – (787-789) Kate, *Street Nurse*

> Everyone is saying our economy is doing better but we were better before I mean it was not so bad a few years ago. Yes there were a few poor people everywhere but we all used to live together we are used to that, it has always been like that. And now we will have a city with only rich people. We are all worried about that. Maybe we dramatize a little I don't know but it is the beginning and we don't like it. – (300-304) Karen, *Street Nurse*

The growth in the number of homeless and underhoused people witnessed first hand by outreach workers in Canada's three largest urban centres comes at a time of unparalleled economic growth for the wealthy.

Some street outreach workers voiced their frustration in the face of worsening poverty and gave some specific examples of structural problems they bear witness to.

Two workers referred to the money that is made as a consequence of policies that criminalize and encourage illicit drug use.

> But the monster named heroin is a huge money making opportunity. You get to employ police, we get to have security firms, higher insurance rates. People are making money off these people and it is going to be hard to walk away from that. ... And who is going to win (if drug policies change), well just your everyday regular Joe is going to win because now he is on methadone and is able to be a taxpayer again. The taxes that he pays are not in comparison to the taxes that are being paid out by the companies that benefit from drug use. – (645-654) Lisa, *Social Worker*

> The other problem is that police targeting is making it difficult, because when the police force gets 2 million dollars per year to put more cops on the street to take the drug users off the street it makes it more difficult to do our job. – (323-326) Susan, *Harm Reduction Worker*

One worker continues by stating that Canada needs to adopt a definitive approach to the issue of drug use.

> Until they can devise a definitive approach to how they want to approach drug use it will remain as it has now for the last 40 years. They have been researching, writing papers, and holding round table discussions. The time for talk and study is over. It is now time to do something definitive. What are we going to do? Are we going to keep this on the books as a criminal activity or is it a medical problem. – (633-641) Lisa, *Social Worker*

Adopting a comprehensive approach to drug use that incorporates harm reduction strategies throughout is compatible with the non-judgemental values inherent in street outreach.

The last comment comes from a worker who makes a gloomy prediction when he comments that although conditions of homelessness are deteriorating in the city he works in, the prospect of them getting worse is a reality.

> I think we are on the cusp of that changing. A lot of the funding for this sort of stuff is just going to dry up and people are just going to have to make due however they can. We have seen indications of that already. We have had welfare cuts and cuts to various services at the provincial level that is going to

> inevitably filter down to… But that is a prediction. – (610-613; 619-624)
> Alexander, *Street Nurse*

If street outreach workers are indeed able to predict future trends in relation to the number of homeless and underhoused people based on their front line experience then the societal transformations advocated for through a structural approach are needed now more than ever.

5.0 Discussion and Conclusion

5.1 Key Findings and Interpretations

Several important themes emerged from this study on street outreach programs for homeless and underhoused people. Collected data provided answers to the main research questions, specifically: (1) What are the main goals and objectives of street outreach work? (2) What are some of the essential components of street outreach work? (3) How do street outreach workers address underlying structural root causes of homelessness and extreme poverty? The following section will provide a brief overview of what we have learned in relation to these three questions.

Street outreach, as a practice intervention was found to exist in all three cities studied – Vancouver, Toronto and Montreal. Workers trained in both social work and nursing used this approach in their work to reach homeless and underhoused clients. Street outreach programs are used to overcome barriers to access a variety of health and social services for homeless and underhoused people. Providing support and "taking care to people where they are at" in the community are priorities of these programs, creating safety and assisting in addressing the power differential that exists between worker and client. The main goals of street outreach as described by workers in this study are threefold and are consistent with the academic literature. They are; 1) to address and satisfy the immediate needs of homeless and underhoused people, including access to basic needs such as food, shelter and clothing; 2) to build relationships and develop trust with homeless and underhoused people; and 3) to link people with a variety of appropriate health and social services.

Relationship building emerged as the core category of this research study. Workers hinted that without establishing a relationship based on trust and respect with homeless and underhoused people, street outreach efforts were likely to fail. Some of the properties and dimensions identified of relationship building include: the non-judgemental values with which workers approached their work; visibility and consistency in the community; having concrete resources to distribute that satisfy immediate needs; incorporating a harm reduction philosophy; allowing clients to determine the pace of work; and, being available during crises. In the absence of these qualities, homeless and underhoused people will be unlikely to approach street outreach workers. As opposed to fixed site agencies that rely on clients coming to them, outreach workers must embrace these qualities in theory and practice when they present themselves in the community.

One aspect of relationship building that raises concern is boundary violations by workers. During this study respondents commented that experience and intuition guided relationships with clients. Not having clear boundaries with clients threatens to create misguided expectations on the nature of relationships between workers and clients. Therefore, organizations involved in street outreach must have clear guidelines on boundaries, ensure that all staff receives training in this regard, and screen job applicants on their experience in adhering to professional boundaries in the workplace. Given that experience and intuition will vary widely among workers, adopting a structural approach can also be helpful in providing a framework that workers can follow when building relationships with clients. Central to the approach is an awareness of power, and intervening whenever possible to unmask worker and agency intentions. Combined with

work that concentrates on consciousness raising and collectivization, workers can be clear in their role as allies as opposed to misinterpreted friends.

The role of advocacy within street outreach work was another important category developed from this grounded research study. As opposed to the literature that limits its description to individual advocacy (Erickson & Page, 1998; Lam & Rosenheck, 1999), advocacy in this study was determined to include three related dimensions – individual, internal and external. Individual advocacy is used on a case-by-case basis to link a person with a specific service or resource. Internal advocacy allows workers to affect change within the agency or organization they work for. Front line street outreach workers bring first hand experience to the table and educate colleagues and managers about current trends and issues on the streets. Internal advocacy challenges organizations that house outreach programs to conduct an internal analysis on barriers that may be present to providing service for homeless and underhoused people, and as such, can have a bottom up effect on the culture and values of the workplace. Workers need to find support in their organizations to participate in internal advocacy. Finding other workers and joining together to bring issues to management may provide safety and legitimacy to concerns. Internal advocacy also lays the foundation for an organization to take part in external advocacy.

External advocacy has the potential to affect the greatest structural and social change. It is aimed at changing government policy and practices, challenging oppressive attitudes and ultimately transforming societal institutions so that they are no longer a root cause of poverty, oppression and homelessness. Respondents in this study shared a variety of examples of external advocacy that they are involved in including: the struggle

for more affordable housing; more humane shelter conditions; safe injection sites for injection drug users; a definitive approach by government to illicit drug use; culturally appropriate services for First Nations people as well as redress for colonial practices; increases to income support programs; support for women and children fleeing physical and sexual abuse; and challenging police violence.

Workers stressed the importance of developing and incorporating community partners in street outreach work. In practice this may translate into pairing up with workers from other agencies or having agreements on referring clients between agencies. The direct benefits of community partnerships include: coordinating services on the street to reduce duplication; providing increased access to a variety of health and social services; having expertise and access to a range of appropriate services that meet the unique needs of individuals determined by their social location; collectivizing workers; and providing opportunities for them to participate in advocacy and social action. Developing successful partnerships between agencies will mean overcoming value differences and putting aside competition for available funding sources. Apart from developing local partnerships, workers also saw merit in developing working relationships with other street outreach programs nationally.

It became apparent during the research that there are a variety of supports required by staff from their agencies. Respondents mentioned that workers benefit from flat management structures that allow staff to share power and decision-making. In the absence of a collective, workers stressed the importance of having supportive and flexible management that understand and participate in external advocacy. Workers talked of the emotional toll associated with working in the field and provided suggestions on how to

avoid the realities of staff burnout. These included, providing ongoing opportunities for debriefing amongst staff and the need to provide everyone with a variety of work experiences that allow for breaks in outreach work.

Street outreach workers evaluated the success of their interventions qualitatively and in small increments over time. They mentioned this was in contrast to program funders that tended to evaluate programs based on the number of people street outreach workers come into contact with. Strictly evaluating programs by the number of contacts made, disregards the complex nature of street outreach work and the time it often takes to develop trusting relationships with clients. Furthermore, numbers alone mask the diversity that is reflected by people who are using outreach programs and thus dispel the reality that some marginalized groups of people, based on their social location, are at greater risk of homelessness than others. This contrast in the way success is measured in street outreach work hints at ideological disparities between workers and funders. Workers bear witness to the impact of repressive government policies and failed free market economic practices, whereas governments fund street outreach activities to provide emergency relief to people that might otherwise pose an increased risk to the status quo. As state power is organized around principals that reinforce dominant liberal capitalist ideology (McQuaig, 2001), so too must street outreach work be organized around principals of a structural approach and analysis in order to stand against state power (Mulally, 1993).

Finally, this research project unveiled some important themes in relation to how street outreach programs should be integrated within larger health and social service institutions. Workers highlighted the importance of being able to link and connect people

with a range of appropriate health and social services. Integrating programs within larger institutions, like community health centres, has many benefits including: providing seamless referrals into a continuum of health and social services; providing stable funding sources to agencies engaged in street outreach work; avoiding the creation of a second tier of services for those living in extreme poverty; and, allowing the non-judgemental values inherent in street outreach work to filter into larger institutions, thereby having an emancipatory effect.

Trustworthiness of the data collected in this study was strengthened through several methods. Credibility was enhanced by prolonged engagement and persistent observation in the field. Referential adequacy was achieved by audio taping and transcribing all interviews. An audit trail was also undertaken throughout the data collection and analysis process. Triangulation was provided through 2 data collection techniques, individual interviews and direct observation. Findings were also contrasted to other literature in the field. One researcher collected all the data and analyzed it over a six-month period strengthening dependability.

This study answers the main research questions by unveiling the main goals and objectives of street outreach work and the essential components of street outreach work. It has demonstrated that street outreach provides an alternative practice model that is consistent with a structural approach. As a result, it suggests that street outreach workers have the ability to address the underlying structural root causes of homelessness and extreme poverty.

5.2 Limitations of the Study

While the present study provides some insight into the core concepts and values associated with street outreach work in Canada, it is limited by a number of factors outlined below. The study was limited due to the sample size (N=13) in contrast to the amount of street outreach activities that are taking place in the cities under study. Limiting research sites to three may have overlooked unique characteristics of outreach work that occur in smaller urban and rural centres. The issue of language posed a barrier in collecting data in Montreal and thus limited data collection in that city. Therefore, results cannot be generalized or considered representative for outreach programs in other regions. The sample was self-selected, as respondents could choose whether or not to reply to the invitation to participate. It is therefore possible that the respondent group is comprised only of those street outreach workers who have strong feelings on the topic of street outreach work. Member checking of the data collected was not pursued with those interviewed and thus also limits findings.

Finally, respondents were made up solely of service providers and therefore conclusions made in regards to street outreach work must be based on their perspective alone. The voices of marginalized people that are the target of street outreach programs are not included in this research study. Unfortunately, time and budget limitations did not allow for client input. Client feedback would have further grounded the conclusions of this research. In addition, the study did not include other health and social service professionals that may have valuable feedback about this practice intervention, including for example, executive directors, agency administrative staff, funders of programs or shelter workers. Consequently, the research findings are limited solely to data collected

from street outreach workers themselves and the interpretations of the data by the researcher.

5.3 Implications for the field of street outreach

This research study has identified a number of important elements that should be considered when implementing street outreach programs. These include: being upfront with clients about outreach goals; establishing and maintaining boundaries with clients; embracing non-judgemental values and harm reduction theory; participating in individual, internal and external advocacy; developing partnerships with other community based services; coordinating street outreach efforts with other agencies involved in similar work; offering peer support programs and employment opportunities to clients; measuring success qualitatively; and, integrating street outreach programs within larger health and social service systems.

Like others working in the helping professions, street outreach workers must guard against burnout. They need to take appropriate steps to incorporate self-care into work routines and be aware of signals when the stress of work is mounting. Agencies that provide street outreach programs must support staff both in providing ample opportunities to debrief work but also incorporating a variety of experiences into staff responsibilities.

Street outreach workers are on the front line of what can be called "a war on the poor". As such, they must be very aware of the greater political significance of their actions and work. This research study suggests that street outreach programs can serve a very conservative agenda if they concentrate only on satisfying the immediate and basic needs of clients. Such interventions serve only to mask the realities of extreme poverty

and suppress resistance among people that otherwise would be starving in the streets. As such, street outreach workers need to work not only on the immediate needs of their clients but also be involved in addressing the root causes of extreme poverty and homelessness. Embracing a structural approach to practice, as this paper suggests, will allow workers to be critical of their practice and align themselves with those working for transformative social change.

5.4 Implications of Future Research

This study was meant to be exploratory and generate some much-needed research on the Canadian experience of street outreach programs. It is clear, however, that further investigation and research into specific aspects of street outreach is necessary. First, as relationship building was determined to be at the core of street outreach work, more research is needed to investigate how they develop, how outreach workers know when this happens and what guidelines are needed to establish and maintain professional boundaries in working relationships.

Second, much could be learned to supplement our knowledge of street outreach programs by collecting data from users of these services. Homeless and underhoused people themselves will have valuable information on what makes for successful programs. Specifically, their feedback could assist in enhancing the skills and knowledge of workers. They will also have first hand experience on how effective street outreach programs are at addressing the root causes of homelessness and poverty.

Third, more debate needs to occur about how services are organized and developed for people that are homeless and underhoused. There is a lack of literature on the political significance of these services and on the growing homeless industry in cities

across Canada. Without leadership and research in this regard, money will continue to flow into emergency relief programming with little regard to funding initiatives that address long-term solutions. Structural theorists have a greater role to play in this debate both within the field of street outreach but more generally in the field of social work itself where priorities of social action have given way to those of professionalism and status.

Finally, more research is needed in the area of preventing homelessness. The bulk of published research literature is aimed primarily at investigating its prevalence (Acorn, 1993; Axelroad & Toff, 1987; Burt, 1996; Drapkin, 1990; Lam & Rosenheck, 1999; Weinreb, 1998). At this time research needs to focus more on solutions that address the specific needs of communities that are at greater risk of homelessness including First Nations people, women, queer people, youth, seniors, refugees, the disabled, people living in poverty and different ethno racial minorities.

5.5 Conclusions

Street outreach workers witness first hand the impacts of extreme poverty and homelessness. They approach their daily work, embracing non-judgmental values with the aim to connect and establish relationships with people that have been excluded and marginalized by government practice and policy. They are working do bring people back into a system that has oppressed them. Month by month the number of people accessing their programs are increasing. Government policy during this time is non responsive to the unique needs of people experiencing homelessness and void in it vision to provide long term transformative solutions. Instead, programs such as the Federal Governments National Homeless Initiative (Government of Canada website, 2003), trickle dollars into emergency based basic needs programs that serve only to mask the results of growing

extreme poverty. The lack of communication between ministries, the lack of coordination with the provinces and the downloading of responsibilities suggest that long term solutions to poverty and homelessness are not a priority. Street outreach programs play a vital role in meeting the immediate and basic needs of homeless and underhoused people. However, they must surpass these band-aid provisions to address the root causes of extreme poverty and homelessness. As this research study indicates, there are a number of important elements that street outreach programs should incorporate to be successful. Embracing a structural approach will assist workers in dealing with the tensions that are inherent to this work.

Street outreach programs that are integrated within larger health and social services will be the most effective in providing a continuum of care to service users that address the social determinants of health. They will also prevent the establishment of a growing homeless industry, or second tier of service that provides sub-standard care to the poor. In addition, integrating these services in larger systems has the potential to internally influence these larger institutions. Street outreach programs must operate in partnership with other community-based services and link clients with appropriate care that respects their unique needs.

Respondents in this study inform us about worsening poverty in their communities. They foreshadow a condition that may affect an increasing number of people in rural and urban centres throughout the country. If government policy does not shift focus from dominant liberal capitalist ideology and transform to respond to the unique needs of people in their communities, homelessness and extreme poverty will continue to grow unchecked.

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Appendix A - Interview Guide

Demographic Information:

Name of Organization
Person's position within the organization / Profession

Interview Questions and Probes:

How many people work for your organization?
- Breakdown of programs and professions

Can you describe your outreach/mobile health program?
- Target population, who qualifies? Any restrictions?
- Services offered
- How are services offered eg. Define outreach/mobile method
- How important is the outreach/mobile aspect of your program? Why?
- What changes would you make, if any, to the program?
- What are the professional backgrounds/disciplines of the outreach members?
- What are the staff roles of these different members?
- When does your program operate, what are the hours of service? Nights/weekends

What values are inherent in your approach to outreach work?

What barriers to accessing Health Care do the people you work with face?
- How does your program address these barriers?

What are some of the essential elements of a successful outreach/mobile health program?
- Staff qualities
- Approach to working with people
- Organizational framework
- Partnerships in the community
- Advocacy

Does you're your agency support advocacy and political work? If so how…

Have there been things you have tried in the program that have not worked?

How do you measure successful outcomes in your program – do funders require you to evaluate you service?

Has the organization's priorities changed in the last five years?
- Needs of people served changed?
- Poverty?
- Homelessness?

- Drug Use?
- Health Needs?
- Legislation?

Have the number of outreach programs in your community increased in this time?
- What do you think of this increase and what the literature calls the growing homeless industry?

Do you think your program is integrated as part of the Universal Health Care System?
- If yes, how do you think it is?
- If no, how is it different?
- Do you feel people presenting to your program get the health care they require?
- Do you have a regular relationship with hospitals, community health centres?
- Can you access specialty care for people if they require it?
- Does your outreach/mobile health team keep health records on people seen?
- Do you feel your program should be more integrated in the Health system?
- Strengths approach on the streets vs. the deficits approach of institutions

What are the implications of not being integrated in the health care system?
- Impact on quality of care
- Impact on continuity of care
- Are people's health needs being met adequately?

What are the implications of being integrated in the health care system?
- Impact on quality of care
- Impact on continuity of care
- Are people's health needs being met adequately?

Where do you receive funding for your organization and its services?
- Stable / Unstable Funding?
- How does this affect workers and programming?
- Private vs. Public
- Direct Health Care Dollars

Can you describe the housing situation in your community?

Does your organization assist people with housing?
- Education
- Employment

Does your organization have any partnerships in the community?
- Other partnerships in the city
- Names and locations
- Province?
- Country?
- What is important in a partnership?

Appendix C – Letter of Invitation to Participate

Date

Address

Dear X,

As a student in the Master's program of the McGill School of Social Work I am writing to you today to seek your participation in a research study of outreach and mobile health programs that increase access to health care and services for homeless and underhoused people. The study involves seeking the expertise of service providers, like yourself, in three urban centres; Montreal, Toronto and Vancouver. I have personally been working with one such program in Toronto for the last three years, the Wellesley Central Health Bus, and am interested in pursuing this topic as the basis of my master's thesis at McGill University in Montreal.

I have found through my own work that there exists a number of unique community based health care services for homeless and underhoused people in different urban centres. However, at present it seems there has not been a formal attempt to compare and contrast these services and to determine the diverse models that exist within this service delivery method.

At the same time I wish to gain a deeper understanding of the relationship between community outreach/mobile health services and the continuum of universal health care services in Canada. Information will also be sought on the role services play in addressing the structural causes of homelessness and poverty.

The overall goals of this study are to:

- Broaden our understanding of the local needs of homeless and underhoused people in regards to health in three large urban communities, Montreal, Toronto, and Vancouver.
- To document the diverse and innovative ways that communities have responded to the local health needs of homeless and underhoused people in the above cities.
- To gain a deeper understanding from front line service providers of where outreach and mobile health services fit into the continuum of health care in Canada and how well they are integrated within it.
- To investigate the role outreach/mobile health services play in addressing the structural causes of homelessness and poverty.

Appendix D – Consent Form for Interviews

Research on Outreach/Mobile Health Services Homeless and Underhoused People

Consent Form for Individual Interviews

I agree to take part in this interview that forms part of a research study on the integration of outreach/mobile health services for homeless and underhoused people conducted by Gordon Tanner, an MSW student from the McGill School of Social Work. The purpose of the study and the potential risks to participation have been adequately explained to me.

In agreeing to participate, I understand that:

- I will not be penalized in any way if I do not take part in this research;
- My involvement is purely voluntary;
- I agree to have the interview tape recorded and I have the right to speak off the record;
- I may stop my involvement in the interview in progress at any time and withdraw from the process;
- I may withdraw from the research at any moment and ask that my portion of the interview be excluded from consideration;
- My name or identity will not be revealed in any publication, and no information that is revealed will be treated in such a way that I am identifiable;
- If I wish, the interviewers are able to furnish me with the resources/services related to information that I may disclose during the interviews.

Name (or initials)_____ Signature_____ Date _____

Witness _____ Signature_____Date_____

Thank you for your participation.