2012

How does homeless outreach work : the perspective of the homeless outreach worker

Carlos E. Encalada
Smith College

Carlos Enrique Encalada
"How does homeless outreach work?" The perspective of the homeless outreach worker

ABSTRACT

This exploratory/descriptive study examines the perspective of workers who provide outreach services to a population experiencing street homelessness, about the work they do. It utilizes a convenience sample derived from the diverse workforce of a five-agency collaborative in a large Northeastern U.S. city. The purpose of this study was to give voice to and contextualize the perspective of outreach workers on the nature of work with vulnerable populations. Largely missing from the literature on outreach work with the chronically homeless, the perspective of outreach workers is needed to inform an understanding of the complexities of this work and to support appropriate training and program design toward the enhancement of services to a vulnerable population.

The research question that guided this study was, "How do outreach workers conceptualize their work: personally, interpersonally, professionally, and socially?" In-person semi-structured interview questions elicited participant perceptions and attitudes towards their work and consumer needs. Qualitative analysis uncovered naturally emerging patterns and themes, which were interpreted through a relational theoretical lens. Analysis of the major finding of a multi-role conceptualization of their work yielded the following salient themes: having to do the work others want done; being an advocate for homeless consumers; being "somebody to talk to" for consumers; being an insider critic of the homeless services milieu; and being the salesperson to a new life. Overarching themes characterizing their general experience

of the work included: disenfranchisement; empowerment; and presence, or existing where the consumer is at. Implications for practice, policy, and research are discussed.

"HOW DOES HOMELESS OUTREACH WORK?" THE PERSPECTIVE OF THE HOMELESS OUTREACH WORKER

A project based upon an independent investigation
in collaboration with a five-agency collaborative,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Carlos Enrique Encalada

Smith College School for Social Work
Northampton, Massachusetts 01060

2012

ACKNOWLEDGEMENTS

I would like to first and foremost thank my parents, Martha and Angel Encalada, for their continued support of my varying and always changing interests over the years. Their consistent inquiry into my happiness before other factors has kept me grounded in times where I was unsure of which direction to take. My sister, Jennie, brother, David, Abuelita Ana, Tia Rosalba, Tio Fabio and the rest of my family have all been extremely supportive over the years.

My second year clinical supervisor and the rest of the staff and coworkers at my second year field placement were critical in supporting a needed flexible schedule that allowed me to do the interviews I needed to do with outreach workers for this study.

This study could not have happened without the outreach worker participants and agencies that provided their experiences and resources to support the development of this paper. The following study was uniquely shaped and could not have occurred without the long and thorough conversations I had with my thesis advisor, Beth Lewis. The experience of going out with Sam, a seasoned outreach worker, was also crucial in shaping the instrument I used in interviewing the outreach workers in this study. To him, I am ever grateful for his gracious sharing of his perspective and experience in this amazing work.

The following people in particular were critical in supporting me during the writing of this thesis. The conversations, check-ins, and retreats with these individuals nourished my mind, body, and soul. Elliott Williams. Olumuyiwa Oni. Sam Prentice. Cameron, Stu, and Lis Bass. Alexandra Jamali. Sean Spears. Beth Kita. Carmella Tress. Tyler Feickert. John Jarboe. Kale Good. Rebecca Kanuch. Sady Horn. Phillip Horner. Kermit Cole. Last but certainly not least, I would like to thank countlessly important Skype, phone, in-person and chat conversations with my sweetheart. You know who you are.

I am additionally grateful for the members of the Council for Students of Color, the Anti-Racism Task Force, fellow Smith SSW classmates, and selected faculty at Smith College School for Social Work including Dr. Irene Rodríguez Martin, Dr. Yoosun Park, Dean Carolyn Jacobs, Carolyn S. du Bois, Marilyn Marks, Fred Newdom, and Rani Varghese.

I would like to dedicate this thesis to the loving memories of my Abuelita Hilda, Montana John Mataga, and Bradley Strange whom all passed away during the course of this Social Work program. Their lasting impression on my life has positively shaped my life. I intend to carry them with me for the rest of my life.

TABLE OF CONTENTS

CHAPTER I

Introduction

The purpose of this exploratory and descriptive study was to understand homeless outreach work from the perspective of the homeless outreach worker. The research question that guided this study was, "How do outreach workers conceptualize their work: personally, interpersonally, professionally, and socially?" The researcher interviewed seven full-time outreach workers in a large Northeastern city asking them about their experiences as outreach workers including personal motivations, their relationships with consumers, the variety of situations that come up in outreach work, and their views and thoughts on homelessness, its causes, and remedies.

Outreach workers are mobile social service workers who go out and find consumers of a particular vulnerability with the underlying purpose or intention of connecting them with available resources. The unique setting and form of outreach work with the chronically homeless often creates opportunities for less traditional, more relational work that some researchers have attempted to qualify through the generation of principles, tasks, or implications of outreach work (Levy 2000; Morse, Calsyn, Miller, Rosenberg, West & Gilliland, 1996; Blankertz, Cnaan, White, Fox & Messinger, 1990), developing models of outreach work (Levy, 1998; Morse, et al., 1996; Blankertz, et al., 1990), and describing the craft of outreach work (Levy, 2004; Ng & McQuisition, 2004).

Similar to finding a common language between outreach worker and consumer (Levy, 2004), psychotherapists have known for some time that the process of alliance building involves the creation of a relationship in which the client feels safe and free to express himself or herself authentically (Rogers, 1961). This process often takes time and requires a consistent stable presence on the provider side. The daily going out and meeting consumers literally where they are physically manifests this process. If the theoretical frame for outreach work is therapeutic alliance-building through workers' relationships with consumers, then the therapeutic skills that workers utilize to build a strong alliance can be seen in the consistent non-judgmental offering of available and appropriate services without condition as well as reducing the harm in any encounter. As referred to in the literature on harm-reduction (Marlatt, 2012), the stance of accepting people as they are without restriction can be seen in the referrals made to housing first modeled programs by outreach workers (Tsemberis, Gulcur, & Nakae, 2004). Additionally the principle of harm reduction is illustrated in the situation of a homeless individual who might reject an outreach worker conversationally or socially but who will accept a blanket or food. In this way, the consistent offering of available and appropriate resources as judged by the consumer employs harm-reduction practices in a relational frame.

In approaching the data analysis of the interviews, the researcher therefore considered the homeless outreach worker-consumer relationship in a relational harm-reduction theoretical frame. The therapeutic relationship between workers and the people with whom they work is of critical importance in any context of treatment and support. Keeping the voice of the consumer, especially among vulnerable populations, is critically important when considering the design and implementation of services offered (Wireman, 2007). Equally important is the perspective of the worker or provider (Zuffrey, 2008). In particular, outreach work with the chronically homeless

population is a unique form of interaction in the social service arena at the fringes of what might be considered traditional work. The literature on outreach work with the homeless has documented challenges faced in doing outreach work and has begun to hypothesize what makes for best practices in outreach work. Largely absent from the literature are studies that consider outreach work from the perspective of the outreach worker themselves. This study taps into that perspective.

The researcher hypothesized that outreach worker experience in connecting with consumers is largely relational, interpersonal, and takes time to establish. In considering the outreach worker perspective, findings led to implications for the practice, policy and program development, and future research of homeless outreach work. Irrespective of the small sample size, participant responses ranged and yet were found to connect to common threads relevant to outreach work. In this way, after the interviews were analyzed and considered, it seemed natural that their responses reflected the variety and breadth of a multi-role position.

Since the perspective of outreach workers is largely missing from the literature on outreach work with the chronically homeless, findings from this study provide an opportunity for this perspective to emerge, contributing to our understanding of the nature of outreach work with people experiencing homelessness and supporting appropriate training and conditions that could lead to an enhancement of the quality of services to vulnerable populations. Incorporating the experience and perspectives of outreach workers into planning for program support and policy will undoubtedly aid in the development of recommendations for effective outreach work.

CHAPTER II

Literature Review

How does Homeless Outreach Work? To begin a case for the need of this study, a review of the literature will focus on homelessness, the nature of outreach and those that do the work with various vulnerable populations in general and chronically homeless outreach in particular, and lastly the clinical and practice theory undergirding this type of work. The review will include a discussion of the current state of homelessness in the United States, different contexts for outreach work, perspectives of outreach workers with vulnerable populations, and what is currently known about homeless outreach work. The review will end with a brief summary of relational theories meant to frame study findings.

Homelessness: An overview

Estimates of the size of the homeless population in the United States vary widely depending upon the source. According to the U.S. Department of Housing and Urban Development (Sullivan, 2010) and as reported by the National Alliance to End Homelessness (2011b), approximately 643,000 individuals were homeless on a given night in 2009 as per the last biennial point-in-time count. Although the causes of homelessness can be attributed to multiple structural factors including lack of affordable housing (Lowe & United States Conference of Mayors, 2001; Quigley, Raphael, & Smolensky, 2001), low-wage jobs (Lipman, 2001), unemployment (Lowe & United States Conference of Mayors, 2001), and other complex

constraints in education and training (National Coalition for the Homeless, 2009), the experience of homelessness takes on many forms.

Of the approximately 643,000 homeless in the United States in 2009, 17 percent or approximately 110,000 were considered "chronically homeless" with the other 83% living in shelters, transitional housing, or recently on the streets (U.S. Department of Housing and Urban Development, 2010). "Chronic homelessness is defined as long-term or repeated homelessness, often coupled with a disability" (National Alliance to End Homelessness, 2011a). Of course, the measurement and categorization of homelessness, affecting both the contest of homelessness as well as funding for services, depends on who is defining the nature, severity, and intensity of the problem. With that said, the U.S. Department of Housing and Urban Development (2010) defined chronic homelessness as follows:

> A chronically homeless person is defined as an unaccompanied homeless individual with a disabling condition who has either been continually homeless for a year or more or who has had at least four episodes of homelessness in the past three years. To be considered chronically homeless, a person must have been on the streets or in emergency shelter (e.g. not in transitional or permanent housing) during these stays. Prior to the passage of the HEARTH Act, persons in families could not be considered chronically homeless. (p. 3)

This definition sets the constraints for programs designed to target "chronic homelessness". The challenges of the homeless who are in shelters, transitional housing, or recently on the streets because of temporary circumstances are qualitatively different from the challenges of the chronically homeless. For this reason, according to the Center for Social Innovation (2011), the approximately 300,000 people in the homeless services workforce who

have a variety of educational, vocational, and clinical experiences require an equally wide array of basic knowledge of homelessness, trauma-informed care, evidence-based practices, and navigating a complex social service system. The need for a broad array of skills and tools in work with the chronically homeless is related to the demonstrated effectiveness of more specialized interventions with the mentally ill homeless population which overlaps the chronically homeless population (Rosenheck, 2000). Rosenheck (2000) compares three overlapping categories of work with the mentally ill homeless population: outreach, case management, and housing placement and transition to mainstream services. In his review of different studies of interventions designed to help the mentally ill homeless population, Rosenheck found that although specialized interventions for this particular population were effective, their cost would be more than standard programs. In his discussion of the findings, Rosenheck (2000) equally notes that since it makes intuitive sense that more specialized programs are more effective, the funding and adoption of specialized interventions such as outreach depend largely on the political and moral value society places on caring for the most vulnerable of needy populations. In this vein, outreach programs with the homeless continue to be created and studied.

Outreach to vulnerable populations

The target of outreach efforts varies widely and is often dependent on the changing emphases of local legislation and social funding which form the larger context of program development in this area. Outreach work has concentrated on specific target populations due to various social and public health concerns such as high-risk HIV populations (Hidalgo, Coombs, Cobbs, Green-Jones, Phillips, Wohl, & Fields, 2011), the elderly (Ma Shwe Zin, Soo Meng, Kumar, Fones, & Tze Pin, 2009), street walking prostitutes (Weiner, 1996), new mothers

(Barnes, MacPherson, & Senior, 2006), families with disabilities (Bray, 2006), involuntary delinquent youth (Chui & Ho, 2006) and, more related to homelessness, older homeless populations (Crane & Warnes, 2005).

To understand the challenges of outreach work with vulnerable populations, it is helpful to gain an understanding of the process by which a population is considered to be "at-risk" or vulnerable. According to Mechanic and Tanner (2007), "Vulnerability, the susceptibility to harm, results from an interaction between the resources available to individuals and communities and the life changes they face" (p. 1220). With regard to the resources available for populations in need, often what makes a resource inaccessible is the perception of its adequacy in terms of meeting a particular need. In the case of the chronically homeless, a lack of confidence in resources often diminishes any motivation towards pursuing such resources (Kryda & Compton, 2009). Among the chronically homeless for instance, shelters are frequently seen as dangerous places where specific needs are often disregarded in favor of generic one-size-fits-all services. Consequently, the challenge of outreach might be seen as a double bind (Bateson, Jackson, Haley, & Weakland, 1972). On one hand, an outreach worker is tasked to assess the needs of the chronically homeless against the potential of available resources, which the client may have already decided against. At the same time, the potential resources may not be adequate, consistent, or trusted by the client and as such their recommendation may have the potential to place outreach workers in a situation where they reinforce distrust in inadequate resources. Outreach work may involve playing multiple roles such as case manager or intake worker, and adopting a position of utilizing what policy makers have decided are the "needed" resources, on behalf of the client population. Thus outreach work with vulnerable populations often requires

mitigating the effects of inadequate or untrustworthy resources meant to combat chronic homelessness.

With regard to vulnerable populations that suffer from significant life changes and transition, the literature on transition of youth from foster care services to adult services provides valuable insights. Osgood, Foster, and Courtney (2010) look at the problems faced by youth in the mental health, foster care, juvenile and criminal justice, and special education systems; youth with physical disabilities and chronic illness; and runaway and homeless youth. Specifically, these youth face the abrupt ending of services in the transition to adulthood. Findings from the Osgood et al. (2010) study are of particular interest to a study of outreach with the chronically homeless population as transitions among this population in employment, housing, health, and/or other unforeseen changes are frequently catalysts to a chronic long-term condition. The charge of outreach to a vulnerable population is thus to help facilitate transition as smoothly as possible. In this vein, programs targeting the chronically homeless such as the Housing First program have gained popularity in recent years as a method of avoiding the long, bureaucratic, requisite-driven process that often exacerbates struggles for consumers with co-occurring mental health and substance use challenges (Levy, 2011; Tsemberis, Gulcur, & Nakae, 2004). The thinking in guiding this service model is that obtaining stable housing as soon as possible for people in transition improves outcomes for this population. In supporting the "housing first" model, homeless services policy has already begun to integrate a consideration of the struggles of those in transition; outreach workers are on the front lines of facilitating this more expedited service delivery.

The discussion of vulnerability is further informed by what we know about how people conceptualize and enact transition and change in life. Part of what makes a population vulnerable

is poverty, lack of social support, lack of employment, and exposure to environmentally adverse conditions (Mechanic & Tanner, 2007). Interventions addressing persistent vulnerability require a consistent and continuing pattern of care and social support (Mechanic & Tanner, 2007).

The circumstances surrounding a specific transition often vary for the chronically homeless population and might call for interventions such as rehabilitation, or detoxification resources, multiple times per week. For others experiencing a shift of attitude toward their personal, employment, or social life, brief consistent mental health support may be sufficient to meet their needs. As the most vulnerable require consistent and continuing care, outreach workers who form trusting relationships build a strong basis of reliable social support in the face of potentially daunting levels of care for consumers.

The contrast between the change state and current circumstances involves a period of transition that is often difficult to manage and may create susceptibility to further life challenges. One example is the higher incidence of suicide for patients discharged from psychiatric inpatient hospital wards (Goldacre & Seagroatt, 1993). Regardless of the type of services or resources received or sought, anyone working towards fundamental change faces multiple challenges in addition to the current set of difficult circumstances that motivate a desire for change.

Schlossberg (1981) claimed that a transition is "said to occur if an event or non-event results in a change in assumptions about oneself and the world and thus requires a corresponding change in one's behavior and relationships" (p. 5). A successful transition, it is claimed by the author, is determined not necessarily by the transition itself, but rather by how the transition fits with a person's life "stage, situation, and style at the time of the transition" (Schlossberg, 1981, p. 5). In looking at adaptation to transition, Schlossberg postulated three sets of factors: characteristics of the particular transition, characteristics of the pre- and post-transition

environments, and characteristics of the individual experiencing the transition. Characteristics of particular transitions could include a role change that is experienced as either a gain or a loss, affectively positive or negative, internal or external, timely or untimely, gradual or sudden, permanent, temporary, or uncertain, and evidencing some degree of stressfulness. Characteristics of the pre- and post-transition environments are those inhering in the interpersonal, institutional, and physical support systems. Lastly, although the characteristics of the individual critically involved with transition are many and complex, Schlossberg (1981) highlights psychosocial competence, sex, age or life stage, health, race or ethnicity, socioeconomic status, value orientation, and previous experience with transition of a similar nature. Given this stratum of interacting variables that can result in "adaptive" transition rather than in relapse or struggle, the journey for many populations through different stages of change is not a simple one. The variety of circumstances and populations that are vulnerable to challenges during transition confirms many of these constructs. Outreach again is called upon to bring to their work a breadth of experience and comfort in working with individuals with a wide variety of circumstances.

Given the consequential nature of transition with respect to vulnerability, conceptualizing the change process for vulnerable populations is paramount to understanding the complexity of outreach work. In the literature on stages of change for those struggling with substance dependencies, Prochaska, DiClemente, and Norcross (1992) view parts of the progression of change as a shift from pre-contemplation (not yet internally considering change to be desirable or necessary) to contemplation (consciously considering and weighing change in one's life). The reasons that someone in a particular situation would be ready to shift from precontemplation to contemplation depend on many of the sets of factors to which Schlossberg (1981) refers. In this

sense, outreach worker interaction might be considered an assessment of the person's current desire for change.

For outreach work with people experiencing chronic homelessness, the precontemplation stage might present as electing not to access services; whereas, the contemplation stage might present as being ready to welcome an outreach worker who may present the options, or the "pros and cons" of different resources (Prochaska et al.,1992). This consideration could equate to the outreach worker-consumer relationship as the potential "event or non-event that results in the change of assumption" for the consumer about the social service system, placing workers in a pivotal role in the pre- and post-environment of interpersonal support for a person in the midst of transition (Schlossberg, 1981). As a potentially significant catalytic agent, the homeless outreach worker perspective is critical.

Additionally relevant here – and possibly controversial to outreach work - might be the outreach practice of facilitating access to services that consumers are not interested in or to rhetorically elicit information from clients for assessment purposes (Spencer & McKinney, 1997). As Spencer and McKinney discuss, the language used in first encounters with consumers often has implicit and embedded biases that shift conversations in a particular direction. In the case of outreach, it may be that worker' questions and ways of being are biased towards accessing particular services. In the language of stages of change, outreach workers might find themselves in a similar situation to that of many substance abuse counselors; that is, trying to facilitate a change the client is not ready for (Prochaska et al., 1992).

Those that do Outreach Work

The roles and professional disciplines associated with outreach work with vulnerable populations vary widely. Nurses working with care assistants often are those doing outreach in

medical situations such as working with families with children with complex disabilities (Bray, 2006). Equally likely, in the human services field, social workers, case managers, volunteers, and outreach workers are the people reaching out to these hard-to-reach populations (Weiner, 1996; Barnes, MacPherson, & Senior, 2006; Crane & Warnes, 2005; Chui & Ho, 2006).

The varied perspectives of workers in different disciplines significantly shape the ways in which outreach work is both designed and implemented. This is evident in the variety of roles that outreach workers play with an increasing array of vulnerable populations. Using the subject of study as an example, outreach work with the chronically homeless may be carried out by different disciplines, take different forms, and play different roles due to the unique combination of co-occurring risk presenting with chronic homelessness: mental illness and substance abuse. The perspective of the service provider has been found to be useful in homeless services (Zuffrey, 2008). Outreach to this population brings with it similar simultaneous challenges in its implementation (Blankertz, Cnaan, White, Fox, & Messinger, 1990; Rowe, Fisk, Frey & Davidson, 2002).

The varied activities of outreach workers depend on the needs of the specific target population. For high-risk HIV populations, outreach workers provide social and educational HIV outreach and education at bars, college campuses, and health fairs, disseminate awareness around youth-focused support initiatives around medical and support services, lead youth advisory councils around HIV education and prevention as well as mobile testing vans and drop-in centers (Hidalgo et al., 2011). Community nurses in the Community-based Early Psychiatric Interventional Strategy (CEPIS) program in Singapore routinely screen the elderly for depressive symptoms while also providing psychoeducational services to clients in the area of mental health and making referrals to primary care treatment for depression (Ma Shwe Zin et al., 2009).

Bachelor's-level case managers, certified HIV counselors, and a phlebotomist participated in a program where a mobile outreach van provided food, HIV testing, condom distribution, and if requested, referrals to medical and social services to street walking prostitutes in New York City (Weiner, 1996). Community volunteers in the Home-Start program in the UK offer support to new families with children aged less than five years old (Barnes, MacPherson, & Senior, 2006). Registered nurses and care assistants provide nursing care to families with complex disabilities in the family home and other community settings (Bray, 2006). Social workers in Hong Kong are tasked with connecting with "delinquent" youth around prevention of undesirable behavior, counseling regarding education, career, family, interpersonal and personal problems (Chui & Ho, 2006). Outreach workers at "Hearth" (an agency specializing in addressing elder homelessness) provide housing search and advocacy services as well as general case management around health, behavioral health, and basic needs to homeless individuals above the age of 50 in Boston,(Crane & Warnes, 2005). It is worth noting that these forms of outreach are distinct from street outreach, the focus of this study, in that these outreach programs concentrate on educational, medical, and preventative interventions that either bring resources directly to clients in an office-agency-home setting or immediately refer them to such resources outside of the client's current location. Street outreach with the chronically homeless, on the other hand, constitutes the intervention itself *wherever the person resides*. Referral to resources and education can happen in the course of open-ended alliance building with outreach workers, but is not always the focus of the intervention.

Equally important in work with the homeless is the consumer perspective (Wireman, 2007). Views of some outreach workers by consumers of services as well as non-client community members are often very positive. Authors Pollack, Frattaroli, Whitehill, and Strother

(2011) surveyed consumers of outreach services and other community members in Lowell, Massachusetts in order to gauge the perceived effectiveness and helpfulness of street outreach workers who work with at risk youth between the ages of 13 and 23. Of the 206 participants who were recruited using respondent driven sampling, 159 participants with average age 17 completed the survey. Among the most common open-ended responses were that the street workers were, "…good listeners; always there; they don't try to be all up in your business like adults" (Pollack et al., 2011). Of note in this observation is the ability and leverage afforded outreach workers in approaching target consumers in more frequent, less formalized ways. To put this in perspective, homeless outreach workers, as will be discussed later, particularly have many challenges including an inherent distrustful stigma which certainly affects how the work happens.

Given that outreach work is difficult, boundary challenging work, many homeless outreach agencies experience difficulty in hiring and retaining appropriate staff (Olivet, McGraw, Grandin, & Bassuk, 2010). Because of low pay, high burnout and turnover, limited supervision availability, and staff training needs, the challenges involved in finding individuals to do this difficult and challenging work are significant.

In contrast, research comparing assertive outreach workers with crisis resolution teams and community mental health teams showed fairly equal levels of satisfaction, wide distributions of burnout among teams, and a pattern suggesting an association between a longer career in mental health and less emotional exhaustion and more personal accomplishment (Nelson, Johnson, & Bebbington, 2009). Why some assertive outreach workers endure the challenging nature of the work, while others do not, is unclear; per this study, the four areas most highly rated as sources of satisfaction for assertive outreach workers were: working in a new type of

team; contributing to the team's service; helping clients; and the company of other staff (Nelson et al., 2009). Not surprisingly the areas identified as sources of greatest stress were "a lack of people/resources in the community to refer on to" followed closely by "too much administrative work" (Nelson et al., 2009, p. 547).

Although few studies focus on outreach worker perspective and experience of their work, one such study looked at assertive outreach nurses in the UK who were interviewed to gather data on their understanding of assertive outreach work (Addis & Gamble, 2004). The themes that emerged from study findings offer a more complete picture of assertive outreach work of five nurses in the UK and included the following; the significance of having time to connect with clients; the high hope and persistence of nurses in the face of ambivalence, hostility, and rejection often followed by the paradoxical tired dejection when relationships were not established; the internal and external pressure to engage clients, the relief when relationships were established, and the satisfaction that followed relationship formation; the desire to be both a caring individual and helpful professional to clients; feeling as though they both worked with and learned from clients; and the tantamount importance of working with a caring attitude in creating successful engagement. These themes speak to the nuances and complexity of outreach work with vulnerable populations in general.

Outreach to the Chronically Street Homeless population

Review of the literature on the challenges of homeless outreach work with the chronically homeless includes exploration of the ethical concerns embedded in work with individuals with co-occurring mental health and substance use issues, and in client refusal of service. Following discussion of these issues, the review will examine writings on what is thought to be effective in

outreach work, and how themes from what is thought to work can be informed by harm-reduction theory and relational clinical perspectives.

Ethical concerns. Before considering the perspectives of outreach workers regarding the nature of their work and the needs of the populations they serve, it is worth revisiting the ethical issues embedded in outreach work with chronically homeless individuals alluded to earlier in the discussion of stages of change, people in transition, and rhetoric as a troublesome tool (Prochaska et al.,1992; Schlossberg, 1981; Spencer & McKinney, 1997). Outreach workers must balance the prospect of either supporting or violating the free will of mentally unstable individuals who decline services and for whom a lack of involuntary intervention on the part of the worker may be tantamount to colluding with a potential client's psychosis (Melamed, Fromer, Kemelman, & Barak, 2000). Melamed et al. (2000) examine three hypothetical vignettes that speak to a weighing of patient rights versus needs. The scenarios include how a person on the street who has not broken the law might potentially suffer from a complex social problem; how a person might deliberately decide to live on the street; and how there might be the need for involuntary intervention on the part of either outreach workers, social workers, or police officers given the potential onset of a mental health or physical safety risk. In the same arena of ethical concern is a consumer's refusal to accept services. From as early as 1999, authors drawing from the street experiences of outreach staff explored issues of boundaries, ethics, and staff safety, suggesting outreach worker experiences as essential in shaping and redefining homeless outreach work (Fisk, Rakfeldt, Heffernan & Rowe, 1999).

Writing about reaching hard-to-reach patients in difficult places, Adlam and Scanlon (2011) offer the parable of the interaction between Diogenes, the Cynic philosopher, and Alexander the Great as a framework for understanding the often problematic interaction between

the antisocial individual and a system of care. As the story goes, Diogenes refused accommodations from societal systems as he regarded them as untruthful. Here he simply understood that societal offence in reaction to his decision to live in a barrel in the main square was the problem of others, while his offence in reaction to the world he saw around him was his problem (one that he had to best manage on his own). In the emblematic moment of interaction between Diogenes and Alexander, when Alexander in respect of Diogenes' ethic asked what he could do for him, Diogenes responded that he could kindly step out of his light. In this way, the article recognizes that if clinicians and outreach workers can essentially offer help in a way that is not tied to a particular outcome or expectation of what constitutes a "successful" encounter, then intervention becomes less defined by the accessing of specific services and more defined by the relationship with the system of care itself (Adlam & Scanton, 2011). Creating a culture or organization where problematic interactions such as those that may occur between outreach workers and hard-to-reach populations can be explored and considered in a new light requires a greater level of permissiveness as well as a stance of "being with" the client than currently exists in many traditional forms of clinical assessment favoring deliberate helping and judgment (Rapoport & Rapoport, 1958). Further exploration of this theme will be included in a later discussion on the relational nature of outreach work.

The Diogenes analogy highlights the conflict between client autonomy and clinical responsibility (Rowe, Frey, Bailey, Fisk & Davidson, 2001). When are workers obliged to intervene in order to protect individuals who are at risk of harming themselves if these individuals have neither accepted nor been formally admitted to treatment? Rowe et al. (2001) offer vignettes that fall into the following four broad categories of conditions and boundaries within which outreach workers must make decisions about whether to intervene, giving

precedence to consumer protection over consumer autonomy: eligibility, functional status, external conditions, and options. Eligibility conditions can confuse decisions for outreach workers working with a population, the majority of which is dually diagnosed with either substance use and/or mental health concerns. Being either unconscious or disoriented is considered a safety concern and therefore protection takes precedence over client autonomy. Similarly, the functional status of the homeless is assessed regardless of the amount of contact in the hopes of preventing serious physical and mental harm. Current external conditions such as weather or local gang conflict are examples of environmental risk factors for this population. Lastly, the category that most readily connects with controversy between client autonomy (the right to refuse or choose a particular treatment) and clinical responsibility (the obligation to intervene on behalf of the client's safety) is that of different resource options being available to the homeless (Rowe et al., 2001). Here, the homeless person's free will is what is often debated if the other criteria favoring clinical responsibility are not in evidence. Once dilemmas over client autonomy are determined and understood, the next challenge facing outreach workers is that of determining the quality and duration of the available resources being offered and whether they in actuality meet the needs of the client. How the reliability of available resources guides worker decision-making with regards to intervention is of particular interest in this study.

Often, the ethical dilemmas embedded in components of homeless outreach work are related to consumers' substance dependence and mental disturbance. Considering the stages of change literature described earlier, Fisk, Rakfeldt, and McCormack (2006) provide evidence for the effectiveness of assertive (proactive) outreach in achieving a gradual, incremental enrollment of homeless individuals with substance use disorders into substance abuse treatment service programs. Although, from an ethical standpoint, involuntary intervention may not seem justified

given that ambivalence is known to be a part of the recovery process for substance use (Fisk et al., 2006), sometimes enrollment may be a safety issue in terms of the physical need for detoxification or psychological need for 24-hour inpatient care. In this regard, Blankertz et al. (1990) recommend nine practice principles of homeless outreach with dually diagnosed homeless persons that should guide the worker in a decision to order involuntary hospitalization and/or commitment to treatment programs: unconditional respect; extended period of engagement; worker as specific trusted link to the "system"; modeling skills of social engagement with others; encouragement of positive supportive and personally specific observations of regard; initially low emphasis on institutional over instrumental support; awareness of verbal and non-verbal cues of safety and acceptable communication; acceptance that the work happens at the pace of the consumer; and lastly, preparation and transference of engagement norms to the receiving resource or support to pass over as much trust and acceptance as possible that will minimize misunderstandings and empathic failures in the new and fragile relationship between consumer and new provider. This last practice principle, in particular, is in line with the consistent and continuing care needed among vulnerable populations and the facilitation of their transition to new resources, as previously mentioned (Mechanic & Tanner, 2007; Schlossberg, 1981).

Similarly, a literature exists on principles of homeless outreach - particularly in work with populations suffering from mental disturbances - in which the worker is conceptualized as a primary partner next to the individual's homelessness. Levy (2000) lays out five principles that could guide pretreatment for homeless outreach activities: promoting safety; forming relationship; developing a common language; promoting and supporting change; and being aware of and utilizing cultural and ecological factors that affect clients, outreach staff, and

communities. In another article, Levy (2004) elaborates on developing a common language with consumers with co-occurring mental disturbances. Adopting the language of clients as a means of building trust and client autonomy, Levy argues, should be considered not as dishonest, but as a method of understanding the world of the client.

What works: intervention models and effectiveness in outreach work. An exploration of the literature on effective practices, strategies, and agency policies in homeless outreach work also includes an exploration of the reasons that homeless populations may avoid outreach workers. Kryda and Compton (2009) interviewed 24 people who had been homeless for over a year in west midtown Manhattan. Findings indicate that the most salient reasons for refusal of services were mistrust of outreach workers and agencies and lack of confidence in available services. The lack of confidence particularly led to beliefs that services were not compatible with their needs. Participant mistrust of outreach workers was reflected in comments about workers' lack of time spent getting to know them, worker prejudicial and stereotypical views of the homeless, not being offered choices, and a sense that outreach workers did not understand what it is like to be homeless. This last point suggests that outreach workers may not have shared similar experiences to homeless participants of the study. In contrast, however, as mentioned in Hidalgo et al. (2011), outreach workers frequently do, in fact, have lived experience in common with the targeted population.

The finding from Kryda and Compton's (2009) study indicating a sense on the part of homeless participant that outreach workers did not understand what it is like to be homeless has been noted by others (Housing Options Made Easy, 2005). Literature on peer advising supports this finding. In New York City, homeless veterans who had completed a community-based drop-in program with psychiatry, primary care, and case-management services were recruited to assist

currently homeless veterans in making the transition from shelter or supportive residential facilities to independent living (Weissman, Covell, Kushner, Irwin, & Essock, 2005). The peer-enhanced case management program that was created with the help of these peer advisors was well received by participants, peer advisors, and staff. Although findings could not be generalized for a variety of reasons that included difficulty in finding participants for follow-up interviews, most staff considered the program a success. This speaks to the potential effectiveness of a peer workforce in homeless outreach work, with formerly homeless outreach workers utilizing a shared experience as a context for connection. Homeless respondents also believed that outreach workers were mostly motivated by their paycheck and were prone to making empty promises about following up on housing possibilities and detox programs, among other potential resources (Kryda & Compton, 2009). With regards to lack of confidence in services, two beliefs prevailed: shelters are unsafe, violent places and often services were only short-term solutions. Kryda and Compton (2009) go on to recommend that workers initially demonstrate that they are openly motivated by the best interest of their client and respect them as individuals, giving them options when available. These options have varied over the years and will be discussed in the following section. Before doing so, it is worth noting that these challenges and ethical concerns actually constitute the working conditions of outreach workers. Particular attention is noted here on the gap in the literature in terms of examining the outreach worker's perspective on all of these issues.

Work with the chronically homeless has manifested in a number of different forms that have strayed from the dominant system of care over the years. The linear residential treatment (LRT) model addresses co-occurring psychiatric disability and homelessness using a series of step-by-step residential programs that eventually lead individuals into independent housing

(Tsemberis, 1999). Different criteria that may be required to remain eligible for some services include sobriety, medication adherence, and mandated mental health screening and treatment. Critics including consumers, advocates, and program planners argue that lack of client choice, stress from multiple moves, the extended period of time before receiving independent housing, and the destabilizing effect of tying housing status to treatment compliance jeopardizes housing retention profoundly (Carling, 1995; Ridgway & Zipple, 1990).

The identification of shortcomings associated with the linear model has led to the development of hybrid forms of service delivery. One such program, drawn from models of successful drop-in centers, is the Choices Unlimited program in New York City. This program includes showers, lockers, laundry, telephones, libraries, computers, televisions, and offers three main types of services from which participants might choose, including: assistance with medical, psychiatric and social services; development and implementation of individual rehabilitation plans with particular emphasis on housing; and opportunities to meet and socialize with others (Shern, Tsemberis, Anthony, Lovell, Richmond, Felton, Winarski, & Cohen, 2000). The Choices Unlimited program design rejects the clinical perspective of a linear continuum model of dissemination of services that imposed threshold expectations such as abstinence and medication compliance before providing services. In their study of program outcomes, Shern et al. (2000) looked at the outcomes of the 168 individuals with psychiatric disabilities living on the streets, 91 of whom had been randomly assigned to the Choices Unlimited program; the remaining 77 participants comprised the control group, which was provided a standard treatment. Compared to the control group, those in the Choices Unlimited program reported significantly less difficulty getting food, finding a place to sleep, keeping clean, and significant reductions in anxiety, depression, and thought disturbances (Shern et al., 2000).

Another program, the Pathways Supported Housing program, was evaluated in New York City (Tsemberis, 1999) and more recently in Washington D. C. (Tsemberis, 2012). Piloted in New York City, this program was designed to specifically meet the needs of the severely mentally ill and substance-addicted homeless population and offered immediate access to independent housing and program services attuned to consumer's priorities. Priority for admission is provided to the most vulnerable in this population and the program does not require tenants to take medication, participate in psychiatric treatment, or abstain from drugs or alcohol in order to be eligible for housing. A history of violence, prison, or jail time does not disqualify applicants from the program. Three strongly recommended but not required preconditions are agreement to seeing a visiting service coordinator at least twice a month, payment of 30% of one's income towards rent, and participation in a money-management program (Tsemberis, 1999). Interdisciplinary Assertive Community Treatment teams often act as the program core services. ACT teams focus on decreasing tenant association as patient in a mental health system and increasing tenant personal efficacy, employment opportunities, ability to meet basic needs, enhancing social skills, and enhancing quality of life (Allness, 1997). In the New York City program, among 139 tenants ranging from 19 to 68 in age, the overall housing-stabilization rate for the Pathways program was 84.2% for a period of almost 30 months, compared with a housing-stabilization rate of only 59.6% over a two-year period in a linear residential treatment setting for a cohort of 2864 individuals, a total of 1707 remained housed (Tsemberis, 1999). In Washington DC, tenants in another Pathways program run by national non-for-profit Pathways to Housing, Inc. had a housing retention rate of 84% after two years as well (Tsemberis, 2012).

The impact of aforementioned threshold expectations and prerequisites common to traditional programs was examined in a longitudinal study of 224 participants randomly assigned

to either of two groups - one receiving housing contingent upon sobriety (control group) and the other participating in a *housing first* program. Housing First refers to a model for housing of homeless individuals that removes all obstacles and prerequisites to housing in favor of getting people in off of the streets first, and later addressing the complexity of consumer needs (Tsemberis, Gulcur, & Nakae, 2004). The Pathways Supported Housing program in New York City was the first program of its kind to employ this model (Tsemberis, 1999). Study findings indicate that dually diagnosed participants in the Pathways program, representing the housing first model choice, were more likely to remain stably housed than control groups without compromising or exacerbating psychiatric or substance abuse symptoms (Tsemberis, Gulcur, and Nakae, 2004). Also reported was higher perceived choice of services used on the part of participants in the housing first sample.

This latter point was examined in another paper looking at both the Pathways and Choices programs. Looking at consumer preference and choice, Tsemberis, Moran, Shinn, Asmussen, and Shern (2003), describe how the Pathways and Choices programs were developed in collaboration with consumers, researchers and clinicians to reduce barriers and obstacles to access of resources. Both programs appear to consider consumer perspective when contact is made. Specifically, the programs took into consideration the social skills necessary to utilize services through various levels of repeated working relationships necessary to meet program objectives in a standard linear continuum of services model. As mentioned by the authors, the taxing demand placed on consumers through these repeated challenging social interactions was thoughtfully considered, and therefore eliminated, in both the Pathways and Choices programs.

The importance of client agency and non-traditional ways of engaging with the homeless will be understood in the context of relational clinical theory and the use of harm-reduction

models. Particularly of interest is how these theories undergird the practices of the homeless outreach worker. A movement composed of those who work with the homeless is advocating a change in this dominant linear continuum model for dissemination of services in favor of housing first modeled programs (Levy, 2011). As seen in the Pathways program examples mentioned earlier, we see a harm-reduction model of care, one characterized by the aim to reduce the problematic effects of behaviors that are often caused by substance use and mental disturbance with the chronically homeless (Marlatt, 2012).

Those that do homeless outreach work

In this section, we shift from a discussion of the nature of outreach work with the chronically street homeless to return to homeless outreach workers themselves, examining the development of outreach work as a way of targeting the vulnerable homeless population.

Factors intrinsic to outreach work. Starting from the notion that "…homeless outreach is in essence a form of street triage" (Ng & McQuistion, 2004, p. 97), authors Ng and McQuistion (2004) look at intrinsic aspects of outreach work that affect the work being done; that is, the outreach model being employed at the agency, the outreach workers themselves, and the teams in which they work. Ng and McQuistion (2004) point out that service delivery models located in more controlled environments, such as program-driven shelters for people with psychiatric disorders, often require less structured outreach services. According to these authors, the inclusion of case management personnel in these settings may preclude the need for intensive outreach service. On the other hand, in less controlled environments such as drop-in centers or general shelters, outreach services are more critical to consumer best use of services. From this understanding a more sophisticated outreach model was born. One of these was the mobile crisis team, an example of which is Project HELP in New York City. The Project HELP team consists

of a psychiatrist, social worker and paraprofessional whose role it is to assess homeless individuals for psychiatric disorders and the need for acute hospitalization, whether voluntary or involuntary (Ng & McQuisition, 2004).

With the creation of mobile crisis teams and homeless outreach came issues of client-staff boundaries, ethics, and staff safety (Fisk, Rakfeldt, Heffernan & Rowe, 1999). Outreach workers, it seemed, were grappling with the issue of how one sustains a complex role in homeless outreach services; fulfilling this role placed outreach workers at the frontier between a vulnerable and marginalized population and the system of social services.

Among the factors intrinsic to workers postulated as being associated with effective homeless outreach work were strong social service work experience, the ability to develop a dynamic relationship with the homeless, the worker's own sociocultural background, and the workers ability to notice and examine countertransference reactions to potential contacts, (Ng & McQuistion, 2004).

Which individuals outreach workers elect to approach for initial contact is also of interest. For example, in researching homeless outreach work, this researcher observed one male outreach worker who came upon a woman on the street appearing scared at his presence; recognizing this, the worker then called upon a female outreach worker whom it was thought would be better received.

Although supervisors and agencies cannot control many of the intrinsic factors associated with characteristics and perspectives of individual outreach workers, other factors such as norms around staff safety, work experience requirements for employment eligibility and the development of dynamic relational skill building can be preemptively encouraged. Fisk et al.

(1999) note that worker street experiences should guide work activity, policies, and procedures in their agencies.

Ng and McQuistion's (2004) discussion of the intrinsic factors among homeless outreach workers that potentially contribute to the effectiveness of their work leads these authors to call for research defining and testing these factors. While there exists a gap in the literature in this area, a recent study provided evidence of assertive outreach as an effective link between substance using consumers and substance abuse treatment services (Fisk, Rakfeldt, & McCormack, 2006).

Factors extrinsic to outreach work. Other issues are extrinsic in that they are not inherently a part of the outreach work experience but often do have the possibility of being a factor in the work (Ng & McQuisition, 2004). Many have already been mentioned such as housing eligibility requirements and lack of confidence in resources being able to fulfill the needs of clientele either because of little financing or lack of continuity of service delivery between different resources. As such, these factors often are not easily modified or planned for ahead of time by supervisors and agencies; such planning might take the form of advocacy and policy reform which seldom are prioritized by homeless service agencies already strapped for resources. Other unforeseen issues include sexual and relational boundary issues that must be assessed in the field by the outreach workers themselves. Regardless, all extrinsic factors that affect outreach work have to be considered by the workers themselves.

Moving from Practice to Theory

In reflecting on the available literature on outreach work, the majority of studies have mainly considered the ethical and social problems associated with the work, emphasizing what doesn't work, or the challenges involved, as opposed to what has worked. Saleebey (2011), who

has written extensively on the strengths perspective in social work, highlights the personal, social, and spiritual resources of an individual that are uncovered in the powerful force of a helping relationship, thus emphasizing individual strengths as opposed to deficits. Although implicit in the work of Fisk et al. (1999), affirmative practices in outreach services among the chronically homeless population is not explicitly emphasized. Embedded in the case vignettes illustrating client-staff boundaries is the practice of consulting supervisors in uncomfortable and unclear situations in which outreach workers may find themselves. Embedded in the case vignettes illustrating ethical concerns are practices of networking and collaboration with local community members in resolving crisis and non-crisis situations. Embedded in the case vignettes illustrating safety concerns is the general notion that outreach workers should trust their own awareness of their sense of safety. In these cases would the unemphasized, unspoken, perhaps taken-for-granted practices used to resolve these challenges speak to necessary changes of agency policy, practice, or procedure if they were explicitly highlighted? Although the literature is sparse, Levy (2004) highlights the practice utilized by some outreach workers to create long-term working relationships by employing a common language with the mentally ill, homeless population. The development of a common language capable of spanning different sociocultural perspectives appears to be an identified strategy and practice utilized by outreach workers with this population that could eventually be implemented into training for outreach workers with this population. Here we find a practice that entails long-term learning of the communication norms of the client. As Levy (2004) mentions and as psychotherapists have known for some time, the process of alliance building involves the creation of a relationship in which the client feels safe and free to express himself or herself authentically (Rogers, 1961). This process often takes time and requires a consistent stable presence on the provider side.

The beneficial implications of the practices that work in reaching one of the most vulnerable populations for social work practice are obvious; less obvious is how determining best practices in this non-traditional encounter between outreach worker and potential client could inform future social work program development and intervention. Ng and McQuistion (2004) allude to the need for a definition of effective outreach work, arguing that consensus on such a definition requires further research. Focusing first on obtaining the outreach worker perspective on their own work therefore is paramount. With a stronger literature base supporting best practices and techniques in outreach work, better outreach programs and intervention strategies could be developed.

Notions of client autonomy and suggestions for more individualized empathic communications with outreach workers speak to the need for worker-homeless consumer interactions that are more relationally based. That is to say, the vulnerability of the chronically homeless, for the reasons mentioned in this literature review, speaks to the need for methods of engagement that may require extended periods of alliance building. Similar to the process by which the observation of the effects of cumulative trauma over long periods of time led some practitioners to determine the need for the new conceptualization of complex post-traumatic stress disorder (Courtois, 2004), in trying to reach the chronically homeless, outreach work practice has skirted the limits of provider-consumer relationship in the personal, professional, and ethical realm. In the case of clients suffering from complex post-traumatic stress, Courtois (2004) mentions that often practitioners will not get past the first stage of treatment which includes pretreatment issues, treatment frame, alliance-building, safety, affect-regulation, stabilization, skill-building, education, self-care, and support. Courtois (2004) states:

> Some clients never move beyond or complete Stage 1. Others may leave treatment prematurely. It is now recognized that good work in Stage 1 is likely to substantially improve the client's life. Some clients may have no need to move into the latter two stages. The primary emphasis of Stage 1 is personal safety in addition to education, personal and life stabilization, skill-building, and the building of social relationships and support. (p. 419)

In working with vulnerable complex trauma clients, the normal expectations of non-vulnerable clients in treatment are not applicable. In the case of the chronically homeless, the intervention of alliance building with outreach workers, although not always resulting in accessing of services, might be considered successful treatment given the population in question. Seen in the context of relationship, the chronically homeless, being isolated from resources and relatively distant from regular human contact, have a valuable intervention in the homeless outreach worker relationship. Wachtel (2011) speaks of the role of affect in the therapeutic relationship and to an emphasis on having an accepting attitude toward clients. In this way, outreach workers' attitudes and perceptions of the homeless populations they seek to reach are of utmost importance in the work that they do. Again, their ability to truly connect with the recipients of outreach services is in large part the intervention itself.

If the theoretical frame for outreach work is therapeutic alliance-building through workers' relationships with consumers, then the therapeutic skills that workers utilize to build a strong alliance can be seen in the consistent non-judgmental offering of available and appropriate services without condition as well as reducing the harm in any encounter. As referred to in the literature on harm-reduction (Marlatt, 2012), the stance of accepting people as they are without restriction can be seen in the referrals made to housing first modeled programs by outreach

workers (Tsemberis, Gulcur, and Nakae, 2004). Additionally the principle of harm reduction is illustrated in the situation of a homeless individual who might reject an outreach worker conversationally or socially but who will accept a blanket or food. In this way, the consistent offering of available and appropriate resources as judged by the consumer employs harm-reduction practices in a relational frame.

In another sense, the outreach worker has an opportunity to facilitate a potentially newly therapeutic, perhaps, reparative relationship between the homeless person and the formal mental health system. Therefore, an accepting attitude towards consumers in the first encounter on the streets might be comparable to the clinical first encounter between client and therapist, or client and service provider. Kryda and Compton (2009) speak to the importance of a non-judgmental encounter as well. Additionally, outreach workers bring their social identity and history as one side of this developing relationship between outreach worker and homeless person. Just as the outreach worker affects the consumer, the consumer affects the outreach worker. This is noted in the implicit moments when a worker decides that someone is not in danger of harming themselves or others, based on the consumer presentation. By virtue of this two-way authentic engagement, this encounter between outreach worker and consumer that stands at the edge of the problem of chronic homelessness can be considered using relational intersubjectivity theory (Stark, 1999). Intersubjectivity theory, a metatheory of psychoanalysis, examines the therapeutic field in which both client and therapist, or in this case consumer and outreach worker, create an "interplay between subjectivities" (Orange, Atwood, & Stolorow, 1997, p. 6). That is, intersubjectivity refuses to place pathology solely within the patients. In the case of consumer and outreach worker, a third space is created in which the subjective reality of the worker and the subjective reality of the consumer can meet and perhaps create a space in which a new reality

can be born. Perhaps this reality does not depend on a past history of disappointment and abuse by an often disenfranchising overdrawn social service system. That is, through the unique outreach worker-consumer relationship, a new chance at change is possible.

As discussed earlier in the literature, both homeless consumer and outreach worker add different perspective and insight to the complexity of tackling chronic homelessness. Outreach worker and homeless person co-create a relationship. By obtaining the outreach worker perspective on this dynamic, the requisites needed to engender trust that leads a homeless individual towards their own sense of progress and growth will begin to be uncovered more completely.

Summary and Motivation for the Study

This literature review begins with the current status of homelessness and work with vulnerable populations as a means of understanding the scale and terrain of the consumer perspective. In gaining a deeper understanding of the challenges involved in work with these consumers, the varying roles and tasks for different kinds of workers becomes clear. In particular, outreach work appears to meet the needs of populations that commonly isolate themselves from their systems of care. In outreach work with the chronically homeless who, as noted, are often afflicted with co-occurring mental health and substance use problems, the ethical concerns regarding involuntary commitment to hospital- or crisis-center mental health units or medical emergency departments has its own flavor of challenge and worker responsibility. In considering the future of work with the chronically homeless, the relational alliance-building that seems to often depend on a stance of harm-reduction and non-judgment can only be verified, extrapolated upon, and more specifically understood from the perspective of the homeless

outreach worker. Learning how they conceptualize their work will serve to improve current practice, policy and programming in work with the chronically homeless.

CHAPTER III

Methodology

This qualitative study explored the experiences of outreach workers who provide services to the chronically street homeless population. As the literature review suggests, the nonconventional nature of outreach work has implications with respect to practice and consequently should effect how program support and resources are designed for outreach workers. Outreach work in practice varies in form and style and uniquely manifests depending on the outreach worker's history, values, and subjective experience. For this reason, learning about how outreach workers conceptualize their work professionally, personally, interpersonally, and socially is of utmost importance to inform practice and program considerations in homeless outreach work. This chapter presents the methods used in this study to discover this perspective, including study design, sample selection, data collection, and data analysis procedures.

Study design and sampling

The exploratory/descriptive study design employed semi-structured interviews with a non-probability purposive sample of seven outreach workers from four different agencies, part of a five-agency collaborative providing street outreach services in the setting of a large Northeastern city. The study instrument consisted of an 18-item questionnaire (Appendix D), informed by literature review and researcher observation of outreach work. Six demographic items (age, gender, race/ethnicity, educational level, spirituality/religiosity, and years of outreach

experience) were followed by 12 open-ended questions covering personal, professional, social, and interpersonal motivations and perceptions of outreach workers regarding the work they do.

Inclusion criteria were: currently employed as outreach workers; 18 years or older; a minimum of six months' experience in outreach work with the homeless; employed in one of five agencies contracted by the city to provide outreach services. The sampling frame consisted of approximately 25 outreach workers in the agencies comprising the city-wide collaborative with the shared goal of providing outreach services to the chronic and at risk street homeless population.

An effort was made to recruit participants from each of the five agencies in the collaborative. Initially, the researcher informed the city director of the topic and plan of study. The researcher was subsequently invited to attend a regular monthly meeting of team agency supervisors to provide an overview and speak to the goals of the study and to distribute a template letter for agencies to use if they agreed to provide approval for recruitment among their staff who met study criteria. All five agency supervisors provided letters giving the researcher permission to locate the study in the agency, subsequent to obtaining approval from the Human Subjects Review (Appendix A), the researcher contacted each of the agency supervisors by phone and e-mail, and provided a recruitment letter (Appendix B) addressed to eligible participants that would be disseminated by supervisors to staff meeting the study criteria. As this method of recruitment yielded one participant, the researcher subsequently contacted each of the agency supervisors by e-mail and phone, offering to present the goals of the study in person to potential participants at agency staff meetings, when necessary and possible, to motivate study participation. Three agency supervisors agreed to make these arrangements. The other two renewed their effort to aid in recruitment and claimed an in-person presentation of the study by

the researcher was unnecessary. The researcher attended a total of three agency staff meetings, reaching a total of 13 staff including two supervisors. In addition, to further support recruitment efforts, following the completion of each interview, the researcher requested of each participant that they let other eligible workers know of the study. In a final attempt to recruit potential participants from all five agencies, another email was sent to one agency supervisor to remind staff of the study and the deadline for indicating interest. These methods proved more successful in yielding a sizeable final sample.

Workers interested in participating in the study were given a choice of contacting the researcher by phone or by e-mail. Most participants contacted the researcher by phone, with only two participants contacting the researcher by email, and one contacting the researcher through their supervisor. The latter participant provided the supervisor with their phone number to then have the researcher contact them directly. Once contact was made, researcher and participant decided on mutually convenient time and private place to have the interview prioritizing participant preference. Nine workers from four agencies contacted the researcher expressing interest in participating in the study and scheduling a time for an interview. One worker failed to follow through with a scheduled appointment despite three efforts at contact on the part of the researcher. It was learned during an interview with another worker that they failed to meet the eligibility criteria for the study. This left a total sample of seven participants with representation from four of five agencies.

Of the seven participants, four requested having interviews at their agency or work location, four interviews were held in a borrowed office space not associated with outreach services arranged by the researcher, and one participant requested that the interview take place at their home of residence. The timing of the interview also varied, depending on current work

schedule demands and availability, with most interviews occurring during the afternoon and evening time during the week, with only one interview occurring on a weekend, and two occurring in the morning. It should be noted that the study recruitment and interviews took place during the winter months, a time of year when outreach workers' hours are extended and efforts are intensified in view of the potential health hazards for consumers associated with the cold weather.

Pre-study observation

In order to understand the actual nature of outreach work, the researcher spent two morning shifts with one outreach worker with years of experience who was not included in the final sample. The experience of observing the outreach worker in the course of their daily work was critical to instrument development. In particular, observation of the worker's different levels of involvement with consumers, peers, local community members and groups, the police, hospitals, shelters, and other consumer programs led to a decision to include a broad selection of questions to garner a comprehensive picture of the outreach worker experience. A question eliciting participant views on the nature of their work with others and the role it plays in shaping their work was directly informed by the researcher's observations. As well, the fluidity and flexibility that appeared to pervade the outreach worker's experience spoke to a complex role that was not easily defined.

Data Collection Methods

Data was collected via semi-structured audio-recorded interviews by permission at mutually convenient and private locations organized between researcher and participant. Procedures to protect the rights and privacy of participants were outlined in a proposal of this study and presented to the Human Subject Review Board (HSRB) at Smith College School for

Social Work before data collection began. Approval of the proposal (see Appendix A) indicated that that the study was in concordance with the NASW *Code of Ethics* and the Federal regulations for the Protection of Human Research Subjects. Prior to each interview participants were given an informed consent document describing their participation in the study and their rights as human subjects, as well as any potential risks or benefits of participation (see Appendix C).

Once informed consent was given and signed by participants, an initial portion of demographic data was collected followed by twelve interview questions asked sequentially. The basic demographic data included age, gender, race, ethnicity, degree of religiosity and spirituality, and highest education level completed as well as the amount of time participant's had working as outreach workers. The subsequent 12 open-ended questions were intended to bring forth the participants' experiences in homeless outreach work (Appendix D). The topics included three main areas: participant thoughts about their work and outreach work, in general; participant's view of the work they do with consumers; and the third, their thoughts about the larger context of outreach work and the issue of homelessness.

Most of the interviews proceeded without interruption. One interview was inadvertently interrupted briefly by a supervisor but the interview was still completed. Another interview had to be periodically paused because of technical difficulties involving the audio recording software. The issue was resolved and the interview was completed. One interview was interrupted by a work phone call that had to be taken but was completed after the call was taken. The same interview was also interrupted by the arrival of a consumer at the office where the interview was being held. That interview continued after the consumer was provided help and offered resources to help their situation. In another interview, the last two questions were

combined because of time constraints, however, content from all questions were covered by the participant before the interview was over.

All data obtained and notes taken by researcher were kept separate from informed consent forms and given identification labels. All identifiable information from participants was removed or disguised from transcriptions and findings in final thesis project to protect identities of participants. At times the researcher clarified questions and gave time for participants to elaborate on questions. The average length of the interviews was 31 minutes with a range of 20 minutes to just under an hour.

Sample Characteristics

A majority of participants identified as male and African-American or Black. All except one participant were over the age of 36. The sample educational level was divided between high school (N=3) and advanced education beyond high school (N=4). The mean years of experience in outreach work was 7.26 years with a median and mode of 5 years and a range of 10 months to 15 years

Data Analysis

Each question response was coded for themes, positions, and beliefs that underlie their responses. In addition to emerging themes in the topic areas covered, findings suggestive of associations between worker characteristics and particular perspectives on outreach work were examined.

The researcher transcribed the audio-files. Once transcribed, the researcher began coding data by adding initial comments to transcribed materials consisting of extrapolated emergent themes particular to the responses given by participants. Any quotes from the participants that seemed poignant expressions of particular themes were noted for inclusion in the findings

section. The coding process further consisted in the researcher reading each interview numerous times, analyzing interview content for relevant and repeating themes, as well as noting material that did not fit into thematic areas. Themes were compiled by question to look for consistencies and patterns across numerous participants.

CHAPTER IV

Findings

This chapter will present the findings of a qualitative analysis of interviews with homeless outreach workers about their perceptions of their work with chronically homeless consumers. The findings begin with an overview of participant responses to questions regarding their thoughts and perceptions on the role and experience of the outreach worker, others' views of outreach work, the role of "relationship" in outreach work, how participant social identity is perceived to interact with outreach work, causes of homelessness, needs of consumers, and program design. Analysis of participant responses revealed the overarching theme of the outreach worker as the key grassroots partner that assumes multiple roles in the consumer-centered milieu of homeless outreach work. Discussion of this overarching theme will include explication of the roles played by the outreach worker. Five salient themes are descriptive of the multiple roles assumed by participants in the course of carrying out this work, including: (1) having to do the work others want done; (2) being an advocate for homeless consumers; (3) being "somebody to talk to" for consumers; (4) being an insider critic of the homeless services milieu; and (5) being the salesperson to a new life. This is followed by discussion of themes that emerged in an analysis of participant responses regarding their experience of outreach work. Their experience of their work will be understood as (1) disenfranchisement; (2) empowerment; and (3) presence, or existing where the consumer is at. Illustrative quotes will be used throughout.

Question Responses

Demographic data. Data on the following characteristics of participants were collected: age group, gender, race/ethnicity, educational level, spirituality/religiosity, and years of outreach experience. A majority of participants identified as male and African-American or Black. Three of the six participants who responded to the question regarding their highest level of education reported having a high school diploma or GED while the other three reported at least some college with one having a two-year degree and another having a graduate degree. All except one participant were over the age of 36. The mean years of experience in outreach work was 7.26 years with a median and mode of 5 years and a range of 10 months to 15 years. Of the six participants who answered the questions: "On a scale of 1 to 5 (5 being the most, 1 being the least), how religious of a person do you consider yourself? How spiritual of a person do you consider yourself?" all indicated some degree of religiosity or spirituality, with most participants indicating average-to-higher levels of both. Of these, only one participant responded differently between religiosity and spirituality, reporting a "1" and "5" respectively.

What led them to this work. In response to the question, "How did you come to do this work?", all seven participants referenced a personal contact - friend, coworker, or peer - who had told them about outreach work. Four participants transferred into homeless outreach work after having worked in some other aspect of homeless services including shelter work, case management, or volunteer work with the homeless.

Perceptions of the role and experience of outreach work. To the question, "…how [do] you see your role in work with the homeless population…What's your experience as an outreach worker?", participant responses varied, with the most salient theme being the experience of their role as a facilitator between different parties in the system. To the follow up

question about how the role of the outreach worker was seen by others (including consumers, community residents, and other stakeholders) and whether these views impacted their work, most participants initially responded with positive perception. Examples include statements such as "They tip their hat to us…for being out there…Other homeless services, we are in harmony with one another. We really know what it is we out there doing," or "I think they see it as a positive thing…I think they see it as a good thing." All participants except one, however, added negative or neutral perceptions such as, "It ranges from not knowing what we do, and an appreciation for helping people. I don't know if there's a very wide knowledge in the community about what outreach workers do," or "I think the consumers, basically…it's a love hate relationship. When they want something or need something they love us, when they don't want to be bothered and don't want to engage us, they hate us."

Four participants indicated that the views of others did not influence their work, and two responded that the views of others positively impacted their work. One participant provided a specific literal way in which the consumer's view of the outreach worker impacted their work.

> R: So it impacts your work because cyclically….
>
> P: Yeah, cyclically, if they're just accessing us when they need something or want something, that's not actually very beneficial to their progress or their treatment then…um, I don't know… I'm not sure how to say that exactly, but just people that don't necessarily want or don't seem to want long-term help or really make a lot of changes…they maybe just want a ride to let's say a shelter, or maybe they want clothes or something, and that's great because we have to provide it for them, and we have to be helpful but at the same time it's not really promoting long term health. I don't know if that makes sense.

Lastly, to the question, "As an outreach worker, what does decision making look like? For example, the kinds of decisions, consulting with others or collaborating, ethical questions, safety, or unclear situations", most participants reported clarity and context-dependency in their decision-making process. Two specifically mentioned confidence in their quick decision-making capability. Two others mentioned that decision-making never need be involved in a grey-area given the phone resources available for consult. Only one participant made reference to the primary role of the consumer in decision-making:

> Far as decision making I'm going to say that the decision is always up to the consumer if they want us to help them… It's not my decision to make where you sleep tonight…If you try to force a person they don't want to go, they're not going to go with you anyway.

Similar to protocol addressing suicide risk in the mental health profession, in practice, many participants reported erring on the side of a conservative approach in making the call for involuntary hospitalization of a consumer if there is any question of safety concern. As expressed in the following quote from a participant, this default stance may be problematic:

> It is a major judgment call who stays on the streets. Sometimes we have to [involuntarily commit] people. I always tell them first. 'It's too cold out.' 'It's a code blue.' 'If you don't come with me….stay in the shelter for just one night, or an overnight café, which is usually in the church, men and women mix, sleep on the floor – I'm gonna have to [involuntarily commit] you.' Because I don't want to… I think they need to be informed when they are [involuntarily commit]-ed. A lot of outreach workers won't tell the consumer when they are [involuntarily commit]-ing them. They'll do a sneak attack and that's in my eyes a shame.

Perceptions of "relationship" in outreach work. In response to the question "In outreach there is a lot of talk about building 'relationships' (with consumers). Tell me about your thoughts about that relationship – for example, what does 'building relationship' with consumers mean to you?" and "How do you go about forming relationship with a consumer that will 'make the work happen'?", all participants agreed that relationship was integral to outreach work. Three participants found meaning in being a "people person" who could build relationship easily, in being a person consumers could come to about anything, and in the awareness that the particular vulnerability of the chronically homeless consumer requires patience in relationship-building. Three other participants moved directly into a description of how relationship building happened without first commenting on what building relationship meant to them personally. One participant, although initially describing relationship building as simply "maintain a good working relationship" with a consumer, followed with this, "I think it's important to establish a rapport with a person because sometimes folks just want somebody to talk to." This straightforward and intuitive understanding of human-to-human connection as important for all people pervaded the interviews of all participants in ways that will be explored later on in the discussion of emergent themes.

Perceptions of social identity as a factor in outreach work. To the question "How do you see your social identity – that is, race, gender, age, education level, class – affecting your work with consumers, if at all?", three participants denied any impact and four participants admitted that their identity affected their work with consumers. One participant who believed it did not affect their work referenced their experience in the field as superseding any importance of social identity.

> I don't think any of that affects my work. Like I said I've been working with the homeless for [X time]. I started when I was [X age], I'm [Y] now. I think I'm a pretty even tempered person. People don't have a problem talking with me. I don't have a problem talking and listening with them.

Another participant who believed that it did impact their work, also described this as a hurdle that was overcome by the relationship over time.

> Um, I think so at least initially. I'm [age], X race, and X class. I'm not even X class, I guess, but that's what they think. So I think initially it can be very…if I'm working with someone that's [different age group] [Y ethnicity person] that's lived in [X city] and smoked crack all their life …um, I got told by them that, a number of times in this project that …they often reminded me of my age and race and where I'm from as a means that I couldn't speak on their life or couldn't provide any advice. I think that's an initial thing I have sometimes, but I also haven't found that it's a barrier that lasts very long. People on the street tend to find more validity and more care in the way that you speak to them, the way that you treat them, then ….if you can show consistency, if you can show care, if you can show that you follow through, that you can listen to what they are saying and not be judgmental and actually showed some type of care, then in general, they overlook it.

Finally, one participant definitively stated that gender stereotypes of approachability affected consumer-outreach worker interactions. This participant also shared the belief that difficulty overcoming differences between outreach worker and consumer social identity might result in (or lead to) a worker's decision to leave.

Perceptions of the causes of homelessness, needs of consumers, and program design. To the question asking about their perceptions regarding the causes of homelessness, all

participants indicated that homelessness was caused by multiple factors. In addition to mental health and substance abuse concerns offered by most participants as primary challenges associated with the condition of homelessness, three outreach workers mentioned insufficient social support as a cause of homelessness. This sentiment is expressed in the following quote:

> I would say, underlying all of [those reasons], is a lack of support with families. I say, 9 times out of 10, if you talk to these guys, they are not connected with their family or they don't have a good relationship with their family. Very sincerely, I don't know if I've ever talked to anyone on the streets that has a good connection with their family or friends. I don't think I've ever heard that. Some of the guys that are "better off" seem to have it more together have better support networks. They might stay in at a friend's house for a while if they need to. The hard core street guys they have no connection with family.

In response to the part of the question asking, "What do you think would remedy the problem," three outreach workers' responses reflected feelings of hopelessness, including a feeling that there is no will on the part of larger society to finding remedies to the problem and that individuals lack the personal and financial resources to change. This hopelessness was captured in the following, "Far as a remedy for it. Honestly, I don't see a remedy."

To the question asking what they felt their consumers needed, participant responses varied. The most frequent response included a focus on individualized programs or services targeting individuals' specific situation. Other responses referencing the needs of their consumers included a strong will to change, a greater support network, and housing. An additional reference to housing needs, mentioned by three participants, appeared in another participant's response that homelessness was considerably more complicated than having enough housing. Here they explain one consumer's mindset.

> I think everyone needs a place to call home, I understand that. … one guy I know …he's not at all interested in going in. … he says, 'because it's quieter out here, it's better to be out here, it's better to be away from people." …I don't know, … For [him], I don't know if the ultimate goal is housing. I don't know exactly what it would be maybe but ….I don't know some people think that if you put people in housing that all the needs are going to go away and they are just going to kind of be all good, and I don't necessarily think that that is true.

In response to the open-ended question, "If money wasn't an issue, and you could design a service, program, or organization specifically for the needs of your people, what would that look like?", five participants responded that they would create a large multi-disciplinary social service hub where consumers could find individualized support. Of the remaining two participants, one responded that they would feed these consumers as much as they could and the other focused on consumer willingness to access already existing resources in lieu of providing their thoughts regarding alternative program design.

Key grassroots partner means having multiple roles

Homeless outreach work by its nature rests at the fringes between society, a social service system that has often let consumers down, and the consumers themselves who bring a wide range of experiences to this outsider status. Outreach workers both explicitly and implicitly understood themselves as the pivotal piece that connects this complicated picture. This notion was shared by one participant in this way. "I think the outreach worker has a real key job on the grassroots level to encourage someone who's homeless to come in, or to get services I should say." The multiple roles with which participants identified as components of outreach work was not surprising,

given their perception of homelessness as complex and dependent on multiple factors. The following emergent subthemes reflect the variety of roles participants experienced as a group.

Doing the work others want done. Participants often expressed the feeling that their work was both influenced by and subject to political, agency, or community pressure. Often this took the form of doing the work others did not want to do, doing the work others prioritized that might not necessarily be reflective of consumer need or interest, and a general report of being used by agency and consumer alike. One such pressure emanating from the community was captured in a participant's response.

> You know X neighborhood? The people that live right there in that area decided that they were tired of having homeless people sleep [there], then we spend [x months] on [x neighborhood initiative]. So definitely [others views] impact it, whether for good or bad, I don't know.

The perceived and real pressure exerted towards outreach workers to obtain consumer contact data for entry into the city's databases, as well as the use of recorded contacts as a means of determining eligibility for services, was reported as negatively affecting their work by two participants. The following quotes reflect the ambivalence shared among most participants regarding this aspect of the work.

> I don't understand the process of being picked. … So it's supposed to be whoever has the most contacts…contact sheets. Right? Which I think is not good. You could have somebody out there for 20 years that an outreach worker doesn't even know because they fly low under the radar. They're not screaming or yelling, they're not laying on the pavement being drunk, they're not in the parks, they're not in the business distr….you know what I mean? They're a loner, and there's a lot of them out there. They've been out

there for 15 or 20 years and maybe only 1 or 2 outreach workers know them. So they're not going to have the other contacts.

When you are looking at somebody who wants to get into a certain kind of placement and they're not eligible. So that's really the only time [decision making] becomes a problem because then you have to look at eligibility requirements for places and that's great, but at the same time what if its somebody who could really benefit from that service, but for some dumb reason they don't fit the criteria. For instance, a safe haven really good for mentally ill men, but one of the requirements is a certain number of outreach contacts but they don't have that amount of outreach contacts but we know they are out on the street, then it becomes a weird issue. Just kind of things like that.

Other pressures created by the documentation of contacts that were mentioned by outreach worker participants were how having to get contact data from consumers interacted with an already challenging atmosphere to earn consumer trust. Similarly, the focus list, a prioritized list of consumers partially constructed from number of contacts, at times symbolized the pressure for timely and streamlined interactions with consumers, an essentially external pressure with which they felt they must comply. Here, one participant poignantly highlights this pressure, and another highlights its benefits.

As we do contacts consistently with certain consumers, you build relationship, then you get their trust. Get their information into the database. I mean, everyday they see me you know, "Give me your contact."…But you have to build that relationship before you get the information that goes in the city database so that they can get the help they need.

> We try to keep everyone in the focus point of the participant to service them as best we can, which is why we have focus lists. We have case managers to work with us, the police, other agencies. It's slowly coming together. We are getting more of a continuity of care who still might fall through the cracks.

One participant pointed out how agency pressure towards documenting contacts leads to a potentially harassing experience for consumers:

> There is a very thin line between doing outreach and harassment. You know if I get a phone call about a guy on [X street and Y Street] and he keeps telling me 'I don't want to be bothered with outreach workers, I don't want an apartment, I want to be left alone.' Then I need to tell the people who are giving me the call and my supervisor, 'This is harassment now." They don't see it like that. Because if you are in the community, in the business district, you know, so who do you listen to? Do you listen to homeless individual, or do you listen to your boss? Because if you don't listen to your boss you're going to be written up and/or fired. And that's a shame, that the outreach worker, who's been on the streets for years, is telling you, 'he feels like he's being harassed and we need to back off.'

Participants voiced a feeling of being used in situations in which the focus of their work was or could be easily influenced by the demands of different stakeholders, including community members and other homeless service agency staff. One participant referred to the feeling of being used in the following way:

> We can kind of tell when the police or the community have particular interests. We can always tell right away. They might be asking, or we might all of a sudden see a whole bunch of people that are told they are supposed to move or not allowed to be where they

are. Maybe they were bothered by the police or different things, and that usually comes from some political agenda of some type. … So, I think it affects it in that sense.

This sentiment was applied not only to community and institutional stakeholders. The same participant pointed out how this played out with consumers.

I think from the client's perspective… there's a tendency for everybody to….not just with homeless individuals but….there is a tendency for people to get what they can get out of us. That's why I said a way to use us and get what they want. If they know outreach workers will give them tokens, or if they know an outreach worker will give them coffee or lunch or something, I think sometimes that they….or provide transportation….then I think sometimes they have a tendency to abuse that access. And to just…if it's towards the end of the month and they don't have money, they know they can call us, and they know we'll help them because we're obligated to in some senses.

Advocate for homeless consumers. Being a key partner at times entails advocacy. As seen in the literature, advocacy services provided by some agencies and outreach workers can take the form of national initiatives to end homelessness (Crane & Warnes, 2005); on an individual outreach worker level, however, this advocacy takes different forms. An advocate role can include educating, defending, making effective use of available resources and support, and knowing when to take action on behalf of someone. Participants found themselves playing an educative role with various community agents with regard to issues of homelessness and on behalf of homeless consumers.

A lot of them don't understand. They see us engaging with the homeless person…I've been questioned a lot by people. "How come you're not getting them off the streets? They shouldn't be here. They've been here for years." And then we have to explain to

> them that we can't force them off the streets. This is their choice. And then its like, "They're mentally ill!" But mentally ill people have rights also. You know? We have to respect their rights. So its like you have to constantly….because you're not only dealing with the homeless person, you're dealing with the community as a whole. The business owners. The residents. Women with their kids, because a lot of homeless congregate through the parks, you know? And it's like you are …almost defend[ing] the homeless person.

One participant expressed the ease with which they could access other providers and insinuated its usefulness in outreach work.

> It's actually very useful, um, because we are very highly protected. I can pick up the phone and pretty much get whatever kind of information I want just by saying I'm an outreach worker. Um, I can talk to so many different agencies and so many doctors, psych units.

The same participant, in response to the question regarding the role of the outreach worker, beautifully encapsulated the essence of advocacy: "So I think the role of the outreach worker is just finding connection with people and advocating and helping them get out of their own way a lot of the time."

"Somebody to talk to". Participants voiced the perception that, for the consumer, the outreach worker is simply someone to talk to and connect with. While on its face this may seem unremarkable, it is of utmost importance when considering that lack of social support or precarious ties to a social network is a contributory factor to the vulnerability of a population (Mechanic & Tanner, 2007). Being someone to talk to most closely connects with a psychotherapeutic function. Similar to therapists, outreach workers offer a listening ear to the

chronically homeless consumer. As per participants' report, this seems to be the role, or service, of which consumers take the most advantage. From the participants' viewpoint, it is also what is most likely to lead to consumers' accessing or reengagement with other social services.

> Being consistent. … Always, at least acknowledging them, speaking to them. Being a good listener to them when they just want to talk. …Pretty much just maintaining a good working relationship with the person. … Some people will try to talk to you for an hour straight if you let them do that, I mean, it's a long shift so we usually let a person talk if that's what they want to do and then, if I see somebody else, that may be in more of a need in just the area. Kind of let 'em know. 'I want to hear what you are saying but I see so and so over there is trying to get my attention, he may want to go in tonight so let me go see what he wanted. If you still want to talk, I'll come back and talk to you.'

This listening is not limitless either, one participant noted.

> It's a very long long process and I believe most of it is by listening and having no judgment, none. For me, I do set the boundaries. I tell them, I'm not their friend, because I wouldn't let a friend sleep on the streets. I'm not one of their peers. I'm not their 'home ---'. I'm an outreach worker. This is what I can do. And this is what I *cannot* [emphasis added] do for them. I cannot lend money. I don't buy them food.

As this participant quote indicates, the consistency in listening extends to the consistent offering of other tangible and intangible services for consumers. Although this participant claims to avoid buying food for consumers, the outreach workers in this study do employ a strategy of consistent offering to consumers. This takes many forms, including referrals to physical services such as shelters, D & A programs, and food banks or physical goods such as socks, tokens, food coupons, or coffee.

Forming a relationship with consumers reflects a principle thought to be effective in outreach work (Levy, 2000). Building this relationship, similar to alliance building in psychotherapy, can be thought of as offering a client or consumer unconditional regard or lack of judgment (Rogers, 1961). In the vein of being at the forefront of homeless services reform, the outreach worker employed a similar condition-less offering of time and a listening ear on the consumer's timeline – a truly extraordinary practice in a time of pressure towards measurable outcomes and practices in social services.

> I wait on them [so] they know who I am. For them, I don't try rush 'em into nothing, you know? I take my time with that because you might run 'em away. I don't want to run 'em away. I want to keep 'em.

Reflective of the literature describing "stages of change", one outreach worker observes differences in consumers' readiness for change through their ability and resolve to ask for help (Prochaska, DiClemente, & Norcross, 1992). "Some people don't ask for help. Or don't know how to ask for help."

According to the literature, the outreach worker does experience challenges and obstacles in connecting with consumers and co-workers for various reasons (Blankertz, Cnaan, White, Fox, & Messinger, 1990; Fisk, Rakfeldt, Heffernan & Rowe, 1999). Emotional groundedness, balance, and stability came up for one outreach worker as important in their ability to remain calm.

> I don't need a whole lot of stress and drama. But whenever that comes up, I'm bottom line saying, I'm learning to focus on [Self-Referencing Name] now. And it's good to help people, but you can't help nobody if we can't help ourselves.

This participant's allusion to stress in outreach work is supported in the literature discussing the potential for burnout in outreach services (Nelson, Johnson & Bebbington, 2009). Another participant was more specific about their internal experience of managing their emotions of their work, providing insight into the unique boundary-setting challenge facing outreach workers.

> Emotionally, I've found a way to detach myself when I go home. Because emotionally it can take a toll on you. Because you do form bonds out there. I'm seeing someone everyday, or twice a week for [X time], I do have a relationship with them. I try to keep the boundaries as tight as I can be. When they die or get sick, it does take an emotional toll on you, it's hard not to think about the person.

Another participant described letting consumers too close emotionally as potentially problematic.

> It's a risky job. Uh, emotionally, I've learned to deal with my emotions as time went on… I don't get too involved emotionally with the job because I know it's risky…uh… I lose interest. Know what I mean? So I keep myself balanced in that area.

Most participants saw relationship and trust-building as primary to the work of homeless outreach. The one participant who emphasized relationship as a means to an end goal of placement still revealed the necessity for respecting the consumer's pace. The following quote speaks to acceptance as a key element in making the connection with consumers.

> "When you ready, let me know. Then we can do the paperwork." And that's basically what it's about. Know what I mean, if you get a relationship in between that, it's fine and good, but the thing is, you're trying to get them into placement. That's it.

This participant played down the importance of relationship in favor of placement in the context of service delivery. Interestingly, the same participant was the only one to include an allusion to a consumer's tendency to return to visit peers and outreach workers in the field after having

already obtained some sort of housing or services. This speaks to the implicit understanding, on the part of the worker, of the value and importance of relationships formed in the course of outreach work, despite a stated emphasis on placement as an end goal. In this poignant statement, the participant again plays down the relationship but does so from a place of wishing a better future for consumers. In this way again, the participant demonstrates the genuine relational care outreach workers have for their consumers.

> I mean and then when it's about housing, it's about keeping the housing. "Don't come back out here." (*voice of outreach worker*) It's about keeping the housing. You don't have to come back out here and let everyone know how you doing. You know, that's just a trap for you. You know, it's all right to come through sometimes but keep it moving. Live life on life terms. But a lot them still come out here.

Acceptance and empathy, in particular, are often tools for therapists. Here one participant's description of an encounter with a potential consumer expresses the use of similar tools.

> Well I think it's like, say you if you're a homeless person and I come up to you, and I'm like, hey George 'how's your day?' And you're having a really bad day. I don't know this, it's my first engagement with you of the week and you're just like, 'get the fuck away from me.' I don't take that personal. Or you might even throw a bottle at me and miss. I'm not going to hold that against you. Number one, I'm being verbally abused or that you threw something against me. I'm going to say, 'George, it's not necessary to treat me like that, but when you're in a better mood, you know how to get in contact with me.' I keep the boundary but I walk away. And I respect where he's coming from. I'm not going to sit there, stand there and argue with him. I'm not going to get in a shouting

> or cursing match. It's useless. So that's where the good attitude comes in. … I don't take nothing personal. Nothing whatsoever from them. I've been yelled at, screamed at, things thrown at me, you know, I just keep it….its not even professionalism, its just the way I am as an individual. I don't let their emotional outbursts affect me whatsoever, but I keep that boundary with them and remind them. You know what I mean? That I'm not going to accept that, but I'm not going to hold it against them.

To this participant, acceptance, respect, and consistent offering, all tools of the therapist, are what is needed in holding the client's often volatile situation.

Insider critic of homeless milieu. Throughout the interviews, participants made critical judgments regarding which groups or individuals have ultimate responsibility for facilitating the connection of street homeless consumers with services aimed at helping them "come in", as well as removing barriers to this connection being made. Some attributed the state of homelessness to the consumer; some recognized the problem as systemically caused. In line with the former viewpoint, one participant's response spoke to the consumer's willingness to access services.

> [There]'s resources available for them, but like I said, you got to be willing. If you ain't willing, it ain't gonna work. We got places for them, we out there for 'em everyday. There's places for them. But once we take 'em there, they got to do the footwork. That's the thing, you know what I mean. They don't do the footwork.

Another participant stated, "The resources are there for them. But it all depends on their state of mind, whether they will pursue any of them. That's the hardest thing really."

These participants refer to this lack of willingness as a tangible barrier to connecting consumers to resources. As expressed in previously quoted material, eligibility criteria for resources were noted as perceived obstacles to consumers' access to needed services. Three

outreach workers took the stance that eligibility requirements or other criteria based on number of contacts presented an obstacle for consumers. One of these workers expressed support for reducing barriers to service provision through mention of housing first models of service:

> We need more programs like that. They don't put all those demands on people that you have to have this to get into this program, you have to have that to get into that program. You homeless, you eligible for housing first. That's the requirement.

Two other participants never mentioned criteria or eligibility requirements as a barrier. One of the remaining two participants accepted eligibility criteria as part of the decision-making process, and the other expressed frustration in conforming to eligibility criteria that was just part of the system. The latter is expressed in the following, "there is a criteria we have to follow. So I've been learning not to get so frustrated and follow the criteria."

Another participant conceptualized barrier to service provision for consumers as a mentality that the consumer might adopt.

> My experience with a lot of the homeless … they are …mentally homeless. … it gets complicated for them to figure out how they are going to come up out of this. And even when you trying to help them, … they get in the way, because of their mental illness. … A lot of people out there they got so accustomed to living like [this], that they don't know any other way.

On the other end of the spectrum were the participant responses that critiqued the mainly systemic inadequacies perceived as contributing to the continuing problem of homelessness. One participant thought that the system was not really interested in ending homelessness.

> I think, deep truly in my heart, that the decision makers, the politicians, the mayor, whoever, I don't think they want to stop homelessness, whatsoever. They come up with

> these X plan, then it's Y plan, then it's Z plan. I don't think United States as a whole wants to stop homelessness…No they're not cutting it. It's just so that they can say they have a policy, so they can say they've had a plan. They've been planning for [some time]. The homeless population is growing and growing. It's just to keep the communities….I guess the politicians or whoever makes the decisions are like, 'see, we are trying to do something with the homeless population.' You know what I mean? I think it's just a subject for people to talk about who makes the decisions.

One participant particularly struggled with balancing frustrations at the system level with a belief that the homeless consumer had an equal part in improving their situation. The following quotes by the same participant highlight this push and pull.

> it's just something that I think stressful that happened for me, the lack of continuity, of a person getting the services when they coming out of prison, coming out of the hospital, … someone might not have followed-up on their part. It's not the homeless person's part, it's not them. They gave me the problem. Mostly I got frustrated with the system itself.

> I've gotten better with not trying to critique the system, and become a part of a problem as opposed to the solution. Sometimes, the solution isn't always like what I might like to see with an agency, … And the person has to do likewise. … you just have to let the system do, and let the process take its own course. So I try to encourage folks to just follow the procedure. … you still have to work with the system to some degree. I assume you can't change things over night by myself. So you just kind of have to buckle yourself in so to speak and just take the ride.

Salesperson for a new life. Participants referred to themselves as [a] "people person", implying a good fit between the nature of this work and their personalities. This self-designation seemed to add a layer of meaning to the participant's work. One participant stated, "but for me this is my passion in life." Another participant's lived experience with homelessness also added an additional layer of meaning to their work expressed in the following, "the giving back thing and that gives me… appreciative, being appreciated by somebody."

The connection to being "made for this kind of work" and finding meaning in and appreciation for the work led to a shared sentiment among participants that they were uniquely qualified to "sell" consumers on a different life.

> I see my role as meeting the homeless person where they're at. I don't put no expectations on them. I don't judge them. If they want shelter or placement, they know how to access those services. I just feel like they need to be heard. And my main role is to just listen to them. Build up some trust and then try to sell them a different life. Like I've become a salesperson, about how people can live indoors and deal with life on life's terms without using or staying on the streets. That their day to day doesn't have to be survival of the fittest.

Experience doing outreach work

Outreach workers shared their experience doing their work through different lenses. They expressed a range of feelings, at times disenfranchised, empowered, or with a sense of existing or understanding where the consumer was "at".

Disenfranchised voice in homeless services. Being the key partner situated between the service system and the homeless consumer was often reported as having an embedded sense of powerlessness. Similar to their feelings of being used to accomplish the work others wanted

done, disenfranchisement for participants included feeling unappreciated, feeling low in rank at their agencies, feeling less than, and feeling disappointed in the treatment of others towards consumers. One participant spoke frankly of their perception of the way in which outreach workers were viewed by their peers in homeless services. “Nobody wants to be an outreach worker, they want to be a case manager, they want to be an after-care…it’s like an outreach worker is extremely low … It’s a thankless job.

The same participant continued to express this sense of being treated as “less than”:

> How other coworkers see us, we’re extremely low on the totem pole, extremely low. I think, even the directors. “OH, outreach, they work with the homeless..” [*said in a disparaging voice*] …They [coworkers] don’t know how to deal with homeless people. Even though, ‘I’m coming to work everyday, you know, I walk by three homeless people, you know, I don’t acknowledge them.’ Your department is outreach, homelessness. You’re not going to even acknowledge the homeless worker let alone the homeless individual.

Being treated as “less than” extended to interactions with the community and other community officials. One participant was ashamed and disappointed at how the community treated or viewed its homeless and therefore, responded negatively to the question “How do you see work with ‘others’ figuring into your work with consumers? For example, community residents, police, elected representatives other consumers, if at all?”

> I really can’t speak on that. (Pause) Because it’s nothing positive. You know, it’s really a shame how people view the homeless. They look what they have on, how they smell, and just forget that they are a person first. You know, and they could be their family. You understand what I’m saying, so it’s always a negative thing. (Pause)

Even though this treatment was not directed at them, this participant responded as though the comment personally hurt them. As will be discussed in the final chapter, this close connection with consumer experience was prevalent throughout all interviews.

Similarly, in a culture of being perceived or treated as less than, some participants observed other outreach workers at times as treating consumers as "less than". One participant voiced this sentiment in the following way, "A lot of people… I can't say a lot of people… some people that does this stuff, that does this work think they up there and they down there. You can't judge a person."

Participants, at times, expressed disappointment with the various agents in homeless services. One participant highlighted a moment when other (non-outreach) workers, involved in the care of their homeless consumer, had let both the outreach worker and their consumer down.

> But the social workers kind of, I would say, dropped the ball. All [they] had to do was make a simple phone call. [They] probably didn't know to make the call. Another person had to make it. And they were frustrated too.

The essence of disenfranchisement was poignantly captured in one participant's expression of frustration at others' perception of their role.

> But if we're the professional outreach worker then you [*seems to emphasize this*] need to respect our ideas, our viewpoints. And I believe they're not respected because most of the outreach workers don't have a college degree. That's what it comes down to. Most of the outreach workers don't have a college degree, um, I can only think of one outreach worker who does have a college degree and absolutely does not like outreach but stays in it because [they] have not gotten a new job yet. So, it's like, 'the outreach worker can't make the serious decisions', or 'they can't give their ideas', or their ideas are just cast

aside because we don't have a degree. And that's what it comes down to… My own coworkers at work. Supervisors. Yeah.

The same participant, in response to what they felt consumers needed spoke what seemed to be the underlying truth for consumer and outreach worker alike.

I think they need more respect, from the community. I think they need more respect from the community, from the professionals, from the politicians, from outreach workers. I think they need…I think people need to stop looking down on them.

This sense of feeling judged was present in other participant responses, this one in response to how the community thought of the role of the outreach worker, "Honestly, the public at large is like, we're not doing our job because they are still on their streets." Another worker expressed the general lack of knowledge.

I'll get someone who says, 'You do such great work, thank you for helping, its really great,' we've also had people come up and tell us to leave people alone that we're talking to…we don't happen to have outreach gear on, or whatever. So I think in general there is a lack of knowledge.

Two participants expressed their wariness of the shelters as a resource. In the following quotes the participants express the challenges shelters face as well as the hesitation of consumers to place their trust in the shelter as a resource.

The hardest problem actually with confidence in resources is the city's shelters and private shelters. Probably the biggest problem with resources. Which is too bad because….they are the biggest ones… part of it is a shortage, but there's just a lot of complaints that come out of the shelters. Some of it's the client's issues, some of it's the staff's. Just thinking about bed bugs is a big huge thing. People won't use certain

resources because they had a bad experience maybe they had bed bugs when they were there or maybe a staff person yelled at them when they were there. I think any resources I would have lack of confidence in would be the shelters, but I think that's because they are so highly used and so big.

Some folks from what they say their experiences are at the shelter are that sometimes the staff aren't so nice, sometimes the other people at the shelter aren't so nice. I haven't witnessed that, so I can only go on what the homeless consumer says to me as to why they don't want to go there. It's probably a little bit of both. I don't think everyone is lying. So, it's probably a little bit of both. Um, so probably a little bit of revamping, maybe some better training for shelter staff and things like that.

Empowered voice in homeless services. Being the key partner at the edge of homelessness was also at times reported as one of being empowered to take certain liberties not easily afforded other service providers. Compared to other civil and social service professionals, the homeless outreach worker relies heavily on the attribute and skill in the use of flexibility and the autonomy accorded them to do their work. One participant highlighted this difference in comparison with police officials.

The police has an entirely different mentality when it comes to the homeless. A criminal is a criminal and a crime is a crime. That is totally understandable. But I think you need to have some flexibility when you talking about someone with a mental health problem, even with someone with a substance problem.

Another manifestation of participants' recognition of the benefits of flexibility in their work with vulnerable populations was the leverage provided by unobstructed access to consumer

records. This was especially true for work that involved facilitating referrals or finding relevant consumer information necessary for a successful engagement with the consumer. One outreach worker highlighted the benefit of this.

> I probably shouldn't say this but we're kind of above HIPAA laws, we're kind of protected by the city and the Department of Behavioral Health so a lot of times we can operate without a lot of restraints which is really really beneficial. I think that's why sometimes we are successful because we are able to jump across things and provide information to people and do things that …yeah….probably can't say that, but… there's also a lot of leeway with us being able to advocate for people. And being able to say, 'no we really think [they are] the best fit,' even if [they are] not eligible [for X program].

Existing where the consumer is at. Outreach workers work at the edge of traditional human service provision for the chronically homeless in that they are physically and psychologically meeting consumers where they are at. Existing where the consumer is at manifests in the physical space outreach worker and homeless consumer share, in the approach outreach workers use to engage homeless consumers, and in the empathic connection or affinity outreach workers have for their consumers and their situations.

As opposed to work that takes place in building-based resources such as shelters, soup kitchens, housing agencies, or D & A programs, outreach workers locate and meet with the chronically homeless wherever they may reside. In response to the question, "What's your experience as an outreach worker?", one participant offered the following.

> Well, physical can be, it does take a toll on your body because you're walking a lot, you're bending down. I like to bend down, meet them where they're at, give them good eye contact. So I'm bending and squatting a lot. Sometimes you have to wake people up

during the winter, and during the summer if it's too hot and they have too many layers on. It can be extremely dangerous. Most homeless consumers do carry weapons. Because they do have to protect themselves. [Work with] the mental health population … most of them are medicated, they do have delusions, some of them could be directed towards us. Then you have the alcohol and drug consumer who will if they don't have the money they will try to rob people or hustle. You know?

Another participant echoed the notion of being at the same level as homeless consumers as both an important and effective use of their physical presence in this space.

Meet them where they are wherever that happens to be. I know that I get some criticism from my coworkers that I sit close to people. That I get on people's level, because they say that that's not safe. Um, but if someone is sitting on the street, I'm not going to stand and talk to them. Nine times out of 10 I'm going to sit down there with them, or at least squat down or kneel down, so that I'm at least somewhat at the same height as their eyes are. … some people stand up and look down at people all the time which isn't very effective, um, so I found that to be.

In this way, the environment of the work is complex, consumer-centered and transient. It requires adaptation on the part of the worker to individual consumer need and circumstance. At times, the space of "where the client is at" manifests as the invisible boundary that the outreach worker must discern in order to non-threateningly engage the homeless consumer. Three participants explicitly expressed a sense that this boundary was important in connecting with consumers, at the same time expressing difficulty clearly defining the nature of that boundary. One of these participants tries here to explain this phenomenon in terms of timing, "I think it's a

lot about consistency and a lot about knowing where boundaries are. Knowing when is the time to back off and let people alone, and when is the time to push for more."

Another participant spoke to the delicate balance that must be reached at times with consumers - a balance best negotiated in the space that the outreach worker and homeless consumer share. In this shared space, participants seemed to empathize strongly with consumers. One participant shared thoughts about how easily one could become homeless.

> It's definitely not that everyone that's homeless is out there on drugs or mentally ill or something like that. Because I see a whole lot of regular folks that are homeless. People that are still working but still can't afford to get an apartment because maybe they are just working at McDonald's or something like that. So they working during the day and sleeping there at night. You know they are saving up money just to get a room or something like that. The thing is unfortunate. I have my own personal friends who have master's degrees and been unemployed for 3 or 4 years, so I know it's not easy…I mean if they can't get a job, this homeless [person] who maybe has no degrees, some of them, it's even tougher for them. I don't judge. It could be either one of us any day. A couple of paychecks short of being homeless.

Several participants expressed statements of genuine humility, which seemed to help one of these participants tangibly take their lead from consumers.

> And they know the system better than us. So with their experiences, they know where they got what seemed to be better treatment, so I let them….letting them make their own decisions. It's not my decision to make where you sleep tonight. I think that's best. My supervisors, they all have been doing outreach a lot longer than me, and that's pretty much what they told me. Let them choose where they want to go. And that's good. If you

try to force a person they don't want to go, they're not going to go with you anyway. [*laughs*] So let them make the decision for their own care.

Another participant referred to learning humility as important in setting an example for consumers about being honest rather than deceitful in engaging the system.

> I guess one of the most frustrating things for me is when someone makes a mistake and they don't own up to it. I had a couple of situations that I was in, [that] I didn't own up to and it was a big stink, a big mess but then I learned to humble myself even more and be honest and take it on the chin if I have to. If I made a mistake, I learned more to own up to it, it could be hurtful and painful … Be honest. Be honest, that's the key factor here. That's what we tell the homeless population. They think lying is going to get them certain services. Just be truthful.

This unclear and varied space (both physical and existential), existing outside the boundaries of what is socially acceptable, exemplifies the unique character of chronic homelessness. This space is one where few service providers enter and one in which only a sub-group of the homeless dwell for long periods of their lives. Both homeless consumer and homeless outreach worker occupy this ever-changing space. One participant expressed their appreciation of being on the frontlines of the effort to end homelessness.

> Now that I've been here so long, I just want to be a part of this. Homelessness. The end of homelessness. And they getting younger. It's not at a rapid growth, but it's growing, it's not decreasing, it's increasing.

CHAPTER V

Discussion

The intent of this qualitative study was to explore the experiences of outreach workers who provide services to the chronically street homeless population. The study elicited participants' in-depth thoughts and perceptions about the work they do. Study findings provide a valuable provider perspective of a generally unknown and unpublicized interaction between a vulnerable population and a service provider.

This discussion will begin with a comparison of study findings to the extant literature on outreach work with the vulnerable chronically homeless population. The discussion will continue with a focus on the most salient findings of outreach worker's perspectives on their work, relating each finding to harm-reduction practices in a relational frame. These findings include the following: conceptualization of the homeless outreach worker as an inherently multi-faceted role; outreach worker experience of clarity and confidence in regards to issues of consumer choice and autonomy; outreach worker feeling of being alone, unheard, and insufficiently supported in their work; and outreach worker reflecting the general paradox or inconsistency of holding both the view of systemic and individual responsibility for changing the state of one's homelessness. This will be followed by implications for practice, policy, and research. A summary will conclude this chapter.

Findings in relation to what is known in the literature

The findings verified varied aspects of what has previously been discussed in the literature. Participants reported being caught in the dilemma of referring to inadequate or low-quality services in order to achieve the implicit goal of connecting consumers with existing, albeit underresourced, programs. Also supportive of the literature on work with vulnerable populations was a reported role of facilitating transition for consumers between varying housing, economic, familial, substance, or mental health circumstances. Participants supported individualized programming, one-stop targeted drop-in-like centers, as well as *housing first* model programs for consumers to support facilitating this transition. Additionally supportive of the literature was participant report of need for a consistent and continuing pattern of care and social support with vulnerable populations (Mechanic & Tanner, 2007). Participants described relationships with consumers that simultaneously provided a rare social contact for a very isolated population and consistent checking-in which was critical to the work.

Participants did not refer to the stages of change model per se (Prochaska, DiClemente, & Norcross, 1992); however, they did report knowing when a consumer was in the mood to talk and/or be referred to some resource. In this way, participants assessed the landscape of consumer readiness for any shift in their current situation. With regards to facilitating connections for consumers with services in which they had little or no interest (Spencer & McKinney, 1997), most participants reported respecting consumer choice unless safety was a concern. In making these decisions, participants reported taking context into account, given potential consumer mental health or substance issues; this finding supports the literature describing the complexity of issues involved in work with this population. Participants frequently reported that the "choice" of a decision was usually clear. This implied that outreach workers did not experience

ethical concerns around consumer choice, although this response may be a reflection of possible weaknesses in the format of the question regarding decision-making, which asked "As an outreach worker, what does decision-making look like?" Although several prompts were included to spark conversation around decision-making which included the kinds of decisions, potentially unclear situations, or situations in which consulting others was critical, participants generally responded formulaically to their experience of decision-making perhaps as a defense of their ability to do their job or as proof thereof. However, since participants did report decisions as, often, clear situations, this did imply a "right" choice. Their use of the word clear indicates an implicit favoring on their part for either client autonomy or client protection depending on the circumstance. Therefore, while on the surface responses appeared formulaic or defensive, in fact, they contained an implicit understanding of the ethical dilemma involved. This further highlights the interaction between client autonomy and client safety in decision making as is currently presented in the literature review.

The literature has just begun to postulate factors that contribute to effective outreach work with specific subsets of the homeless population including substance abuse and homelessness (Fisk, Rakfeldt, and McCormack, 2006), mental health and homelessness (Tsemberis, Moran, Shinn, Asmussen, and Shern, 2003; Tsemberis, 1999), and more generally with the chronically homeless as a whole (Kryda and Compton, 2009; Levy, 2004; Levy, 2011; Ng & McQuistion, 2004). Participants reported a stance of unconditional acceptance in engaging consumers, reflected in the literature on the housing first model which endorses elimination of housing prerequisites (Tsemberis, Gulcur, and Nakae, 2004). Also observed in the literature was a tendency to hire outreach workers with similar lived experiences with consumers (Hidalgo et al., 2011); the report of some participants of histories of homelessness and/or participation in

rehabilitation from substance abuse or mental health services supported this finding in the literature.

The literature on what doesn't work and the challenges present in homeless outreach has been more clearly developed (Fisk, Rakfeldt, Heffernan & Rowe, 1999; Melamed, Fromer, Kemelman, & Barak, 2000; Kryda & Compton, 2009). Participants confirmed that many consumers found it difficult to trust others because of their complex past experiences. They also made reference to the delicate balance between knowing when to engage and when to lean into consumer interaction which may lead to some accessing of services. Also consistent with the literature was the observation of consumer lack of confidence in available services such as shelters. This was additionally supported by participants themselves expressing lack of confidence in resources for reasons including scarcity, quality, and rigidity in eligibility requirements.

As alluded to in the literature on embedded biases that shift conversations (and therefore service provision) between social workers and consumers (Spencer & McKinney, 1997), participants had mostly aversive and defensive reactions to the question about the interaction between social identity and service provision. Of the four participants who responded that their identity did not affect their work with consumers, three appeared to interpret the question as asking whether they discriminated in helping consumers either because of their own or the consumer's social identity or if they themselves had been discriminated against. Interestingly, all of the remaining participants who indicated a belief that social identity did affect interaction with consumers in some way referred to outreach worker-consumer differences they or their consumers observed in terms of education level, ethnicity, race, and gender. Although statistical associations cannot be drawn given the small size of the sample, it is interesting to note that

participants who most frequently voiced the importance of "being with" consumers "where they were at" were also those whose social identity differed in some way from the majority homeless consumer demographic. This may imply an imperative on the outreach worker's part to be aware of differences in social identity between themselves and consumers and to appropriately inquire, understand, and contextualize their consumer's background. Complementary to this would be the tendency on the part of outreach workers who share more visibly recognizable similarities between themselves and the consumers to overlook specific individual social identities and therefore the potential risk to consumer well-being that may result from decontexualitizing a particular consumer's situation.

Homeless Outreach Work as Multi-Faceted

Participants reported carrying out a variety of roles in homeless outreach work, with their most important skills perceived as being their ability to be flexible in their approach with individuals and systems, their ability to listen, knowing how and when to advocate for the consumer, and being consistent for consumers. Their ability to connect with consumers largely depends on locating consumers, the nature of interactions with consumers, whether they have the time to subsequently listen to a consumer, and lastly whether they can synthesize their knowledge of available resources, the current perception of the state of the consumer, and timing to determine whether safety concerns override the consumer's autonomy.

For outreach workers to find and reconnect with members of the chronically homeless population, they necessarily need and are generally given the autonomy to use their knowledge of the local area to locate and/or intuit where a consumer or consumers might be frequenting. Additionally helpful in locating consumers is the network of consumers, community members, police, local businesses, hospitals and other service providers who might provide useful

information to facilitate the frequency of these encounters. All of this requires flexibility, time, and patience on the outreach workers part. For consumers with isolating, antisocial tendencies to be heard, frequent check-ins, a listening ear when they are ready to share their experiences, and their connection to someone with a knowledge of currently available resources and unregimented flexible time commitments, as offered by outreach workers, are invaluable in making connection possible.

Similarly, advocacy for consumers may take many forms for outreach workers. Directly contacting service providers such as shelters, churches, D&A programs, social workers and if need be, "back door"-ing consumers to avoid potential barriers to accessing treatment implies knowledge of multiple systems, program requirements, and their consumers' current situation. Similarly, in weighing the appropriateness of available resources, consumers and outreach workers together may critique and thoughtfully consider current service provision while simultaneously engendering a perhaps regained sense of empowerment on the consumer's part. Also embedded in the advocate role was a community education function. The context for this function included: the inclusion of consumer perspective for new community outreach initiatives being implemented; in response to the inquiries of the general public regarding the frequenting of homeless individuals in a particular area; or in general community forums in response to a blaming of consumers for their homeless situation, invoking outreach worker education with regard to consumer situation.

It emerged through the findings that since the nature of their work requires a variety of roles often necessitating consistent contact with consumers before referral to other resources, continuing contact with consumers acted as the consistent pattern of care particularly helpful to engage vulnerable populations and facilitate their potential reengagement with the broader

system of resources. Considering the variety of manifestations of outreach work with vulnerable populations that include educational outreach for HIV prevention (Hidalgo et al., 2011), community-based early psychiatric intervention with the elderly (Ma Shwe Zin et al., 2009), and assertive outreach nurses (Addis, & Gamble, 2004), it is not surprising that work with one of the most vulnerable populations - the chronically homeless who often suffer from co-occurring behavioral, as well as physical health problems - encompasses a multi-role conceptualization. Just as the parable between Diogenes and Alexander the Great highlighted the need to offer help not tied to a particular outcome with vulnerable hard-to-reach populations (Adlam & Scanton, 2011), outreach worker responses described a heavily context-dependent work practice with a wide range of "successful" outcome definitions.

Whether it is determining the best time to have a difficult conversation with a consumer, or being flexible with regard to what a particular consumer might need, it is hard to ignore the non-judgmental form of this relational work. Similarly, when a consumer is angry and needs space, or when a determination is made that an offer of shelter or other housing is the more appropriate option for the consumer than involuntary commitment, the outreach worker employs methods of harm-reduction which serve both consumer safety and autonomy.

The Choice is "Clear"

Outreach workers reported that decision-making was usually a straightforward, clear process. The clarity with which outreach workers referred to situations in which consumers had finite choices between being involuntarily brought into hospitals and staying on the streets was different from the ethical dilemma presented in the literature (Fisk, Rakfeldt, Heffernan & Rowe, 1999; Melamed, Fromer, Kemelman, & Barak, 2000). The findings imply a somewhat default formula for situations where the potential for safety concerns are an issue. Clarity and

confidence may have been reflective of a reliance on agreed-upon safety measures for potentially complicated situations. The implications for practice – discussed at greater length below – are clear, as being attuned to the difference between an uncomfortable situation and a dangerous one requires skill and training.

As amply illustrated in the findings, outreach workers breach the consumer's autonomy and infringe on the trust building relationship only when safety is an issue. Again harm-reduction in the midst of relationship building is the frame in which the outreach worker exists with homeless consumers.

Alone Together

Collaboration and communication were surprisingly unreported as part of the outreach worker role. Particularly striking in the findings on disenfranchisement and doing the work others want done was the participants' report of feeling alone in their work and feeling not highly valued among peers.

The participant experience of not feeling understood was apparent in the findings. Being let down also fit with this notion. Participants expressed the experience of feeling disappointment in being let down by coworkers and community members in reference to perceived coworker/community lack of effort in understanding their homeless consumers. The outreach worker felt vulnerable to the whims of community interests and homeless services funding, as well as to an ever-changing political attention to the problem of homelessness. Similarly disenfranchising for participants was the reported emphasis on the use of contact database entry and focus lists as a primary guide to service delivery; in the context of continued failure to provide adequate services to consumers, exemplified by over-crowded or distrusted shelters, this emphasis engendered resentment, frustration, and a perception of an additional barrier to smooth

service provision. Perhaps the most striking finding was the pervading sense among respondents that outreach workers were not acknowledged for the importance of their work with consumers. As noted in the findings, one participant stated explicitly that their views were not valued by their own supervisors, as well as by others. Even though outreach workers expressed pride in the work they did, the findings indicate their perception that the greater system values, instead, the number of "contacts" they or the consumer have – sometimes to the detriment of the consumer. The use of outreach contacts as a proxy for meeting eligibility criteria falls far short, in workers' eyes, of an equitable method of documenting need among those they serve. Given the drive in social services for more measurable evidence-based practices this finding was not surprising.

In the space of work with the homeless, no other individual role seems to be closer to the homeless consumer than that of the outreach worker. The homeless outreach worker necessarily must push the limit of what might be considered appropriate, effective, or the norm in working with a vulnerable hard-to-reach population. As seen in the findings, participant report of having the support and flexibility to push these limits implied their perception of value and appreciation by others for their work. However, similar to their homeless consumers, the homeless outreach worker often felt "less than" others in the field of homeless services because their voice was not heard and the expression of appreciation from others for their role too infrequent.

In the course of interviewing outreach worker participants with experience ranging from under a year to over a decade, findings emerged indicating a wealth of experience in outreach work that could be used more regularly to inform practice, policy, programming, and research. The interviews with outreach workers were a unique experience in which they were the focus of study and their own voice the desired perspective. In this way, their responsiveness to questions

in the context of the interview setting was a reflection of an evident lack of any similar opportunity to provide feedback in the course of being an outreach worker.

This finding more than the others illustrates the relational frame of outreach work. Particularly, intersubjectivity regards two individuals with their own perspective and histories, in this case outreach worker and consumer, as two interacting beings that create a new space. In terms of outreach workers' relative disenfranchisement that is both similar and unique to the consumer's experience, this new space can be a space of mutual understanding to some extent. To be understood and heard is a powerful experience that, just as the consumer may experience in the outreach worker-consumer interaction, so it appeared the outreach worker participants also partially experienced throughout the course of their interviews.

Holding the paradox

The findings illustrate an interesting paradox in relation to both the cause of homelessness and the responsibility for its cessation. Among the homeless population, the chronically homeless are largely distinguished as a subpopulation by their repeated decision not to initiate help-seeking (National Alliance to End Homelessness, 2011a). However, on the surface, this characterization appears to contrast with the multiple causes of homelessness mentioned in the literature (Lowe, 2001; Quigley, Raphael, & Smolensky, 2001; Lipman, 2001) and those reported by participants in the study. Outreach workers acknowledged the complexities that contribute to chronic homelessness and still at times provided what appeared to be unidimensional descriptions of the problem. In providing their perspectives on the problem of homelessness, participants often focused on consumer willingness as the primary obstacle to consumers accessing resources. This individualistic viewpoint contrasted with participant responses that at times attributed the responsibility for chronic homelessness to either systemic

inadequacies, professional and societal interactions with consumers, or punitive policies for consumers. This push and pull between an individual versus a systemic focus for homeless outreach was not something highlighted in the literature thus far. For homeless outreach workers, holding the paradox - that the cause of homelessness is both due to often complex and circumstantial forces such as employment, recent disability, economic and social hardships as well as individual choice and preparedness for accessing available resources – perhaps reflects the complex nature of homelessness as viewed by the homeless outreach worker who is privy to one of the closest perspectives to consumers available. Holding this paradox as a front-line homeless services worker has implications for the practice of homeless outreach work.

For therapists, holding paradoxes that consumers are unable to hold at any particular moment is one of the primary functions that they serve. Similarly, it is possible that outreach workers serve an equally important function relationally for consumers: that of someone who can wait and hold the complexity of their situation just long enough for the consumer to re-appropriate control of their life by whatever means they find suitable or dignified.

Implications for Practice

In carrying out the role of advocate for the consumer perspective in homeless services as well as the role of insider critic, outreach workers embody a critically important role in any system where human service provision is the goal – that of the person who empathizes with the consumer of said services. The closer the voice to the consumer, the closer service provision meets the needs of consumers. Opportunities for the voice of outreach workers to be seriously considered consist, in part, in being included in decisions about whether, when and how new neighborhood initiatives might commence; how seasonal outreach efforts such as Code Blue or Code Red are implemented; what types of opportunities may exist for the creation of new ways

in which to engage consumers such as centrally-located or targeted area outreach worker offices; and being represented on organized homeless services consultation committees or meetings.

Findings of frustration with and ambivalence towards eligibility requirements perceived as obstacles to consumer access to resources speak to the need for increased opportunity for outreach worker input regarding flexibility in the application of eligibility requirements for services. Building in opportunities for outreach worker input regarding decisions involving access to scarce services should be seen as a crucial element of program design involving outreach workers, homeless service agencies, consumers, and other resources.

The finding of participant perception of the advocacy role in the form of a community educative function lends itself to several practice implications. First, there is a need for outreach worker training targeting skill development in engaging community members, the police, business owners, and other homeless service agencies around understanding homelessness in general. Second, such training should aim to enhance worker understanding of consumer context in general so that this component of work can be skillfully conveyed to community partners. Third, training should be provided in methods of collaborating with these various community partners in order to create larger networks of helpful support around consumers. Additionally, resources in the form of pamphlets, websites, advocacy groups, and local community representative contacts can help outreach workers offer the questioning public opportunities to continue to understand the situation of the consumer through the encouragement of further self-education around homelessness.

For the outreach worker, or analogously a therapist, the conception of one's role only as "somebody to talk to", is inadequate both as a reflection of the comprehensive role as solitary arbiter of a consumer's ability to live safely, and given what is known about therapists'

countertransference and its influence on the direction of therapy (Berzoff, Flanagan, & Hertz, 2011). With this in mind, an additional implication for outreach worker development is the need for supervision. Such supervision must inform worker self awareness and skills in relationship-building with a vulnerable population for whom the failure of previous interventions by other service systems and habitation in potentially harmful and dangerous situations is more the rule than the exception. Just as mental health clinicians must have an understanding of suicide risk-management, so is having such understanding relevant to outreach work.

In terms of the form and type of supervision that might suit homeless outreach, outreach workers might regularly consult, conceptualize, and plan their complex interactions with an estranged and potentially volatile population. This might be done in a peer, group, or senior-outreach worker format. A practical outcome of such supervision might be a meaningful construction of focus lists in light of this regular, perhaps weekly, supervision. Akin to clinical supervision, this format may additionally serve outreach worker culture in that it may also be a venue for old and new outreach workers to share their experiences as well as channel feedback through senior outreach worker supervisors who presumably will be peer administrators in the macro functioning and management of homeless outreach work agencies.

Similar to the pre-treatment principles for homeless outreach practice suggested by Levy (2000), the findings related to psychotherapeutic practice forms relevant to outreach work as per participant responses might include promoting principles and teaching skills in the arena of humility, showing respect for consumers, giving consumers the benefit of the doubt especially in volatile situations, unconditionally and consistently offering a listening space, learning the timely and at times delicate art of referral making, and keeping appropriate and comfortable personal

boundaries with consumers. The implications for a more clinical conceptualization of the provision of services speak to a need for clinical training.

Lastly, given participants' reported experience of a push and pull between varied external causes for homelessness and the internal motivations and choices that also keep a consumer in chronic homelessness, holding the paradox would appear to be an important component of the outreach worker position. As such, training aimed at developing worker consciousness regarding the ambiguity of causality in homelessness and the need to bring an awareness of this paradox to one's work would aid outreach workers in adopting a lighter hold on particular notions of why someone is on the streets. This might help outreach workers in the development of less rigid boundaries or judgments towards consumers, thus supporting relationship-building with this hard-to-reach population.

Obtaining consent from consumers and partnering social service agencies to use and share partial knowledge of a consumer's medical, psychological, and socioeconomic history and situation was found to be important for outreach workers. The ability to communicate relevant information for the purpose of creating a trusted network of support for consumers appears to be a needed skill among outreach workers. This network is important in supporting consumers in following through with a complex and daunting system. Practice implications of these findings include the need for training in skillful and appropriate disclosure of relevant consumer information. This is particularly important in work that may be more informal in nature, and in which formal consent for disclosure of personal information may not be a built-in component of regular practice with consumers. Worker development of skills in discerning how and when to obtain information, what information is appropriate to share, how, and with whom, will ultimately assist in helping consumers make best use of resources. In the development of new

trainings, the importance of flexibility and adaptability for outreach workers should not be forgotten. For example, in developing trainings around appropriate and practical means of sharing consumer information and communicating between various parties, the issue of confidentiality should be addressed in such a way that it not be perceived as restricting outreach workers from doing what needs to be done on behalf of consumers.

Implications for Policy and Program Development

Possessing a valuable vantage point for homeless services provision, the outreach worker as a critic of homeless services implies more regular outreach worker feedback and involvement in policy development and in the creation of new and even temporary services that can improve service effectiveness and housing retention among this population. For example, outreach worker input could inform consideration of the need for funding of non-clinical support groups that may deter social isolation, end of month meal and transit services for consumers who are without resources at this time, and building in opportunities for involvement with past consumer peers interested in staying connected to the support network that may have helped them get off the streets.

Mitigating the factors that disenfranchise, inhibit, put pressure on, or deter from outreach workers' engagement with consumers is of utmost importance. Given findings that point to participant perceptions of others as not seeking outreach workers' perspectives on the work they do, it is important for policy makers as well as agency executives to develop forums for obtaining outreach worker consultation and input in the development of new policies or practices. As well, given findings of the multi-faceted nature of their work, it follows that outreach workers should regularly be given venue to suggest, design, and implement changes in the current focus of resources. Finally, given findings that indicate worker's feelings of being

subject to the changing pressures of agency and communities, their inclusion in the planning and creation of outreach work implementation and focus would contribute to a deserved sense of empowerment in the field. As noted above, the need for outreach worker supervision that is more focused on the outreach worker-consumer interaction may warrant the creation of new positions in outreach worker agencies, perhaps more properly contextualized as a peer or senior experienced outreach worker positions.

Just as the participant who reported that their "above HIPAA" status afforded them flexibility in delivering and receiving information about consumers and programs, so might a newly conceived role for the outreach worker as "systemic advocates" for consumers help to dynamically shape service provision - including counseling, referral and placement - to the specific situation of chronically homeless consumers.

In playing the role of "somebody to talk to", outreach workers fulfill the equally important role of developing a therapeutic alliance with consumers - a seemingly necessary component for engagement with an isolated and vulnerable population. As it takes time to develop trust, rapport, and connection in any alliance, policy and program development may include structures that encourage, rather than simply allow, outreach workers to take their time developing relationships with consumers as they feel appropriate. As participants responded that relationship was integral to the work, the outreach worker-consumer relationship can be conceptualized more profoundly as necessary in order for a shift to occur in the chronically homeless situation. While questions may be raised regarding the measurement of the outcomes or effectiveness of such relationship-building, study findings point to the possibility that the development of relationship should be considered the intervention or sought-after outcome in and of itself. Policies and procedures that give more value and weight to the outreach worker role

in consideration of intervention with the chronically homeless should therefore be encouraged. As opposed to pretreatment, outreach work might start to be considered treatment.

Implications for future research

Given the finding of perceived utility in having access to consumer information that removes obstacles to communication between providers, consumer and consumer support systems, future research should focus on the critical connector role of outreach workers and the extent to which this overlaps or augments the current role of case manager. For example, future study could look at the outreach worker role in keeping the case managers, service provider, consumer and their support networks in verbal communication and coordination with each other. Just as health care systems are evolving new roles for patient navigators (Ferrante, Cohen & Crosson, 2010), so the outreach worker role in coordinating, advocating and connecting people and systems is deserving of further study in a changing service environment.

An in-depth understanding of how outreach workers experience, conceptualize, and value their current forms of training requires further research with a larger sample specifically focused on educational and training needs of this workforce. Future evaluation of a range of additional training opportunities, including the implementation of new forums for worker input and peer supervision, should look at the impact of different types of training on worker sense of empowerment, success in relationship building with a range of consumers, agency workers, and community partners. Such research can evaluate the effectiveness of training in important clinical areas that are relevant to outreach worker practice and program development such as relationship-building skills, including active listening, identification and assessment of suicide risk and monitoring, as well as self-care.

In regards to future research on variations in outreach worker supervision, it is possible that varied outreach worker program designs already exist in other homeless outreach agencies. Further descriptive research might highlight such programs, the variety and form of supervision structure, the agencies that do so, and their experiences as such.

Finally, given the difficulty experienced in recruiting outreach workers for this study and in safeguarding confidentiality in a small sample, recommendations for future research would include limiting the role of supervisor in the recruitment process, the use of pro-active methods by the researcher to individually follow-up with potential participants; and minimizing barriers to or delay in interview appointment scheduling.

Limitations in study data and design

This study was limited by sample size (N=7) and non-random method of sample selection. Challenges in recruitment of a sample of sufficient size were pervasive throughout this study. Efforts to recruit a minimum of 12 to 15 participants proved more frustrating than had been anticipated. Several times, participants did not show for a scheduled interview because of busy outreach schedules and second or third jobs. It appeared true that participants were neither used to having time dedicated for feedback and perspective about their work, nor easily able to use free non-work time to have an interview.

The human subject review process necessarily required agency agreement and permission to carry out the study, in advance. Agency supervisors were informed about the study in advance and letters of agreement were signed and submitted along with the Human Subjects Review application. Following study approval, supervisors were asked to pass recruitment letters through staff meetings to eligible participants. It soon became clear that it was difficult to know whether and how outreach worker staff were being introduced to the study. Lack of uniformity in

the way in which potential participants learned about the study presented an additional limitation, affecting both the nature and size of the sample: some participants followed up with the researcher after receiving the recruitment letter with no motivation from supervisors; some participants may have interpreted an imperative to participate because their supervisors were the ones who initially presented or reminded of the study irrespective of the voluntary nature of the study; and still others may have felt more inclined to participate when the researcher presented the study to outreach workers when their supervisors were not present, which happened in at least one case when the researcher came to an all-staff outreach worker meeting.

Supervisory involvement in the recruitment process, combined with a small sample frame, additionally strained plausible efforts towards true confidentiality. For example, some participants chose agency offices to hold interviews, which exposed them immediately as participants in the study. Additionally, in at least one agency, a supervisor asked who had participated from their agency to make the second wave of recruitment easier. Given the small number of eligible participants, these seemingly benign instances were all opportunities for disclosure of participation in the study.

Additionally, the small size of the sample and sampling frame from which it was derived, as well as potential breach of confidentiality in terms of supervisors and other workers' knowledge of participant identity, curtailed presentation of certain components of the findings, ensuring that quotes could not easily identify participants.

Despite the small size of this convenience sample, this study has many strengths. The opportunity to conduct qualitative interviews in a private setting, as well as the range of agencies represented by participants, provided a window into the breadth of previously untapped, rich perspective of members of this workforce.

Conclusion

The finding of a multi-role conceptualization of the homeless outreach worker emerging from this study is helpful in considering a range of programmatic, practice and policy innovations, as well as training and educative opportunities. Such developments will support the autonomy, flexibility, and leverage this position demands given the variety of consumer situations and interactions faced in the field. Further research is needed looking at the efficacy of different organizational forms and training opportunities on homeless outreach worker skill development in relationship-building with a variety of constituents.

The demands of homeless outreach work are many, and yet these remarkable individuals have balanced a delicate field of experiences with some of the most vulnerable consumers in society. Decreasing the obstacles, pressure, and distractions that impede the outreach worker from connecting meaningfully to consumers is the least agencies and policymakers can provide for these people who are at the frontlines of ending chronic homelessness. Increasing the respect for consumers and outreach workers, the conversations about the multiple causes of homelessness in our communities, and advocacy for funding of homeless services is the least citizens and community groups can do to support outreach workers in doing the work that most others find too difficult.

References

Addis, J. J., & Gamble, C. C. (2004). Assertive outreach nurses' experience of engagement. *Journal Of Psychiatric And Mental Health Nursing*, *11*(4), 452-460. doi:10.1111/j.1365-2850.2004.00742.x

Adlam, J., & Scanlon, C. (2011). Working with hard-to-reach patients in difficult places: A democratic therapeutic community approach to consultation. In A. Rubitel, D. Reiss, A. Rubitel & D. Reiss (Eds.), *Containment in the community: Supportive frameworks for thinking about antisocial behaviour and mental health.* (pp. 1-22). London England: Karnac Books.

Allness, D.J. (1997). The program of assertive community treatment (PACT): The model and its replication. *New Directions for Mental Health Services, 74*, 17–26. Retrieved from http://search.ebscohost.com

Barnes, J. J., MacPherson, K. K., & Senior, R. R. (2006). Factors influencing the acceptance of volunteer home-visiting support offered to families with new babies. *Child & Family Social Work*, *11*(2), 107-117. Retrieved from http://search.ebscohost.com

Bateson, G., Jackson, D., Haley, J., & Weakland, J. (1972). Toward a theory of schizophrenia. In Bateson, G., *Steps to an ecology of mind*. (pp. 201 – 227) Chicago: University of Chicago Press. Retrieved from http://search.ebscohost.com

Berzoff, J., Flanagan, L., & Hertz, P. (2011). *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts (3rd ed.)*. Plymouth, United Kingdom: Rowman & Littlefield Publishers.

Blankertz, L. E., Cnaan, R. A., White, K., & Fox, J. (1990). Outreach efforts with dually diagnosed homeless persons. *Families in Society, 71*(7), 387-397. Retrieved from http://search.ebscohost.com.

Bray, L. (2006). Outreach: making a difference in family life. *Paediatric Nursing*, *18*(8), 27. Retrieved from http://search.ebscohost.com.

Carling, P.J. (1995). Return to community: Building support systems for people with psychiatric disabilities. New York: Guilford Press.

Center for Social Innovation. (2011). Homelessness: Solutions tailored to individual needs. Retrieved from http://www.center4si.com/issues/homelessness.cfm

Chui, W., & Ho, K. (2006). Working with involuntary clients: Perceptions and experiences of social workers in Hong Kong. *Journal of Social Work Practice*, *20*(2), 205-222. doi:10.1080/02650530600776947

Courtois, C. A. (2008). Complex trauma, complex reactions: Assessment and treatment. *Psychological Trauma: Theory, Research, Practice, And Policy,* (1), 86-100. doi:10.1037/1942-9681.S.1.86

Crane, M., & Warnes, A. (2005). Responding to the needs of older homeless people. *Innovation: The European Journal Of Social Sciences*, *18*(2), 137-152. doi:10.1080/13511610500096434

Fisk, D., Rakfeldt, J., Heffernan, K., & Rowe, M. (1999). Outreach workers' experiences in a homeless outreach project: Issues of boundaries, ethics and staff safety. *Psychiatric Quarterly, 70*(3), 231-246. doi:10.1023/A:1022003226967

Fisk, D., Rakfeldt, J., & McCormack, E. (2006). Assertive outreach: An effective strategy for engaging homeless persons with substance use disorders into treatment. *The American Journal of Drug and Alcohol Abuse, 32*(3), 479-486. doi:10.1080/00952990600754006

Ferrante, J.M., Cohen, D.J., & Crosson, J.C. (2010) Translating the patient navigator approach to meet the needs of primary care. *Journal of the American Board of Family Medicine 23(*6):736-744. Retrieved from EBSCO*host.*

Goldacre, M., & Seagroatt, V. (1993). Suicide after discharge from psychiatric inpatient care. *Lancet*, 342(8866), 283. Retrieved from EBSCO*host.*

Housing Options Made Easy, Inc. (2005, January). Role of peers subcommittee white paper. Retrieved from http://housingoptions.us

Hidalgo, J., Coombs, E., Cobbs, W. O., Green-Jones, M., Phillips, G., Wohl, A., & ... Fields, F. D. (2011). Roles and challenges of outreach workers in HIV clinical and support programs serving young racial/ethnic minority men who have sex with men. *AIDS Patient Care & Stds*,*25,* S15-S22. doi:10.1089/apc.2011.9880

Kryda, A. D., & Compton, M. T. (2009). Mistrust of outreach workers and lack of confidence in available services among individuals who are chronically street homeless. *Community Mental Health Journal, 45*(2), 144-150. doi:10.1007/s10597-008-9163-6

Levy, J. S. (2000). Homeless outreach: On the road to pretreatment alternatives. *Families in Society, 81*(4), 360-368. Retrieved from www.familiesinsociety.org

Levy, J. S. (2004). Pathway to a common language: A homeless outreach perspective. *Families in Society, 85*(3), 371-378. Retrieved from www.familiesinsociety.org

Levy, J. S. (2011). The case of housing-first: Moral, fiscal, and quality-of-life reasons for ending chronic homelessness. *Recovering the Self*, *Vol. III (*3), 45 – 51. Retrieved from www.recoveringself.com

Lipman, B. (2001). A job doesn't guarantee a home. *Journal Of Housing & Community Development*, *58*(5), 35. Retrieved from ebscohost.com

Lowe, E. T., & United States Conference of Mayors, W. C. (2001). A status report on hunger and homelessness in America's cities, 2001: A 27-city survey. Retrieved from http://www.eric.ed.gov/PDFS/ED463348.pdf

Ma Shwe Zin, N., Soo Meng, K., Kumar, R., Fones, C., & Tze Pin, N. (2009). Improving treatment access and primary care referrals for depression in a national community-based outreach programme for the elderly. *International Journal Of Geriatric Psychiatry*, *24*(11), 1267-1276. doi:10.1002/gps.2256

Marlatt, G.A. (Ed.). (2012). Harm reduction: Pragmatic strategies for managing high-risk behaviors (2 ed.). New York, NY: Guilford Press.

Mechanic, D., & Tanner, J. (2007). Vulnerable people, groups, and populations: Societal view. *Health Affairs*, *26*(5), 1220-1230. doi:10.1377/hlthaff.26.5.1220

Melamed, Y., Fromer, D., Kemelman, Z., & Barak, Y. (2000). Working with mentally ill homeless persons: Should we respect their quest for anonymity? *Journal of Medical Ethics, 26*(3), 175 - 178. Retrieved from www.jmebmj.com

Morse, G. A., Calsyn, R. J., Miller, J., Rosenberg, P., West, L., & Gilliland, J. (1996). Outreach to homeless mentally ill people: Conceptual and clinical considerations. *Community Mental Health Journal, 32*(3), 261-274. doi:10.1007/BF02249427

National Alliance to End Homelessness. (2011a). Chronic homelessness. Retrieved from http://www.endhomelessness.org/

National Alliance to End Homelessness. (2011b). Snapshot of homelessness. Retrieved from http://www.endhomelessness.org/

National Coalition for the Homeless. (2009). Education of homeless children and youth. Retrieved from http://homeless.samhsa.gov/ResourceFiles/duxws2dr.pdf

Nelson, T., Johnson, S., & Bebbington, P. (2009). Satisfaction and burnout among staff of crisis resolution, assertive outreach and community mental health teams: A multicentre cross sectional survey. *Social Psychiatry & Psychiatric Epidemiology, 44*(7), 541-549. doi:10.1007/s00127-008-0480-4

Ng, A. T., & McQuistion, H. L. (2004). Outreach to the homeless: Craft, science, and future implications. *Journal of Psychiatric Practice*, *10*(2), 95-105. doi:10.1097/00131746-200403000-00004

Olivet, J., McGraw, S., Grandin, M., & Bassuk, E. (2010). Staffing challenges and strategies for organizations serving individuals who have experienced chronic homelessness. *The Journal Of Behavioral Health Services & Research*, *37*(2), 226-238. doi:10.1007/s11414-009-9201-3

Orange, D.M., Atwood, G.E. & Stolorow, R.D. (1997). Intersubjectivity theory and the clinical exchange. In *Working Intersubjectively : Contextualism in Psychoanalytic Practice* (pp. 3 – 18). Hillsdale NJ : The Analytic Press.

Osgood, D., Foster, E., & Courtney, M. E. (2010). Vulnerable populations and the transition to adulthood. *Future Of Children*, *20*(1), 209-229. Retrieved from http://www.eric.ed.gov/PDFS/EJ883086.pdf

Pollack, K., Frattaroli, S., Whitehill, J., & Strother, K. (2011). Youth perspectives on street outreach workers: Results from a community-based survey. *Journal of Community Health, 36*(3), 469-476. doi:10.1007/s10900-010-9329-3

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*(9), 1102-1114. doi:10.1037/0003-066X.47.9.1102

Quigley, J. M., Raphael, S., & Smolensky, E. (2001). Homeless in America, homeless in California. *Review of Economics and Statistics, 83*(1), 37-51. doi:http://www.mitpressjournals.org.libproxy.smith.edu

Rapoport, R. N., & Rapoport, R. (1958). Community as the doctor. *Human Organization, 16*, 28-31. Retrieved from http://search.ebscohost.com.libproxy.smith.edu

Ridgway, P., & Zipple, A.M. (1990). The paradigm shift in residential services: From the linear continuum to supported housing approaches. *Psychosocial Rehabilitation Journal, 13*, 20–31. Retrieved from http://search.ebscohost.com

Rogers, C. (1961). On becoming a person: A therapist's view of psychotherapy. Boston: Houghton Mifflin

Rosenheck, R. (2000). Cost-effectiveness of services for mentally ill homeless people: The application of research to policy and practice. *The American Journal Of Psychiatry, 157*(10), 1563-1570. doi:10.1176/appi.ajp.157.10.1563

Rowe, M., Frey, J., Bailey, M., Fisk, D., & Davidson, L. (2001). Clinical responsibility and client autonomy: Dilemmas in mental health work at the margins. *American Journal of Orthopsychiatry, 71*(4), 400-407. doi:10.1037/0002-9432.71.4.400

Rowe, M., Fisk, D., Frey, J., & Davidson, L. (2002). Engaging persons with substance use disorders: Lessons from homeless outreach. *Administration And Policy In Mental Health, 29*(3), 263-273. doi:10.1023/A:1015147710813

Saleebey, D. (2011). Some basic ideas about the strengths perspective. In F. J. Turner, & F. J. Turner (Eds.), *Social work treatment: Interlocking theoretical approaches (5th ed.)*. (pp. 477-485). New York, NY US: Oxford University Press. Retrieved from http://search.ebscohost.com.libproxy.smith.edu

Schlossberg, N. K. (1981). A model for analyzing human adaptation to transition. *The Counseling Psychologist, 9*(2), 2-18. doi:10.1177/001100008100900202

Shern, D. L., Tsemberis, S., Anthony, W., Lovell, A. M., Richmond, L., Felton, C. J., . . . Cohen, M. (2000). Serving street-dwelling individuals with psychiatric disabilities: Outcomes of a psychiatric rehabilitation clinical trial. *American Journal of Public Health, 90*(12), 1873-1878. Retrieved from www.ajph.org

Spencer, J. W., & McKinney, J. L. (1997). "We don't pay for bus tickets, but we can help you find work ": The micropolitics of trouble in human service encounters. *Sociological Quarterly, 38*(1), 185-203. Retrieved from http://search.ebscohost.com.libproxy.smith.edu

Stark, M. (1999). Authentic Engagement. In *Modes of Therapeutic Actions* (pp. 56 – 68). NJ: Jason Aronson Press

Sullivan, B. (2010, June 16). HUD Issues 2009 annual homeless assessment report to Congress: Individual homelessness down; Family homelessness up for second straight year [Press release]. Retrieved from http://portal.hud.gov/

Tsemberis, S. (1999). From streets to homes: An innovative approach to supported housing for homeless adults with psychiatric disabilities. *Journal of Community Psychology, 27*(2), 225-241. Retrieved from http://search.ebscohost.com.

Tsemberis, S., Kent, D., & Respress, C. (2012). Housing stability and recovery among chronically homeless persons with co-occurring disorders in Washington, DC. *American Journal of Public Health, 102*(1), 13-16. doi:10.2105/AJPH.2011.300320

Tsemberis, S. J., Moran, L., Shinn, M., Asmussen, S. M., & Shern, D. L. (2003). Consumer preference programs for individuals who are homeless and have psychiatric disabilities: A drop-in center and a supported housing program. *American Journal of Community Psychology, 32*(3-4), 305-317. doi:10.1023/B:AJCP.0000004750.66957.bf

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*(4), 651-656. Retrieved from www.ajph.org

Wachtel, P. (2011). Therapeutic communication: Knowing what to say when, 2nd ed. New York: Guilford Press.

Weiner, A. (1996). Understanding the social needs of streetwalking prostitutes. *Social Work*, *41,* 97-105. Retrieved from ebscohost.com

Weissman, E.M., Covell, N.H., Kushner, M., Irwin, J. & Essock, S.M. (2005). Implementing peer-assisted case management to help homeless veterans with mental illness transition to independent housing. *Community Mental Health Journal, 4*(3), 267 – 276. Retrieved from ebscohost.com

Wireman, K.R. (2007). Preventing homelessness: A consumer perspective. *Journal of Primary Preventive Health, 28*, 205-212. Retrieved from ebscohost.com

U.S. Department of Housing and Urban Development. (2010). The 2010 annual homeless assessment report to Congress. Retrieved from http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf

Zuffrey, C. (2008). Responses to homelessness in Australian cities: Social worker perspectives. *Australian Social Work, 61*(4), 357-371. Retrieved from ebscohost.com

Appendix A

HSR Approval Letter

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 2, 2012

Carlos Encalada
Dear Carlos,

Your HSR application is hereby accepted. You may want to create a flyer in addition to the mailer. Your responses to me and committee were professional and carefully thought out, the changes rapid and right on target. Very nice work!
Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your study!

Sincerely,

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Beth Lewis, Research Advisor

Appendix B
Recruitment Letter to Potential Participants

Hello,

My name is Carlos Encalada, and I am a graduate student in social work doing an exploratory interview-based study on outreach workers' views about the work they do with the homeless population. I'm interested in interviewing outreach workers with *at least six-months experience* in the field. The interview would explore how you view your work, what your thoughts are about the people you reach out to, how you came to do this work, and your perspectives on outreach work, in general. If this sounds like something you would be interested in, you can email me any time at cencalad@smith.edu or call me at 413-570-0579 to let me know of your interest in the study so that I can answer any questions you might have about the study and arrange a time to meet.

The interview would last up to one-hour and would be audio recorded with every measure taken to ensure confidentiality. If you are interested in the study and schedule an interview, before conducting the interview itself, I will share with you an informed consent form explaining the measures that will be taken to protect confidentiality in greater detail.

If you are interested, my contact information is listed again below for ease. I look forward to speaking with you if you are interested. Thank you for your time.

Carlos Encalada
cencalad@smith.edu
413-570-0579

Appendix C
Informed Consent Form

Dear Participant,

I am a graduate student at Smith College School for Social Work and I am conducting a study exploring the work of outreach workers with the chronically street homeless population. The purpose of this study is to gain an understanding of the perspective of outreach workers about their role and the nature of their work. The data from this study will be used for my MSW thesis and in professional publications and presentations on this topic.

Participation in this study will include an in-person interview of approximately one hour duration with the researcher. Interview questions will include your thoughts about outreach work, in general, your views on the work you do with consumers, and your thoughts about the larger context of outreach work and the issue of homelessness. You are being asked to participate as an outreach worker currently providing services to the homeless population, the criteria for inclusion in the study. Interviews will be audiotaped and later transcribed by me, in private. Should I use an additional transcriber, she/he will sign confidentiality forms.

Your risk of participation will be minimal. It is possible that, for some, thinking in depth and sharing thoughts about the work they do may be uncomfortable. Should you wish to consult anyone regarding any concerns that may arise, a list of referral sources is attached. By participating in this study, you may increase your awareness of outreach practices and the context of outreach services, which may aid in your future outreach work. By participating in this study you will also have the opportunity to contribute to knowledge about outreach work and the types of policies and procedures that can support effective practice with vulnerable populations. Compensation will not be provided for participation in this study.

Every measure will be taken to maintain confidentiality. Your responses will be kept separate from your name and other identifying information. Basic demographic information will be collected and reported on in general and descriptive terms to protect your identity. All data will be stored in an electronic file that is password protected. Besides the researcher, only the research advisor, and transcriber, if used, will have access to the data. Data will be separated from participant identification before it is shared with the research advisor or transcriber. If a transcriber is used, they will sign a confidentiality form. Data will be presented as a whole unless specific quotes or vignettes are used in which case they will be carefully disguised using phrases such as “one participant said” and “another participant said”. Themes derived from interviews and observations will be disconnected from identities of study participants. The informed consent forms will be immediately be stored in a locked container as this will be the only document explicitly connecting you, the outreach worker, to the study in name. Before data is processed with the research advisor, identifications will be removed. Audio files and transcriptions will be kept in securely off-line on password-protected computer files during the internship year, and will be kept for three years as stipulated by federal guidelines until no longer needed and then will be destroyed. In the interest of your participation in this study that looks at your direct practice, caution in not identifying clients specifically in your responses should be taken.

Your participation in this study is voluntary. You may withdraw from the study at any time before, during, or after the interview, and you may refuse to answer any question. If you wish to withdraw from the study you must notify the researcher in writing by April 1st, 2012. Upon withdrawal all materials pertaining to your interview as well as any identifying information will be immediately destroyed. If you have not withdrawn from the study by April 1st, 2012, your answers will be a permanent part of this study. You may contact me or the Chair of the Human Subjects Review Committee at Smith College School for Social Work at the email or phone listed below for questions or concerns about this study.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature of Participant _____ Date:_____

Signature of Researcher:_____ Date:_____

Contact Information:
Carlos Encalada
Smith College School for Social Work Master's Candidate
413-570-0579
cencalad@smith.edu

or

Chair of the Smith College School for Social Work Human Subjects Review Committee
413-585-7974

PLEASE KEEP A COPY OF THIS AGREEMENT FOR YOUR OWN RECORDS. THE RESEARCHER WILL PROVIDE THIS COPY EITHER BY SCANNED EMAIL OR SENT IN THE MAIL TO YOUR DESIRED ADDRESS.

Thank you for taking the time to learn about this study. Whether you decide to participate or not, your work and opinion are appreciated in this study.

Appendix D
Instrument

Introduction: I'm interested in learning about outreach work from the viewpoint of the worker. There are no "right" or "wrong" answers to these questions – it is an opportunity for you to share your thoughts in a number of areas. The interview will cover three main areas: The first will be about your thoughts about your work and outreach work, in general; then we'll talk about how you view the work you do with consumers; and the third will be about your thoughts about the larger context of outreach work and the issue of homelessness. Before we begin, if I could just ask you some questions about your demographic data.

Gender	Which of the following best describes your gender? Male, Female, Transgender, other.
Race/Ethnicity	How would you identify your race or ethnicity?
Age	Which age range do you fall into? (18 – 25; 26 – 35; 36 – 45; 46 – 55; 56 – 60; 61 or older)
Religiosity/Spirituality	On a scale of 1 to 5 (5 being the most, 1 being the least), how religious of a person do you consider yourself? How spiritual of a person do you consider yourself?
Highest Education Level	What is the highest level of education you have completed? (less than high school, high school GED, some college, 2-year college degree, 4 –year college degree, beyond college)
Years(months) of experience doing outreach work	How long have you been working as an outreach worker with the homeless?

Ok, now, let's begin.

Personal: History, your experience, perception of others

1. How did you come to do this work? Tell me about this.
2. I'm interested in your thoughts about the role of the outreach worker. Let's start with how you see your role in work with the homeless population – can you tell me a little about that? What's your experience as an outreach worker? (Probes: challenges, safety risks, situations you might approach or not, physical/emotional strains, rewards, autonomy, spending time with people)
3. How do you think the role of the outreach worker is seen by others? the consumer? The community or public at large? Other homeless services agencies? How do these views impact the work you do (if at all?)

Interpersonal - Relationships on the job

4. In outreach there is a lot of talk about building "relationships" (with consumers). Tell me about your thoughts about that relationship – for example, what does "building relationship" with consumers mean to you? How do you go about forming a relationship with a consumer that will "make the work happen"?
5. How do you see work with "others" (for example, community residents, police, elected representatives, other consumers) figuring into your work with consumers?

Professional
6. What works well for you in outreach work? What doesn't work so well? Tell me more about this.
7. As an outreach worker, what does decision making look like? (Prompts: kinds of decisions, consult with others or collaboration, ethical questions between self-determination and safety, unclear)
8. How do you see your social identity – that is, race, gender, age, education level, class– affecting your work with consumers, if at all?
9. Part of the role of outreach is informing individuals about resources that exist. How do you feel about this aspect of the work? Do you feel the existing resources meet individual's needs?

Social: Issue and problem of homelessness/organization of services
10. I'd like to know about your views about homelessness. What do you think is the cause of the problem? What do you think would remedy the problem?
11. What do you think people experiencing homelessness and living on the street need? What do you hope for your consumers, in terms of their situations?
12. If money wasn't an issue, and you could design a service, program, or organization specifically for the needs of your people, what would that look like?

CHAPTER I

Introduction

The purpose of this exploratory and descriptive study was to understand homeless outreach work from the perspective of the homeless outreach worker. The research question that guided this study was, "How do outreach workers conceptualize their work: personally, interpersonally, professionally, and socially?" The researcher interviewed seven full-time outreach workers in a large Northeastern city asking them about their experiences as outreach workers including personal motivations, their relationships with consumers, the variety of situations that come up in outreach work, and their views and thoughts on homelessness, its causes, and remedies.

Outreach workers are mobile social service workers who go out and find consumers of a particular vulnerability with the underlying purpose or intention of connecting them with available resources. The unique setting and form of outreach work with the chronically homeless often creates opportunities for less traditional, more relational work that some researchers have attempted to qualify through the generation of principles, tasks, or implications of outreach work (Levy 2000; Morse, Calsyn, Miller, Rosenberg, West & Gilliland, 1996; Blankertz, Cnaan, White, Fox & Messinger, 1990), developing models of outreach work (Levy, 1998; Morse, et al., 1996; Blankertz, et al., 1990), and describing the craft of outreach work (Levy, 2004; Ng & McQuisition, 2004).

Similar to finding a common language between outreach worker and consumer (Levy, 2004), psychotherapists have known for some time that the process of alliance building involves the creation of a relationship in which the client feels safe and free to express himself or herself authentically (Rogers, 1961). This process often takes time and requires a consistent stable presence on the provider side. The daily going out and meeting consumers literally where they are physically manifests this process. If the theoretical frame for outreach work is therapeutic alliance-building through workers' relationships with consumers, then the therapeutic skills that workers utilize to build a strong alliance can be seen in the consistent non-judgmental offering of available and appropriate services without condition as well as reducing the harm in any encounter. As referred to in the literature on harm-reduction (Marlatt, 2012), the stance of accepting people as they are without restriction can be seen in the referrals made to housing first modeled programs by outreach workers (Tsemberis, Gulcur, & Nakae, 2004). Additionally the principle of harm reduction is illustrated in the situation of a homeless individual who might reject an outreach worker conversationally or socially but who will accept a blanket or food. In this way, the consistent offering of available and appropriate resources as judged by the consumer employs harm-reduction practices in a relational frame.

In approaching the data analysis of the interviews, the researcher therefore considered the homeless outreach worker-consumer relationship in a relational harm-reduction theoretical frame. The therapeutic relationship between workers and the people with whom they work is of critical importance in any context of treatment and support. Keeping the voice of the consumer, especially among vulnerable populations, is critically important when considering the design and implementation of services offered (Wireman, 2007). Equally important is the perspective of the worker or provider (Zuffrey, 2008). In particular, outreach work with the chronically homeless

population is a unique form of interaction in the social service arena at the fringes of what might be considered traditional work. The literature on outreach work with the homeless has documented challenges faced in doing outreach work and has begun to hypothesize what makes for best practices in outreach work. Largely absent from the literature are studies that consider outreach work from the perspective of the outreach worker themselves. This study taps into that perspective.

The researcher hypothesized that outreach worker experience in connecting with consumers is largely relational, interpersonal, and takes time to establish. In considering the outreach worker perspective, findings led to implications for the practice, policy and program development, and future research of homeless outreach work. Irrespective of the small sample size, participant responses ranged and yet were found to connect to common threads relevant to outreach work. In this way, after the interviews were analyzed and considered, it seemed natural that their responses reflected the variety and breadth of a multi-role position.

Since the perspective of outreach workers is largely missing from the literature on outreach work with the chronically homeless, findings from this study provide an opportunity for this perspective to emerge, contributing to our understanding of the nature of outreach work with people experiencing homelessness and supporting appropriate training and conditions that could lead to an enhancement of the quality of services to vulnerable populations. Incorporating the experience and perspectives of outreach workers into planning for program support and policy will undoubtedly aid in the development of recommendations for effective outreach work.

CHAPTER II

Literature Review

How does Homeless Outreach Work? To begin a case for the need of this study, a review of the literature will focus on homelessness, the nature of outreach and those that do the work with various vulnerable populations in general and chronically homeless outreach in particular, and lastly the clinical and practice theory undergirding this type of work. The review will include a discussion of the current state of homelessness in the United States, different contexts for outreach work, perspectives of outreach workers with vulnerable populations, and what is currently known about homeless outreach work. The review will end with a brief summary of relational theories meant to frame study findings.

Homelessness: An overview

Estimates of the size of the homeless population in the United States vary widely depending upon the source. According to the U.S. Department of Housing and Urban Development (Sullivan, 2010) and as reported by the National Alliance to End Homelessness (2011b), approximately 643,000 individuals were homeless on a given night in 2009 as per the last biennial point-in-time count. Although the causes of homelessness can be attributed to multiple structural factors including lack of affordable housing (Lowe & United States Conference of Mayors, 2001; Quigley, Raphael, & Smolensky, 2001), low-wage jobs (Lipman, 2001), unemployment (Lowe & United States Conference of Mayors, 2001), and other complex

constraints in education and training (National Coalition for the Homeless, 2009), the experience of homelessness takes on many forms.

Of the approximately 643,000 homeless in the United States in 2009, 17 percent or approximately 110,000 were considered “chronically homeless” with the other 83% living in shelters, transitional housing, or recently on the streets (U.S. Department of Housing and Urban Development, 2010). “Chronic homelessness is defined as long-term or repeated homelessness, often coupled with a disability” (National Alliance to End Homelessness, 2011a). Of course, the measurement and categorization of homelessness, affecting both the contest of homelessness as well as funding for services, depends on who is defining the nature, severity, and intensity of the problem. With that said, the U.S. Department of Housing and Urban Development (2010) defined chronic homelessness as follows:

> A chronically homeless person is defined as an unaccompanied homeless individual with a disabling condition who has either been continually homeless for a year or more or who has had at least four episodes of homelessness in the past three years. To be considered chronically homeless, a person must have been on the streets or in emergency shelter (e.g. not in transitional or permanent housing) during these stays. Prior to the passage of the HEARTH Act, persons in families could not be considered chronically homeless. (p. 3)

This definition sets the constraints for programs designed to target “chronic homelessness”. The challenges of the homeless who are in shelters, transitional housing, or recently on the streets because of temporary circumstances are qualitatively different from the challenges of the chronically homeless. For this reason, according to the Center for Social Innovation (2011), the approximately 300,000 people in the homeless services workforce who

have a variety of educational, vocational, and clinical experiences require an equally wide array of basic knowledge of homelessness, trauma-informed care, evidence-based practices, and navigating a complex social service system. The need for a broad array of skills and tools in work with the chronically homeless is related to the demonstrated effectiveness of more specialized interventions with the mentally ill homeless population which overlaps the chronically homeless population (Rosenheck, 2000). Rosenheck (2000) compares three overlapping categories of work with the mentally ill homeless population: outreach, case management, and housing placement and transition to mainstream services. In his review of different studies of interventions designed to help the mentally ill homeless population, Rosenheck found that although specialized interventions for this particular population were effective, their cost would be more than standard programs. In his discussion of the findings, Rosenheck (2000) equally notes that since it makes intuitive sense that more specialized programs are more effective, the funding and adoption of specialized interventions such as outreach depend largely on the political and moral value society places on caring for the most vulnerable of needy populations. In this vein, outreach programs with the homeless continue to be created and studied.

Outreach to vulnerable populations

The target of outreach efforts varies widely and is often dependent on the changing emphases of local legislation and social funding which form the larger context of program development in this area. Outreach work has concentrated on specific target populations due to various social and public health concerns such as high-risk HIV populations (Hidalgo, Coombs, Cobbs, Green-Jones, Phillips, Wohl, & Fields, 2011), the elderly (Ma Shwe Zin, Soo Meng, Kumar, Fones, & Tze Pin, 2009), street walking prostitutes (Weiner, 1996), new mothers

(Barnes, MacPherson, & Senior, 2006), families with disabilities (Bray, 2006), involuntary delinquent youth (Chui & Ho, 2006) and, more related to homelessness, older homeless populations (Crane & Warnes, 2005).

To understand the challenges of outreach work with vulnerable populations, it is helpful to gain an understanding of the process by which a population is considered to be "at-risk" or vulnerable. According to Mechanic and Tanner (2007), "Vulnerability, the susceptibility to harm, results from an interaction between the resources available to individuals and communities and the life changes they face" (p. 1220). With regard to the resources available for populations in need, often what makes a resource inaccessible is the perception of its adequacy in terms of meeting a particular need. In the case of the chronically homeless, a lack of confidence in resources often diminishes any motivation towards pursuing such resources (Kryda & Compton, 2009). Among the chronically homeless for instance, shelters are frequently seen as dangerous places where specific needs are often disregarded in favor of generic one-size-fits-all services. Consequently, the challenge of outreach might be seen as a double bind (Bateson, Jackson, Haley, & Weakland, 1972). On one hand, an outreach worker is tasked to assess the needs of the chronically homeless against the potential of available resources, which the client may have already decided against. At the same time, the potential resources may not be adequate, consistent, or trusted by the client and as such their recommendation may have the potential to place outreach workers in a situation where they reinforce distrust in inadequate resources. Outreach work may involve playing multiple roles such as case manager or intake worker, and adopting a position of utilizing what policy makers have decided are the "needed" resources, on behalf of the client population. Thus outreach work with vulnerable populations often requires

mitigating the effects of inadequate or untrustworthy resources meant to combat chronic homelessness.

With regard to vulnerable populations that suffer from significant life changes and transition, the literature on transition of youth from foster care services to adult services provides valuable insights. Osgood, Foster, and Courtney (2010) look at the problems faced by youth in the mental health, foster care, juvenile and criminal justice, and special education systems; youth with physical disabilities and chronic illness; and runaway and homeless youth. Specifically, these youth face the abrupt ending of services in the transition to adulthood. Findings from the Osgood et al. (2010) study are of particular interest to a study of outreach with the chronically homeless population as transitions among this population in employment, housing, health, and/or other unforeseen changes are frequently catalysts to a chronic long-term condition. The charge of outreach to a vulnerable population is thus to help facilitate transition as smoothly as possible. In this vein, programs targeting the chronically homeless such as the Housing First program have gained popularity in recent years as a method of avoiding the long, bureaucratic, requisite-driven process that often exacerbates struggles for consumers with co-occurring mental health and substance use challenges (Levy, 2011; Tsemberis, Gulcur, & Nakae, 2004). The thinking in guiding this service model is that obtaining stable housing as soon as possible for people in transition improves outcomes for this population. In supporting the “housing first” model, homeless services policy has already begun to integrate a consideration of the struggles of those in transition; outreach workers are on the front lines of facilitating this more expedited service delivery.

The discussion of vulnerability is further informed by what we know about how people conceptualize and enact transition and change in life. Part of what makes a population vulnerable

is poverty, lack of social support, lack of employment, and exposure to environmentally adverse conditions (Mechanic & Tanner, 2007). Interventions addressing persistent vulnerability require a consistent and continuing pattern of care and social support (Mechanic & Tanner, 2007).

The circumstances surrounding a specific transition often vary for the chronically homeless population and might call for interventions such as rehabilitation, or detoxification resources, multiple times per week. For others experiencing a shift of attitude toward their personal, employment, or social life, brief consistent mental health support may be sufficient to meet their needs. As the most vulnerable require consistent and continuing care, outreach workers who form trusting relationships build a strong basis of reliable social support in the face of potentially daunting levels of care for consumers.

The contrast between the change state and current circumstances involves a period of transition that is often difficult to manage and may create susceptibility to further life challenges. One example is the higher incidence of suicide for patients discharged from psychiatric inpatient hospital wards (Goldacre & Seagroatt, 1993). Regardless of the type of services or resources received or sought, anyone working towards fundamental change faces multiple challenges in addition to the current set of difficult circumstances that motivate a desire for change.

Schlossberg (1981) claimed that a transition is “said to occur if an event or non-event results in a change in assumptions about oneself and the world and thus requires a corresponding change in one’s behavior and relationships” (p. 5). A successful transition, it is claimed by the author, is determined not necessarily by the transition itself, but rather by how the transition fits with a person’s life “stage, situation, and style at the time of the transition” (Schlossberg, 1981, p. 5). In looking at adaptation to transition, Schlossberg postulated three sets of factors: characteristics of the particular transition, characteristics of the pre- and post-transition

environments, and characteristics of the individual experiencing the transition. Characteristics of particular transitions could include a role change that is experienced as either a gain or a loss, affectively positive or negative, internal or external, timely or untimely, gradual or sudden, permanent, temporary, or uncertain, and evidencing some degree of stressfulness. Characteristics of the pre- and post-transition environments are those inhering in the interpersonal, institutional, and physical support systems. Lastly, although the characteristics of the individual critically involved with transition are many and complex, Schlossberg (1981) highlights psychosocial competence, sex, age or life stage, health, race or ethnicity, socioeconomic status, value orientation, and previous experience with transition of a similar nature. Given this stratum of interacting variables that can result in "adaptive" transition rather than in relapse or struggle, the journey for many populations through different stages of change is not a simple one. The variety of circumstances and populations that are vulnerable to challenges during transition confirms many of these constructs. Outreach again is called upon to bring to their work a breadth of experience and comfort in working with individuals with a wide variety of circumstances.

Given the consequential nature of transition with respect to vulnerability, conceptualizing the change process for vulnerable populations is paramount to understanding the complexity of outreach work. In the literature on stages of change for those struggling with substance dependencies, Prochaska, DiClemente, and Norcross (1992) view parts of the progression of change as a shift from pre-contemplation (not yet internally considering change to be desirable or necessary) to contemplation (consciously considering and weighing change in one's life). The reasons that someone in a particular situation would be ready to shift from precontemplation to contemplation depend on many of the sets of factors to which Schlossberg (1981) refers. In this

sense, outreach worker interaction might be considered an assessment of the person's current desire for change.

For outreach work with people experiencing chronic homelessness, the precontemplation stage might present as electing not to access services; whereas, the contemplation stage might present as being ready to welcome an outreach worker who may present the options, or the “pros and cons” of different resources (Prochaska et al.,1992). This consideration could equate to the outreach worker-consumer relationship as the potential “event or non-event that results in the change of assumption” for the consumer about the social service system, placing workers in a pivotal role in the pre- and post-environment of interpersonal support for a person in the midst of transition (Schlossberg, 1981). As a potentially significant catalytic agent, the homeless outreach worker perspective is critical.

Additionally relevant here – and possibly controversial to outreach work - might be the outreach practice of facilitating access to services that consumers are not interested in or to rhetorically elicit information from clients for assessment purposes (Spencer & McKinney, 1997). As Spencer and McKinney discuss, the language used in first encounters with consumers often has implicit and embedded biases that shift conversations in a particular direction. In the case of outreach, it may be that worker’ questions and ways of being are biased towards accessing particular services. In the language of stages of change, outreach workers might find themselves in a similar situation to that of many substance abuse counselors; that is, trying to facilitate a change the client is not ready for (Prochaska et al., 1992).

Those that do Outreach Work

The roles and professional disciplines associated with outreach work with vulnerable populations vary widely. Nurses working with care assistants often are those doing outreach in

medical situations such as working with families with children with complex disabilities (Bray, 2006). Equally likely, in the human services field, social workers, case managers, volunteers, and outreach workers are the people reaching out to these hard-to-reach populations (Weiner, 1996; Barnes, MacPherson, & Senior, 2006; Crane & Warnes, 2005; Chui & Ho, 2006).

The varied perspectives of workers in different disciplines significantly shape the ways in which outreach work is both designed and implemented. This is evident in the variety of roles that outreach workers play with an increasing array of vulnerable populations. Using the subject of study as an example, outreach work with the chronically homeless may be carried out by different disciplines, take different forms, and play different roles due to the unique combination of co-occurring risk presenting with chronic homelessness: mental illness and substance abuse. The perspective of the service provider has been found to be useful in homeless services (Zuffrey, 2008). Outreach to this population brings with it similar simultaneous challenges in its implementation (Blankertz, Cnaan, White, Fox, & Messinger, 1990; Rowe, Fisk, Frey & Davidson, 2002).

The varied activities of outreach workers depend on the needs of the specific target population. For high-risk HIV populations, outreach workers provide social and educational HIV outreach and education at bars, college campuses, and health fairs, disseminate awareness around youth-focused support initiatives around medical and support services, lead youth advisory councils around HIV education and prevention as well as mobile testing vans and drop-in centers (Hidalgo et al., 2011). Community nurses in the Community-based Early Psychiatric Interventional Strategy (CEPIS) program in Singapore routinely screen the elderly for depressive symptoms while also providing psychoeducational services to clients in the area of mental health and making referrals to primary care treatment for depression (Ma Shwe Zin et al., 2009).

Bachelor's-level case managers, certified HIV counselors, and a phlebotomist participated in a program where a mobile outreach van provided food, HIV testing, condom distribution, and if requested, referrals to medical and social services to street walking prostitutes in New York City (Weiner, 1996). Community volunteers in the Home-Start program in the UK offer support to new families with children aged less than five years old (Barnes, MacPherson, & Senior, 2006). Registered nurses and care assistants provide nursing care to families with complex disabilities in the family home and other community settings (Bray, 2006). Social workers in Hong Kong are tasked with connecting with "delinquent" youth around prevention of undesirable behavior, counseling regarding education, career, family, interpersonal and personal problems (Chui & Ho, 2006). Outreach workers at "Hearth" (an agency specializing in addressing elder homelessness) provide housing search and advocacy services as well as general case management around health, behavioral health, and basic needs to homeless individuals above the age of 50 in Boston,(Crane & Warnes, 2005). It is worth noting that these forms of outreach are distinct from street outreach, the focus of this study, in that these outreach programs concentrate on educational, medical, and preventative interventions that either bring resources directly to clients in an office-agency-home setting or immediately refer them to such resources outside of the client's current location. Street outreach with the chronically homeless, on the other hand, constitutes the intervention itself *wherever the person resides*. Referral to resources and education can happen in the course of open-ended alliance building with outreach workers, but is not always the focus of the intervention.

Equally important in work with the homeless is the consumer perspective (Wireman, 2007). Views of some outreach workers by consumers of services as well as non-client community members are often very positive. Authors Pollack, Frattaroli, Whitehill, and Strother

(2011) surveyed consumers of outreach services and other community members in Lowell, Massachusetts in order to gauge the perceived effectiveness and helpfulness of street outreach workers who work with at risk youth between the ages of 13 and 23. Of the 206 participants who were recruited using respondent driven sampling, 159 participants with average age 17 completed the survey. Among the most common open-ended responses were that the street workers were, "…good listeners; always there; they don't try to be all up in your business like adults" (Pollack et al., 2011). Of note in this observation is the ability and leverage afforded outreach workers in approaching target consumers in more frequent, less formalized ways. To put this in perspective, homeless outreach workers, as will be discussed later, particularly have many challenges including an inherent distrustful stigma which certainly affects how the work happens.

Given that outreach work is difficult, boundary challenging work, many homeless outreach agencies experience difficulty in hiring and retaining appropriate staff (Olivet, McGraw, Grandin, & Bassuk, 2010). Because of low pay, high burnout and turnover, limited supervision availability, and staff training needs, the challenges involved in finding individuals to do this difficult and challenging work are significant.

In contrast, research comparing assertive outreach workers with crisis resolution teams and community mental health teams showed fairly equal levels of satisfaction, wide distributions of burnout among teams, and a pattern suggesting an association between a longer career in mental health and less emotional exhaustion and more personal accomplishment (Nelson, Johnson, & Bebbington, 2009). Why some assertive outreach workers endure the challenging nature of the work, while others do not, is unclear; per this study, the four areas most highly rated as sources of satisfaction for assertive outreach workers were: working in a new type of

team; contributing to the team's service; helping clients; and the company of other staff (Nelson et al., 2009). Not surprisingly the areas identified as sources of greatest stress were "a lack of people/resources in the community to refer on to" followed closely by "too much administrative work" (Nelson et al., 2009, p. 547).

Although few studies focus on outreach worker perspective and experience of their work, one such study looked at assertive outreach nurses in the UK who were interviewed to gather data on their understanding of assertive outreach work (Addis & Gamble, 2004). The themes that emerged from study findings offer a more complete picture of assertive outreach work of five nurses in the UK and included the following; the significance of having time to connect with clients; the high hope and persistence of nurses in the face of ambivalence, hostility, and rejection often followed by the paradoxical tired dejection when relationships were not established; the internal and external pressure to engage clients, the relief when relationships were established, and the satisfaction that followed relationship formation; the desire to be both a caring individual and helpful professional to clients; feeling as though they both worked with and learned from clients; and the tantamount importance of working with a caring attitude in creating successful engagement. These themes speak to the nuances and complexity of outreach work with vulnerable populations in general.

Outreach to the Chronically Street Homeless population

Review of the literature on the challenges of homeless outreach work with the chronically homeless includes exploration of the ethical concerns embedded in work with individuals with co-occurring mental health and substance use issues, and in client refusal of service. Following discussion of these issues, the review will examine writings on what is thought to be effective in

outreach work, and how themes from what is thought to work can be informed by harm-reduction theory and relational clinical perspectives.

Ethical concerns. Before considering the perspectives of outreach workers regarding the nature of their work and the needs of the populations they serve, it is worth revisiting the ethical issues embedded in outreach work with chronically homeless individuals alluded to earlier in the discussion of stages of change, people in transition, and rhetoric as a troublesome tool (Prochaska et al.,1992; Schlossberg, 1981; Spencer & McKinney, 1997). Outreach workers must balance the prospect of either supporting or violating the free will of mentally unstable individuals who decline services and for whom a lack of involuntary intervention on the part of the worker may be tantamount to colluding with a potential client's psychosis (Melamed, Fromer, Kemelman, & Barak, 2000). Melamed et al. (2000) examine three hypothetical vignettes that speak to a weighing of patient rights versus needs. The scenarios include how a person on the street who has not broken the law might potentially suffer from a complex social problem; how a person might deliberately decide to live on the street; and how there might be the need for involuntary intervention on the part of either outreach workers, social workers, or police officers given the potential onset of a mental health or physical safety risk. In the same arena of ethical concern is a consumer’s refusal to accept services. From as early as 1999, authors drawing from the street experiences of outreach staff explored issues of boundaries, ethics, and staff safety, suggesting outreach worker experiences as essential in shaping and redefining homeless outreach work (Fisk, Rakfeldt, Heffernan & Rowe, 1999).

Writing about reaching hard-to-reach patients in difficult places, Adlam and Scanlon (2011) offer the parable of the interaction between Diogenes, the Cynic philosopher, and Alexander the Great as a framework for understanding the often problematic interaction between

the antisocial individual and a system of care. As the story goes, Diogenes refused accommodations from societal systems as he regarded them as untruthful. Here he simply understood that societal offence in reaction to his decision to live in a barrel in the main square was the problem of others, while his offence in reaction to the world he saw around him was his problem (one that he had to best manage on his own). In the emblematic moment of interaction between Diogenes and Alexander, when Alexander in respect of Diogenes' ethic asked what he could do for him, Diogenes responded that he could kindly step out of his light. In this way, the article recognizes that if clinicians and outreach workers can essentially offer help in a way that is not tied to a particular outcome or expectation of what constitutes a "successful" encounter, then intervention becomes less defined by the accessing of specific services and more defined by the relationship with the system of care itself (Adlam & Scanton, 2011). Creating a culture or organization where problematic interactions such as those that may occur between outreach workers and hard-to-reach populations can be explored and considered in a new light requires a greater level of permissiveness as well as a stance of "being with" the client than currently exists in many traditional forms of clinical assessment favoring deliberate helping and judgment (Rapoport & Rapoport, 1958). Further exploration of this theme will be included in a later discussion on the relational nature of outreach work.

The Diogenes analogy highlights the conflict between client autonomy and clinical responsibility (Rowe, Frey, Bailey, Fisk & Davidson, 2001). When are workers obliged to intervene in order to protect individuals who are at risk of harming themselves if these individuals have neither accepted nor been formally admitted to treatment? Rowe et al. (2001) offer vignettes that fall into the following four broad categories of conditions and boundaries within which outreach workers must make decisions about whether to intervene, giving

precedence to consumer protection over consumer autonomy: eligibility, functional status, external conditions, and options. Eligibility conditions can confuse decisions for outreach workers working with a population, the majority of which is dually diagnosed with either substance use and/or mental health concerns. Being either unconscious or disoriented is considered a safety concern and therefore protection takes precedence over client autonomy. Similarly, the functional status of the homeless is assessed regardless of the amount of contact in the hopes of preventing serious physical and mental harm. Current external conditions such as weather or local gang conflict are examples of environmental risk factors for this population. Lastly, the category that most readily connects with controversy between client autonomy (the right to refuse or choose a particular treatment) and clinical responsibility (the obligation to intervene on behalf of the client's safety) is that of different resource options being available to the homeless (Rowe et al., 2001). Here, the homeless person's free will is what is often debated if the other criteria favoring clinical responsibility are not in evidence. Once dilemmas over client autonomy are determined and understood, the next challenge facing outreach workers is that of determining the quality and duration of the available resources being offered and whether they in actuality meet the needs of the client. How the reliability of available resources guides worker decision-making with regards to intervention is of particular interest in this study.

Often, the ethical dilemmas embedded in components of homeless outreach work are related to consumers' substance dependence and mental disturbance. Considering the stages of change literature described earlier, Fisk, Rakfeldt, and McCormack (2006) provide evidence for the effectiveness of assertive (proactive) outreach in achieving a gradual, incremental enrollment of homeless individuals with substance use disorders into substance abuse treatment service programs. Although, from an ethical standpoint, involuntary intervention may not seem justified

given that ambivalence is known to be a part of the recovery process for substance use (Fisk et al., 2006), sometimes enrollment may be a safety issue in terms of the physical need for detoxification or psychological need for 24-hour inpatient care. In this regard, Blankertz et al. (1990) recommend nine practice principles of homeless outreach with dually diagnosed homeless persons that should guide the worker in a decision to order involuntary hospitalization and/or commitment to treatment programs: unconditional respect; extended period of engagement; worker as specific trusted link to the "system"; modeling skills of social engagement with others; encouragement of positive supportive and personally specific observations of regard; initially low emphasis on institutional over instrumental support; awareness of verbal and non-verbal cues of safety and acceptable communication; acceptance that the work happens at the pace of the consumer; and lastly, preparation and transference of engagement norms to the receiving resource or support to pass over as much trust and acceptance as possible that will minimize misunderstandings and empathic failures in the new and fragile relationship between consumer and new provider. This last practice principle, in particular, is in line with the consistent and continuing care needed among vulnerable populations and the facilitation of their transition to new resources, as previously mentioned (Mechanic & Tanner, 2007; Schlossberg, 1981).

Similarly, a literature exists on principles of homeless outreach - particularly in work with populations suffering from mental disturbances - in which the worker is conceptualized as a primary partner next to the individual's homelessness. Levy (2000) lays out five principles that could guide pretreatment for homeless outreach activities: promoting safety; forming relationship; developing a common language; promoting and supporting change; and being aware of and utilizing cultural and ecological factors that affect clients, outreach staff, and

communities. In another article, Levy (2004) elaborates on developing a common language with consumers with co-occurring mental disturbances. Adopting the language of clients as a means of building trust and client autonomy, Levy argues, should be considered not as dishonest, but as a method of understanding the world of the client.

What works: intervention models and effectiveness in outreach work. An exploration of the literature on effective practices, strategies, and agency policies in homeless outreach work also includes an exploration of the reasons that homeless populations may avoid outreach workers. Kryda and Compton (2009) interviewed 24 people who had been homeless for over a year in west midtown Manhattan. Findings indicate that the most salient reasons for refusal of services were mistrust of outreach workers and agencies and lack of confidence in available services. The lack of confidence particularly led to beliefs that services were not compatible with their needs. Participant mistrust of outreach workers was reflected in comments about workers' lack of time spent getting to know them, worker prejudicial and stereotypical views of the homeless, not being offered choices, and a sense that outreach workers did not understand what it is like to be homeless. This last point suggests that outreach workers may not have shared similar experiences to homeless participants of the study. In contrast, however, as mentioned in Hidalgo et al. (2011), outreach workers frequently do, in fact, have lived experience in common with the targeted population.

The finding from Kryda and Compton's (2009) study indicating a sense on the part of homeless participant that outreach workers did not understand what it is like to be homeless has been noted by others (Housing Options Made Easy, 2005). Literature on peer advising supports this finding. In New York City, homeless veterans who had completed a community-based drop-in program with psychiatry, primary care, and case-management services were recruited to assist

currently homeless veterans in making the transition from shelter or supportive residential facilities to independent living (Weissman, Covell, Kushner, Irwin, & Essock, 2005). The peer-enhanced case management program that was created with the help of these peer advisors was well received by participants, peer advisors, and staff. Although findings could not be generalized for a variety of reasons that included difficulty in finding participants for follow-up interviews, most staff considered the program a success. This speaks to the potential effectiveness of a peer workforce in homeless outreach work, with formerly homeless outreach workers utilizing a shared experience as a context for connection. Homeless respondents also believed that outreach workers were mostly motivated by their paycheck and were prone to making empty promises about following up on housing possibilities and detox programs, among other potential resources (Kryda & Compton, 2009). With regards to lack of confidence in services, two beliefs prevailed: shelters are unsafe, violent places and often services were only short-term solutions. Kryda and Compton (2009) go on to recommend that workers initially demonstrate that they are openly motivated by the best interest of their client and respect them as individuals, giving them options when available. These options have varied over the years and will be discussed in the following section. Before doing so, it is worth noting that these challenges and ethical concerns actually constitute the working conditions of outreach workers. Particular attention is noted here on the gap in the literature in terms of examining the outreach worker's perspective on all of these issues.

Work with the chronically homeless has manifested in a number of different forms that have strayed from the dominant system of care over the years. The linear residential treatment (LRT) model addresses co-occurring psychiatric disability and homelessness using a series of step-by-step residential programs that eventually lead individuals into independent housing

(Tsemberis, 1999). Different criteria that may be required to remain eligible for some services include sobriety, medication adherence, and mandated mental health screening and treatment. Critics including consumers, advocates, and program planners argue that lack of client choice, stress from multiple moves, the extended period of time before receiving independent housing, and the destabilizing effect of tying housing status to treatment compliance jeopardizes housing retention profoundly (Carling, 1995; Ridgway & Zipple, 1990).

The identification of shortcomings associated with the linear model has led to the development of hybrid forms of service delivery. One such program, drawn from models of successful drop-in centers, is the Choices Unlimited program in New York City. This program includes showers, lockers, laundry, telephones, libraries, computers, televisions, and offers three main types of services from which participants might choose, including: assistance with medical, psychiatric and social services; development and implementation of individual rehabilitation plans with particular emphasis on housing; and opportunities to meet and socialize with others (Shern, Tsemberis, Anthony, Lovell, Richmond, Felton, Winarski, & Cohen, 2000). The Choices Unlimited program design rejects the clinical perspective of a linear continuum model of dissemination of services that imposed threshold expectations such as abstinence and medication compliance before providing services. In their study of program outcomes, Shern et al. (2000) looked at the outcomes of the 168 individuals with psychiatric disabilities living on the streets, 91 of whom had been randomly assigned to the Choices Unlimited program; the remaining 77 participants comprised the control group, which was provided a standard treatment. Compared to the control group, those in the Choices Unlimited program reported significantly less difficulty getting food, finding a place to sleep, keeping clean, and significant reductions in anxiety, depression, and thought disturbances (Shern et al., 2000).

Another program, the Pathways Supported Housing program, was evaluated in New York City (Tsemberis, 1999) and more recently in Washington D. C. (Tsemberis, 2012). Piloted in New York City, this program was designed to specifically meet the needs of the severely mentally ill and substance-addicted homeless population and offered immediate access to independent housing and program services attuned to consumer's priorities. Priority for admission is provided to the most vulnerable in this population and the program does not require tenants to take medication, participate in psychiatric treatment, or abstain from drugs or alcohol in order to be eligible for housing. A history of violence, prison, or jail time does not disqualify applicants from the program. Three strongly recommended but not required preconditions are agreement to seeing a visiting service coordinator at least twice a month, payment of 30% of one's income towards rent, and participation in a money-management program (Tsemberis, 1999). Interdisciplinary Assertive Community Treatment teams often act as the program core services. ACT teams focus on decreasing tenant association as patient in a mental health system and increasing tenant personal efficacy, employment opportunities, ability to meet basic needs, enhancing social skills, and enhancing quality of life (Allness, 1997). In the New York City program, among 139 tenants ranging from 19 to 68 in age, the overall housing-stabilization rate for the Pathways program was 84.2% for a period of almost 30 months, compared with a housing-stabilization rate of only 59.6% over a two-year period in a linear residential treatment setting for a cohort of 2864 individuals, a total of 1707 remained housed (Tsemberis, 1999). In Washington DC, tenants in another Pathways program run by national non-for-profit Pathways to Housing, Inc. had a housing retention rate of 84% after two years as well (Tsemberis, 2012).

The impact of aforementioned threshold expectations and prerequisites common to traditional programs was examined in a longitudinal study of 224 participants randomly assigned

to either of two groups - one receiving housing contingent upon sobriety (control group) and the other participating in a *housing first* program. Housing First refers to a model for housing of homeless individuals that removes all obstacles and prerequisites to housing in favor of getting people in off of the streets first, and later addressing the complexity of consumer needs (Tsemberis, Gulcur, & Nakae, 2004). The Pathways Supported Housing program in New York City was the first program of its kind to employ this model (Tsemberis, 1999). Study findings indicate that dually diagnosed participants in the Pathways program, representing the housing first model choice, were more likely to remain stably housed than control groups without compromising or exacerbating psychiatric or substance abuse symptoms (Tsemberis, Gulcur, and Nakae, 2004). Also reported was higher perceived choice of services used on the part of participants in the housing first sample.

This latter point was examined in another paper looking at both the Pathways and Choices programs. Looking at consumer preference and choice, Tsemberis, Moran, Shinn, Asmussen, and Shern (2003), describe how the Pathways and Choices programs were developed in collaboration with consumers, researchers and clinicians to reduce barriers and obstacles to access of resources. Both programs appear to consider consumer perspective when contact is made. Specifically, the programs took into consideration the social skills necessary to utilize services through various levels of repeated working relationships necessary to meet program objectives in a standard linear continuum of services model. As mentioned by the authors, the taxing demand placed on consumers through these repeated challenging social interactions was thoughtfully considered, and therefore eliminated, in both the Pathways and Choices programs.

The importance of client agency and non-traditional ways of engaging with the homeless will be understood in the context of relational clinical theory and the use of harm-reduction

models. Particularly of interest is how these theories undergird the practices of the homeless outreach worker. A movement composed of those who work with the homeless is advocating a change in this dominant linear continuum model for dissemination of services in favor of housing first modeled programs (Levy, 2011). As seen in the Pathways program examples mentioned earlier, we see a harm-reduction model of care, one characterized by the aim to reduce the problematic effects of behaviors that are often caused by substance use and mental disturbance with the chronically homeless (Marlatt, 2012).

Those that do homeless outreach work

In this section, we shift from a discussion of the nature of outreach work with the chronically street homeless to return to homeless outreach workers themselves, examining the development of outreach work as a way of targeting the vulnerable homeless population.

Factors intrinsic to outreach work. Starting from the notion that "…homeless outreach is in essence a form of street triage" (Ng & McQuistion, 2004, p. 97), authors Ng and McQuistion (2004) look at intrinsic aspects of outreach work that affect the work being done; that is, the outreach model being employed at the agency, the outreach workers themselves, and the teams in which they work. Ng and McQuistion (2004) point out that service delivery models located in more controlled environments, such as program-driven shelters for people with psychiatric disorders, often require less structured outreach services. According to these authors, the inclusion of case management personnel in these settings may preclude the need for intensive outreach service. On the other hand, in less controlled environments such as drop-in centers or general shelters, outreach services are more critical to consumer best use of services. From this understanding a more sophisticated outreach model was born. One of these was the mobile crisis team, an example of which is Project HELP in New York City. The Project HELP team consists

of a psychiatrist, social worker and paraprofessional whose role it is to assess homeless individuals for psychiatric disorders and the need for acute hospitalization, whether voluntary or involuntary (Ng & McQuisition, 2004).

With the creation of mobile crisis teams and homeless outreach came issues of client-staff boundaries, ethics, and staff safety (Fisk, Rakfeldt, Heffernan & Rowe, 1999). Outreach workers, it seemed, were grappling with the issue of how one sustains a complex role in homeless outreach services; fulfilling this role placed outreach workers at the frontier between a vulnerable and marginalized population and the system of social services.

Among the factors intrinsic to workers postulated as being associated with effective homeless outreach work were strong social service work experience, the ability to develop a dynamic relationship with the homeless, the worker's own sociocultural background, and the workers ability to notice and examine countertransference reactions to potential contacts, (Ng & McQuistion, 2004).

Which individuals outreach workers elect to approach for initial contact is also of interest. For example, in researching homeless outreach work, this researcher observed one male outreach worker who came upon a woman on the street appearing scared at his presence; recognizing this, the worker then called upon a female outreach worker whom it was thought would be better received.

Although supervisors and agencies cannot control many of the intrinsic factors associated with characteristics and perspectives of individual outreach workers, other factors such as norms around staff safety, work experience requirements for employment eligibility and the development of dynamic relational skill building can be preemptively encouraged. Fisk et al.

(1999) note that worker street experiences should guide work activity, policies, and procedures in their agencies.

Ng and McQuistion's (2004) discussion of the intrinsic factors among homeless outreach workers that potentially contribute to the effectiveness of their work leads these authors to call for research defining and testing these factors. While there exists a gap in the literature in this area, a recent study provided evidence of assertive outreach as an effective link between substance using consumers and substance abuse treatment services (Fisk, Rakfeldt, & McCormack, 2006).

Factors extrinsic to outreach work. Other issues are extrinsic in that they are not inherently a part of the outreach work experience but often do have the possibility of being a factor in the work (Ng & McQuisition, 2004). Many have already been mentioned such as housing eligibility requirements and lack of confidence in resources being able to fulfill the needs of clientele either because of little financing or lack of continuity of service delivery between different resources. As such, these factors often are not easily modified or planned for ahead of time by supervisors and agencies; such planning might take the form of advocacy and policy reform which seldom are prioritized by homeless service agencies already strapped for resources. Other unforeseen issues include sexual and relational boundary issues that must be assessed in the field by the outreach workers themselves. Regardless, all extrinsic factors that affect outreach work have to be considered by the workers themselves.

Moving from Practice to Theory

In reflecting on the available literature on outreach work, the majority of studies have mainly considered the ethical and social problems associated with the work, emphasizing what doesn't work, or the challenges involved, as opposed to what has worked. Saleebey (2011), who

has written extensively on the strengths perspective in social work, highlights the personal, social, and spiritual resources of an individual that are uncovered in the powerful force of a helping relationship, thus emphasizing individual strengths as opposed to deficits. Although implicit in the work of Fisk et al. (1999), affirmative practices in outreach services among the chronically homeless population is not explicitly emphasized. Embedded in the case vignettes illustrating client-staff boundaries is the practice of consulting supervisors in uncomfortable and unclear situations in which outreach workers may find themselves. Embedded in the case vignettes illustrating ethical concerns are practices of networking and collaboration with local community members in resolving crisis and non-crisis situations. Embedded in the case vignettes illustrating safety concerns is the general notion that outreach workers should trust their own awareness of their sense of safety. In these cases would the unemphasized, unspoken, perhaps taken-for-granted practices used to resolve these challenges speak to necessary changes of agency policy, practice, or procedure if they were explicitly highlighted? Although the literature is sparse, Levy (2004) highlights the practice utilized by some outreach workers to create long-term working relationships by employing a common language with the mentally ill, homeless population. The development of a common language capable of spanning different sociocultural perspectives appears to be an identified strategy and practice utilized by outreach workers with this population that could eventually be implemented into training for outreach workers with this population. Here we find a practice that entails long-term learning of the communication norms of the client. As Levy (2004) mentions and as psychotherapists have known for some time, the process of alliance building involves the creation of a relationship in which the client feels safe and free to express himself or herself authentically (Rogers, 1961). This process often takes time and requires a consistent stable presence on the provider side.

The beneficial implications of the practices that work in reaching one of the most vulnerable populations for social work practice are obvious; less obvious is how determining best practices in this non-traditional encounter between outreach worker and potential client could inform future social work program development and intervention. Ng and McQuistion (2004) allude to the need for a definition of effective outreach work, arguing that consensus on such a definition requires further research. Focusing first on obtaining the outreach worker perspective on their own work therefore is paramount. With a stronger literature base supporting best practices and techniques in outreach work, better outreach programs and intervention strategies could be developed.

Notions of client autonomy and suggestions for more individualized empathic communications with outreach workers speak to the need for worker-homeless consumer interactions that are more relationally based. That is to say, the vulnerability of the chronically homeless, for the reasons mentioned in this literature review, speaks to the need for methods of engagement that may require extended periods of alliance building. Similar to the process by which the observation of the effects of cumulative trauma over long periods of time led some practitioners to determine the need for the new conceptualization of complex post-traumatic stress disorder (Courtois, 2004), in trying to reach the chronically homeless, outreach work practice has skirted the limits of provider-consumer relationship in the personal, professional, and ethical realm. In the case of clients suffering from complex post-traumatic stress, Courtois (2004) mentions that often practitioners will not get past the first stage of treatment which includes pretreatment issues, treatment frame, alliance-building, safety, affect-regulation, stabilization, skill-building, education, self-care, and support. Courtois (2004) states:

> Some clients never move beyond or complete Stage 1. Others may leave treatment prematurely. It is now recognized that good work in Stage 1 is likely to substantially improve the client's life. Some clients may have no need to move into the latter two stages. The primary emphasis of Stage 1 is personal safety in addition to education, personal and life stabilization, skill-building, and the building of social relationships and support. (p. 419)

In working with vulnerable complex trauma clients, the normal expectations of non-vulnerable clients in treatment are not applicable. In the case of the chronically homeless, the intervention of alliance building with outreach workers, although not always resulting in accessing of services, might be considered successful treatment given the population in question. Seen in the context of relationship, the chronically homeless, being isolated from resources and relatively distant from regular human contact, have a valuable intervention in the homeless outreach worker relationship. Wachtel (2011) speaks of the role of affect in the therapeutic relationship and to an emphasis on having an accepting attitude toward clients. In this way, outreach workers' attitudes and perceptions of the homeless populations they seek to reach are of utmost importance in the work that they do. Again, their ability to truly connect with the recipients of outreach services is in large part the intervention itself.

If the theoretical frame for outreach work is therapeutic alliance-building through workers' relationships with consumers, then the therapeutic skills that workers utilize to build a strong alliance can be seen in the consistent non-judgmental offering of available and appropriate services without condition as well as reducing the harm in any encounter. As referred to in the literature on harm-reduction (Marlatt, 2012), the stance of accepting people as they are without restriction can be seen in the referrals made to housing first modeled programs by outreach

workers (Tsemberis, Gulcur, and Nakae, 2004). Additionally the principle of harm reduction is illustrated in the situation of a homeless individual who might reject an outreach worker conversationally or socially but who will accept a blanket or food. In this way, the consistent offering of available and appropriate resources as judged by the consumer employs harm-reduction practices in a relational frame.

In another sense, the outreach worker has an opportunity to facilitate a potentially newly therapeutic, perhaps, reparative relationship between the homeless person and the formal mental health system. Therefore, an accepting attitude towards consumers in the first encounter on the streets might be comparable to the clinical first encounter between client and therapist, or client and service provider. Kryda and Compton (2009) speak to the importance of a non-judgmental encounter as well. Additionally, outreach workers bring their social identity and history as one side of this developing relationship between outreach worker and homeless person. Just as the outreach worker affects the consumer, the consumer affects the outreach worker. This is noted in the implicit moments when a worker decides that someone is not in danger of harming themselves or others, based on the consumer presentation. By virtue of this two-way authentic engagement, this encounter between outreach worker and consumer that stands at the edge of the problem of chronic homelessness can be considered using relational intersubjectivity theory (Stark, 1999). Intersubjectivity theory, a metatheory of psychoanalysis, examines the therapeutic field in which both client and therapist, or in this case consumer and outreach worker, create an "interplay between subjectivities" (Orange, Atwood, & Stolorow, 1997, p. 6). That is, intersubjectivity refuses to place pathology solely within the patients. In the case of consumer and outreach worker, a third space is created in which the subjective reality of the worker and the subjective reality of the consumer can meet and perhaps create a space in which a new reality

can be born. Perhaps this reality does not depend on a past history of disappointment and abuse by an often disenfranchising overdrawn social service system. That is, through the unique outreach worker-consumer relationship, a new chance at change is possible.

As discussed earlier in the literature, both homeless consumer and outreach worker add different perspective and insight to the complexity of tackling chronic homelessness. Outreach worker and homeless person co-create a relationship. By obtaining the outreach worker perspective on this dynamic, the requisites needed to engender trust that leads a homeless individual towards their own sense of progress and growth will begin to be uncovered more completely.

Summary and Motivation for the Study

This literature review begins with the current status of homelessness and work with vulnerable populations as a means of understanding the scale and terrain of the consumer perspective. In gaining a deeper understanding of the challenges involved in work with these consumers, the varying roles and tasks for different kinds of workers becomes clear. In particular, outreach work appears to meet the needs of populations that commonly isolate themselves from their systems of care. In outreach work with the chronically homeless who, as noted, are often afflicted with co-occurring mental health and substance use problems, the ethical concerns regarding involuntary commitment to hospital- or crisis-center mental health units or medical emergency departments has its own flavor of challenge and worker responsibility. In considering the future of work with the chronically homeless, the relational alliance-building that seems to often depend on a stance of harm-reduction and non-judgment can only be verified, extrapolated upon, and more specifically understood from the perspective of the homeless

outreach worker. Learning how they conceptualize their work will serve to improve current practice, policy and programming in work with the chronically homeless.

CHAPTER III

Methodology

This qualitative study explored the experiences of outreach workers who provide services to the chronically street homeless population. As the literature review suggests, the nonconventional nature of outreach work has implications with respect to practice and consequently should effect how program support and resources are designed for outreach workers. Outreach work in practice varies in form and style and uniquely manifests depending on the outreach worker's history, values, and subjective experience. For this reason, learning about how outreach workers conceptualize their work professionally, personally, interpersonally, and socially is of utmost importance to inform practice and program considerations in homeless outreach work. This chapter presents the methods used in this study to discover this perspective, including study design, sample selection, data collection, and data analysis procedures.

Study design and sampling

The exploratory/descriptive study design employed semi-structured interviews with a non-probability purposive sample of seven outreach workers from four different agencies, part of a five-agency collaborative providing street outreach services in the setting of a large Northeastern city. The study instrument consisted of an 18-item questionnaire (Appendix D), informed by literature review and researcher observation of outreach work. Six demographic items (age, gender, race/ethnicity, educational level, spirituality/religiosity, and years of outreach

experience) were followed by 12 open-ended questions covering personal, professional, social, and interpersonal motivations and perceptions of outreach workers regarding the work they do.

Inclusion criteria were: currently employed as outreach workers; 18 years or older; a minimum of six months' experience in outreach work with the homeless; employed in one of five agencies contracted by the city to provide outreach services. The sampling frame consisted of approximately 25 outreach workers in the agencies comprising the city-wide collaborative with the shared goal of providing outreach services to the chronic and at risk street homeless population.

An effort was made to recruit participants from each of the five agencies in the collaborative. Initially, the researcher informed the city director of the topic and plan of study. The researcher was subsequently invited to attend a regular monthly meeting of team agency supervisors to provide an overview and speak to the goals of the study and to distribute a template letter for agencies to use if they agreed to provide approval for recruitment among their staff who met study criteria. All five agency supervisors provided letters giving the researcher permission to locate the study in the agency, subsequent to obtaining approval from the Human Subjects Review (Appendix A), the researcher contacted each of the agency supervisors by phone and e-mail, and provided a recruitment letter (Appendix B) addressed to eligible participants that would be disseminated by supervisors to staff meeting the study criteria. As this method of recruitment yielded one participant, the researcher subsequently contacted each of the agency supervisors by e-mail and phone, offering to present the goals of the study in person to potential participants at agency staff meetings, when necessary and possible, to motivate study participation. Three agency supervisors agreed to make these arrangements. The other two renewed their effort to aid in recruitment and claimed an in-person presentation of the study by

the researcher was unnecessary. The researcher attended a total of three agency staff meetings, reaching a total of 13 staff including two supervisors. In addition, to further support recruitment efforts, following the completion of each interview, the researcher requested of each participant that they let other eligible workers know of the study. In a final attempt to recruit potential participants from all five agencies, another email was sent to one agency supervisor to remind staff of the study and the deadline for indicating interest. These methods proved more successful in yielding a sizeable final sample.

Workers interested in participating in the study were given a choice of contacting the researcher by phone or by e-mail. Most participants contacted the researcher by phone, with only two participants contacting the researcher by email, and one contacting the researcher through their supervisor. The latter participant provided the supervisor with their phone number to then have the researcher contact them directly. Once contact was made, researcher and participant decided on mutually convenient time and private place to have the interview prioritizing participant preference. Nine workers from four agencies contacted the researcher expressing interest in participating in the study and scheduling a time for an interview. One worker failed to follow through with a scheduled appointment despite three efforts at contact on the part of the researcher. It was learned during an interview with another worker that they failed to meet the eligibility criteria for the study. This left a total sample of seven participants with representation from four of five agencies.

Of the seven participants, four requested having interviews at their agency or work location, four interviews were held in a borrowed office space not associated with outreach services arranged by the researcher, and one participant requested that the interview take place at their home of residence. The timing of the interview also varied, depending on current work

schedule demands and availability, with most interviews occurring during the afternoon and evening time during the week, with only one interview occurring on a weekend, and two occurring in the morning. It should be noted that the study recruitment and interviews took place during the winter months, a time of year when outreach workers' hours are extended and efforts are intensified in view of the potential health hazards for consumers associated with the cold weather.

Pre-study observation

In order to understand the actual nature of outreach work, the researcher spent two morning shifts with one outreach worker with years of experience who was not included in the final sample. The experience of observing the outreach worker in the course of their daily work was critical to instrument development. In particular, observation of the worker's different levels of involvement with consumers, peers, local community members and groups, the police, hospitals, shelters, and other consumer programs led to a decision to include a broad selection of questions to garner a comprehensive picture of the outreach worker experience. A question eliciting participant views on the nature of their work with others and the role it plays in shaping their work was directly informed by the researcher's observations. As well, the fluidity and flexibility that appeared to pervade the outreach worker's experience spoke to a complex role that was not easily defined.

Data Collection Methods

Data was collected via semi-structured audio-recorded interviews by permission at mutually convenient and private locations organized between researcher and participant. Procedures to protect the rights and privacy of participants were outlined in a proposal of this study and presented to the Human Subject Review Board (HSRB) at Smith College School for

Social Work before data collection began. Approval of the proposal (see Appendix A) indicated that that the study was in concordance with the NASW *Code of Ethics* and the Federal regulations for the Protection of Human Research Subjects. Prior to each interview participants were given an informed consent document describing their participation in the study and their rights as human subjects, as well as any potential risks or benefits of participation (see Appendix C).

Once informed consent was given and signed by participants, an initial portion of demographic data was collected followed by twelve interview questions asked sequentially. The basic demographic data included age, gender, race, ethnicity, degree of religiosity and spirituality, and highest education level completed as well as the amount of time participant's had working as outreach workers. The subsequent 12 open-ended questions were intended to bring forth the participants' experiences in homeless outreach work (Appendix D). The topics included three main areas: participant thoughts about their work and outreach work, in general; participant's view of the work they do with consumers; and the third, their thoughts about the larger context of outreach work and the issue of homelessness.

Most of the interviews proceeded without interruption. One interview was inadvertently interrupted briefly by a supervisor but the interview was still completed. Another interview had to be periodically paused because of technical difficulties involving the audio recording software. The issue was resolved and the interview was completed. One interview was interrupted by a work phone call that had to be taken but was completed after the call was taken. The same interview was also interrupted by the arrival of a consumer at the office where the interview was being held. That interview continued after the consumer was provided help and offered resources to help their situation. In another interview, the last two questions were

combined because of time constraints, however, content from all questions were covered by the participant before the interview was over.

All data obtained and notes taken by researcher were kept separate from informed consent forms and given identification labels. All identifiable information from participants was removed or disguised from transcriptions and findings in final thesis project to protect identities of participants. At times the researcher clarified questions and gave time for participants to elaborate on questions. The average length of the interviews was 31 minutes with a range of 20 minutes to just under an hour.

Sample Characteristics

A majority of participants identified as male and African-American or Black. All except one participant were over the age of 36. The sample educational level was divided between high school (N=3) and advanced education beyond high school (N=4). The mean years of experience in outreach work was 7.26 years with a median and mode of 5 years and a range of 10 months to 15 years

Data Analysis

Each question response was coded for themes, positions, and beliefs that underlie their responses. In addition to emerging themes in the topic areas covered, findings suggestive of associations between worker characteristics and particular perspectives on outreach work were examined.

The researcher transcribed the audio-files. Once transcribed, the researcher began coding data by adding initial comments to transcribed materials consisting of extrapolated emergent themes particular to the responses given by participants. Any quotes from the participants that seemed poignant expressions of particular themes were noted for inclusion in the findings

section. The coding process further consisted in the researcher reading each interview numerous times, analyzing interview content for relevant and repeating themes, as well as noting material that did not fit into thematic areas. Themes were compiled by question to look for consistencies and patterns across numerous participants.

CHAPTER IV

Findings

This chapter will present the findings of a qualitative analysis of interviews with homeless outreach workers about their perceptions of their work with chronically homeless consumers. The findings begin with an overview of participant responses to questions regarding their thoughts and perceptions on the role and experience of the outreach worker, others' views of outreach work, the role of "relationship" in outreach work, how participant social identity is perceived to interact with outreach work, causes of homelessness, needs of consumers, and program design. Analysis of participant responses revealed the overarching theme of the outreach worker as the key grassroots partner that assumes multiple roles in the consumer-centered milieu of homeless outreach work. Discussion of this overarching theme will include explication of the roles played by the outreach worker. Five salient themes are descriptive of the multiple roles assumed by participants in the course of carrying out this work, including: (1) having to do the work others want done; (2) being an advocate for homeless consumers; (3) being "somebody to talk to" for consumers; (4) being an insider critic of the homeless services milieu; and (5) being the salesperson to a new life. This is followed by discussion of themes that emerged in an analysis of participant responses regarding their experience of outreach work. Their experience of their work will be understood as (1) disenfranchisement; (2) empowerment; and (3) presence, or existing where the consumer is at. Illustrative quotes will be used throughout.

Question Responses

Demographic data. Data on the following characteristics of participants were collected: age group, gender, race/ethnicity, educational level, spirituality/religiosity, and years of outreach experience. A majority of participants identified as male and African-American or Black. Three of the six participants who responded to the question regarding their highest level of education reported having a high school diploma or GED while the other three reported at least some college with one having a two-year degree and another having a graduate degree. All except one participant were over the age of 36. The mean years of experience in outreach work was 7.26 years with a median and mode of 5 years and a range of 10 months to 15 years. Of the six participants who answered the questions: "On a scale of 1 to 5 (5 being the most, 1 being the least), how religious of a person do you consider yourself? How spiritual of a person do you consider yourself?" all indicated some degree of religiosity or spirituality, with most participants indicating average-to-higher levels of both. Of these, only one participant responded differently between religiosity and spirituality, reporting a "1" and "5" respectively.

What led them to this work. In response to the question, "How did you come to do this work?", all seven participants referenced a personal contact - friend, coworker, or peer - who had told them about outreach work. Four participants transferred into homeless outreach work after having worked in some other aspect of homeless services including shelter work, case management, or volunteer work with the homeless.

Perceptions of the role and experience of outreach work. To the question, "…how [do] you see your role in work with the homeless population…What's your experience as an outreach worker?", participant responses varied, with the most salient theme being the experience of their role as a facilitator between different parties in the system. To the follow up

question about how the role of the outreach worker was seen by others (including consumers, community residents, and other stakeholders) and whether these views impacted their work, most participants initially responded with positive perception. Examples include statements such as "They tip their hat to us…for being out there…Other homeless services, we are in harmony with one another. We really know what it is we out there doing," or "I think they see it as a positive thing…I think they see it as a good thing." All participants except one, however, added negative or neutral perceptions such as, "It ranges from not knowing what we do, and an appreciation for helping people. I don't know if there's a very wide knowledge in the community about what outreach workers do," or "I think the consumers, basically…it's a love hate relationship. When they want something or need something they love us, when they don't want to be bothered and don't want to engage us, they hate us."

Four participants indicated that the views of others did not influence their work, and two responded that the views of others positively impacted their work. One participant provided a specific literal way in which the consumer's view of the outreach worker impacted their work.

> R: So it impacts your work because cyclically….
>
> P: Yeah, cyclically, if they're just accessing us when they need something or want something, that's not actually very beneficial to their progress or their treatment then…um, I don't know… I'm not sure how to say that exactly, but just people that don't necessarily want or don't seem to want long-term help or really make a lot of changes…they maybe just want a ride to let's say a shelter, or maybe they want clothes or something, and that's great because we have to provide it for them, and we have to be helpful but at the same time it's not really promoting long term health. I don't know if that makes sense.

Lastly, to the question, “As an outreach worker, what does decision making look like? For example, the kinds of decisions, consulting with others or collaborating, ethical questions, safety, or unclear situations”, most participants reported clarity and context-dependency in their decision-making process. Two specifically mentioned confidence in their quick decision-making capability. Two others mentioned that decision-making never need be involved in a grey-area given the phone resources available for consult. Only one participant made reference to the primary role of the consumer in decision-making:

> Far as decision making I’m going to say that the decision is always up to the consumer if they want us to help them… It’s not my decision to make where you sleep tonight…If you try to force a person they don’t want to go, they’re not going to go with you anyway.

Similar to protocol addressing suicide risk in the mental health profession, in practice, many participants reported erring on the side of a conservative approach in making the call for involuntary hospitalization of a consumer if there is any question of safety concern. As expressed in the following quote from a participant, this default stance may be problematic:

> It is a major judgment call who stays on the streets. Sometimes we have to [involuntarily commit] people. I always tell them first. ‘It’s too cold out.’ ‘It’s a code blue.’ ‘If you don’t come with me….stay in the shelter for just one night, or an overnight café, which is usually in the church, men and women mix, sleep on the floor – I’m gonna have to [involuntarily commit] you.’ Because I don’t want to… I think they need to be informed when they are [involuntarily commit]-ed. A lot of outreach workers won’t tell the consumer when they are [involuntarily commit]-ing them. They’ll do a sneak attack and that’s in my eyes a shame.

Perceptions of "relationship" in outreach work. In response to the question "In outreach there is a lot of talk about building 'relationships' (with consumers). Tell me about your thoughts about that relationship – for example, what does 'building relationship' with consumers mean to you?" and "How do you go about forming relationship with a consumer that will 'make the work happen'?", all participants agreed that relationship was integral to outreach work. Three participants found meaning in being a "people person" who could build relationship easily, in being a person consumers could come to about anything, and in the awareness that the particular vulnerability of the chronically homeless consumer requires patience in relationship-building. Three other participants moved directly into a description of how relationship building happened without first commenting on what building relationship meant to them personally. One participant, although initially describing relationship building as simply "maintain a good working relationship" with a consumer, followed with this, "I think it's important to establish a rapport with a person because sometimes folks just want somebody to talk to." This straightforward and intuitive understanding of human-to-human connection as important for all people pervaded the interviews of all participants in ways that will be explored later on in the discussion of emergent themes.

Perceptions of social identity as a factor in outreach work. To the question "How do you see your social identity – that is, race, gender, age, education level, class – affecting your work with consumers, if at all?", three participants denied any impact and four participants admitted that their identity affected their work with consumers. One participant who believed it did not affect their work referenced their experience in the field as superseding any importance of social identity.

> I don't think any of that affects my work. Like I said I've been working with the homeless for [X time]. I started when I was [X age], I'm [Y] now. I think I'm a pretty even tempered person. People don't have a problem talking with me. I don't have a problem talking and listening with them.

Another participant who believed that it did impact their work, also described this as a hurdle that was overcome by the relationship over time.

> Um, I think so at least initially. I'm [age], X race, and X class. I'm not even X class, I guess, but that's what they think. So I think initially it can be very…if I'm working with someone that's [different age group] [Y ethnicity person] that's lived in [X city] and smoked crack all their life …um, I got told by them that, a number of times in this project that …they often reminded me of my age and race and where I'm from as a means that I couldn't speak on their life or couldn't provide any advice. I think that's an initial thing I have sometimes, but I also haven't found that it's a barrier that lasts very long. People on the street tend to find more validity and more care in the way that you speak to them, the way that you treat them, then ….if you can show consistency, if you can show care, if you can show that you follow through, that you can listen to what they are saying and not be judgmental and actually showed some type of care, then in general, they overlook it.

Finally, one participant definitively stated that gender stereotypes of approachability affected consumer-outreach worker interactions. This participant also shared the belief that difficulty overcoming differences between outreach worker and consumer social identity might result in (or lead to) a worker's decision to leave.

Perceptions of the causes of homelessness, needs of consumers, and program design. To the question asking about their perceptions regarding the causes of homelessness, all

participants indicated that homelessness was caused by multiple factors. In addition to mental health and substance abuse concerns offered by most participants as primary challenges associated with the condition of homelessness, three outreach workers mentioned insufficient social support as a cause of homelessness. This sentiment is expressed in the following quote:

> I would say, underlying all of [those reasons], is a lack of support with families. I say, 9 times out of 10, if you talk to these guys, they are not connected with their family or they don't have a good relationship with their family. Very sincerely, I don't know if I've ever talked to anyone on the streets that has a good connection with their family or friends. I don't think I've ever heard that. Some of the guys that are "better off" seem to have it more together have better support networks. They might stay in at a friend's house for a while if they need to. The hard core street guys they have no connection with family.

In response to the part of the question asking, "What do you think would remedy the problem," three outreach workers' responses reflected feelings of hopelessness, including a feeling that there is no will on the part of larger society to finding remedies to the problem and that individuals lack the personal and financial resources to change. This hopelessness was captured in the following, "Far as a remedy for it. Honestly, I don't see a remedy."

To the question asking what they felt their consumers needed, participant responses varied. The most frequent response included a focus on individualized programs or services targeting individuals' specific situation. Other responses referencing the needs of their consumers included a strong will to change, a greater support network, and housing. An additional reference to housing needs, mentioned by three participants, appeared in another participant's response that homelessness was considerably more complicated than having enough housing. Here they explain one consumer's mindset.

> I think everyone needs a place to call home, I understand that. … one guy I know …he's not at all interested in going in. … he says, 'because it's quieter out here, it's better to be out here, it's better to be away from people." …I don't know, … For [him], I don't know if the ultimate goal is housing. I don't know exactly what it would be maybe but ….I don't know some people think that if you put people in housing that all the needs are going to go away and they are just going to kind of be all good, and I don't necessarily think that that is true.

In response to the open-ended question, "If money wasn't an issue, and you could design a service, program, or organization specifically for the needs of your people, what would that look like?", five participants responded that they would create a large multi-disciplinary social service hub where consumers could find individualized support. Of the remaining two participants, one responded that they would feed these consumers as much as they could and the other focused on consumer willingness to access already existing resources in lieu of providing their thoughts regarding alternative program design.

Key grassroots partner means having multiple roles

Homeless outreach work by its nature rests at the fringes between society, a social service system that has often let consumers down, and the consumers themselves who bring a wide range of experiences to this outsider status. Outreach workers both explicitly and implicitly understood themselves as the pivotal piece that connects this complicated picture. This notion was shared by one participant in this way. "I think the outreach worker has a real key job on the grassroots level to encourage someone who's homeless to come in, or to get services I should say." The multiple roles with which participants identified as components of outreach work was not surprising,

given their perception of homelessness as complex and dependent on multiple factors. The following emergent subthemes reflect the variety of roles participants experienced as a group.

Doing the work others want done. Participants often expressed the feeling that their work was both influenced by and subject to political, agency, or community pressure. Often this took the form of doing the work others did not want to do, doing the work others prioritized that might not necessarily be reflective of consumer need or interest, and a general report of being used by agency and consumer alike. One such pressure emanating from the community was captured in a participant's response.

> You know X neighborhood? The people that live right there in that area decided that they were tired of having homeless people sleep [there], then we spend [x months] on [x neighborhood initiative]. So definitely [others views] impact it, whether for good or bad, I don't know.

The perceived and real pressure exerted towards outreach workers to obtain consumer contact data for entry into the city's databases, as well as the use of recorded contacts as a means of determining eligibility for services, was reported as negatively affecting their work by two participants. The following quotes reflect the ambivalence shared among most participants regarding this aspect of the work.

> I don't understand the process of being picked. … So it's supposed to be whoever has the most contacts…contact sheets. Right? Which I think is not good. You could have somebody out there for 20 years that an outreach worker doesn't even know because they fly low under the radar. They're not screaming or yelling, they're not laying on the pavement being drunk, they're not in the parks, they're not in the business distr….you know what I mean? They're a loner, and there's a lot of them out there. They've been out

there for 15 or 20 years and maybe only 1 or 2 outreach workers know them. So they're not going to have the other contacts.

When you are looking at somebody who wants to get into a certain kind of placement and they're not eligible. So that's really the only time [decision making] becomes a problem because then you have to look at eligibility requirements for places and that's great, but at the same time what if its somebody who could really benefit from that service, but for some dumb reason they don't fit the criteria. For instance, a safe haven really good for mentally ill men, but one of the requirements is a certain number of outreach contacts but they don't have that amount of outreach contacts but we know they are out on the street, then it becomes a weird issue. Just kind of things like that.

Other pressures created by the documentation of contacts that were mentioned by outreach worker participants were how having to get contact data from consumers interacted with an already challenging atmosphere to earn consumer trust. Similarly, the focus list, a prioritized list of consumers partially constructed from number of contacts, at times symbolized the pressure for timely and streamlined interactions with consumers, an essentially external pressure with which they felt they must comply. Here, one participant poignantly highlights this pressure, and another highlights its benefits.

As we do contacts consistently with certain consumers, you build relationship, then you get their trust. Get their information into the database. I mean, everyday they see me you know, "Give me your contact."…But you have to build that relationship before you get the information that goes in the city database so that they can get the help they need.

> We try to keep everyone in the focus point of the participant to service them as best we can, which is why we have focus lists. We have case managers to work with us, the police, other agencies. It's slowly coming together. We are getting more of a continuity of care who still might fall through the cracks.

One participant pointed out how agency pressure towards documenting contacts leads to a potentially harassing experience for consumers:

> There is a very thin line between doing outreach and harassment. You know if I get a phone call about a guy on [X street and Y Street] and he keeps telling me 'I don't want to be bothered with outreach workers, I don't want an apartment, I want to be left alone.' Then I need to tell the people who are giving me the call and my supervisor, 'This is harassment now." They don't see it like that. Because if you are in the community, in the business district, you know, so who do you listen to? Do you listen to homeless individual, or do you listen to your boss? Because if you don't listen to your boss you're going to be written up and/or fired. And that's a shame, that the outreach worker, who's been on the streets for years, is telling you, 'he feels like he's being harassed and we need to back off.'

Participants voiced a feeling of being used in situations in which the focus of their work was or could be easily influenced by the demands of different stakeholders, including community members and other homeless service agency staff. One participant referred to the feeling of being used in the following way:

> We can kind of tell when the police or the community have particular interests. We can always tell right away. They might be asking, or we might all of a sudden see a whole bunch of people that are told they are supposed to move or not allowed to be where they

are. Maybe they were bothered by the police or different things, and that usually comes from some political agenda of some type. … So, I think it affects it in that sense.

This sentiment was applied not only to community and institutional stakeholders. The same participant pointed out how this played out with consumers.

I think from the client's perspective… there's a tendency for everybody to….not just with homeless individuals but….there is a tendency for people to get what they can get out of us. That's why I said a way to use us and get what they want. If they know outreach workers will give them tokens, or if they know an outreach worker will give them coffee or lunch or something, I think sometimes that they….or provide transportation….then I think sometimes they have a tendency to abuse that access. And to just…if it's towards the end of the month and they don't have money, they know they can call us, and they know we'll help them because we're obligated to in some senses.

Advocate for homeless consumers. Being a key partner at times entails advocacy. As seen in the literature, advocacy services provided by some agencies and outreach workers can take the form of national initiatives to end homelessness (Crane & Warnes, 2005); on an individual outreach worker level, however, this advocacy takes different forms. An advocate role can include educating, defending, making effective use of available resources and support, and knowing when to take action on behalf of someone. Participants found themselves playing an educative role with various community agents with regard to issues of homelessness and on behalf of homeless consumers.

A lot of them don't understand. They see us engaging with the homeless person…I've been questioned a lot by people. "How come you're not getting them off the streets? They shouldn't be here. They've been here for years." And then we have to explain to

> them that we can't force them off the streets. This is their choice. And then its like, "They're mentally ill!" But mentally ill people have rights also. You know? We have to respect their rights. So its like you have to constantly….because you're not only dealing with the homeless person, you're dealing with the community as a whole. The business owners. The residents. Women with their kids, because a lot of homeless congregate through the parks, you know? And it's like you are …almost defend[ing] the homeless person.

One participant expressed the ease with which they could access other providers and insinuated its usefulness in outreach work.

> It's actually very useful, um, because we are very highly protected. I can pick up the phone and pretty much get whatever kind of information I want just by saying I'm an outreach worker. Um, I can talk to so many different agencies and so many doctors, psych units.

The same participant, in response to the question regarding the role of the outreach worker, beautifully encapsulated the essence of advocacy: "So I think the role of the outreach worker is just finding connection with people and advocating and helping them get out of their own way a lot of the time."

"Somebody to talk to". Participants voiced the perception that, for the consumer, the outreach worker is simply someone to talk to and connect with. While on its face this may seem unremarkable, it is of utmost importance when considering that lack of social support or precarious ties to a social network is a contributory factor to the vulnerability of a population (Mechanic & Tanner, 2007). Being someone to talk to most closely connects with a psychotherapeutic function. Similar to therapists, outreach workers offer a listening ear to the

chronically homeless consumer. As per participants' report, this seems to be the role, or service, of which consumers take the most advantage. From the participants' viewpoint, it is also what is most likely to lead to consumers' accessing or reengagement with other social services.

> Being consistent. … Always, at least acknowledging them, speaking to them. Being a good listener to them when they just want to talk. …Pretty much just maintaining a good working relationship with the person. … Some people will try to talk to you for an hour straight if you let them do that, I mean, it's a long shift so we usually let a person talk if that's what they want to do and then, if I see somebody else, that may be in more of a need in just the area. Kind of let 'em know. 'I want to hear what you are saying but I see so and so over there is trying to get my attention, he may want to go in tonight so let me go see what he wanted. If you still want to talk, I'll come back and talk to you.'

This listening is not limitless either, one participant noted.

> It's a very long long process and I believe most of it is by listening and having no judgment, none. For me, I do set the boundaries. I tell them, I'm not their friend, because I wouldn't let a friend sleep on the streets. I'm not one of their peers. I'm not their 'home ---'. I'm an outreach worker. This is what I can do. And this is what I *cannot* [emphasis added] do for them. I cannot lend money. I don't buy them food.

As this participant quote indicates, the consistency in listening extends to the consistent offering of other tangible and intangible services for consumers. Although this participant claims to avoid buying food for consumers, the outreach workers in this study do employ a strategy of consistent offering to consumers. This takes many forms, including referrals to physical services such as shelters, D & A programs, and food banks or physical goods such as socks, tokens, food coupons, or coffee.

Forming a relationship with consumers reflects a principle thought to be effective in outreach work (Levy, 2000). Building this relationship, similar to alliance building in psychotherapy, can be thought of as offering a client or consumer unconditional regard or lack of judgment (Rogers, 1961). In the vein of being at the forefront of homeless services reform, the outreach worker employed a similar condition-less offering of time and a listening ear on the consumer's timeline – a truly extraordinary practice in a time of pressure towards measurable outcomes and practices in social services.

> I wait on them [so] they know who I am. For them, I don't try rush 'em into nothing, you know? I take my time with that because you might run 'em away. I don't want to run 'em away. I want to keep 'em.

Reflective of the literature describing "stages of change", one outreach worker observes differences in consumers' readiness for change through their ability and resolve to ask for help (Prochaska, DiClemente, & Norcross, 1992). "Some people don't ask for help. Or don't know how to ask for help."

According to the literature, the outreach worker does experience challenges and obstacles in connecting with consumers and co-workers for various reasons (Blankertz, Cnaan, White, Fox, & Messinger, 1990; Fisk, Rakfeldt, Heffernan & Rowe, 1999). Emotional groundedness, balance, and stability came up for one outreach worker as important in their ability to remain calm.

> I don't need a whole lot of stress and drama. But whenever that comes up, I'm bottom line saying, I'm learning to focus on [Self-Referencing Name] now. And it's good to help people, but you can't help nobody if we can't help ourselves.

This participant's allusion to stress in outreach work is supported in the literature discussing the potential for burnout in outreach services (Nelson, Johnson & Bebbington, 2009). Another participant was more specific about their internal experience of managing their emotions of their work, providing insight into the unique boundary-setting challenge facing outreach workers.

> Emotionally, I've found a way to detach myself when I go home. Because emotionally it can take a toll on you. Because you do form bonds out there. I'm seeing someone everyday, or twice a week for [X time], I do have a relationship with them. I try to keep the boundaries as tight as I can be. When they die or get sick, it does take an emotional toll on you, it's hard not to think about the person.

Another participant described letting consumers too close emotionally as potentially problematic.

> It's a risky job. Uh, emotionally, I've learned to deal with my emotions as time went on… I don't get too involved emotionally with the job because I know it's risky…uh… I lose interest. Know what I mean? So I keep myself balanced in that area.

Most participants saw relationship and trust-building as primary to the work of homeless outreach. The one participant who emphasized relationship as a means to an end goal of placement still revealed the necessity for respecting the consumer's pace. The following quote speaks to acceptance as a key element in making the connection with consumers.

> "When you ready, let me know. Then we can do the paperwork." And that's basically what it's about. Know what I mean, if you get a relationship in between that, it's fine and good, but the thing is, you're trying to get them into placement. That's it.

This participant played down the importance of relationship in favor of placement in the context of service delivery. Interestingly, the same participant was the only one to include an allusion to a consumer's tendency to return to visit peers and outreach workers in the field after having

already obtained some sort of housing or services. This speaks to the implicit understanding, on the part of the worker, of the value and importance of relationships formed in the course of outreach work, despite a stated emphasis on placement as an end goal. In this poignant statement, the participant again plays down the relationship but does so from a place of wishing a better future for consumers. In this way again, the participant demonstrates the genuine relational care outreach workers have for their consumers.

> I mean and then when it's about housing, it's about keeping the housing. "Don't come back out here." (*voice of outreach worker*) It's about keeping the housing. You don't have to come back out here and let everyone know how you doing. You know, that's just a trap for you. You know, it's all right to come through sometimes but keep it moving. Live life on life terms. But a lot them still come out here.

Acceptance and empathy, in particular, are often tools for therapists. Here one participant's description of an encounter with a potential consumer expresses the use of similar tools.

> Well I think it's like, say you if you're a homeless person and I come up to you, and I'm like, hey George 'how's your day?' And you're having a really bad day. I don't know this, it's my first engagement with you of the week and you're just like, 'get the fuck away from me.' I don't take that personal. Or you might even throw a bottle at me and miss. I'm not going to hold that against you. Number one, I'm being verbally abused or that you threw something against me. I'm going to say, 'George, it's not necessary to treat me like that, but when you're in a better mood, you know how to get in contact with me.' I keep the boundary but I walk away. And I respect where he's coming from. I'm not going to sit there, stand there and argue with him. I'm not going to get in a shouting

> or cursing match. It's useless. So that's where the good attitude comes in. … I don't take nothing personal. Nothing whatsoever from them. I've been yelled at, screamed at, things thrown at me, you know, I just keep it….its not even professionalism, its just the way I am as an individual. I don't let their emotional outbursts affect me whatsoever, but I keep that boundary with them and remind them. You know what I mean? That I'm not going to accept that, but I'm not going to hold it against them.

To this participant, acceptance, respect, and consistent offering, all tools of the therapist, are what is needed in holding the client's often volatile situation.

Insider critic of homeless milieu. Throughout the interviews, participants made critical judgments regarding which groups or individuals have ultimate responsibility for facilitating the connection of street homeless consumers with services aimed at helping them "come in", as well as removing barriers to this connection being made. Some attributed the state of homelessness to the consumer; some recognized the problem as systemically caused. In line with the former viewpoint, one participant's response spoke to the consumer's willingness to access services.

> [There]'s resources available for them, but like I said, you got to be willing. If you ain't willing, it ain't gonna work. We got places for them, we out there for 'em everyday. There's places for them. But once we take 'em there, they got to do the footwork. That's the thing, you know what I mean. They don't do the footwork.

Another participant stated, "The resources are there for them. But it all depends on their state of mind, whether they will pursue any of them. That's the hardest thing really."

These participants refer to this lack of willingness as a tangible barrier to connecting consumers to resources. As expressed in previously quoted material, eligibility criteria for resources were noted as perceived obstacles to consumers' access to needed services. Three

outreach workers took the stance that eligibility requirements or other criteria based on number of contacts presented an obstacle for consumers. One of these workers expressed support for reducing barriers to service provision through mention of housing first models of service:

> We need more programs like that. They don't put all those demands on people that you have to have this to get into this program, you have to have that to get into that program. You homeless, you eligible for housing first. That's the requirement.

Two other participants never mentioned criteria or eligibility requirements as a barrier. One of the remaining two participants accepted eligibility criteria as part of the decision-making process, and the other expressed frustration in conforming to eligibility criteria that was just part of the system. The latter is expressed in the following, "there is a criteria we have to follow. So I've been learning not to get so frustrated and follow the criteria."

Another participant conceptualized barrier to service provision for consumers as a mentality that the consumer might adopt.

> My experience with a lot of the homeless … they are …mentally homeless. … it gets complicated for them to figure out how they are going to come up out of this. And even when you trying to help them, … they get in the way, because of their mental illness. … A lot of people out there they got so accustomed to living like [this], that they don't know any other way.

On the other end of the spectrum were the participant responses that critiqued the mainly systemic inadequacies perceived as contributing to the continuing problem of homelessness. One participant thought that the system was not really interested in ending homelessness.

> I think, deep truly in my heart, that the decision makers, the politicians, the mayor, whoever, I don't think they want to stop homelessness, whatsoever. They come up with

> these X plan, then it's Y plan, then it's Z plan. I don't think United States as a whole wants to stop homelessness…No they're not cutting it. It's just so that they can say they have a policy, so they can say they've had a plan. They've been planning for [some time]. The homeless population is growing and growing. It's just to keep the communities….I guess the politicians or whoever makes the decisions are like, 'see, we are trying to do something with the homeless population.' You know what I mean? I think it's just a subject for people to talk about who makes the decisions.

One participant particularly struggled with balancing frustrations at the system level with a belief that the homeless consumer had an equal part in improving their situation. The following quotes by the same participant highlight this push and pull.

> it's just something that I think stressful that happened for me, the lack of continuity, of a person getting the services when they coming out of prison, coming out of the hospital, … someone might not have followed-up on their part. It's not the homeless person's part, it's not them. They gave me the problem. Mostly I got frustrated with the system itself.

> I've gotten better with not trying to critique the system, and become a part of a problem as opposed to the solution. Sometimes, the solution isn't always like what I might like to see with an agency, … And the person has to do likewise. … you just have to let the system do, and let the process take its own course. So I try to encourage folks to just follow the procedure. … you still have to work with the system to some degree. I assume you can't change things over night by myself. So you just kind of have to buckle yourself in so to speak and just take the ride.

Salesperson for a new life. Participants referred to themselves as [a] "people person", implying a good fit between the nature of this work and their personalities. This self-designation seemed to add a layer of meaning to the participant's work. One participant stated, "but for me this is my passion in life." Another participant's lived experience with homelessness also added an additional layer of meaning to their work expressed in the following, "the giving back thing and that gives me… appreciative, being appreciated by somebody."

The connection to being "made for this kind of work" and finding meaning in and appreciation for the work led to a shared sentiment among participants that they were uniquely qualified to "sell" consumers on a different life.

> I see my role as meeting the homeless person where they're at. I don't put no expectations on them. I don't judge them. If they want shelter or placement, they know how to access those services. I just feel like they need to be heard. And my main role is to just listen to them. Build up some trust and then try to sell them a different life. Like I've become a salesperson, about how people can live indoors and deal with life on life's terms without using or staying on the streets. That their day to day doesn't have to be survival of the fittest.

Experience doing outreach work

Outreach workers shared their experience doing their work through different lenses. They expressed a range of feelings, at times disenfranchised, empowered, or with a sense of existing or understanding where the consumer was "at".

Disenfranchised voice in homeless services. Being the key partner situated between the service system and the homeless consumer was often reported as having an embedded sense of powerlessness. Similar to their feelings of being used to accomplish the work others wanted

done, disenfranchisement for participants included feeling unappreciated, feeling low in rank at their agencies, feeling less than, and feeling disappointed in the treatment of others towards consumers. One participant spoke frankly of their perception of the way in which outreach workers were viewed by their peers in homeless services. “Nobody wants to be an outreach worker, they want to be a case manager, they want to be an after-care…it’s like an outreach worker is extremely low … It’s a thankless job.

The same participant continued to express this sense of being treated as “less than”:

> How other coworkers see us, we’re extremely low on the totem pole, extremely low. I think, even the directors. “OH, outreach, they work with the homeless..” [*said in a disparaging voice*] …They [coworkers] don’t know how to deal with homeless people. Even though, ‘I’m coming to work everyday, you know, I walk by three homeless people, you know, I don’t acknowledge them.’ Your department is outreach, homelessness. You’re not going to even acknowledge the homeless worker let alone the homeless individual.

Being treated as “less than” extended to interactions with the community and other community officials. One participant was ashamed and disappointed at how the community treated or viewed its homeless and therefore, responded negatively to the question “How do you see work with ‘others’ figuring into your work with consumers? For example, community residents, police, elected representatives other consumers, if at all?”

> I really can’t speak on that. (Pause) Because it’s nothing positive. You know, it’s really a shame how people view the homeless. They look what they have on, how they smell, and just forget that they are a person first. You know, and they could be their family. You understand what I’m saying, so it’s always a negative thing. (Pause)

Even though this treatment was not directed at them, this participant responded as though the comment personally hurt them. As will be discussed in the final chapter, this close connection with consumer experience was prevalent throughout all interviews.

Similarly, in a culture of being perceived or treated as less than, some participants observed other outreach workers at times as treating consumers as "less than". One participant voiced this sentiment in the following way, "A lot of people… I can't say a lot of people… some people that does this stuff, that does this work think they up there and they down there. You can't judge a person."

Participants, at times, expressed disappointment with the various agents in homeless services. One participant highlighted a moment when other (non-outreach) workers, involved in the care of their homeless consumer, had let both the outreach worker and their consumer down.

> But the social workers kind of, I would say, dropped the ball. All [they] had to do was make a simple phone call. [They] probably didn't know to make the call. Another person had to make it. And they were frustrated too.

The essence of disenfranchisement was poignantly captured in one participant's expression of frustration at others' perception of their role.

> But if we're the professional outreach worker then you [*seems to emphasize this*] need to respect our ideas, our viewpoints. And I believe they're not respected because most of the outreach workers don't have a college degree. That's what it comes down to. Most of the outreach workers don't have a college degree, um, I can only think of one outreach worker who does have a college degree and absolutely does not like outreach but stays in it because [they] have not gotten a new job yet. So, it's like, 'the outreach worker can't make the serious decisions', or 'they can't give their ideas', or their ideas are just cast

> aside because we don't have a degree. And that's what it comes down to… My own coworkers at work. Supervisors. Yeah.

The same participant, in response to what they felt consumers needed spoke what seemed to be the underlying truth for consumer and outreach worker alike.

> I think they need more respect, from the community. I think they need more respect from the community, from the professionals, from the politicians, from outreach workers. I think they need…I think people need to stop looking down on them.

This sense of feeling judged was present in other participant responses, this one in response to how the community thought of the role of the outreach worker, "Honestly, the public at large is like, we're not doing our job because they are still on their streets." Another worker expressed the general lack of knowledge.

> I'll get someone who says, 'You do such great work, thank you for helping, its really great,' we've also had people come up and tell us to leave people alone that we're talking to…we don't happen to have outreach gear on, or whatever. So I think in general there is a lack of knowledge.

Two participants expressed their wariness of the shelters as a resource. In the following quotes the participants express the challenges shelters face as well as the hesitation of consumers to place their trust in the shelter as a resource.

> The hardest problem actually with confidence in resources is the city's shelters and private shelters. Probably the biggest problem with resources. Which is too bad because….they are the biggest ones… part of it is a shortage, but there's just a lot of complaints that come out of the shelters. Some of it's the client's issues, some of it's the staff's. Just thinking about bed bugs is a big huge thing. People won't use certain

resources because they had a bad experience maybe they had bed bugs when they were there or maybe a staff person yelled at them when they were there. I think any resources I would have lack of confidence in would be the shelters, but I think that's because they are so highly used and so big.

Some folks from what they say their experiences are at the shelter are that sometimes the staff aren't so nice, sometimes the other people at the shelter aren't so nice. I haven't witnessed that, so I can only go on what the homeless consumer says to me as to why they don't want to go there. It's probably a little bit of both. I don't think everyone is lying. So, it's probably a little bit of both. Um, so probably a little bit of revamping, maybe some better training for shelter staff and things like that.

Empowered voice in homeless services. Being the key partner at the edge of homelessness was also at times reported as one of being empowered to take certain liberties not easily afforded other service providers. Compared to other civil and social service professionals, the homeless outreach worker relies heavily on the attribute and skill in the use of flexibility and the autonomy accorded them to do their work. One participant highlighted this difference in comparison with police officials.

The police has an entirely different mentality when it comes to the homeless. A criminal is a criminal and a crime is a crime. That is totally understandable. But I think you need to have some flexibility when you talking about someone with a mental health problem, even with someone with a substance problem.

Another manifestation of participants' recognition of the benefits of flexibility in their work with vulnerable populations was the leverage provided by unobstructed access to consumer

records. This was especially true for work that involved facilitating referrals or finding relevant consumer information necessary for a successful engagement with the consumer. One outreach worker highlighted the benefit of this.

> I probably shouldn't say this but we're kind of above HIPAA laws, we're kind of protected by the city and the Department of Behavioral Health so a lot of times we can operate without a lot of restraints which is really really beneficial. I think that's why sometimes we are successful because we are able to jump across things and provide information to people and do things that …yeah….probably can't say that, but… there's also a lot of leeway with us being able to advocate for people. And being able to say, 'no we really think [they are] the best fit,' even if [they are] not eligible [for X program].

Existing where the consumer is at. Outreach workers work at the edge of traditional human service provision for the chronically homeless in that they are physically and psychologically meeting consumers where they are at. Existing where the consumer is at manifests in the physical space outreach worker and homeless consumer share, in the approach outreach workers use to engage homeless consumers, and in the empathic connection or affinity outreach workers have for their consumers and their situations.

As opposed to work that takes place in building-based resources such as shelters, soup kitchens, housing agencies, or D & A programs, outreach workers locate and meet with the chronically homeless wherever they may reside. In response to the question, "What's your experience as an outreach worker?", one participant offered the following.

> Well, physical can be, it does take a toll on your body because you're walking a lot, you're bending down. I like to bend down, meet them where they're at, give them good eye contact. So I'm bending and squatting a lot. Sometimes you have to wake people up

> during the winter, and during the summer if it's too hot and they have too many layers on. It can be extremely dangerous. Most homeless consumers do carry weapons. Because they do have to protect themselves. [Work with] the mental health population … most of them are medicated, they do have delusions, some of them could be directed towards us. Then you have the alcohol and drug consumer who will if they don't have the money they will try to rob people or hustle. You know?

Another participant echoed the notion of being at the same level as homeless consumers as both an important and effective use of their physical presence in this space.

> Meet them where they are wherever that happens to be. I know that I get some criticism from my coworkers that I sit close to people. That I get on people's level, because they say that that's not safe. Um, but if someone is sitting on the street, I'm not going to stand and talk to them. Nine times out of 10 I'm going to sit down there with them, or at least squat down or kneel down, so that I'm at least somewhat at the same height as their eyes are. … some people stand up and look down at people all the time which isn't very effective, um, so I found that to be.

In this way, the environment of the work is complex, consumer-centered and transient. It requires adaptation on the part of the worker to individual consumer need and circumstance. At times, the space of "where the client is at" manifests as the invisible boundary that the outreach worker must discern in order to non-threateningly engage the homeless consumer. Three participants explicitly expressed a sense that this boundary was important in connecting with consumers, at the same time expressing difficulty clearly defining the nature of that boundary. One of these participants tries here to explain this phenomenon in terms of timing, "I think it's a

lot about consistency and a lot about knowing where boundaries are. Knowing when is the time to back off and let people alone, and when is the time to push for more."

Another participant spoke to the delicate balance that must be reached at times with consumers - a balance best negotiated in the space that the outreach worker and homeless consumer share. In this shared space, participants seemed to empathize strongly with consumers. One participant shared thoughts about how easily one could become homeless.

> It's definitely not that everyone that's homeless is out there on drugs or mentally ill or something like that. Because I see a whole lot of regular folks that are homeless. People that are still working but still can't afford to get an apartment because maybe they are just working at McDonald's or something like that. So they working during the day and sleeping there at night. You know they are saving up money just to get a room or something like that. The thing is unfortunate. I have my own personal friends who have master's degrees and been unemployed for 3 or 4 years, so I know it's not easy…I mean if they can't get a job, this homeless [person] who maybe has no degrees, some of them, it's even tougher for them. I don't judge. It could be either one of us any day. A couple of paychecks short of being homeless.

Several participants expressed statements of genuine humility, which seemed to help one of these participants tangibly take their lead from consumers.

> And they know the system better than us. So with their experiences, they know where they got what seemed to be better treatment, so I let them….letting them make their own decisions. It's not my decision to make where you sleep tonight. I think that's best. My supervisors, they all have been doing outreach a lot longer than me, and that's pretty much what they told me. Let them choose where they want to go. And that's good. If you

try to force a person they don't want to go, they're not going to go with you anyway. [*laughs*] So let them make the decision for their own care.

Another participant referred to learning humility as important in setting an example for consumers about being honest rather than deceitful in engaging the system.

> I guess one of the most frustrating things for me is when someone makes a mistake and they don't own up to it. I had a couple of situations that I was in, [that] I didn't own up to and it was a big stink, a big mess but then I learned to humble myself even more and be honest and take it on the chin if I have to. If I made a mistake, I learned more to own up to it, it could be hurtful and painful … Be honest. Be honest, that's the key factor here. That's what we tell the homeless population. They think lying is going to get them certain services. Just be truthful.

This unclear and varied space (both physical and existential), existing outside the boundaries of what is socially acceptable, exemplifies the unique character of chronic homelessness. This space is one where few service providers enter and one in which only a sub-group of the homeless dwell for long periods of their lives. Both homeless consumer and homeless outreach worker occupy this ever-changing space. One participant expressed their appreciation of being on the frontlines of the effort to end homelessness.

> Now that I've been here so long, I just want to be a part of this. Homelessness. The end of homelessness. And they getting younger. It's not at a rapid growth, but it's growing, it's not decreasing, it's increasing.

CHAPTER V

Discussion

The intent of this qualitative study was to explore the experiences of outreach workers who provide services to the chronically street homeless population. The study elicited participants' in-depth thoughts and perceptions about the work they do. Study findings provide a valuable provider perspective of a generally unknown and unpublicized interaction between a vulnerable population and a service provider.

This discussion will begin with a comparison of study findings to the extant literature on outreach work with the vulnerable chronically homeless population. The discussion will continue with a focus on the most salient findings of outreach worker's perspectives on their work, relating each finding to harm-reduction practices in a relational frame. These findings include the following: conceptualization of the homeless outreach worker as an inherently multi-faceted role; outreach worker experience of clarity and confidence in regards to issues of consumer choice and autonomy; outreach worker feeling of being alone, unheard, and insufficiently supported in their work; and outreach worker reflecting the general paradox or inconsistency of holding both the view of systemic and individual responsibility for changing the state of one's homelessness. This will be followed by implications for practice, policy, and research. A summary will conclude this chapter.

Findings in relation to what is known in the literature

The findings verified varied aspects of what has previously been discussed in the literature. Participants reported being caught in the dilemma of referring to inadequate or low-quality services in order to achieve the implicit goal of connecting consumers with existing, albeit underresourced, programs. Also supportive of the literature on work with vulnerable populations was a reported role of facilitating transition for consumers between varying housing, economic, familial, substance, or mental health circumstances. Participants supported individualized programming, one-stop targeted drop-in-like centers, as well as *housing first* model programs for consumers to support facilitating this transition. Additionally supportive of the literature was participant report of need for a consistent and continuing pattern of care and social support with vulnerable populations (Mechanic & Tanner, 2007). Participants described relationships with consumers that simultaneously provided a rare social contact for a very isolated population and consistent checking-in which was critical to the work.

Participants did not refer to the stages of change model per se (Prochaska, DiClemente, & Norcross, 1992); however, they did report knowing when a consumer was in the mood to talk and/or be referred to some resource. In this way, participants assessed the landscape of consumer readiness for any shift in their current situation. With regards to facilitating connections for consumers with services in which they had little or no interest (Spencer & McKinney, 1997), most participants reported respecting consumer choice unless safety was a concern. In making these decisions, participants reported taking context into account, given potential consumer mental health or substance issues; this finding supports the literature describing the complexity of issues involved in work with this population. Participants frequently reported that the "choice" of a decision was usually clear. This implied that outreach workers did not experience

ethical concerns around consumer choice, although this response may be a reflection of possible weaknesses in the format of the question regarding decision-making, which asked "As an outreach worker, what does decision-making look like?" Although several prompts were included to spark conversation around decision-making which included the kinds of decisions, potentially unclear situations, or situations in which consulting others was critical, participants generally responded formulaically to their experience of decision-making perhaps as a defense of their ability to do their job or as proof thereof. However, since participants did report decisions as, often, clear situations, this did imply a "right" choice. Their use of the word clear indicates an implicit favoring on their part for either client autonomy or client protection depending on the circumstance. Therefore, while on the surface responses appeared formulaic or defensive, in fact, they contained an implicit understanding of the ethical dilemma involved. This further highlights the interaction between client autonomy and client safety in decision making as is currently presented in the literature review.

The literature has just begun to postulate factors that contribute to effective outreach work with specific subsets of the homeless population including substance abuse and homelessness (Fisk, Rakfeldt, and McCormack, 2006), mental health and homelessness (Tsemberis, Moran, Shinn, Asmussen, and Shern, 2003; Tsemberis, 1999), and more generally with the chronically homeless as a whole (Kryda and Compton, 2009; Levy, 2004; Levy, 2011; Ng & McQuistion, 2004). Participants reported a stance of unconditional acceptance in engaging consumers, reflected in the literature on the housing first model which endorses elimination of housing prerequisites (Tsemberis, Gulcur, and Nakae, 2004). Also observed in the literature was a tendency to hire outreach workers with similar lived experiences with consumers (Hidalgo et al., 2011); the report of some participants of histories of homelessness and/or participation in

rehabilitation from substance abuse or mental health services supported this finding in the literature.

The literature on what doesn't work and the challenges present in homeless outreach has been more clearly developed (Fisk, Rakfeldt, Heffernan & Rowe, 1999; Melamed, Fromer, Kemelman, & Barak, 2000; Kryda & Compton, 2009). Participants confirmed that many consumers found it difficult to trust others because of their complex past experiences. They also made reference to the delicate balance between knowing when to engage and when to lean into consumer interaction which may lead to some accessing of services. Also consistent with the literature was the observation of consumer lack of confidence in available services such as shelters. This was additionally supported by participants themselves expressing lack of confidence in resources for reasons including scarcity, quality, and rigidity in eligibility requirements.

As alluded to in the literature on embedded biases that shift conversations (and therefore service provision) between social workers and consumers (Spencer & McKinney, 1997), participants had mostly aversive and defensive reactions to the question about the interaction between social identity and service provision. Of the four participants who responded that their identity did not affect their work with consumers, three appeared to interpret the question as asking whether they discriminated in helping consumers either because of their own or the consumer's social identity or if they themselves had been discriminated against. Interestingly, all of the remaining participants who indicated a belief that social identity did affect interaction with consumers in some way referred to outreach worker-consumer differences they or their consumers observed in terms of education level, ethnicity, race, and gender. Although statistical associations cannot be drawn given the small size of the sample, it is interesting to note that

participants who most frequently voiced the importance of "being with" consumers "where they were at" were also those whose social identity differed in some way from the majority homeless consumer demographic. This may imply an imperative on the outreach worker's part to be aware of differences in social identity between themselves and consumers and to appropriately inquire, understand, and contextualize their consumer's background. Complementary to this would be the tendency on the part of outreach workers who share more visibly recognizable similarities between themselves and the consumers to overlook specific individual social identities and therefore the potential risk to consumer well-being that may result from decontexualitizing a particular consumer's situation.

Homeless Outreach Work as Multi-Faceted

Participants reported carrying out a variety of roles in homeless outreach work, with their most important skills perceived as being their ability to be flexible in their approach with individuals and systems, their ability to listen, knowing how and when to advocate for the consumer, and being consistent for consumers. Their ability to connect with consumers largely depends on locating consumers, the nature of interactions with consumers, whether they have the time to subsequently listen to a consumer, and lastly whether they can synthesize their knowledge of available resources, the current perception of the state of the consumer, and timing to determine whether safety concerns override the consumer's autonomy.

For outreach workers to find and reconnect with members of the chronically homeless population, they necessarily need and are generally given the autonomy to use their knowledge of the local area to locate and/or intuit where a consumer or consumers might be frequenting. Additionally helpful in locating consumers is the network of consumers, community members, police, local businesses, hospitals and other service providers who might provide useful

information to facilitate the frequency of these encounters. All of this requires flexibility, time, and patience on the outreach workers part. For consumers with isolating, antisocial tendencies to be heard, frequent check-ins, a listening ear when they are ready to share their experiences, and their connection to someone with a knowledge of currently available resources and unregimented flexible time commitments, as offered by outreach workers, are invaluable in making connection possible.

Similarly, advocacy for consumers may take many forms for outreach workers. Directly contacting service providers such as shelters, churches, D&A programs, social workers and if need be, “back door”-ing consumers to avoid potential barriers to accessing treatment implies knowledge of multiple systems, program requirements, and their consumers’ current situation. Similarly, in weighing the appropriateness of available resources, consumers and outreach workers together may critique and thoughtfully consider current service provision while simultaneously engendering a perhaps regained sense of empowerment on the consumer’s part. Also embedded in the advocate role was a community education function. The context for this function included: the inclusion of consumer perspective for new community outreach initiatives being implemented; in response to the inquiries of the general public regarding the frequenting of homeless individuals in a particular area; or in general community forums in response to a blaming of consumers for their homeless situation, invoking outreach worker education with regard to consumer situation.

It emerged through the findings that since the nature of their work requires a variety of roles often necessitating consistent contact with consumers before referral to other resources, continuing contact with consumers acted as the consistent pattern of care particularly helpful to engage vulnerable populations and facilitate their potential reengagement with the broader

system of resources. Considering the variety of manifestations of outreach work with vulnerable populations that include educational outreach for HIV prevention (Hidalgo et al., 2011), community-based early psychiatric intervention with the elderly (Ma Shwe Zin et al., 2009), and assertive outreach nurses (Addis, & Gamble, 2004), it is not surprising that work with one of the most vulnerable populations - the chronically homeless who often suffer from co-occurring behavioral, as well as physical health problems - encompasses a multi-role conceptualization. Just as the parable between Diogenes and Alexander the Great highlighted the need to offer help not tied to a particular outcome with vulnerable hard-to-reach populations (Adlam & Scanton, 2011), outreach worker responses described a heavily context-dependent work practice with a wide range of "successful" outcome definitions.

Whether it is determining the best time to have a difficult conversation with a consumer, or being flexible with regard to what a particular consumer might need, it is hard to ignore the non-judgmental form of this relational work. Similarly, when a consumer is angry and needs space, or when a determination is made that an offer of shelter or other housing is the more appropriate option for the consumer than involuntary commitment, the outreach worker employs methods of harm-reduction which serve both consumer safety and autonomy.

The Choice is "Clear"

Outreach workers reported that decision-making was usually a straightforward, clear process. The clarity with which outreach workers referred to situations in which consumers had finite choices between being involuntarily brought into hospitals and staying on the streets was different from the ethical dilemma presented in the literature (Fisk, Rakfeldt, Heffernan & Rowe, 1999; Melamed, Fromer, Kemelman, & Barak, 2000). The findings imply a somewhat default formula for situations where the potential for safety concerns are an issue. Clarity and

confidence may have been reflective of a reliance on agreed-upon safety measures for potentially complicated situations. The implications for practice – discussed at greater length below – are clear, as being attuned to the difference between an uncomfortable situation and a dangerous one requires skill and training.

As amply illustrated in the findings, outreach workers breach the consumer's autonomy and infringe on the trust building relationship only when safety is an issue. Again harm-reduction in the midst of relationship building is the frame in which the outreach worker exists with homeless consumers.

Alone Together

Collaboration and communication were surprisingly unreported as part of the outreach worker role. Particularly striking in the findings on disenfranchisement and doing the work others want done was the participants' report of feeling alone in their work and feeling not highly valued among peers.

The participant experience of not feeling understood was apparent in the findings. Being let down also fit with this notion. Participants expressed the experience of feeling disappointment in being let down by coworkers and community members in reference to perceived coworker/community lack of effort in understanding their homeless consumers. The outreach worker felt vulnerable to the whims of community interests and homeless services funding, as well as to an ever-changing political attention to the problem of homelessness. Similarly disenfranchising for participants was the reported emphasis on the use of contact database entry and focus lists as a primary guide to service delivery; in the context of continued failure to provide adequate services to consumers, exemplified by over-crowded or distrusted shelters, this emphasis engendered resentment, frustration, and a perception of an additional barrier to smooth

service provision. Perhaps the most striking finding was the pervading sense among respondents that outreach workers were not acknowledged for the importance of their work with consumers. As noted in the findings, one participant stated explicitly that their views were not valued by their own supervisors, as well as by others. Even though outreach workers expressed pride in the work they did, the findings indicate their perception that the greater system values, instead, the number of "contacts" they or the consumer have – sometimes to the detriment of the consumer. The use of outreach contacts as a proxy for meeting eligibility criteria falls far short, in workers' eyes, of an equitable method of documenting need among those they serve. Given the drive in social services for more measurable evidence-based practices this finding was not surprising.

In the space of work with the homeless, no other individual role seems to be closer to the homeless consumer than that of the outreach worker. The homeless outreach worker necessarily must push the limit of what might be considered appropriate, effective, or the norm in working with a vulnerable hard-to-reach population. As seen in the findings, participant report of having the support and flexibility to push these limits implied their perception of value and appreciation by others for their work. However, similar to their homeless consumers, the homeless outreach worker often felt "less than" others in the field of homeless services because their voice was not heard and the expression of appreciation from others for their role too infrequent.

In the course of interviewing outreach worker participants with experience ranging from under a year to over a decade, findings emerged indicating a wealth of experience in outreach work that could be used more regularly to inform practice, policy, programming, and research. The interviews with outreach workers were a unique experience in which they were the focus of study and their own voice the desired perspective. In this way, their responsiveness to questions

in the context of the interview setting was a reflection of an evident lack of any similar opportunity to provide feedback in the course of being an outreach worker.

This finding more than the others illustrates the relational frame of outreach work. Particularly, intersubjectivity regards two individuals with their own perspective and histories, in this case outreach worker and consumer, as two interacting beings that create a new space. In terms of outreach workers' relative disenfranchisement that is both similar and unique to the consumer's experience, this new space can be a space of mutual understanding to some extent. To be understood and heard is a powerful experience that, just as the consumer may experience in the outreach worker-consumer interaction, so it appeared the outreach worker participants also partially experienced throughout the course of their interviews.

Holding the paradox

The findings illustrate an interesting paradox in relation to both the cause of homelessness and the responsibility for its cessation. Among the homeless population, the chronically homeless are largely distinguished as a subpopulation by their repeated decision not to initiate help-seeking (National Alliance to End Homelessness, 2011a). However, on the surface, this characterization appears to contrast with the multiple causes of homelessness mentioned in the literature (Lowe, 2001; Quigley, Raphael, & Smolensky, 2001; Lipman, 2001) and those reported by participants in the study. Outreach workers acknowledged the complexities that contribute to chronic homelessness and still at times provided what appeared to be unidimensional descriptions of the problem. In providing their perspectives on the problem of homelessness, participants often focused on consumer willingness as the primary obstacle to consumers accessing resources. This individualistic viewpoint contrasted with participant responses that at times attributed the responsibility for chronic homelessness to either systemic

inadequacies, professional and societal interactions with consumers, or punitive policies for consumers. This push and pull between an individual versus a systemic focus for homeless outreach was not something highlighted in the literature thus far. For homeless outreach workers, holding the paradox - that the cause of homelessness is both due to often complex and circumstantial forces such as employment, recent disability, economic and social hardships as well as individual choice and preparedness for accessing available resources – perhaps reflects the complex nature of homelessness as viewed by the homeless outreach worker who is privy to one of the closest perspectives to consumers available. Holding this paradox as a front-line homeless services worker has implications for the practice of homeless outreach work.

For therapists, holding paradoxes that consumers are unable to hold at any particular moment is one of the primary functions that they serve. Similarly, it is possible that outreach workers serve an equally important function relationally for consumers: that of someone who can wait and hold the complexity of their situation just long enough for the consumer to re-appropriate control of their life by whatever means they find suitable or dignified.

Implications for Practice

In carrying out the role of advocate for the consumer perspective in homeless services as well as the role of insider critic, outreach workers embody a critically important role in any system where human service provision is the goal – that of the person who empathizes with the consumer of said services. The closer the voice to the consumer, the closer service provision meets the needs of consumers. Opportunities for the voice of outreach workers to be seriously considered consist, in part, in being included in decisions about whether, when and how new neighborhood initiatives might commence; how seasonal outreach efforts such as Code Blue or Code Red are implemented; what types of opportunities may exist for the creation of new ways

in which to engage consumers such as centrally-located or targeted area outreach worker offices; and being represented on organized homeless services consultation committees or meetings.

Findings of frustration with and ambivalence towards eligibility requirements perceived as obstacles to consumer access to resources speak to the need for increased opportunity for outreach worker input regarding flexibility in the application of eligibility requirements for services. Building in opportunities for outreach worker input regarding decisions involving access to scarce services should be seen as a crucial element of program design involving outreach workers, homeless service agencies, consumers, and other resources.

The finding of participant perception of the advocacy role in the form of a community educative function lends itself to several practice implications. First, there is a need for outreach worker training targeting skill development in engaging community members, the police, business owners, and other homeless service agencies around understanding homelessness in general. Second, such training should aim to enhance worker understanding of consumer context in general so that this component of work can be skillfully conveyed to community partners. Third, training should be provided in methods of collaborating with these various community partners in order to create larger networks of helpful support around consumers. Additionally, resources in the form of pamphlets, websites, advocacy groups, and local community representative contacts can help outreach workers offer the questioning public opportunities to continue to understand the situation of the consumer through the encouragement of further self-education around homelessness.

For the outreach worker, or analogously a therapist, the conception of one's role only as "somebody to talk to", is inadequate both as a reflection of the comprehensive role as solitary arbiter of a consumer's ability to live safely, and given what is known about therapists'

countertransference and its influence on the direction of therapy (Berzoff, Flanagan, & Hertz, 2011). With this in mind, an additional implication for outreach worker development is the need for supervision. Such supervision must inform worker self awareness and skills in relationship-building with a vulnerable population for whom the failure of previous interventions by other service systems and habitation in potentially harmful and dangerous situations is more the rule than the exception. Just as mental health clinicians must have an understanding of suicide risk-management, so is having such understanding relevant to outreach work.

In terms of the form and type of supervision that might suit homeless outreach, outreach workers might regularly consult, conceptualize, and plan their complex interactions with an estranged and potentially volatile population. This might be done in a peer, group, or senior-outreach worker format. A practical outcome of such supervision might be a meaningful construction of focus lists in light of this regular, perhaps weekly, supervision. Akin to clinical supervision, this format may additionally serve outreach worker culture in that it may also be a venue for old and new outreach workers to share their experiences as well as channel feedback through senior outreach worker supervisors who presumably will be peer administrators in the macro functioning and management of homeless outreach work agencies.

Similar to the pre-treatment principles for homeless outreach practice suggested by Levy (2000), the findings related to psychotherapeutic practice forms relevant to outreach work as per participant responses might include promoting principles and teaching skills in the arena of humility, showing respect for consumers, giving consumers the benefit of the doubt especially in volatile situations, unconditionally and consistently offering a listening space, learning the timely and at times delicate art of referral making, and keeping appropriate and comfortable personal

boundaries with consumers. The implications for a more clinical conceptualization of the provision of services speak to a need for clinical training.

Lastly, given participants' reported experience of a push and pull between varied external causes for homelessness and the internal motivations and choices that also keep a consumer in chronic homelessness, holding the paradox would appear to be an important component of the outreach worker position. As such, training aimed at developing worker consciousness regarding the ambiguity of causality in homelessness and the need to bring an awareness of this paradox to one's work would aid outreach workers in adopting a lighter hold on particular notions of why someone is on the streets. This might help outreach workers in the development of less rigid boundaries or judgments towards consumers, thus supporting relationship-building with this hard-to-reach population.

Obtaining consent from consumers and partnering social service agencies to use and share partial knowledge of a consumer's medical, psychological, and socioeconomic history and situation was found to be important for outreach workers. The ability to communicate relevant information for the purpose of creating a trusted network of support for consumers appears to be a needed skill among outreach workers. This network is important in supporting consumers in following through with a complex and daunting system. Practice implications of these findings include the need for training in skillful and appropriate disclosure of relevant consumer information. This is particularly important in work that may be more informal in nature, and in which formal consent for disclosure of personal information may not be a built-in component of regular practice with consumers. Worker development of skills in discerning how and when to obtain information, what information is appropriate to share, how, and with whom, will ultimately assist in helping consumers make best use of resources. In the development of new

trainings, the importance of flexibility and adaptability for outreach workers should not be forgotten. For example, in developing trainings around appropriate and practical means of sharing consumer information and communicating between various parties, the issue of confidentiality should be addressed in such a way that it not be perceived as restricting outreach workers from doing what needs to be done on behalf of consumers.

Implications for Policy and Program Development

Possessing a valuable vantage point for homeless services provision, the outreach worker as a critic of homeless services implies more regular outreach worker feedback and involvement in policy development and in the creation of new and even temporary services that can improve service effectiveness and housing retention among this population. For example, outreach worker input could inform consideration of the need for funding of non-clinical support groups that may deter social isolation, end of month meal and transit services for consumers who are without resources at this time, and building in opportunities for involvement with past consumer peers interested in staying connected to the support network that may have helped them get off the streets.

Mitigating the factors that disenfranchise, inhibit, put pressure on, or deter from outreach workers' engagement with consumers is of utmost importance. Given findings that point to participant perceptions of others as not seeking outreach workers' perspectives on the work they do, it is important for policy makers as well as agency executives to develop forums for obtaining outreach worker consultation and input in the development of new policies or practices. As well, given findings of the multi-faceted nature of their work, it follows that outreach workers should regularly be given venue to suggest, design, and implement changes in the current focus of resources. Finally, given findings that indicate worker's feelings of being

subject to the changing pressures of agency and communities, their inclusion in the planning and creation of outreach work implementation and focus would contribute to a deserved sense of empowerment in the field. As noted above, the need for outreach worker supervision that is more focused on the outreach worker-consumer interaction may warrant the creation of new positions in outreach worker agencies, perhaps more properly contextualized as a peer or senior experienced outreach worker positions.

Just as the participant who reported that their "above HIPAA" status afforded them flexibility in delivering and receiving information about consumers and programs, so might a newly conceived role for the outreach worker as "systemic advocates" for consumers help to dynamically shape service provision - including counseling, referral and placement - to the specific situation of chronically homeless consumers.

In playing the role of "somebody to talk to", outreach workers fulfill the equally important role of developing a therapeutic alliance with consumers - a seemingly necessary component for engagement with an isolated and vulnerable population. As it takes time to develop trust, rapport, and connection in any alliance, policy and program development may include structures that encourage, rather than simply allow, outreach workers to take their time developing relationships with consumers as they feel appropriate. As participants responded that relationship was integral to the work, the outreach worker-consumer relationship can be conceptualized more profoundly as necessary in order for a shift to occur in the chronically homeless situation. While questions may be raised regarding the measurement of the outcomes or effectiveness of such relationship-building, study findings point to the possibility that the development of relationship should be considered the intervention or sought-after outcome in and of itself. Policies and procedures that give more value and weight to the outreach worker role

in consideration of intervention with the chronically homeless should therefore be encouraged. As opposed to pretreatment, outreach work might start to be considered treatment.

Implications for future research

Given the finding of perceived utility in having access to consumer information that removes obstacles to communication between providers, consumer and consumer support systems, future research should focus on the critical connector role of outreach workers and the extent to which this overlaps or augments the current role of case manager. For example, future study could look at the outreach worker role in keeping the case managers, service provider, consumer and their support networks in verbal communication and coordination with each other. Just as health care systems are evolving new roles for patient navigators (Ferrante, Cohen & Crosson, 2010), so the outreach worker role in coordinating, advocating and connecting people and systems is deserving of further study in a changing service environment.

An in-depth understanding of how outreach workers experience, conceptualize, and value their current forms of training requires further research with a larger sample specifically focused on educational and training needs of this workforce. Future evaluation of a range of additional training opportunities, including the implementation of new forums for worker input and peer supervision, should look at the impact of different types of training on worker sense of empowerment, success in relationship building with a range of consumers, agency workers, and community partners. Such research can evaluate the effectiveness of training in important clinical areas that are relevant to outreach worker practice and program development such as relationship-building skills, including active listening, identification and assessment of suicide risk and monitoring, as well as self-care.

In regards to future research on variations in outreach worker supervision, it is possible that varied outreach worker program designs already exist in other homeless outreach agencies. Further descriptive research might highlight such programs, the variety and form of supervision structure, the agencies that do so, and their experiences as such.

Finally, given the difficulty experienced in recruiting outreach workers for this study and in safeguarding confidentiality in a small sample, recommendations for future research would include limiting the role of supervisor in the recruitment process, the use of pro-active methods by the researcher to individually follow-up with potential participants; and minimizing barriers to or delay in interview appointment scheduling.

Limitations in study data and design

This study was limited by sample size (N=7) and non-random method of sample selection. Challenges in recruitment of a sample of sufficient size were pervasive throughout this study. Efforts to recruit a minimum of 12 to 15 participants proved more frustrating than had been anticipated. Several times, participants did not show for a scheduled interview because of busy outreach schedules and second or third jobs. It appeared true that participants were neither used to having time dedicated for feedback and perspective about their work, nor easily able to use free non-work time to have an interview.

The human subject review process necessarily required agency agreement and permission to carry out the study, in advance. Agency supervisors were informed about the study in advance and letters of agreement were signed and submitted along with the Human Subjects Review application. Following study approval, supervisors were asked to pass recruitment letters through staff meetings to eligible participants. It soon became clear that it was difficult to know whether and how outreach worker staff were being introduced to the study. Lack of uniformity in

the way in which potential participants learned about the study presented an additional limitation, affecting both the nature and size of the sample: some participants followed up with the researcher after receiving the recruitment letter with no motivation from supervisors; some participants may have interpreted an imperative to participate because their supervisors were the ones who initially presented or reminded of the study irrespective of the voluntary nature of the study; and still others may have felt more inclined to participate when the researcher presented the study to outreach workers when their supervisors were not present, which happened in at least one case when the researcher came to an all-staff outreach worker meeting.

Supervisory involvement in the recruitment process, combined with a small sample frame, additionally strained plausible efforts towards true confidentiality. For example, some participants chose agency offices to hold interviews, which exposed them immediately as participants in the study. Additionally, in at least one agency, a supervisor asked who had participated from their agency to make the second wave of recruitment easier. Given the small number of eligible participants, these seemingly benign instances were all opportunities for disclosure of participation in the study.

Additionally, the small size of the sample and sampling frame from which it was derived, as well as potential breach of confidentiality in terms of supervisors and other workers' knowledge of participant identity, curtailed presentation of certain components of the findings, ensuring that quotes could not easily identify participants.

Despite the small size of this convenience sample, this study has many strengths. The opportunity to conduct qualitative interviews in a private setting, as well as the range of agencies represented by participants, provided a window into the breadth of previously untapped, rich perspective of members of this workforce.

Conclusion

The finding of a multi-role conceptualization of the homeless outreach worker emerging from this study is helpful in considering a range of programmatic, practice and policy innovations, as well as training and educative opportunities. Such developments will support the autonomy, flexibility, and leverage this position demands given the variety of consumer situations and interactions faced in the field. Further research is needed looking at the efficacy of different organizational forms and training opportunities on homeless outreach worker skill development in relationship-building with a variety of constituents.

The demands of homeless outreach work are many, and yet these remarkable individuals have balanced a delicate field of experiences with some of the most vulnerable consumers in society. Decreasing the obstacles, pressure, and distractions that impede the outreach worker from connecting meaningfully to consumers is the least agencies and policymakers can provide for these people who are at the frontlines of ending chronic homelessness. Increasing the respect for consumers and outreach workers, the conversations about the multiple causes of homelessness in our communities, and advocacy for funding of homeless services is the least citizens and community groups can do to support outreach workers in doing the work that most others find too difficult.

References

Addis, J. J., & Gamble, C. C. (2004). Assertive outreach nurses' experience of engagement. *Journal Of Psychiatric And Mental Health Nursing, 11*(4), 452-460. doi:10.1111/j.1365-2850.2004.00742.x

Adlam, J., & Scanlon, C. (2011). Working with hard-to-reach patients in difficult places: A democratic therapeutic community approach to consultation. In A. Rubitel, D. Reiss, A. Rubitel & D. Reiss (Eds.), *Containment in the community: Supportive frameworks for thinking about antisocial behaviour and mental health.* (pp. 1-22). London England: Karnac Books.

Allness, D.J. (1997). The program of assertive community treatment (PACT): The model and its replication. *New Directions for Mental Health Services, 74,* 17–26. Retrieved from http://search.ebscohost.com

Barnes, J. J., MacPherson, K. K., & Senior, R. R. (2006). Factors influencing the acceptance of volunteer home-visiting support offered to families with new babies. *Child & Family Social Work, 11*(2), 107-117. Retrieved from http://search.ebscohost.com

Bateson, G., Jackson, D., Haley, J., & Weakland, J. (1972). Toward a theory of schizophrenia. In Bateson, G., *Steps to an ecology of mind*. (pp. 201 – 227) Chicago: University of Chicago Press. Retrieved from http://search.ebscohost.com

Berzoff, J., Flanagan, L., & Hertz, P. (2011). *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts (3rd ed.).* Plymouth, United Kingdom: Rowman & Littlefield Publishers.

Blankertz, L. E., Cnaan, R. A., White, K., & Fox, J. (1990). Outreach efforts with dually diagnosed homeless persons. *Families in Society, 71*(7), 387-397. Retrieved from http://search.ebscohost.com.

Bray, L. (2006). Outreach: making a difference in family life. *Paediatric Nursing*, *18*(8), 27. Retrieved from http://search.ebscohost.com.

Carling, P.J. (1995). Return to community: Building support systems for people with psychiatric disabilities. New York: Guilford Press.

Center for Social Innovation. (2011). Homelessness: Solutions tailored to individual needs. Retrieved from http://www.center4si.com/issues/homelessness.cfm

Chui, W., & Ho, K. (2006). Working with involuntary clients: Perceptions and experiences of social workers in Hong Kong. *Journal of Social Work Practice*, *20*(2), 205-222. doi:10.1080/02650530600776947

Courtois, C. A. (2008). Complex trauma, complex reactions: Assessment and treatment. *Psychological Trauma: Theory, Research, Practice, And Policy*, (1), 86-100. doi:10.1037/1942-9681.S.1.86

Crane, M., & Warnes, A. (2005). Responding to the needs of older homeless people. *Innovation: The European Journal Of Social Sciences*, *18*(2), 137-152. doi:10.1080/13511610500096434

Fisk, D., Rakfeldt, J., Heffernan, K., & Rowe, M. (1999). Outreach workers' experiences in a homeless outreach project: Issues of boundaries, ethics and staff safety. *Psychiatric Quarterly*, *70*(3), 231-246. doi:10.1023/A:1022003226967

Fisk, D., Rakfeldt, J., & McCormack, E. (2006). Assertive outreach: An effective strategy for engaging homeless persons with substance use disorders into treatment. *The American Journal of Drug and Alcohol Abuse, 32*(3), 479-486. doi:10.1080/00952990600754006

Ferrante, J.M., Cohen, D.J., & Crosson, J.C. (2010) Translating the patient navigator approach to meet the needs of primary care. *Journal of the American Board of Family Medicine 23(*6):736-744. Retrieved from EBSCO*host.*

Goldacre, M., & Seagroatt, V. (1993). Suicide after discharge from psychiatric inpatient care. *Lancet,* 342(8866), 283. Retrieved from EBSCO*host.*

Housing Options Made Easy, Inc. (2005, January). Role of peers subcommittee white paper. Retrieved from http://housingoptions.us

Hidalgo, J., Coombs, E., Cobbs, W. O., Green-Jones, M., Phillips, G., Wohl, A., & ... Fields, F. D. (2011). Roles and challenges of outreach workers in HIV clinical and support programs serving young racial/ethnic minority men who have sex with men. *AIDS Patient Care & Stds,25,* S15-S22. doi:10.1089/apc.2011.9880

Kryda, A. D., & Compton, M. T. (2009). Mistrust of outreach workers and lack of confidence in available services among individuals who are chronically street homeless. *Community Mental Health Journal, 45*(2), 144-150. doi:10.1007/s10597-008-9163-6

Levy, J. S. (2000). Homeless outreach: On the road to pretreatment alternatives. *Families in Society, 81*(4), 360-368. Retrieved from www.familiesinsociety.org

Levy, J. S. (2004). Pathway to a common language: A homeless outreach perspective. *Families in Society, 85*(3), 371-378. Retrieved from www.familiesinsociety.org

Levy, J. S. (2011). The case of housing-first: Moral, fiscal, and quality-of-life reasons for ending chronic homelessness. *Recovering the Self, Vol. III (*3), 45 – 51. Retrieved from www.recoveringself.com

Lipman, B. (2001). A job doesn't guarantee a home. *Journal Of Housing & Community Development*, *58*(5), 35. Retrieved from ebscohost.com

Lowe, E. T., & United States Conference of Mayors, W. C. (2001). A status report on hunger and homelessness in America's cities, 2001: A 27-city survey. Retrieved from http://www.eric.ed.gov/PDFS/ED463348.pdf

Ma Shwe Zin, N., Soo Meng, K., Kumar, R., Fones, C., & Tze Pin, N. (2009). Improving treatment access and primary care referrals for depression in a national community-based outreach programme for the elderly. *International Journal Of Geriatric Psychiatry*, *24*(11), 1267-1276. doi:10.1002/gps.2256

Marlatt, G.A. (Ed.). (2012). Harm reduction: Pragmatic strategies for managing high-risk behaviors (2 ed.). New York, NY: Guilford Press.

Mechanic, D., & Tanner, J. (2007). Vulnerable people, groups, and populations: Societal view. *Health Affairs*, *26*(5), 1220-1230. doi:10.1377/hlthaff.26.5.1220

Melamed, Y., Fromer, D., Kemelman, Z., & Barak, Y. (2000). Working with mentally ill homeless persons: Should we respect their quest for anonymity? *Journal of Medical Ethics, 26*(3), 175 - 178. Retrieved from www.jmebmj.com

Morse, G. A., Calsyn, R. J., Miller, J., Rosenberg, P., West, L., & Gilliland, J. (1996). Outreach to homeless mentally ill people: Conceptual and clinical considerations. *Community Mental Health Journal, 32*(3), 261-274. doi:10.1007/BF02249427

National Alliance to End Homelessness. (2011a). Chronic homelessness. Retrieved from http://www.endhomelessness.org/

National Alliance to End Homelessness. (2011b). Snapshot of homelessness. Retrieved from http://www.endhomelessness.org/

National Coalition for the Homeless. (2009). Education of homeless children and youth. Retrieved from http://homeless.samhsa.gov/ResourceFiles/duxws2dr.pdf

Nelson, T., Johnson, S., & Bebbington, P. (2009). Satisfaction and burnout among staff of crisis resolution, assertive outreach and community mental health teams: A multicentre cross sectional survey. *Social Psychiatry & Psychiatric Epidemiology, 44*(7), 541-549. doi:10.1007/s00127-008-0480-4

Ng, A. T., & McQuistion, H. L. (2004). Outreach to the homeless: Craft, science, and future implications. *Journal of Psychiatric Practice, 10*(2), 95-105. doi:10.1097/00131746-200403000-00004

Olivet, J., McGraw, S., Grandin, M., & Bassuk, E. (2010). Staffing challenges and strategies for organizations serving individuals who have experienced chronic homelessness. *The Journal Of Behavioral Health Services & Research, 37*(2), 226-238. doi:10.1007/s11414-009-9201-3

Orange, D.M., Atwood, G.E. & Stolorow, R.D. (1997). Intersubjectivity theory and the clinical exchange. In *Working Intersubjectively : Contextualism in Psychoanalytic Practice* (pp. 3 – 18). Hillsdale NJ : The Analytic Press.

Osgood, D., Foster, E., & Courtney, M. E. (2010). Vulnerable populations and the transition to adulthood. *Future Of Children, 20*(1), 209-229. Retrieved from http://www.eric.ed.gov/PDFS/EJ883086.pdf

Pollack, K., Frattaroli, S., Whitehill, J., & Strother, K. (2011). Youth perspectives on street outreach workers: Results from a community-based survey. *Journal of Community Health, 36*(3), 469-476. doi:10.1007/s10900-010-9329-3

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*(9), 1102-1114. doi:10.1037/0003-066X.47.9.1102

Quigley, J. M., Raphael, S., & Smolensky, E. (2001). Homeless in America, homeless in California. *Review of Economics and Statistics, 83*(1), 37-51. doi:http://www.mitpressjournals.org.libproxy.smith.edu

Rapoport, R. N., & Rapoport, R. (1958). Community as the doctor. *Human Organization, 16,* 28-31. Retrieved from http://search.ebscohost.com.libproxy.smith.edu

Ridgway, P., & Zipple, A.M. (1990). The paradigm shift in residential services: From the linear continuum to supported housing approaches. *Psychosocial Rehabilitation Journal, 13,* 20–31. Retrieved from http://search.ebscohost.com

Rogers, C. (1961). On becoming a person: A therapist's view of psychotherapy. Boston: Houghton Mifflin

Rosenheck, R. (2000). Cost-effectiveness of services for mentally ill homeless people: The application of research to policy and practice. *The American Journal Of Psychiatry, 157*(10), 1563-1570. doi:10.1176/appi.ajp.157.10.1563

Rowe, M., Frey, J., Bailey, M., Fisk, D., & Davidson, L. (2001). Clinical responsibility and client autonomy: Dilemmas in mental health work at the margins. *American Journal of Orthopsychiatry, 71*(4), 400-407. doi:10.1037/0002-9432.71.4.400

Rowe, M., Fisk, D., Frey, J., & Davidson, L. (2002). Engaging persons with substance use disorders: Lessons from homeless outreach. *Administration And Policy In Mental Health, 29*(3), 263-273. doi:10.1023/A:1015147710813

Saleebey, D. (2011). Some basic ideas about the strengths perspective. In F. J. Turner, & F. J. Turner (Eds.), *Social work treatment: Interlocking theoretical approaches (5th ed.).* (pp. 477-485). New York, NY US: Oxford University Press. Retrieved from http://search.ebscohost.com.libproxy.smith.edu

Schlossberg, N. K. (1981). A model for analyzing human adaptation to transition. *The Counseling Psychologist, 9*(2), 2-18. doi:10.1177/001100008100900202

Shern, D. L., Tsemberis, S., Anthony, W., Lovell, A. M., Richmond, L., Felton, C. J., . . . Cohen, M. (2000). Serving street-dwelling individuals with psychiatric disabilities: Outcomes of a psychiatric rehabilitation clinical trial. *American Journal of Public Health, 90*(12), 1873-1878. Retrieved from www.ajph.org

Spencer, J. W., & McKinney, J. L. (1997). "We don't pay for bus tickets, but we can help you find work ": The micropolitics of trouble in human service encounters. *Sociological Quarterly, 38*(1), 185-203. Retrieved from http://search.ebscohost.com.libproxy.smith.edu

Stark, M. (1999). Authentic Engagement. In *Modes of Therapeutic Actions* (pp. 56 – 68). NJ: Jason Aronson Press

Sullivan, B. (2010, June 16). HUD Issues 2009 annual homeless assessment report to Congress: Individual homelessness down; Family homelessness up for second straight year [Press release]. Retrieved from http://portal.hud.gov/

Tsemberis, S. (1999). From streets to homes: An innovative approach to supported housing for homeless adults with psychiatric disabilities. *Journal of Community Psychology, 27*(2), 225-241. Retrieved from http://search.ebscohost.com.

Tsemberis, S., Kent, D., & Respress, C. (2012). Housing stability and recovery among chronically homeless persons with co-occurring disorders in Washington, DC. *American Journal of Public Health, 102*(1), 13-16. doi:10.2105/AJPH.2011.300320

Tsemberis, S. J., Moran, L., Shinn, M., Asmussen, S. M., & Shern, D. L. (2003). Consumer preference programs for individuals who are homeless and have psychiatric disabilities: A drop-in center and a supported housing program. *American Journal of Community Psychology, 32*(3-4), 305-317. doi:10.1023/B:AJCP.0000004750.66957.bf

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*(4), 651-656. Retrieved from www.ajph.org

Wachtel, P. (2011). Therapeutic communication: Knowing what to say when, 2nd ed. New York: Guilford Press.

Weiner, A. (1996). Understanding the social needs of streetwalking prostitutes. *Social Work, 41,* 97-105. Retrieved from ebscohost.com

Weissman, E.M., Covell, N.H., Kushner, M., Irwin, J. & Essock, S.M. (2005). Implementing peer-assisted case management to help homeless veterans with mental illness transition to independent housing. *Community Mental Health Journal, 4*(3), 267 – 276. Retrieved from ebscohost.com

Wireman, K.R. (2007). Preventing homelessness: A consumer perspective. *Journal of Primary Preventive Health, 28,* 205-212. Retrieved from ebscohost.com

U.S. Department of Housing and Urban Development. (2010). The 2010 annual homeless assessment report to Congress. Retrieved from http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf

Zuffrey, C. (2008). Responses to homelessness in Australian cities: Social worker perspectives. *Australian Social Work, 61*(4), 357-371. Retrieved from ebscohost.com

Appendix A

HSR Approval Letter

SMITH COLLEGE

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 2, 2012

Carlos Encalada
Dear Carlos,

Your HSR application is hereby accepted. You may want to create a flyer in addition to the mailer. Your responses to me and committee were professional and carefully thought out, the changes rapid and right on target. Very nice work!
Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

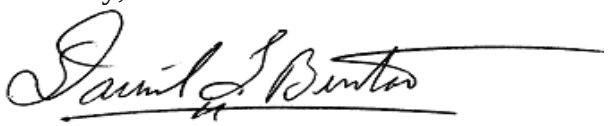
Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your study!

Sincerely,



David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Beth Lewis, Research Advisor

Appendix B
Recruitment Letter to Potential Participants

Hello,

My name is Carlos Encalada, and I am a graduate student in social work doing an exploratory interview-based study on outreach workers' views about the work they do with the homeless population. I'm interested in interviewing outreach workers with *at least six-months experience* in the field. The interview would explore how you view your work, what your thoughts are about the people you reach out to, how you came to do this work, and your perspectives on outreach work, in general. If this sounds like something you would be interested in, you can email me any time at **(personal information deleted by Laura H. Wyman, 11/30/12)** or call me at **(personal information deleted by Laura H. Wyman, 11/30/12)** to let me know of your interest in the study so that I can answer any questions you might have about the study and arrange a time to meet.

The interview would last up to one-hour and would be audio recorded with every measure taken to ensure confidentiality. If you are interested in the study and schedule an interview, before conducting the interview itself, I will share with you an informed consent form explaining the measures that will be taken to protect confidentiality in greater detail.

If you are interested, my contact information is listed again below for ease. I look forward to speaking with you if you are interested. Thank you for your time.

Carlos Encalada

Appendix C
Informed Consent Form

Dear Participant,

I am a graduate student at Smith College School for Social Work and I am conducting a study exploring the work of outreach workers with the chronically street homeless population. The purpose of this study is to gain an understanding of the perspective of outreach workers about their role and the nature of their work. The data from this study will be used for my MSW thesis and in professional publications and presentations on this topic.

Participation in this study will include an in-person interview of approximately one hour duration with the researcher. Interview questions will include your thoughts about outreach work, in general, your views on the work you do with consumers, and your thoughts about the larger context of outreach work and the issue of homelessness. You are being asked to participate as an outreach worker currently providing services to the homeless population, the criteria for inclusion in the study. Interviews will be audiotaped and later transcribed by me, in private. Should I use an additional transcriber, she/he will sign confidentiality forms.

Your risk of participation will be minimal. It is possible that, for some, thinking in depth and sharing thoughts about the work they do may be uncomfortable. Should you wish to consult anyone regarding any concerns that may arise, a list of referral sources is attached. By participating in this study, you may increase your awareness of outreach practices and the context of outreach services, which may aid in your future outreach work. By participating in this study you will also have the opportunity to contribute to knowledge about outreach work and the types of policies and procedures that can support effective practice with vulnerable populations. Compensation will not be provided for participation in this study.

Every measure will be taken to maintain confidentiality. Your responses will be kept separate from your name and other identifying information. Basic demographic information will be collected and reported on in general and descriptive terms to protect your identity. All data will be stored in an electronic file that is password protected. Besides the researcher, only the research advisor, and transcriber, if used, will have access to the data. Data will be separated from participant identification before it is shared with the research advisor or transcriber. If a transcriber is used, they will sign a confidentiality form. Data will be presented as a whole unless specific quotes or vignettes are used in which case they will be carefully disguised using phrases such as “one participant said” and “another participant said”. Themes derived from interviews and observations will be disconnected from identities of study participants. The informed consent forms will be immediately be stored in a locked container as this will be the only document explicitly connecting you, the outreach worker, to the study in name. Before data is processed with the research advisor, identifications will be removed. Audio files and transcriptions will be kept in securely off-line on password-protected computer files during the internship year, and will be kept for three years as stipulated by federal guidelines until no longer needed and then will be destroyed. In the interest of your participation in this study that looks at your direct practice, caution in not identifying clients specifically in your responses should be taken.

Your participation in this study is voluntary. You may withdraw from the study at any time before, during, or after the interview, and you may refuse to answer any question. If you wish to withdraw from the study you must notify the researcher in writing by April 1st, 2012. Upon withdrawal all materials pertaining to your interview as well as any identifying information will be immediately destroyed. If you have not withdrawn from the study by April 1st, 2012, your answers will be a permanent part of this study. You may contact me or the Chair of the Human Subjects Review Committee at Smith College School for Social Work at the email or phone listed below for questions or concerns about this study.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature of Participant _____ Date:_____

Signature of Researcher:_____ Date:_____

Contact Information:
Carlos Encalada
Smith College School for Social Work Master's Candidate
(personal information deleted by Laura H. Wyman, 11/30/12)

or

Chair of the Smith College School for Social Work Human Subjects Review Committee
413-585-7974

PLEASE KEEP A COPY OF THIS AGREEMENT FOR YOUR OWN RECORDS. THE RESEARCHER WILL PROVIDE THIS COPY EITHER BY SCANNED EMAIL OR SENT IN THE MAIL TO YOUR DESIRED ADDRESS.

Thank you for taking the time to learn about this study. Whether you decide to participate or not, your work and opinion are appreciated in this study.

Appendix D
Instrument

Introduction: I'm interested in learning about outreach work from the viewpoint of the worker. There are no "right" or "wrong" answers to these questions – it is an opportunity for you to share your thoughts in a number of areas. The interview will cover three main areas: The first will be about your thoughts about your work and outreach work, in general; then we'll talk about how you view the work you do with consumers; and the third will be about your thoughts about the larger context of outreach work and the issue of homelessness. Before we begin, if I could just ask you some questions about your demographic data.

Gender	Which of the following best describes your gender? Male, Female, Transgender, other.
Race/Ethnicity	How would you identify your race or ethnicity?
Age	Which age range do you fall into? (18 – 25; 26 – 35; 36 – 45; 46 – 55; 56 – 60; 61 or older)
Religiosity/Spirituality	On a scale of 1 to 5 (5 being the most, 1 being the least), how religious of a person do you consider yourself? How spiritual of a person do you consider yourself?
Highest Education Level	What is the highest level of education you have completed? (less than high school, high school GED, some college, 2-year college degree, 4 –year college degree, beyond college)
Years(months) of experience doing outreach work	How long have you been working as an outreach worker with the homeless?

Ok, now, let's begin.

Personal: History, your experience, perception of others

1. How did you come to do this work? Tell me about this.
2. I'm interested in your thoughts about the role of the outreach worker. Let's start with how you see your role in work with the homeless population – can you tell me a little about that? What's your experience as an outreach worker? (Probes: challenges, safety risks, situations you might approach or not, physical/emotional strains, rewards, autonomy, spending time with people)
3. How do you think the role of the outreach worker is seen by others? the consumer? The community or public at large? Other homeless services agencies? How do these views impact the work you do (if at all?)

Interpersonal - Relationships on the job

4. In outreach there is a lot of talk about building "relationships" (with consumers). Tell me about your thoughts about that relationship – for example, what does "building relationship" with consumers mean to you? How do you go about forming a relationship with a consumer that will "make the work happen"?
5. How do you see work with "others" (for example, community residents, police, elected representatives, other consumers) figuring into your work with consumers?

Professional

6. What works well for you in outreach work? What doesn't work so well? Tell me more about this.
7. As an outreach worker, what does decision making look like? (Prompts: kinds of decisions, consult with others or collaboration, ethical questions between self-determination and safety, unclear)
8. How do you see your social identity – that is, race, gender, age, education level, class– affecting your work with consumers, if at all?
9. Part of the role of outreach is informing individuals about resources that exist. How do you feel about this aspect of the work? Do you feel the existing resources meet individual's needs?

Social: Issue and problem of homelessness/organization of services

10. I'd like to know about your views about homelessness. What do you think is the cause of the problem? What do you think would remedy the problem?
11. What do you think people experiencing homelessness and living on the street need? What do you hope for your consumers, in terms of their situations?
12. If money wasn't an issue, and you could design a service, program, or organization specifically for the needs of your people, what would that look like?