
OUTREACH CONTINUUM PLANNING WORKGROUP RECOMMENDATIONS



City of Seattle

Edward B. Murray, Mayor

Human Services Department

Catherine Lester, Director



BACKGROUND

The City of Seattle Human Services Department (HSD), All Home and REACH co-facilitated a workgroup during 2016 to review current outreach practices and develop recommendations to create a more defined approach to outreach and case management to people living unsheltered. Outreach has played a significant and important role in *relationship development* and *survival services* to those in need for many years in the City of Seattle and throughout King County. However, historically outreach providers struggle to create the necessary linkages needed to connect those they serve to the housing and other supportive services they need in an immediate fashion. This struggle is part of a systemic challenge resulting in barriers to housing services access as a result of distrust, mistrust and inability to navigate a complex system on the part of people living unsheltered. As well as, lack of resources allocated to outreach providers who are working to connect people living unsheltered with viable and immediate safe alternatives. The role of outreach providers in ending the crisis of homelessness is significant, USICH has published some [lessons learned](#) that highlight much of what is discussed in this report.

It became evident through the development of the Pathway's Home work with [Barb Poppe](#) and [Focus Strategies](#) that persons living unsheltered did not have direct access to the housing and services needed to end their homelessness. Data showed that a range of 23% to 53% of programs are accepting individuals from housed situations. With Coordinated Entry for All and specifically for single adults on the horizon it was critical to begin planning for deeper connections between outreach and housing.

The Outreach Continuum Planning workgroup has met monthly since July 2016 with the objective of **1) assessing and defining what outreach is, 2) development of a standard of practice for all outreach providers, and 3) developing tools for coordination of care particularly to Coordinated Entry for All.**

What follows in this report are clear recommendations provided by members of the workgroup that provide a clear working definition of the purpose of outreach as well as a common standard of care that Providers must adhere to ensure the greatest efficacy in moving those living outside into safer alternatives. However, there is still work to be done by this group in conjunction with All Home and King County to further refine how a By Name List process can support housing navigation services provided by outreach teams and the launch of coordinated entry for single adults anticipated to begin in early 2017.

DEFINITION OF OUTREACH

The Workgroup has developed the following definition: *Coordinated, person centered, and persistent engagement bringing services directly to the people experiencing homelessness who might not seek out services and connect them to permanent housing and necessary supports.*

INVENTORY OF OUTREACH PROGRAMS

King County Department of Community and Human Services (DCHS) conducted a survey of Outreach programs in 2016 and found that 15 programs operate throughout King County. Of those, 7 outreach programs are specifically funded by the City to conduct outreach work. Each of these programs has a target population that they support including individuals with mental illness, individuals living in encampments, young adults living unsheltered, and individuals with significant street presence in the downtown and Capitol Hill areas. Overall, HSD funds roughly 22 outreach positions to operate throughout the City. Considering the vast area these staff must cover and the volume of people they must attempt to engage demand continues to outpace

capacity. At this rate, each outreach provider would have to engage regularly with over 130 people (using the One Night Count numbers of unsheltered) to coordinate access to services.

ORGANIZATION	FTE'S	TARGET POPULATION	GEOGRAPHIC AREA
REACH	8	Adults in encampments	Throughout the City
DESC-HOST	2	Adults with mental illness	Downtown/U-Disrict/Lake City
YouthCare	4	Youth/Young Adults	Downtown/U-district/Capitol Hill
Kids Plus	2	Families	Throughout the City
Metropolitan Improvement District	3	Adults	Downtown/Capitol Hill
Road to Housing	3	Adults in vehicles	Throughout the City

PROPOSED OUTREACH STANDARDS

The role of outreach should primarily be directed towards ending a person's homelessness. As All Home, the City of Seattle HSD, and King County DCHS work towards systems transformation efforts it is important to identify opportunities for improved service delivery and enhanced systems coordination. While outreach providers operating now within King County utilize many of the following practices, increasing skills and standardizing tools will further enhance the ability of outreach providers to move people living unsheltered with more efficacy.

Assessment and Service Provision Competency

- An outreach provider should be able to establish a trusting relationship with the individual experiencing homelessness.
- An outreach provider should be qualified to conduct and document a reliable assessment of needs of individuals experiencing homelessness which includes, but is not limited to, needs related to: behavioral health, including mental illness or other mental or emotional limitations; substance use and treatment status, and harm reduction measures; physical health, including need for assessment and care by medical professionals; disability; housing; employment; household composition considerations; and geographic considerations.
- An agency deploying outreach providers should have the capacity to train and deploy outreach-based staff such that it can engage clients with intensive and ongoing support, when needed, in order to ensure successful linkages to community services that address the needs that the provider has assessed. Thus a provider's operating model must afford its staff the flexibility to accommodate a broad spectrum of client capability for self-advocacy and navigating the complex processes that often present barriers to sustainable linkages to services.
- Agencies should devote staff time and other resources to ascertaining when a simple referral to services has been insufficient to effectuate a successful linkage to an agency that provides shelter and/or housing; outpatient mental health, substance use, or physical health care services; and/or more intensive inpatient health services such as a hospital or respite care facility. Further, it must also devote staff time and other resources to following up in an intensive fashion to walk with the client through the linkage process, as required.
- An outreach provider should be prepared to attempt to secure shelter/housing services based on what the client determines they want or need.

Housing System Competency

Several comprehensive systems exist that address the critical needs of individuals experiencing homelessness in Seattle. Providers should support people experiencing homelessness to access housing, and to provide effective means to support people to resolve their homeless crisis. A Provider should go beyond simply referring clients to other agencies and should have extensive knowledge and internal processes for assisting clients to access resources.

- Understanding of Coordinated Entry for All (CEA) a federally-mandated King County-wide system that establishes a coordinated, transparent, and equitable system for connecting individuals and families experiencing homelessness to housing interventions such as emergency shelter, rapid rehousing, and permanent housing. Outreach providers participate in CEA by providing housing assessor and navigation services.
- All Housing Assessors are required to complete CEA Housing Assessor Training and once trained, will complete HMIS intake and CEA housing assessment with individuals in need of housing. When possible, the Housing Assessor will connect the individual with a Housing Navigator. Housing Assessors' responsibilities include, but are not limited to the following:
 - Operating as the initial contact for the CEA and communicating eligibility for CEA
 - Exploring resources other than homeless housing programs, such as diversion or employment/education
 - Conducting Housing Assessments
 - Communication with assessed households about next steps and types of resources the household may be referred to
 - Participation in By Name List processes as needed
 - Notifying households about other services/resources, programs they may be eligible for outside of CEA, including housing through BHRD, Section 8, emergency housing, and other community-based resources (employment services, behavioral health, domestic violence services, etc.)
- All Housing Assessors are required to complete CEA Housing Assessor Training and once trained, will complete HMIS intake and CEA housing assessment with individuals in need of housing. When possible, the Housing Assessor will connect the individual with a Housing Navigator. Housing Assessors' responsibilities include, but are not limited to the following:
 - Operating as the initial contact for the CEA and communicating eligibility for CEA
 - Exploring resources other than homeless housing programs, such as diversion or employment/education,
 - Conducting Housing Assessments
 - Communication with assessed households about next steps and types of resources the household may be referred to
 - Participation in By Name List processes as needed
 - Notifying households about other services/resources, programs they may be eligible for outside of CEA, including housing through BHRD, Section 8, emergency housing, and other community-based resources (employment services, behavioral health, domestic violence services, etc.)

- Knowledge of emergency shelter programs and housing resources that are not part of CEA – section 8 vouchers, affordable housing resources, motel vouchers, etc...

Behavioral and Physical Health Competency

- When an outreach provider assesses an individual experiencing homelessness as needing access to behavioral and/or physical health services, they should be able to directly refer the person to a licensed behavioral health and/or physical health care services.
 - An outreach provider should be able to verify such services are provided to the individual experiencing homelessness either where the individual resides or at the behavioral health provider's location.
 - When individuals have an existing provider, outreach teams should be able to coordinate care.
- An outreach provider should be trained in harm reduction practices including: safe needle exchange and disposal; carrying and using Narcan and training other individuals to carry and use Narcan; informing individuals of their rights related to drug overdose (e.g. Good Samaritan Law); drug treatment options, including Medication Assisted Treatment (Buprenorphine and Methodone); and focusing on minimizing physical, social and legal harms.
- An outreach provider should execute harm reduction practices where needed and in accordance with the standards set forth by the National Health Care of the Homeless Council.

Training and Safety Competency

- An outreach provider should be trained in best practices of outreach and engagement, including: Engaging in Person Centered Approach, Trauma Informed Care, Motivational Interviewing, Skill Based assessments, and Stages of change/engagement.
- An outreach provider should practice adequate safety and backup for outreach workers in the field always by perform duties in pairs.
- An outreach provider should coordinate with Law Enforcement, First Responders, Designated Mental Health Professional (DMHP), and WSDOT as needed to ensure safety of persons experiencing homelessness as well as outreach providers.
- An outreach provider should be trained in self-care practices related to secondary trauma and burn out which are very real risks associated with this practice.

Cultural Competency

- A provider should have a policy for how they will work with the following groups and any other protected class in compliance with City non-discrimination laws and racial equity principles:
 - Those affected by Domestic Violence
 - People living with physical or intellectual disabilities

- LGBTQ Community
- Distinct racial and ethnic communities, including Immigrants and Refugees
- Youth who have been sexually exploited
- Veterans

Data Management and Documentation Competency

Data management is a critical component of this work, particularly as it relates to documentation of homeless status required by housing providers and federal funding requirements for targeted housing programs. *Regular and consistent documentation of outreach efforts decreases the likelihood of overlooking individuals experiencing homelessness who are most in need, as well as the duplication of services. A systematic approach also allows greater participation from other partners and systems in the community and faster access to a wider variety of targeted and mainstream programs - USICH.* Confidentiality is required when providing direct services to individuals particularly as information pertaining to health status and personally identifying information (PPI). Compliance with federal and state regulations is required in the management of PPI is required for outreach providers.

- An outreach provider shall protect the confidentiality of individuals experiencing homelessness and comply with all relevant laws to such confidentiality. This includes Mandated Reporting, Domestic Violence laws, Run Away laws and any other contracted requirements.
- An outreach provider must collect and enter information in Homeless Management Information System (HMIS) to satisfy contractual reporting requirements in adherence to HMIS performance standards.

Performance Measures

Outreach is a critical component of the network of services designed to support persons experiencing homelessness. It is important to ensure that outreach efforts are measured to ensure that people living unsheltered have access to the housing and services that they need to end their crisis of homelessness.

- Providers must measure and report rates of success in the System Wide Performance Targets established by All Home:
 - Reduction in length of time homeless and increase rates of exits to permanent housing evidenced by: Navigating people living unsheltered into shelter or housing by completing or confirming the completion of a Coordinated Entry for All assessment.
 - Reduction in returns to homelessness evidenced by: linking people living unsheltered to outpatient physical, mental health, substance use treatment, e.g., confirmed attendance at a clinical visit
 - Reduction the number of unsheltered as evidenced by: documentation of homeless status for all clients served.
- Providers may also be required, depending on specific outreach program objectives, to measure specific instances of:
 - Syringe distribution
 - Narcan training and distribution
 - Referrals to medically assisted treatment (MAT) and other substance use treatment
 - Placement in employment
 - Obtaining IDs

- Securing financial assistance, such as public benefits
- Client-centered goal setting related to physical or behavioral health.

TOOLS FOR COORDINATION OF CARE

Ongoing work is needed to develop and maintain coordination between other systems of care and outreach providers. HMIS and CEA are the first two primary tools available for the coordination of services with the homeless housing and services arena. The outreach workgroup will continue to explore opportunities and tools to increase coordination with non-homeless specific providers as Phase II of this work during 2017.

To support providers to develop outreach programs that meet the competencies outlined above and achieve the performance measures additional work is required by the Outreach Continuum Workgroup to ensure seamless connections to and coordination with various systems including:

Law enforcement	Healthcare for the Homeless	WSDOT
Needle Exchange	First Responders	HMIS
CEA	Housing Navigation	Park Rangers
DMHP's	Business Districts	Neighborhood councils
Jails	Hospitals	Courts

NEXT STEPS

Systems transformation planning is underway with All Home, King County DCHS, United Way of King County and the City of Seattle Human Services Department to align investments and performance commitments towards the goal of moving people rapidly into housing. The recommendations from the Outreach Continuum planning group as well as other engagement efforts will help to inform and shape future funding opportunities. HSD is planning now for the release of a competitive funding process during 2017 which will include funding for outreach programs. The awards made in 2017 will be contracted in 2018. While Phase I of this effort focused on competencies required for outreach providers, Phase II will focus on coordination of resources and services that further support ending the crisis of homelessness for people in our community.

Phase II components

- Mobile access to HMIS and CEA
- Communication tools that work across various systems not linked to HMIS
- Refinement of system wide performance targets

OUTREACH CONTINUUM PLANNING WORKGROUP MEMBERS

Thank you to the following people for your invaluable insight and commitment to this effort.

Sola Plumacher - City of Seattle

Chloe Gale - REACH

Kira Zylstra – All Home

Margo Burnison – King County

Christina Clayton - DESC

Grayden Andrus - DESC

Francesca Martin – Compass Housing Alliance

Hillary Carr – Compass Housing Alliance

Emma Nierman – Veteran’s Administration

Craig Jacobson – Sound Mental Health

Coleen Echohawk – Chief Seattle Club

Derrick – Chief Seattle Club

Richard McAdams – UGM

Bob Chandler – UGM

Darren Caves – UGM

Laurel Snow – YouthCare

Alexis Lopez – YouthCare

Arita Atwal – YouthCare

Johnny Schilling -YouthCare

Brenda Frazier- REACH

Whitney Walker– REACH

Dan Nelson - SPD

Kent Hay – City of Redmond

John Gilvar – Healthcare of the Homeless

Noel Rees – Healthcare for the Homeless

Jeff Lilley - UGM

Jackie St. Louis – MID

Ben Curtis – Operation Nightwatch

Laird Redway – King County

Gretchen Bruce – King County

Laurie Becker – King County

Alicia Benish – King County