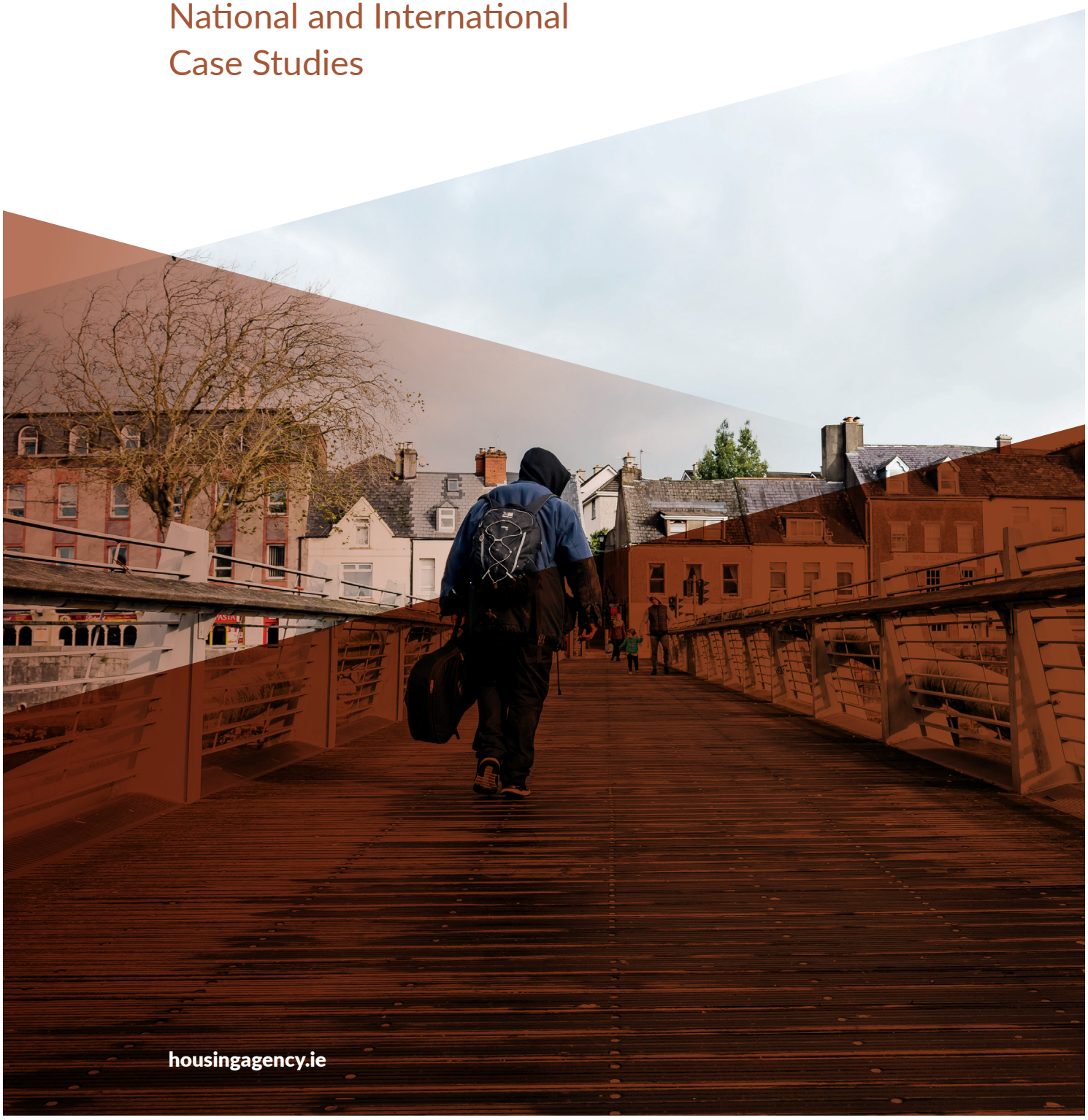
An Ghníomhaireacht Tithíochta
The Housing Agency

Assertive Street Outreach Guide

National and International Case Studies



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Introduction

Assertive Street Outreach is a persistent strategy that aims to end rough sleeping by bringing services directly to people who are sleeping rough and ensures that people without shelter are linked in with appropriate supports and services through a multidisciplinary approach.

This guide provides examples of Assertive Street Outreach services in Ireland as well as international examples. It is designed as a flexible tool to demonstrate different practical scenarios that ASO staff may experience as well approaches for these scenarios.

In addition to the Case Study Guide, there are other complementary resources available to assist ASO in setting up and expanding Assertive Street Outreach services in their area. These include:

- Assertive Street Outreach Guide – A good practice guide for local authority staff
- Assertive Street Outreach Summary Guide
- Infographic

These resources are available on The Housing Agency's website or scan the QR code below.

International Case Studies

Background

The Housing Agency commissioned the LGIU to source examples of good practice in jurisdictions outside of Ireland of assertive street outreach services for homeless people.

The research initially drew upon the LGIU's contacts in the Local Government Information Unit, with suggested avenues followed up in Canada, Scotland and London. Further background research found that there were only a handful of publicly available research papers dedicated to the assertive outreach research subject, primarily in the UK, Australia, Canada, and the United States of America, with little reference found to assertive outreach in other parts of the world. The case studies selected for inclusion are based on recommendations from peers working in the field and from resources publicly available.

The London contact resulted in the case study with The Connection at St Martin in the Fields. The case study with Stonepillow in Chichester came about through informal discussions with peers who work in the sector. Unfortunately while efforts were made to contact assertive outreach projects in two areas of Scotland, and also one in Wales, the organisations did not respond.

In Canada, the first research path originally signposted to the municipality of Medicine Hat and the work undertaken there to be one of the first communities to end chronic homelessness. There is a great deal of information about their work in the resources of Built for Zero Canada (an alliance working to end homelessness), including a webinar and case study resources. However, from the information available it was difficult to understand what role outreach played in their approach. While contact was made with the Medicine Hat Community Housing Society, no clarity was established on the role of outreach and therefore Medicine Hat was not included as a case study. A contact at Built for Zero Canada, helpfully signposted to the work in Niagara and a wealth of information was gleaned from webinar and video footage resources. The Niagara Region team also forwarded further supplementary information when contacted.

In undertaking background research on assertive outreach, one of the first articles to come to attention was the rapid review of assertive outreach undertaken by the University of Newcastle (Australia) and led to a plethora of further information and research in Australia, albeit from a decade ago. It was apparent that in many Australian states there is a current and recent history of using the assertive outreach approach. Unfortunately, despite numerous efforts and avenues it was a challenge to make contact with those delivering services. A successful contact was made with NOVA for women and children, who were very helpful, but an organisation only at the start of its assertive outreach journey and therefore not yet appropriate as a case study at present.

With grateful thanks to all those who contributed to these case studies and signposted to the background research.

Case Study 1 – Stonepillow, Chichester, UK

Stonepillow is a charity operating in the Chichester and Arun districts in the South of England. It runs a collection of services and hubs including an assertive outreach service, as well as emergency accommodation for rough sleepers in the area.

> The aim of the outreach service is to engage with rough sleepers in order to establish a relationship and gain trust and gradually introduce them to services that can help them out of their current circumstances. It looks at the person as a whole and how services can meet immediate needs, beyond accommodation, to make small differences to that person's life, in that moment. "Outreach used to be about getting people in, now outreach is about finding out what people need."

Homeless people usually have multiple disadvantages, trust and trauma issues, are self-medicating with substances, and are often within the criminal justice system. As a result, the outreach approach is person-centred, psychologically and trauma-informed and strengthsbased and central to this is the person only having to tell their story once. It works on the basis of flexibility and can take months and years to build up relationships and trust, there are no requirements and no sanctions, and it is about responding not directing. Assertive outreach is not a quick fix method.

The eventual aim through this slow and measured approach is helping the individual to understand that speaking to an outreach worker can lead to positive outcomes and options

e.g. access to a doctor or dentist, re-establishing identification documents. The Stonepillow assertive outreach workers are called 'Navigators'. They have a team of five with a caseload of about 20 people. While they are rostered nine-to-five, the Navigators have to be incredibly flexible with and fit around the person they are working with – understanding the patterns and times individuals prefer and finding out their strengths. It focuses on small, positive steps e.g. the person changes their socks, or agrees to go for a coffee. Staff require a "never-ending tenacity" and need a subtlety in the steps they take with the person, whether that be practical or emotional support. Contact can be hourly or daily depending on the needs of that person.

Clinical supervision of staff is imperative, providing them with access to debrief following stressful situations and counselling to help deal with death and trauma. A team approach is key, and the Navigators are surrounded by a support team of experts (hospital discharge workers, mental health specialists, accommodation support workers) and volunteers (dentists, hairdressers), who provide additional wraparound support for both the individual and the staff.

Navigators must be linked and connected to all local services and partnership is essential, at both the ground and the organisational level. Access to support and services needs to be quick and seamless to keep the person engaged.

Risk is a two-way approach for both staff and the individual, managed in terms of health, safeguarding, exploitation, violence and criminal behaviour, risk to the public and risk of abuse.

An example given by Stonepillow, is a person addicted to heroin. The primary step may be about harm reduction and therefore linking them to basic services, such as needle exchange or providing information that bad batches are circulating. With future steps such as medication, treatment and recovery services, much further down the line in the best judgement of the Navigator and through discussion with the person they are working with.

As a consequence they must collect a lot of information and record-keeping is essential. This helps the organisation manage risk, which they generally update monthly, but in certain situations such as suicide ideation, it is increased to daily. Risk is a two-way approach for both staff and the individual, managed in terms of health, safeguarding, exploitation, violence and criminal behaviour, risk to the public and risk of abuse. Each individual case is risk assessed and policies implemented in terms of lone-working or the gender of the Navigator, for example to ensure that safety is paramount for all involved.

In terms of staff training, Stonepillow recruit on the basis of attitude – kindness and compassion being stand out attributes. Many of the skills associated with the role can be learned on the job, although key training is provided on de-escalation, trauma-informed care, safeguarding etc.

> *"Often it is the systems in place that are more complex to navigate, than the issues of the individual"*

Staff need to be comfortable operating in the field and be able to work as a team. It is essential that Navigators are kind and compassionate to others and themselves. They also run a 'Value Star' programme to recognise good staff work. Good leadership, particularly from team leaders is also critical in the support network of the Navigator in enabling them to do the best they can.

Stonepillow services are part of a wider network of outreach and support. Each district has a rough sleeper panel of which Stonepillow is a member, along with Chichester District Council, West Sussex County Council (housing, social care, community wardens), police, drug agencies and mental health partners. They look at a collective and strategic approach to rough sleeping, what is working and not working in particular geographic areas, but will also focus in on particular individual cases if they are very complex. They also offer communication channels to escalate and ensure those seamless links are working. This infrastructure provides the vital support network for the Navigator and the individual at the heart of the service.

Mental health, substance misuse and police/community wardens are the most critical partners needed – the latter in helping to find people and secondly to get them the crucial services they need to address the trauma often at the root of their homelessness.

"Often it is the systems in place that are more complex to navigate, than the issues of the individual"

In an example of good practice, Stonepillow works to look to the future and help individuals avoid repeating patterns. They share an instance of an individual known to them, currently serving a prison sentence and trying to engage with services in advance of his release, with a Navigator ready to support and avoid a cycle of homelessness, substance abuse and violent behaviour. This early intervention is being undertaken with the rough sleeper panel and the prison service in an attempt to reduce the negative and repeating behaviours, which ultimately lead to a continuation of his homeless situation.

Covid-19 response policies, such as the UK Government's 'Everyone In' policy helped Stonepillow and their partners to make contact with those most difficult to reach and opened more avenues to those individuals in terms of the options available. One of the challenges in appraising this approach lies in the need for it to be time intensive, there are no quick wins and therefore it can be difficult to demonstrate impact. Outcomes must be seen over the longer term. However, as with many services, Stonepillow identifies the biggest challenge to be funding – a never-ending cycle of grants and trust funding, presenting challenges for planning ahead and responding to the ebb and flow of cases and meeting the complex needs of the people they serve.

This case study is based on an in-depth conversation with Hilary Bartle, CEO at Stonepillow.

Case Study 2 – The Connection at St Martin in the Fields, Westminster, UK

The Connection is a charity operating in the borough of Westminster in London. It runs a range of practical services to support rough sleepers out of homelessness, including a day centre with a clinic, counselling services, educational workshops, dedicated women's support and is the base for the assertive outreach service.

The aim of the outreach service is to assist and build relationships with people sleeping rough in the Westminster area and understand what their unmet needs are and how they can help them. The team are particularly driven to understand why these clients have not engaged with formal services themselves. The focus is on daytime outreach, as they have found it more effective than approaching people bedding down for the night.

The team was formed in 2018 and is part commissioned by Westminster City Council and through the charity's own fundraising activity. The funding allows them great flexibility in delivering their services and being client-led. There are six outreach workers (plus three vacancies) and two members of staff dedicated to supporting those people at the transition and resettlement stage from street to a home. Each outreach worker has a maximum workload of 10 cases. The team technically work set hours, but there is flexibility around this depending on how the team member judges the best way to manage their cases for best results.

Most of the people they encounter are not working with other services and are "locked into a cycle" of making money in whatever way they can to pay for drugs. Many of the individuals the outreach teamwork with have traumas that stem from childhood and an understanding,

non-judgemental, consistent and proactive approach is crucial. What works best is taking the time to become a familiar friendly face, with a light touch and no pressure to go to this or that service. The simplest of gestures, such as buying a hot drink, help to build trust and helps to begin the journey to find out what that individual wants. It is vital that outreach staff keep their word and do what they say they will do. This is described as "layers of support" – all different depending on the person and requires a level of skill and expertise to understand what might offer a solution for an individual and judging this at the right time.

The team uses a reflective practice and has two psychologists on site, with whom they can discuss cases and approaches.

Of particular success is that the day centre operates a rapid prescription methadone clinic. Individuals can be seen by an on-site GP for a health check and can receive a methadone prescription within the hour, often delivered by the outreach team who act as a go-between. Some of the health services are also taken out on the streets, delivering test in-situ and prescriptions there and then.

The team uses a reflective practice and has two psychologists on site, with whom they can discuss cases and approaches. The psychologists also provide staff support and help staff deal with the disclosures they hear and the tragedies that sometimes occur. Strong team leadership and an open door culture is also an essential component of staff support. The team have regular one-to-ones, daily informal briefings to exchange information (which includes partners), as well as a Whatsapp group to exchange information quickly when they are out on the streets. They have regular away days that act as both a training function and mutual support function to deal with complex cases.

The 'Everyone In' pandemic policy had a massive positive impact, although not without challenges, particularly for those who had been homeless for a long time and the outreach team noted that mental health issues were more apparent. Since then the streets have been much quieter, in terms of the numbers of cases the team are dealing with, however their skill set enables them to flex to other parts of the wider charity's work in supporting people. The service is delivered through a partnership with other services, and outreach team members will often go out on their shift partnered with someone from another service. These include mental health staff, nurses and staff from Turning Point (a drug and alcohol recovery charity).

These collaborations are described as best practice, and the combination of skills and expertise are more effective than single services approaching alone. The partnerships are managed by service level agreements and priorities of each organisation are understood. There is a data-sharing agreement for colleagues across the partners to be able to share details for example, for 'clients of concern', the numbers and progress of referrals.

This partnership element is also used to assist in risk management out in the field. If they come across a new face on the streets, they never approach alone. They always approach in pairs until they have got to know the person and assessed the best approach, which as the relationship develops may be judged to happen as a lone-worker, or not, or whether male or female approach would be appropriate. There is a skill also in knowing when to approach – particularly in group gatherings of rough sleepers. On the first approach there is a need to listen and to observe behaviours.

> *"I wish every service had an assertive outreach element"*

There is some pan-London working but the focus for this charity is mainly within the borough, although the transitional workers have a wider focus depending on where suitable accommodation is found. Their women's project is a particular project that has been set up with others to work across London, to deal with rough sleeping as a result of domestic violence or help those women wanting to get out of sex work.

Data collection is a very important part of the role, and the charity uses a pan-London management information system called CHAIN to do this. This helps with inter-borough working but is essential to the charity in demonstrating impact for funding bids. As well as statistical data they also track what are described as 'soft outcomes.

The biggest challenges tend to be the inflexibility of other connection services, often because of the way they are commissioned. There is sometimes a lack of understanding that this client group are some of the most vulnerable out there, with mental health, addiction and trauma all in the mix. Often pathways for services to help move them on are very rigid.

"I wish every service had an assertive outreach element"

But the ultimate big issue is a lack of affordable housing and supported housing. The Connection has identified this as a key barrier and contributor to repeated homelessness.

They cite a major cause of homelessness as the ending of assured shorthold tenancies. People often become homeless when their tenure ends and interventions that were made

by resourced Tenancy Sustainment Services, which helped to delay or reduce repeat homelessness, are cut.[1] Housing that allows pets is also in short supply. Many rough sleepers have pets as companions and a source of comfort. Those pets may have been with them for many years, and they are, therefore, understandably unwilling to relinquish them.

Another issue, which also features in case study one, is housing support for those leaving prison. The Connection regularly comes across people in a cycle of rough sleeping and prison stays and there is very little focus on trying to break this cycle. They have now been running their own 'action experiments', meeting people as they leave prison who need a layered support approach to ensure they have access to the services they need to avoid rough sleeping and the subsequent behaviours that often leads them back to prison.

Street Engagement Team Casework Scenario

Marco is a 35-year-old male who has been rough sleeping for 5 years. He has been in Westminster for 9 months. He struggles in traditional service environments like day centres, other services and hostels. Marco finds it difficult to communicate with people, and often is perceived as being aggressive (he can be verbally abusive when he is frustrated). Marco has previously mentioned that his mental health fluctuates and when he is seen on the street it has been noted that he is often drowsy or on the move trying to make money. Marco has said that he is accessing Turning Point, but Turning Point have said Marco has never used their services. Staff have also observed that Marco often has bruises or cuts to his face and body and can appear submissive when in groups of other rough sleepers. Marco has been into CSTM once but did not feel able to sit through the assessment. The SET have since then seen him on outreach and have agreed to take his case on.

What approach would you use with Marco?

The SET would use the following approaches:

- Pre-treatment (relationship building) – Marco seems to have no engagement with services
- Trauma informed – Marco has been out for a long time and has been carrying a lot of trauma
- Flexible – Marco has no contact with services, he needs flexibility and time

1. Five policy changes that would radically combat homelessness, The Connection at St Martin in the Fields, February 2020

- No lone working – until the risk information around Marco is clearer
- Systems approach – what are the barriers for Marco to move forward and how do we move them?
- Client led and strengths based – ask Marco what he wants and create a plan with him from there

How would you build engagement with Marco?

- Consistently and proactively try to find Marco and offer support on outreach – try to find
- a pattern of what time might work for him. Turn up when you say you will
- Intensive engagement, but light touch – tea, coffee, a chat, informal – offer accompaniment to services
- Meet his immediate needs – what does Marco want first? This will build trust
- Get his consent to start doing some support work
- Think about joint-working Marco with another member of the team due to risk and his case being a lot of work

From this case study do you have any immediate concerns for Marco, or identified areas of work?

- Safeguarding referral – people have noticed Marco is often injured, and is possibly being exploited by other clients
- EVF – Marco has been out for 5 years, he presents as vulnerable, raise him to the vulnerability forum
- Mental health – contact mental health services to see if Marco has ever been referred or admitted
- Physical health (GP) – is Marco registered with a GP? If not support him to do this
- Welfare – is Marco receiving benefits? Does he have ID or a bank account?
- Lack of engagement – unpack with Marco why other placements and services have fallen through
- Substance use – support Marco to address his substance use
- Communication – look into speech and language therapy or psychological support
- Housing – does Marco want to go into housing and if so where? Work with him to identify an appropriate place
- Behaviour – does Marco have insight into his own behaviour? Can he be helped to build coping mechanisms?

What are some innovative ways of working that might support Marco to access services?

- Substance use – use the SET Clinic or offer for him to do a urine sample on outreach and call DHS
- Health – refer him to the homeless health / JHT target list, as a route in for addressing his health needs
- Out of hours day centre access – if he won't come into CSTM with other people there, be flexible and offer a quiet spot
- Get Marco involved in his own support plan – does he want to attend a case conference / Team Around Me?

How would you support Marco to work on his move-on plan? And how would you identify the most appropriate options for him?

- Utilise the approaches above and discuss the reality of the situation, there are limited options
- Work with Marco to build a picture of his housing history and what has led to placements breaking down
- Look at Marcos support needs – can he manage his own tenancy? Does he need supported accommodation? Could he do semi-independent? Why have his other accommodation placements fallen through? Is he able to live alongside other people knowing that he struggles in busy places?
- Look into if Marco has a local connection – how this would be done? Housing history, has he had a settled base in Westminster (like accommodation) before? Has he had any bedded downs in Westminster? What does his CHAIN history look like? Speak to the Rough Sleeping Pathway Coordinator at WCC to discuss access to the pathway.
- If Marco does not have an established local connection you could look at: reconnection services – assessment centres, a clearing house, or PRS. You could also advocate to the commissioners that Marco is placed into the pathway due to his vulnerabilities
- If Marco does have a local connection you could look at appropriate pathways for Marco depending on his support needs – including a referral to WCC Housing options for Emergency Accommodation if he is in priority need

If Marco is accepted for housing in Westminster and there is a waiting list, how would you support him to find interim accommodation?

- Look into emergency bed spaces via WCC Rough Sleepers pathway
- Look into making an Emergency Accommodation referral via Westminster Housing Services (priority need)
- Look into any health beds available
- Look into any B&B budgets
- Call a case conference and raise the profile of the case

How would you support Marco to sustain his accommodation once he is moved in?

- Allocate a transition period so that Marco has time to adjust to moving into accommodation / moving on from the service. Discuss this with him and make it clear what the boundaries are
- Identify with Marco areas that he might still need more support in and put other services in place
- Ensure he has support from other services still e.g. substance use, health etc. and make sure he is linked in with local providers if he has moved area
- Ask Marco what type of activities interest him and how he would like to fill his time e.g. local support groups, activities and groups etc.
- Use the move-in budget to offer some personalisation to Marco – e.g. he might want a TV or a smartphone – something to keep him distracted
- Speak with Marco about budgeting and life skills – does he understand his rent or hostel payments etc.
- Apply and look for grants with Marco that can fund him to settling in more – e.g. wavelength, charity grants and government loans / grants

This case study is based on an in-depth conversation with Paul Grieve, Outreach & Innovation Coordinator, Street Engagement Team at The Connection at St Martin in the Fields.

Case Study 3 – Way2Home / Homeless Assertive Response Team (HART), Sydney, Australia

In Australia, following the publication of a key White Paper in 2008,[2] there has been an emphasis on assertive outreach, with 'Street to Home' a prominent feature in several Australian states and territories since then. The programme is modelled on the Rough Sleepers Initiative but with a clear Housing First approach.

A recent rapid review of assertive outreach[3] on behalf of NOVA for women and children – a specialist organisation aiming to set up a new assertive outreach service, identifies that in the early days following the White Paper, there was a plethora of research to analyse and evaluate impact, but there has been no recent research or case studies.

The following summary therefore, is based on a case study from a key report published in 2012 by the Australian Housing and Urban Research Institute.[4] This report is particularly insightful and referenced widely as a key study on assertive outreach. However, as it is from almost a decade ago, the summary below is cross-referenced to existing services, which serve to demonstrate the longevity of the practice in Sydney.

Assertive outreach was introduced as a primary mechanism of responding to rough sleeping in Sydney, in the City of Sydney Homelessness Strategy 2010 and remains a key part of their current strategy.[5] Rough sleepers became a policy and practice focus for the New South Wales Government, due to a realisation that they faced a significant risk of premature death because of a range of complex health and social problems.

In 2012, there were two teams providing assertive outreach under the Way2Home programme: an 'assertive outreach housing support' team, provided by Neami, a non-government mental health provider, and an 'assertive outreach health' team, provided by St Vincent's Hospital, a large public and teaching hospital located in Sydney's inner eastern suburbs for over 150 years.

The model of assertive outreach used was a persistent and deliberate street outreach method, focused on identifying people in the highest need, and then assisting them to exit rough

2. The Road Home: A national approach to reducing homelessness, Department of Families, Housing, Community Services and Indigenous Affairs – Australia, December 2008
3. Assertive outreach with women experiencing homelessness: a rapid review of the literature, Blakemore, Tamara; Stuart, Graeme; McGregor, Joel, University of Newcastle (Australia), October 2021
4. The role of assertive outreach in ending 'rough sleeping', Rhonda Phillips and Cameron Parsell, Australian Housing and Urban Research Institute (AHURI), Queensland Research Centre, January 2012, p.33-44
5. A City for All: homelessness action plan, City of Sydney, October 2019, p.24

sleeping. The Sydney model was to enable people to exit rough sleeping by immediately accessing permanent housing, rather than moving through various forms of homeless and transitional accommodation. This would be followed up by tailored support services to people in their homes.

Sydney's assertive outreach consisted of two dimensions: primarily outreach into public places (street-based outreach); and outreach into people's homes (housing support), including temporary accommodation.

Neami's assertive outreach support team followed a team-based approach, whereby they were not allocated specific clients. It consisted of practitioners working in Community Rehabilitation and Support Worker roles, who tended to have social work and welfare backgrounds, but specific qualifications were not a requirement. They also employed two full-time equivalent workers who have previously experienced homelessness, referred to as Peer Support Workers (PSW). The PSW in particular was seen as playing a central role in facilitating the engagement with people sleeping rough. Through their lived experiences as homeless, the PSW knew many of the people the service attempted to engage with, and their life experiences provide them with added credibility and provided optimism to people sleeping rough that exiting homelessness is a reality.

The assertive outreach health team was comprised of specific roles that require individuals with specific medical qualifications to fill. This includes: two drug and alcohol workers, two mental health workers, one full-time and one part-time registered nurse, and a part-time specialist consultant psychiatrist. Reflecting the different medical specialities of each worker, the assertive outreach health team contrasts with the support team in that it practices from a case management approach (rather than a team approach).

Sydney's assertive outreach consisted of two dimensions: primarily outreach into public places (street-based outreach); and outreach into people's homes (housing support), including temporary accommodation.

Street-based outreach consisted of daily patrols of public places to identify people sleeping rough and to engage them with the service. 'Patrolling' took place in 'hot spots', a term referring to places with high numbers of rough sleepers. Patrolling also occurred in public places where people sleeping rough are known to isolate themselves. Assertive outreach workers approached people in public places to initiate dialogue, which was both casual and purposeful to be both friendly but determine levels of need. In addition to patrolling public places, street-

The outreach team also found that a number of people sleeping rough expressed a desire to exit rough sleeping, but were unwilling to do so if entering homeless accommodation was the only means to achieve this exit.

based outreach consisted of more purposeful efforts to locate specific individuals for the purposes of providing pre-arranged services in situ, for example locating a person to complete a housing application. For the assertive outreach health team, street-based outreach involved locating a person for the purposes of a health assessment or to administer medication. Although the two outreach teams are described separately, there was a joint street-based outreach approach.

Joint outreach was viewed to be particularly effective when, for example, the assertive outreach support team required medical assessments and interventions from the health team. A medical assessment was a powerful means of enhancing a person's application for priority housing or documentation for benefits.

The study found that the numbers of people sleeping rough engaged by the service far outstripped the housing resources the service could access and make available to their service users. The outreach team also found that a number of people sleeping rough expressed a desire to exit rough sleeping, but were unwilling to do so if entering homeless accommodation was the only means to achieve this exit.

For those service users who had accessed housing, the assertive outreach service continued to provide support, as a means to ensure people sustain their tenancies. The outreach into people's houses was still client-focused, but the ultimate goal was housing stabilisation and the exiting of the assertive outreach service. The assertive outreach health team focused on establishing links and working relationships between their clients and mainstream health providers.

The study obtained feedback from service-users, who on the whole referred to their assertive outreach as very positive and housing focused. They made interesting practical suggestions to improve services, for example that approaches should not be made too early in the mornings, due to tiredness amongst rough sleepers and the effects of alcohol from the night before. And to avoid approaching individuals in groups, due to group dynamics and priorities often meaning that people were not focused on what outreach workers had to say at that time. One feedback participant named Bill, explained his experience which neatly sums up the assertive outreach approach: "I don't like services that are pushy. Neami puts suggestions into your head, letting

you think it's your idea, but it's theirs. They let you work out what you want." Suggesting that the approach was not directive, but rather the outreach workers skilfully and persistently worked with him to help him to a place whereby he was ready to accept housing.

> *Sydney's assertive outreach consisted of two dimensions: primarily outreach into public places (street-based outreach); and outreach into people's homes (housing support), including temporary accommodation.*

The feedback also showed that assertive outreach is not and cannot be a 'one-size fits all' approach. Bill's experience, coupled with the insights from other participants, demonstrated the efficacy of assertive outreach when it was able to be delivered flexibly and in a way that was responsive to an individual's needs. The service was known for its focus on providing housing (or at least trying to), but at the same time, assertive outreach was not perceived as imposing an agenda that sought to move people from public places against their wishes.

The Way2Home programme is still in existence and Neami indicate that they continue to work in partnership with health services, general practitioners and other community services in delivering assertive outreach to people sleeping rough in Sydney. It indicates that it still has a Housing First approach. Further information indicates that their contract has been renewed at a value of AUS$700,000 per year, for the next three years as they 'remain best equipped to continue to deliver these specialised programs' and specifies assertive outreach as a key component.[6]

This information also refers to the Homeless Assertive Response Team (HART), which appears to be a subsequent collective group of the above case study, launched in 2015, with additional partners.[7] An article[8] from March 2020 with staff from St Vincent's Hospital, confirms their continued provision of health-focussed assertive outreach services, also part of HART.

6. Community Services Grant – Funding to Address Homelessness in the Inner City, Healthy Communities Sub-Committee, City of Sydney, May 2021
7. Partnership referenced as including St Vincent's Hospital's Homeless Health Service, Department of Communities and Justice, City of Sydney, Missionbeat Outreach, Neami National, Innari Housing, Launchpad Youth Services, Aboriginal Corporation for Homelessness and other non-specified specialist homelessness services
8. Tackling Homelessness and Healthcare on the Frontline: The Innovative Response of the Homelessness Assertive outreach Response Team and the role of the St Vincent's Hospital Sydney Homeless Health Service, Parity, Vol33-2, March 2020, p.12

The article describes how one morning a week HART services meet in the city, are coordinated into small groups and allocated an area of the city to patrol by foot or by car. Each small group consists of housing workers, specialist homelessness service personnel and health workers, although people sleeping rough are only approached by two people as more can be overwhelming.

The HART services meet monthly to discuss patrols, share service information and to coordinate care for HART clients as required. There is a shared consent form that ensures the group has consent to work with people and exchange information as required. HART members are available to each other outside patrols or meetings for referral, consultation and advice. The author of the article reflects that the partnership is a 'mutually beneficial collaboration' for health and housing outcomes for people sleeping rough in the City of Sydney.

St Vincent's continues to utilise the Peer Support Worker role described earlier and the article also indicates the specific employment of an Aboriginal Health Worker role, who partners with a clinician on patrol and provides cultural support to people sleeping rough who identify as Aboriginal or Torres Strait Islander.

A second article, provides more information on the health based assertive outreach, describing a trauma-informed, strengths-based, culturally sensitive approach, addressing the health needs of a service user with a tri-morbidity framework (physical health, mental health and drug and alcohol use).[9] Further insight into the role of a health assertive outreach worker is described in this video from March 2020.

While the original case study is based on outreach from a decade ago, it is clear that assertive outreach remains a key feature of the homeless strategy in Sydney and perhaps has been strengthened with even more partners involved in this collaborative approach. Please note contact was attempted, but no response was received.

9. A Day in the Life of an Assertive Outreach Team Clinician, Parity, Vol33-2, March 2020, p.20

Case Study 4 – Niagara Assertive Street Outreach (NASO), Ontario, Canada

Homelessness in Canada is a shared federal-provincial responsibility, with municipalities playing a key role. Reaching Home is the national strategy, which is a community-based programme aimed at preventing and reducing homelessness across Canada, providing funding to urban, indigenous, rural and remote communities to help address local homelessness needs.

Outreach is a critical component for addressing homelessness in Canada, to reach those who are farthest from engaging with services. There is a focus on coordinating and mapping outreach, to identify both people in need, but also mapping of services to avoid duplication. This is backed up by a wealth of resources provided by the Built for Zero Canada campaign (Canadian Alliance to End Homelessness), which tracks efforts to reach zero homelessness, build alliances and share best practice.

Niagara's homelessness response has been going through a transformation, in the past couple of years through a streamlining of services, including their assertive street outreach programme. They are at the start of a journey aiming for 'net zero' homelessness (defined as three or less chronic homeless people over three months).

A key tenet of achieving this is performance management, including achieving a 'quality by name list' – a comprehensive list of every person in a community experiencing homelessness, updated in real time.

NASO formed in April 2020 as a region-wide collaborative of four service providers – Gateway residential and community support services, Southridge Shelter, RAFT and PortCares. Gateway is the lead agency, supporting with resources, scheduling and administration. The pandemic gave the impetus to progress the work of the providers in establishing the team and building other partnerships along the way with the police and health colleagues including paramedics.

The Assertive Street Outreach workers are focused on ending the experience of homelessness, particularly for those who would otherwise be underserved in traditional settings. The outreach team comprises of 12 full time employees, including two team leaders and weekend support. They have a daily catch up and bi-weekly meetings often joined by other community resources and a joint monthly management meeting. As has been identified in other case studies, time and flexibility to build trust, to move at the individual's pace, are identified as the important features of this approach. In January 2021, there were over 1,000 people identified as homeless, with around a third experiencing chronic homelessness.

NASO partnered with Ontario 211, a free helpline to connect to community and social services to establish a referral service. Operators obtain as much information from the caller as possible and relay an automated message to a central NASO inbox for deployment to a team member.

Like many Canadian homeless programmes, there is a big emphasis on using technology and data as a tool in outreach. The outreach team uses HIFIS, a homelessness management information system, for case management. They use this out in the field to obtain and relay information quickly (e.g. legal information, consent).

> "We would work with whatever we have in the interests of our client, but ultimately… this tech has made us more efficient and effective… to make things happen for our clients when they want them"

This service also uses a 'Hot Spot Mapping' tool, provided by ArcGIS (Homeless Risk Reduction solution), primarily used to map encampments, but there is ambition to use it further. The deployment of this solution was requested by staff to help manage the huge areas they have to cover. It enables the prioritisation of resources and will assist in collecting data as part of the 'point in time' count. It can be accessed by an app and, therefore, effective in mapping real-time data and provides data insights through a built-in dashboard. However, it is expensive and it can be difficult to track historical data or a change in an individual's habits.

Overall the collaborative support and cooperation, particularly with two of the larger municipalities (Niagara and St Catharine's) have been a big win. Partnerships with existing service providers have resulted in a better use of resources and expertise, e.g. in harm reduction support services, public health, Ontario Works, ID clinic).

The big challenges include:

- Change management – the team grew rapidly and had to take on new technology, which was difficult for some. 21 Assertive Outreach – International Good Practice Examples Four case studies prepared by the LGIU
- The size of the region is also a challenge with 12 municipalities who all operate a little differently to work with and cover geographically.

Moving forward, there is a plan for greater use of performance management and phase two of hot spot mapping to link to HIFIS. They have ambitions to further the partnerships they work with and improve communication platforms.

This case study is based on a presentation and information from Carla Montana, Service

System and Performance Management Advisor, Community Services, Niagara Region. Please note contact was attempted particularly to explore staff training and support and risk management, but unfortunately no response was forthcoming.

Conclusion

From the conversations, research and pre-recorded accounts the Changing Lives definition is accurate in its description.[10] The need for establishing trusting relationships based on consistency, respect and flexibility are key. The need to be trauma-informed and personcentred and have harm reduction in mind are also clearly a priority. Collaboration and partnership are essential to avoid duplication and for rough sleepers to avoid 'intervention fatigue' and to address the multiple disadvantages and vulnerabilities of the people involved. Early intervention is perhaps the only element that hasn't stood out, but one that is vital and one that the services do all they can to identify anyone new to the streets.

Assertive outreach appears to be a powerful tool in the challenge of addressing homelessness, underpinned by teams of compassionate and patient people, who are able to recognise trauma and multiple-disadvantage and despite this find ways to help people reach better outcomes.

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Overall, there appear to be few limitations or challenges to this approach.

Although as a final point and one picked up in two of the studies, there were barriers around a good supply of affordable and suitable housing in enabling assertive outreach to achieve the ultimate goal for people sleeping rough to find a permanent home. This is also highlighted by Crisis who conclude that "the approach [assertive outreach] is seriously undermined when suitable accommodation is not offered or temporary shelter is the only option. There was a common view that the accommodation available had to be appropriate and of good quality otherwise the whole approach and method of actively targeting people could be deemed to be unethical and ineffective.[11]

10. Changing Lives Outreach Guidance and Templates, October 2018
11. Ending Rough Sleeping: What Works?, Crisis, December 2017, p.103-104

National Examples

Background

There is a wide variation evident in the level and extent of Street Outreach services established in Ireland across the homeless regions.

The case studies below are good practice examples of existing Assertive Street Outreach services in Ireland provided by four local authorities.

- In the Dublin region, Assertive Street Outreach services are provided by the Dublin Simon Community in partnership with the Dublin Region Homeless Executive.
- In Cork, the Cork Simon Community provide an Assertive Street Outreach service in partnership with Cork City Council.
- In Waterford, Outreach services are delivered by an integrated team made up of staff from various services, both statutory and non-statutory, who work in partnership to deliver a service that aims to meet the needs of rough sleepers.
- In Limerick, ASO is provided by the local authority with supports being offered by NGOs in the area.

We are extremely grateful to all those who generously donated their time and provided the case studies below.

Case Study 1- Assertive Approach

John would walk the same route around Dublin every day, and rough sleep each night. Outreach assigned John a keyworker to meet him regularly and walk with him. Initially, John would only provide his first name, and he declined any support, but after a few weeks, John slowly began to engage with his keyworker. John gave his surname and then later agreed to complete a housing application. This was the key to referring him to Housing First for long-term accommodation support. Outreach and Housing First worked together with John to transfer the relationship from Outreach to Housing First, who then took the lead in organising long-term accommodation for John.

Dublin Simon Community

Case Study 2 – Person Centred Approach

Patrick was a 48-year-old male who had been in and out of emergency homeless services for approximately eight years. He had a history of dependent alcohol use and mental health issues, which at times culminated in aggressive behaviours towards other people sleeping rough and towards service providers. This in turn led Patrick to be isolated from static/clinical service providers, as he was unable to attend structured appointments and adhere to emergency accommodation policies due to his complex needs.

Therapeutic relationship: it was important that the development of a therapeutic relationship occurred, and that the worker and Patrick were aware of the dynamic of the relationship, and also the boundaries of the relationship. Outreach visited Patrick three to four times per week, and interventions were based on his presentation at that particular time. Initially, the interventions focused on crisis intervention, harm reduction, etc., but fundamentally it provided the workers with an opportunity to analyse and identify when the best times were to provide Outreach to Patrick. Key indicators of the potential for successful engagement included his mood and level of alcohol consumption. This in turn allowed the workers to monitor his socio-emotional wellbeing, and increased the possibility of positive outcomes. It also provided an environment for both the workers and Patrick to be in tune with one another.

Type of interventions provided

- Education and Awareness: Information-based interventions that are designed to create a self-awareness of the impacts of Patrick's alcohol consumption on his physical, cognitive and socio-emotional wellbeing.
- Harm Reduction: Referral to HSE Substance Misuse Liaison Nurse. Referral and advocacy to a General Practitioner (GP) for exploration, discussion and possible medical response/detox.
- Advocacy to Homeless Action Team (HAT) to advocate/seek referral to emergency accommodation.
- Assisted in the administrative aspect of applying for supports/logistics of accessing supports, etc. Outcomes
- HSE Outreach continued to link with Patrick while he was residing in the tent; this occurred for a further nine months. This provided Patrick with a constant in terms of support and provided both parties with an opportunity and environment to develop a basis for a therapeutic relationship.
- Patrick reduced his alcohol consumption before attending meetings as per care plan and began the process of communicating his feelings and became assertive rather than aggressive in expressing these feelings.
- Patrick accessed a medical card and GP, HSE Substance Misuse Services and HSE Liaison Nurse.
- Outreach advocated for Patrick at HAT meetings, and he was referred to emergency accommodation. HSE Outreach remained key working with Patrick, and was part of his care team moving forward.
- Knowledge/insights/observations gained from an eight-month period outreaching to Patrick provided emergency services with a specific Individual Crisis Management Plan (ICMP), which in turn provided emergency accommodation services with the information and skills to identify escalation traits and also provide de-escalation techniques.
- Patrick began stabilising in terms of his alcohol use and the risk behaviours associated with it. Communication with services became clear, stable and productive.
- Currently Patrick has moved on to become a Housing First tenant (approx. one year); he continues to consume alcohol, however his consumption rates have decreased and he is managing at present to maintain the tenancy.
- Outreach still continues to link in with Patrick around his alcohol use, and is a part of his current care team. The pathway from street homelessness, emergency accommodation and on to housing has been clear for Outreach and Patrick to navigate together. Communication throughout all stages from crisis to stabilisation and everything in between has been key. Outreach's primary goals were to reduce harm, build a therapeutic relationship and advocate with appropriate services for Patrick to gain housing and supports.

- This has been achieved by being constant and assertive in our Outreach, being open to two-way dialogue, adopting a partnership approach and being willing to adapt our practices and interventions to suit Patrick and where he is at any particular time. This has provided us with a therapeutic base to build upon.

Actions

Identify the hazard:

In this case, the individual was potentially aggressive if excessive amounts of alcohol had been consumed, or if his mental health had deteriorated. Also, the tent was located in an isolated area, which increased the risks for the Outreach worker.

Identify the risks associated with the hazard:

In this case, the risk of aggression and potential violence from Patrick, and also the isolation associated with the area, placed the Outreach worker at risk if something had happened. Rate the risk: Based on the information at hand, we deemed this a high-risk intervention.

Identify control measures:

We designed an Outreach plan based on the risk, in this case no lone working was encouraged when outreaching to Patrick. Also, the HSE SMS team was informed of location and expected return time before outreaching to Patrick. Based on the information provided, we created a ICMP (Individual Crisis Management Plan), which identified possible triggers for escalation and also skills required to de-escalate if necessary. Ideally, an ICMP will be done inclusively with an individual rough sleeper; however, this will only be possible if a therapeutic relationship is formed.

Initial contact:

We introduced ourselves and requested consent to inform Patrick of the services and supports available. Once consent was provided, the process of conducting an initial assessment could begin. This was done in an informal manner; however, the worker was seeking responses that would identify needs in terms of physical well-being, mental health status, substance use, housing needs and in essence to identify if Patrick had the cognitive capacity to engage in such a process. In this case, Patrick provided consent and was deemed appropriate to provide Outreach interventions to

Waterford Integrated Homeless Services

Case Study 3 – Trauma Informed Approach

Rosemary endured complex trauma as a child and a young adult, including violence and sexual abuse, which left her unable to feel safe in close quarters with others, or to trust people who sought to build relationships with her. At 32, she was a long-term rough sleeper and well known to the Outreach team. Rosemary used alcohol and drugs, including heroin. She stayed by herself on the street and was a victim of abuse and assault while rough sleeping; however, Rosemary more often than not refused the offer of emergency accommodation, as she reported that she felt unsafe anytime anyone was trying to control her, which is how she experienced the rules and interventions of emergency shelter settings.

The Outreach team established a rapport with Rosemary, which was based upon their acceptance of her need to engage entirely on her own terms, and to retreat from services and supports periodically. They encouraged her to use the Day Service, which she did sometimes, availing of food and drink, showers, laundry facilities and access to the HSE Adult Homeless Integrated health team. She was also provided with harm-reduction supports around her substance use, including advice on smoking rather than injecting heroin, safer injecting and safer disposal information and one-hit kits.

Rosemary did occasionally use the Emergency Shelter but would sometimes be allocated a bed and then not take it up, or leave during the evening or overnight. The Outreach team advocated with the Shelter service to ensure that they understood these repeated refusals or changes of mind as a trauma response and did not interpret it as an intentional lack of engagement or refusal of service. They established an agreement that an additional space within the service would be made available to Rosemary on those occasions when she did take up the offer of a bed.

As part of the consultation process on the prioritisation of service participants for Housing First, the Outreach team put Rosemary forward and strongly advocated for her inclusion on the priority list. She was accepted onto the priority list, and the Outreach team began working closely with the Housing First team to establish a rapport with Rosemary and seek her engagement in the programme. Outreach would meet with her in the morning, on the street or in the Day Service on days when she attended and would then contact the Housing First team to communicate whether she was willing to meet them that day.

The Outreach team communicated to their colleagues how important it was to Rosemary that she be in control of any interventions or engagement. The approach of the Housing First team

was an excellent fit for Rosemary's needs, as its principles uphold the rights of participants to make their own choices and does not require any pre-conditions to housing or access to support. Rosemary engaged well with the Housing First team, and was invited to view multiple apartments in recent weeks. She identified the one which she felt most comfortable in, and has moved in in recent days.

Cork Simon Community

Case Study 4 – Harm Reduction Approach

Conor The Outreach team met with Conor on a regular basis. He was in Private Emergency Accommodation (PEA) but returning to the tent each day to drink alcohol, as he was not allowed to do this in the PEA. Conor had previously lost his bed in PEA accommodation, due to behaviour associated with his drinking. The Outreach team received a lot of complaints from the public in relation to the tent and associated rubbish. Conor was not engaging with any visiting support staff in the PEA, as he was out in his tent all day. The Outreach team persistently engaged with Conor and arranged a single room in a STA (Supported Temporary Accommodation) that did not require him to be abstinent. This meant that Conor did not need to return to the tent during the day, and instead the Outreach team were able to create a care plan based on Conor's needs that gave him access to health and housing support services.

Dublin Simon Community

Case Study 5 – Harm Reduction Approach

Outreach were undertaking a late-night welfare check on a couple who were rough sleeping in a tent in a quiet laneway in the city centre. When Outreach approached the tent they could hear subtle noises from inside the tent but there was no response when they called out the client's names. Outreach carefully opened the tent and used their torches to look around the immediate area.

The couple were inside the tent and appeared to be sleeping, and there was drug paraphernalia scattered around the inside of the tent. One of them began to engage with Outreach but

appeared to be under the influence of a substance, and her partner was not responding to Outreach. Outreach were advised that they both used heroin earlier in the night.

The Outreach staff risk assessed the immediate area to identify a way to safely reach the unresponsive man. Outreach contacted the emergency services and administered intra nasal naloxone to the unresponsive man. After a couple of minutes, he became responsive and was verbally aggressive with Outreach for intervening. Outreach staff were able to safely manage the situation until the paramedics arrived. Outreach and the man's partner were eventually able to convince him to go to hospital, along with his partner, for medical support.

The next day Outreach staff visited the couple in their tent to continue their support. Later in the week Outreach supported them to access supported accommodation, something that they were reluctant to do prior to their overdose incident.

Dublin Simon Community

Case study 6 – Access to Healthcare Services

Jim was made homeless after his wife passed away. He also suffered from undiagnosed dementia. Jim would frequently travel to various locations outside of Dublin, and as a result kept losing his bed in all of the Dublin hostels, as well as access to medical services to get the health supports that he needed. Dublin Outreach started linking in with Jim regularly and built up a rapport with him. This allowed the Outreach team to complete an application for social housing supports. After advocating with various stakeholders, Dublin Outreach were able to secure him a bed in LongTerm Supported Accommodation that would be kept open while he was travelling. Once Jim had access to accommodation, Outreach services linked him in with a visiting nurse, Linda. Linda completed a medical assessment with Jim, which confirmed he had dementia. She was then able to put the necessary supports in place for him.

Dublin Simon Community

Case Study 7 – Access to Accommodation

Alex was sleeping in a tent pitched in a popular walkway area on the outskirts of Limerick city. The assessment and placement coordinator and his colleague Laura went out one morning to investigate. Upon arrival they engaged with Alex and discovered he had been sleeping in the tent for a few weeks. Alex was using heroin, but had not engaged with any services for a number of years. Alex refused a bed in the 9-9 service, as he owed money to one or two clients staying there. The Outreach team offered him a bed in a hostel but he didn't present. Eventually, after persistent engagement, Alex took an offer of a low-threshold accommodation in a "pod", which is individual accommodation with supports. The Assertive Outreach approach we took that day had an extremely positive outcome for this client, but also the accommodation options are an important factor here. Not every client can stay in a congregated setting, but options are limited.

Limerick Outreach

Case Study 8 – Access to Mental Health Services

The Outreach team received reports of a vulnerable woman called Fiona sitting on a bench in Dublin City. Fiona refused to say a single word to the Outreach team. The Outreach team checked on her throughout the day, but she did not engage, and then bedded down by the bench at night. The Outreach team assigned two keyworkers to visit her every day, seven days a week, to provide consistency. It took two weeks for Fiona to give her first name to the Outreach team, and a few days later she gave her second name. The Outreach team, in partnership with Safetynet, arranged a mental health assessment for Fiona, and she was referred to specialist psychiatric support.

Dublin Simon Community

Case Study 9 – Access to Mental Health Services

IMHT Community Liaison service recently received referral of an elderly gentleman who was repeatedly excluded from homeless accommodations due to unmanageable behavioural issues. IMHT Community Liaison liaised with Dublin Simon to have him moved to the StepUp/StepDown service where we could assess him, evaluate the risks and initiate treatment if necessary. In collaboration with Simon staff and the Inclusion Health team at the Mater Hospital, he had a comprehensive medical and psychiatric evaluation. It emerged he had had undiagnosed and untreated psychosis for approximately 15years and his illness had led directly to him becoming homeless. He commenced treatment under the supervision of IMHT and the Dublin Simon staff and responded well. IMHT were able to have his care taken over by the appropriate Psychiatry for the Elderly service who are committed to supporting him to reinstate his functional independence and access permanent accommodation. This intervention was an example of IMHT's core values of Assertive Outreach, Community Liaison and Integrated Care with a very successful outcome.

Case Study 10 – Identifying and working with Service Partners

The Outreach team were contacted by a member of the public who was concerned about her son, aged in his 30s and with a long history of mental health problems. She explained that he had left the family home weeks ago and had had periods of sleeping rough in the past. She gave information on some locations where he had been known to go during those times.

The team carried out expanded rounds that week, to incorporate the various locations where the woman thought her son might be staying. They located him in a shed at the back of a business property. The man did not wish to come out of the shed, and so the team spoke to him through the door. They explained who they were and told them about the phone call, seeking consent for them to advise his mother that they had engaged with him. He agreed to this but did not respond to efforts to offer emergency accommodation or to further assess his needs.

Over a period of over two years, the Outreach team called to Darragh at the shed at least twice each week. They liaised with the Community Gardaí, the owners of the business property where the shed was located, Cork Simon's Emergency Shelter and Darragh's family to ensure

that his basic needs were met insofar as possible, and that all parties were aware of how to access an emergency bed should Darragh take up that offer at any point. Darragh continually refused the offer of emergency accommodation, and engaged only minimally with the team, but they were able to establish a level of trust whereby he accepted provisions that they left for him, including food parcels, clothing and bedding. From there, the team was able to gain Darragh's consent to talk to his GP, who worked with the Social Inclusion nurse to put a plan in motion to arrange for a mental health admission.

After a period of hospitalisation, the Outreach team was contacted again by Darragh's family, who advised that his mental health had stabilised, and that he had returned to the family home.

Cork Simon Community

Case Study 11 – Early Intervention

The Outreach team met Brian bedded down in the city centre. Brian was not known to the team and presented as extremely vulnerable. He initially refused to give his name, but after persistent engagement from the Outreach team, he eventually began engaging with the team and they got his details. The Outreach team looked him up online and realised that he was from the UK. They contacted British police and eventually got in touch with Brian's social worker, Laura. The Outreach team contacted the British embassy in Dublin and arranged for temporary travel documents and a temporary credit card to be provided for Brian. With the help of the Outreach team, Brian booked a ferry from Dublin to the UK, and arranged for Laura to meet him in Holyhead. The Outreach team brought Brian to Dublin Port and waited with him until his ferry arrived, and he got on the ferry 14 hours after first engaging with the Outreach team that morning. The alternative option would have been to quickly book Brian into homeless accommodation in Dublin and not follow up with the services.

Dublin Simon Community

Case study 12 – Access to Accommodation

Tom and Anna Tom and Anna were sleeping in a tent in Dublin city centre for months. They were not from Dublin, and due to local connection criteria, they could not get stable couple's accommodation in Dublin. Both Tom and Anna used drugs regularly and really needed a stable base, as their health was deteriorating. Initially, the Outreach team started to support them in advocating to Dublin services to get accommodation locally. Through regular engagement the Outreach team discovered that they came from a different local authority area. The Outreach team discussed the challenges of getting registered in Dublin with the couple and helped them contact the local authority area that they were from. The couple were unsure about returning but eventually they decided to return after a prolonged period in a tent in Dublin. They were accepted onto Housing First and were in their own home after a few weeks of leaving Dublin.

Dublin Simon Community

Case Study 13 – Working with Vulnerable Cohorts

In late 2020, the Outreach team came into contact with Oliver when he came into the rough sleeper service. Oliver was aged in his 30s and was originally from another European country. He had come to Ireland for a job and had settled here for a number of months. In a short period of time during the early months of the Covid-19 pandemic, Oliver suffered a number of personal crises that led to his becoming homeless: his relationship broke down and he had to move out of the shared rented apartment where he had lived with his partner; he began suffering from seizures and was diagnosed with epilepsy; and he lost his job due in part to problematic drinking, which had worsened as he used alcohol to cope with the relationship breakdown, housing crisis and health problem.

Because Oliver had not been living in Cork for long enough to satisfy the Habitual Residence Condition for social welfare and housing supports, he was not assessed as having a Centre of Interest in Cork and had been advised that he could only access emergency accommodation through the one-night-only Nightlight service. Concerned that he would become entrenched in homelessness for lack of move-on options, the Outreach team advised him and signposted to organisations to support his repatriation to his home country. However, Oliver was unwilling to return at that time, as he was suffering multiple seizures per week and was fearful of travelling. He also did not have a support system in his home country.

The team continued to work with Oliver while he accessed one-night-only beds and used the facilities of the Day Service for food, showers, laundry and, crucially, access to the HSE Adult Homeless Integrated team. The GP on the HSE team explained to Oliver how his drinking was interacting with his epilepsy and worked closely with the Outreach team to support Oliver with a Librium detox to help him cease his alcohol use, as well as treating his epilepsy with medication. Oliver's health began to stabilise, and the frequency of his seizures reduced dramatically.

The Outreach team engaged with him on exploring his limited options, and with him they determined that, due to his prior work history, his best option for a sustainable exit from homelessness would be a return to employment. Through the Cork Simon Employment and Training service they secured him a place on a Career Readiness training, where he was provided with a volunteer mentor who helped him to update his CV, resolve his exit with his former employer and secure a positive reference, and use the service's computers to carry out a job search daily. After weeks of applying for posts in Ireland, in his native country and elsewhere in the EU, Oliver secured a job offer in another country and was provided with funds to travel there. Eighteen months later, he remains in touch, emailing the Outreach team occasionally to say that he is doing well, working and in good health, and thankful for the interventions that supported an exit from homelessness despite multiple barriers and very limited options.

Cork Simon Community

Case Study 14 – Co-ordinated Case Management

On three occasions last year, Dublin Outreach team supported Adam from Galway, who would come to Dublin and engage in chaotic drug use. While the simplest option would have been to support Adam to access emergency accommodation, an Outreach keyworker reached out to his youth worker, Alan, who was already involved in his care. On two separate occasions, Alan drove a significant journey to Dublin to meet the Outreach team and Adam. He built up a rapport with Adam, and was able to drive him back to Galway, where he had supported accommodation.

Dublin Simon Community

Spunout EPIC Focus Ireland Crosscare
Pavee Point Family Resource Centres
Education and Training Board ALONE
Focus Ireland Safe Ireland Threshold
Belong To Citizens Information
Local Authorities
RTB Irish Refugee
Novas Council
MABS Treoir
PAS National
Advocacy
Service
Crosscare
Depaul
HSE

Homeless Prevention Service Directory

If you are homeless or at risk of homelessness please scan the QR code to find available services in your area.

Scan here

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