Mobile Outreach and Support Team (MOST):

Windsor, ON

OMSSA Conference
June 13th, 2019

Canadian Mental Health Association
Windsor-Essex County
Mental health for all

familyservices
WINDSOR-ESSEX
COUNSELLING & ADVOCACY CENTRE

ALSO
Assisted Living Southwestern Ontario | Aide à la vie autonome Sud Ouest de l'Ontario

HÔTEL-DIEU
ESTD GRACE 1888
HEALTHCARE

INTROS

Rob Moroz

Integrated Director
HDGH and CMHA
Windsor, ON

Tatum Dault

Program Coordinator,
Family Services
Windsor Essex

Abe Salame

RN/ETN
CTO Case Manager,
CMHA

Mobile Outreach and Support Team (MOST)

Laying the Foundation

1

- High profile program
- Strong leadership support + multiple partners
- Prioritized evidenced based decision making and continuous quality improvement
  - Engaged in **NEEDS BASED PLANNING**
  - Focused on **PROGRAM EVALUATION** as a key component

Mobile Outreach and Support Team (MOST)

Needs Based Planning

2

Target Audience

Who should we serve?
What do they need?

Best Practice Review

What does the literature show?
What has worked elsewhere?

Environmental Scan

What else exists in our community?
What are similar programs like elsewhere?

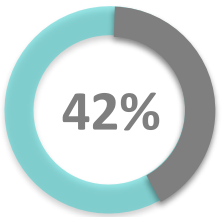
Who is experiencing homelessness in Windsor-Essex in 2018?

197 PEOPLE IN W-E COUNTY ARE HOMELESS ON A GIVEN NIGHT

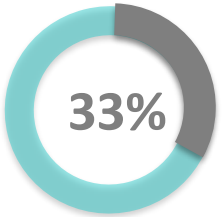
68% ARE MEN

53% ARE BETWEEN THE AGES OF 25 AND 49

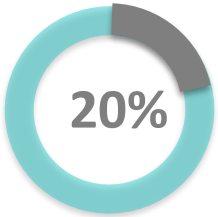
22% IDENTIFIED AS ABORIGINAL/INDIGENOUS



REPORTED COMPROMISED MENTAL HEALTH



REPORTED HAVING SUBSTANCE USE CONCERN

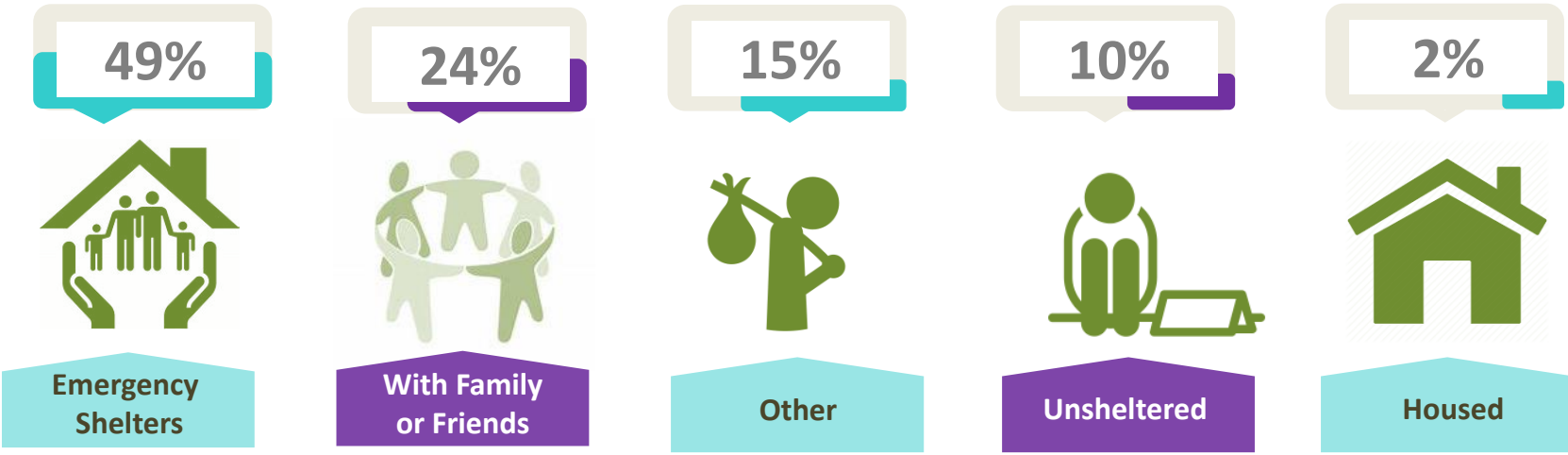


REPORTED HAVING A PHYSICAL HEALTH CONDITION

TOP CAUSES OF HOMELESSNESS

- Unable to pay rent or eviction
- Conflict with spouse
- Addictions or substance use
- Conflict with parent or guardian
- Unsafe housing
- Incarceration
- Job loss

WHERE DO PEOPLE EXPERIENCING HOMELESSNESS MOST FREQUENTLY SLEEP?



Source: City of Windsor 2018 Preliminary Point-in-Time Count

City of Windsor - 2016 vs. 2018 Point in Time Count

City of Windsor Profile

Population: 329, 144 (2016)
Unemployment rate: 6.9% (Nov. 2017)
Minimum wage: $14/hr (Jan 2018)
Total number of Shelters: 5 (2016)
Total number of Beds: 102 (2016)

Homelessness Indicators	2016 PiT	2018 PiT
# of people experiencing homelessness	201	197
% of chronically homeless	48%	46%
% under 24 years old	21%	27%
% between the ages 25-64 years	74%	70%
% reported frequently staying in an emergency shelter or transitional housing unit	46%	49%
% reported frequently staying with friends or family	39%	24%
% reporting frequently "staying outdoors" (unsheltered)	5%	10%
% reporting a mental health condition	34%	42%
% reporting chronic health condition*	35%	20%
% reporting substance abuse	31%	33%
# of ED visits in past 12 months	124	-
% reporting avoiding getting help when unwell	47%	-

**Note*. Indicator listed as "having physical health condition" in 2018

What we Know about Mobile Units

Greatest distinguishing advantage is their mobility

- Can go to areas where options aren't available
- Can move to different neighbourhoods as trends change

There are 5 common tasks:

1. Establishing contact and credibility
2. Identifying people with mental illness
3. Engaging clients
4. Conducting assessments and treatment planning
5. Providing ongoing, consistent service

Main objectives are to improve:

- Quality of life
- Access to other services

Structured assessments and referral pathways to from/to formal partners

Mobile units can enhance the credibility of other providers by becoming a recognizable presence in high risk neighbourhoods.

Mobile Units provide a greater amount of privacy, safety and resources than street outreach individuals can.

Mobile Outreach can Increase Access to Primary Care

People who receive outreach and orientation/education have better access to primary care

Mobile Outreach for Homeless with Serious Mental Illness is more effective
(vs. contacted in shelters, and other agencies)

More severely impaired
Have more basic service needs
Less motivated to seek help/treatment
Take longer to engage
Less likely to be engaged elsewhere

Why do people use Mobile Units?

Most people who use a Mobile Unit are currently homeless

60% were defined as currently homeless, 92% had history of homelessness and were at risk

Reasons for Visiting a Mobile Unit

1. Supplies (86%)
2. Health Assessment (37%)
    1. OTC meds
    2. Skin/wound care
    3. Foot care
    4. BP check
3. Other (5.4%)
    1. Social interaction
    2. To get info on services
    3. Link to housing services

80% of people who use a Mobile Unit are in possessions of their health card

Once engaged, clients visit the Mobile Unit frequently

Median of 7 visits in 3 months

The majority of homeless people do not have a family doctor (59%)

29% have no usual source of care

Primary Reasons for visiting a Mobile Unit instead of usual care

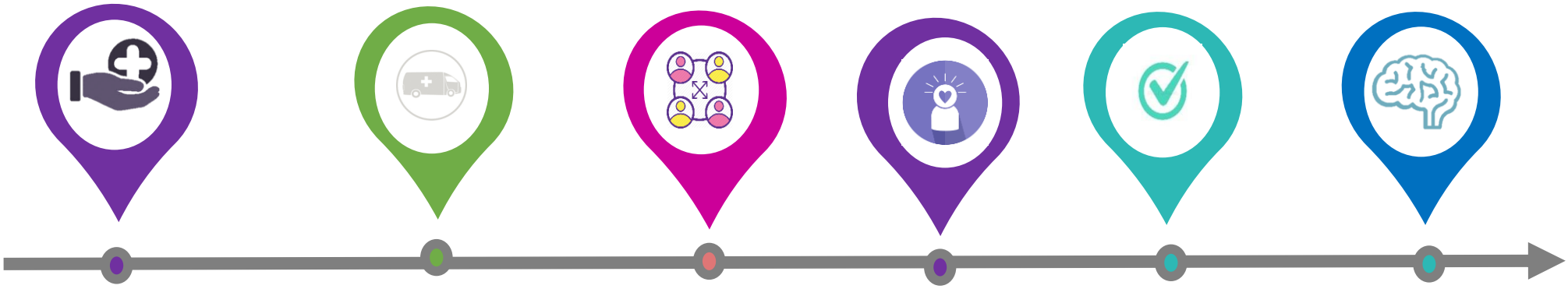
1. Personal supplies or clothing
2. Location is more convenient
3. Treated with respect and dignity
4. Time is more convenient
5. Don't have to pay for anything

The majority of clients visit Mobile Units to get basic necessities (86%)

1. Vitamins
2. Socks
3. Shampoo/soap
4. Toothbrush/toothpaste
5. Bottled water
6. Underwear
7. Harm reduction supplies (needle exchange)
8. Condoms
9. Creams/lotions

Journal of Primary Care and Community Health (2010) 1(2) 78-82: Why do Homeless People Use a Mobile Unit

Spectrum of Outreach Programs



Street Outreach

Providing essential goods such as food & hygiene products, and services such as basic first aid, referrals & screenings.

Mobile Outreach

Customized vehicle that provides essential goods such as food & hygiene products, and services such as basic first aid, referrals & screenings.

Mobile Health Clinic

Customized vehicles that travel to high risk communities and provide prevention and healthcare services

Mobile Mental Health Clinic

Customized vehicles specializing in providing mental health services in high risk communities

Mental Health Mobile Crisis

A mental health service providing immediate response emergency mental health evaluations and stabilization

Psychiatric Outreach Team

Provides psychiatric services to the individual who is homeless or at risk of homelessness, as well as to the partner agency serving the particular individual

- ✓ Street Health
- ✓ CMHA Community Outreach
- ✓ Family Services
- ✓ Windsor Youth Center
- ✓ Windsor Essex Housing Connections (WEHC) Housing First Program
- ✓ New Beginnings
- ✓ Can Am Friendship Centre

- ✓ Street Health Outreach Van

- ✓ WECHC Mobile Health Clinic

- ✓ Windsor COAST

Sample: Outreach/Mobile Unit Programs in other Regions

Street Outreach:
SOS - CMHA Street Outreach & Stabilization Program (Calgary)

Linkage to psychiatric and medical treatments, income support, housing referrals and daily living skills

Mobile Outreach:
HOST - Housing Outreach and Support Team (Toronto)

Offers housing support, counselling & emergency support.

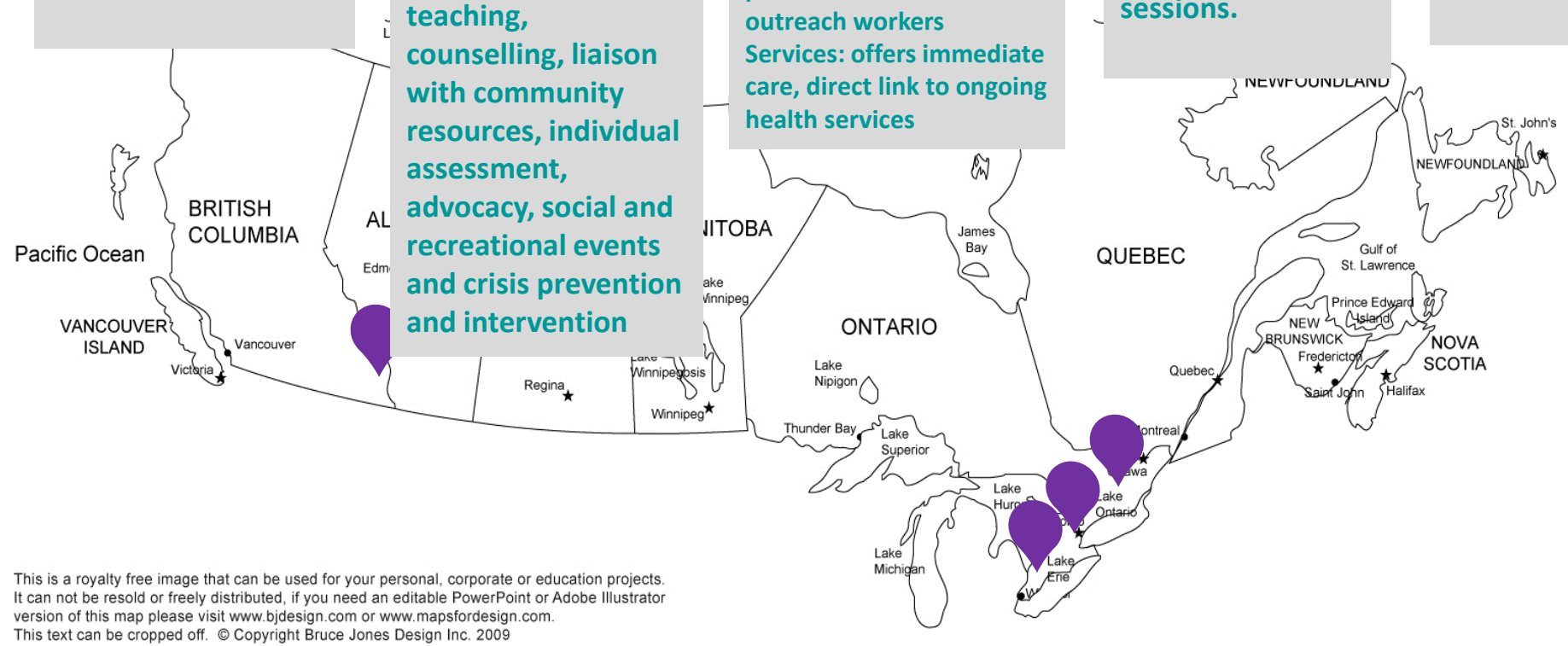
Direct skills teaching, counselling, liaison with community resources, individual assessment, advocacy, social and recreational events and crisis prevention and intervention

Mobile Health Clinic:
SHERBOURNE HEALTH BUS PROGRAM
Provides an entry point to healthcare services for people who often face barriers in accessing traditional health care services
Location: shelters, street, densely population housing
Staff: Healthcare professionals and outreach workers
Services: offers immediate care, direct link to ongoing health services

Mobile Mental Health Clinic (Youth)
CMHA York Region and South Simcoe

A private exam room, a curtained-off space for one-on-one counselling and an open lounge, group sessions.

Psychiatric Outreach Team (Ottawa)
Psychiatric services to the individual who is homeless or at risk as well as to the partner agency serving the particular individual
Provides assessment, short term intervention and links to other services.



Mobile Outreach and Support Team (MOST)

Program Planning

3

Project Charter

Authorizes the project, and provides authority to apply organizational resources.

Program Logic Model

A visual illustration of a program's goals, activities and expected outcomes.

Evaluation Plan

Describes how you will monitor and evaluate your program.

HÔTEL-DIEU GRACE HEALTHCARE

Project Charter

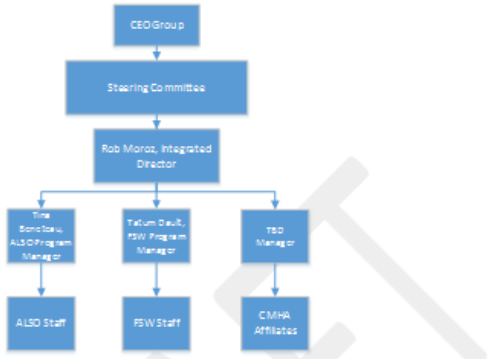
Mobile Outreach and Support Team (MOST) Project Charter

Project Overview

Charter Creation Date	December 2018	***Last Revision Date***	Jan 22, 2019
Charter Status (Pending/Approved)	Pending		
Project Duration	August 2018 - August 2019		
Operating Plan #	Not Applicable		
HDGH Executive Sponsor	Sonja Grebvski , VP Mental Health and Addictions		

Project Details

Project Purpose	The Mobile Outreach and Support Team is a temporary pilot designed to provide mental health supports to homeless persons in the downtown region of Windsor, Ontario. The project is a joint venture between Hôtel-Dieu Grace Healthcare (HDGH), Canadian Mental Health Association Windsor-Essex (CMHA), Family Services Windsor Essex (FSWE), and Assisted Living Southwestern Ontario (ALSO) .
Identified Objectives	The objectives of the project are to: • Provide for basic needs by distributing essential goods • Provide immediate mental health supports • Establish connections to additional services The program will launch by January 31th, 2019 and be active for six months, with an additional two months thereafter to complete program evaluation.
Project Scope	Given the project timelines and the collaborative nature of the work, employees of each respective organization will follow their own HR and Occupational Health and Safety policies and procedures. Client record keeping will follow current program practices of the respective organization's program from which the employee originates. This means the program is essentially co-locating existing programs and employees from all partner organizations. The following categories of work are within scope: • Communications • Materials and Supplies • Program Evaluation & Required Documentation • IT Equipment and Access • Program Operations and Management Structure • Internal Organizational Approvals Categories of work currently *out of scope* include: • All program specific policies and procedures • Client record keeping policies and procedures • Health and Safety / HR policies

Project Structure		
Steering Committee Members	• Sonja Grebvski *(Executive Sponsor)* • Claudia Den Boer *(Executive Sponsor)* • Joyce Zuk *(Executive Sponsor)* • Lynn Calder *(Executive Sponsor)* • Robert Moroz *(Operations)* • Erica Colovic *(Communications)* • Marla Jackson *(PMO / Evaluation)* • Terra Cadeau *(PMO)* • Colin Matthews *(PMO)*	
Roles and Responsibilities	***Executive Sponsor***	• Set overall project direction • Ensure project is appropriately resourced • Act as project champion at respective organizations
	Steering Committee Members	• Provide guidance and make decisions regarding project plan and deliverables • Act as project Champions within individual portfolios/teams • Address risks and barriers to success • Lead associated work within individual portfolios/teams
	HDGH	• Provide Senior Management Program oversight through Integrated Director, Mental Health • Provide Project Management, Program Evaluation and Communications Support • Provide program operational funding
	Assisted Living Southwestern Ontario (ALSO)	• Provide and maintain van, including fueling • Arrange and manage Attendant Service Worker for 25 hrs/week • Order and maintain stock for program supplies

Program Logic Model

MOST – Mobile Outreach Support Team | 2018/2019

Goal: A collaborative, inter-agency, multi-disciplinary outreach team that engages with hard-to-reach homeless individuals experiencing mental health concerns in their own environment to develop trust, address immediate needs, and provide supported linkages to essential community services

Target Population: Hard-to-reach homeless or street involved individuals experiencing mental health and addiction concerns in the City of Windsor

Assertive Outreach

Objective

Assertive outreach to people in non-traditional settings who have not successfully responded to other programs.

Activities

- Liaise with other providers
- Visit known encampments and reported sleeping areas
- Mobile search for clients

Indicators

- #/type of outreach activities conducted

Identification and Engagement

Objective

Establish rapport and form a trusting relationship that provides the opportunity to assess needs and gain agreement on a plan.

Activities

- Identify and have frequent contact with known target population
- Communication attempts and offering essential items. (food, clothing, harm reduction, transportation)

Indicators

- #/type people identified/ engaged
- #/type of communication attempts
- #/type of essential items dispensed

Rapid Assessment and Goal Setting

Objective

Improve comprehensive case planning by assessing needs and gaining agreement on a plan of care.

Activities

- Assess imminent danger, psychosocial needs, medical needs, concurrent disorder needs, housing needs
- Conduct ongoing goal setting and evaluation

Indicators

- #/type assessments completed
- #/type of needs identified
- #/type of goals set
- #/type of goals met

Interim Case Management and Supported Linkages

Objective

Improve access to care by conducting comprehensive case planning, promoting linkages to appropriate resources, and by providing education and assistance in interfacing with the health and social service systems.

Activities

- Motivational counselling
- Crisis intervention
- Accompaniment to appts
- Housing Plan and Disability applications
- Advocacy

Indicators

- #/type of interventions provided
- #/type of referrals made
- #/type of referrals supported
- #/type of referrals successful

Community Education and Support

Objective

Reduce system fragmentation and serve as a resource for other programs/services, allowing for more effective collaboration and community capacity building.

Activities

- Community education, consultation and training
- Education and consultation about mental illness, medication, behavioral strategies to work with clients

Indicators

- #/type of inbound referrals
- #/type of community education and training events
- #/type of consults

OUTCOMES

Short Term: • Improved awareness of population needs • Increased trust and confidence in traditional services • Increased participation in treatment, services and recovery supports

Long Term: • Enhanced community capacity • Reduced system fragmentation • Improved functional outcomes • Reduced Crisis Events/ED Visits • Improved housing status

Evaluation Plan

MOBILE OUTREACH SUPPORT TEAM (MOST): 2019 Demonstration Project Evaluation Plan

Process Evaluation

Objective	Activities	Metrics	Data Source	Timing
Assertive outreach to people in non-traditional settings who have not successfully responded to other programs.	• Liaise with other providers • Visit known encampments and reported sleeping areas • Mobile search for clients	• #/type of outreach activities conducted	Outreach Encounter Summary Form	Submitted after every shift
Establish rapport and form a trusting relationship that provides the opportunity to assess needs and gain agreement on a plan.	• Identify and have frequent contact with known target population • Communication attempts and offering essential items. (food, clothing, harm reduction, transportation)	• #/type people identified/ engaged • #/type of communication attempts • #/type of essential items dispensed	Outreach Encounter Summary Form	Submitted after every shift
Provide rapid assessment and support linkages to appropriate resources through education and assistance.	• Assess imminent danger, psychosocial needs, medical needs, mental health needs, housing needs • Conduct motivational counselling and provide interventions to increase uptake in health and social services	• #/type of needs identified • #/type of services provided • #/type of referrals made • #/type of referrals supported • #/type of referrals successful	Individual Engagement Form	After each individual engagement

Short Term Outcome Evaluation

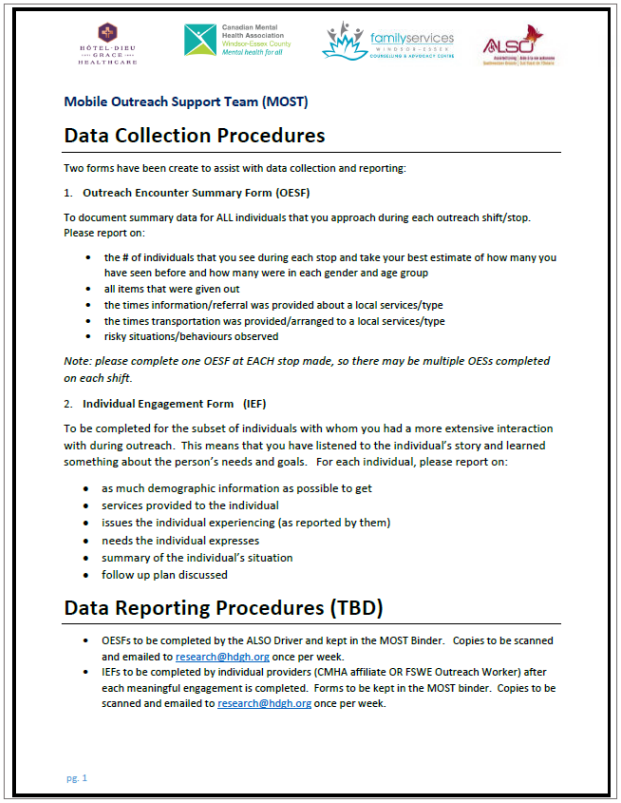
Objective	Metrics	Data Source	Timing
Improved awareness of population needs	#/type of population needs	Outreach Encounter Summary Form Individual Engagement Form	Quarterly
Increased trust and confidence in traditional services	#/type of referrals made	Outreach Encounter Summary Form Individual Engagement Form	Quarterly
Increased participation in treatment, services and recovery supports	Service Uptake	Individual Engagement Form	After each individual engagement
Demonstrate effectiveness of model	Outreach Team Feedback Participant Feedback	Outreach Team Interviews Participant Interviews	3 and 6 months

Long Term Outcome Evaluation (TBD)

Objective	Metrics	Data Source	Timing
Enhanced community capacity			
Reduced system fragmentation			
Improved functional outcomes			
Reduced Crisis Events/ED Visits			
Improved housing status			

Mobile Outreach and Support Team (MOST)

Measurement Tools



Mobile Outreach Support Team (MOST)

Data Collection Procedures

Two forms have been create to assist with data collection and reporting:

1. **Outreach Encounter Summary Form (OESF)**

To document summary data for ALL individuals that you approach during each outreach shift/stop. Please report on:

- the # of individuals that you see during each stop and take your best estimate of how many you have seen before and how many were in each gender and age group
- all items that were given out
- the times information/referral was provided about a local services/type
- the times transportation was provided/arranged to a local services/type
- risky situations/behaviours observed

Note: please complete one OESF at EACH stop made, so there may be multiple OESs completed on each shift.

2. **Individual Engagement Form (IEF)**

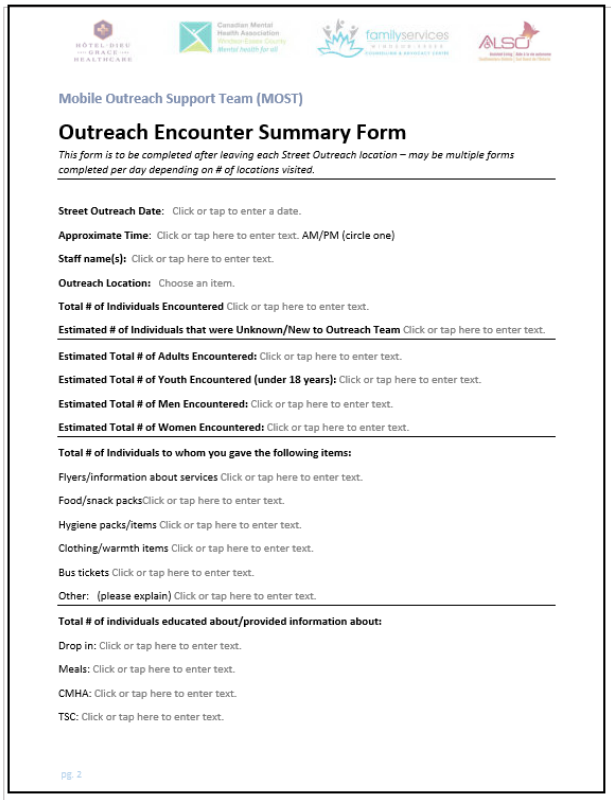
To be completed for the subset of individuals with whom you had a more extensive interaction with during outreach. This means that you have listened to the individual's story and learned something about the person's needs and goals. For each individual, please report on:

- as much demographic information as possible to get
- services provided to the individual
- issues the individual experiencing (as reported by them)
- needs the individual expresses
- summary of the individual's situation
- follow up plan discussed

Data Reporting Procedures (TBD)

- OESFs to be completed by the ALSO Driver and kept in the MOST Binder. Copies to be scanned and emailed to research@hdgh.org once per week.
- IEFs to be completed by individual providers (CMHA affiliate OR FSWE Outreach Worker) after each meaningful engagement is completed. Forms to be kept in the MOST binder. Copies to be scanned and emailed to research@hdgh.org once per week.

pg. 1



Mobile Outreach Support Team (MOST)

Outreach Encounter Summary Form

This form is to be completed after leaving each Street Outreach location – may be multiple forms completed per day depending on # of locations visited.

Street Outreach Date: Click or tap to enter a date.

Approximate Time: Click or tap here to enter text. AM/PM (circle one)

Staff name(s): Click or tap here to enter text.

Outreach Location: Choose an item.

Total # of Individuals Encountered Click or tap here to enter text.

Estimated # of Individuals that were Unknown/New to Outreach Team Click or tap here to enter text.

Estimated Total # of Adults Encountered: Click or tap here to enter text.

Estimated Total # of Youth Encountered (under 18 years): Click or tap here to enter text.

Estimated Total # of Men Encountered: Click or tap here to enter text.

Estimated Total # of Women Encountered: Click or tap here to enter text.

Total # of Individuals to whom you gave the following items:

Flyers/information about services Click or tap here to enter text.

Food/snack packs Click or tap here to enter text.

Hygiene packs/items Click or tap here to enter text.

Clothing/warmth items Click or tap here to enter text.

Bus tickets Click or tap here to enter text.

Other: (please explain) Click or tap here to enter text.

Total # of individuals educated about/provided information about:

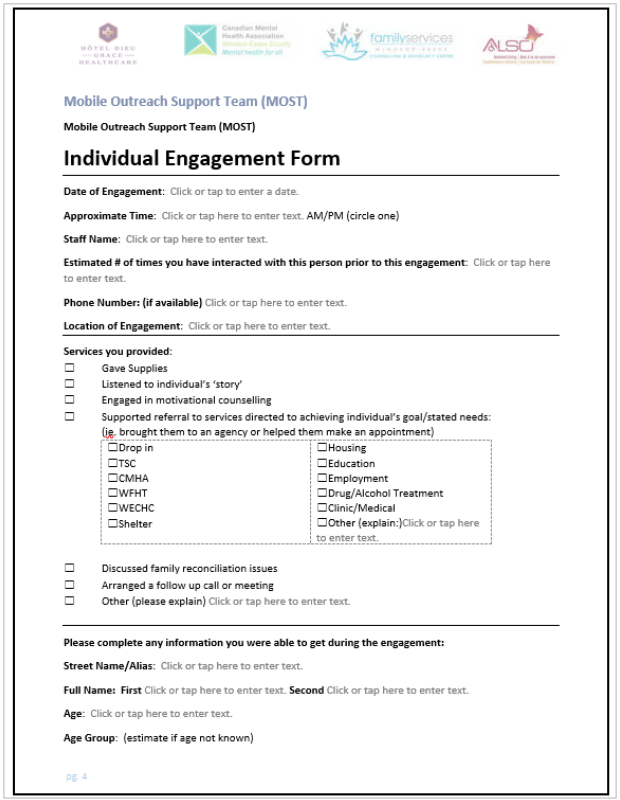
Drop in: Click or tap here to enter text.

Meals: Click or tap here to enter text.

CMHA: Click or tap here to enter text.

TSC: Click or tap here to enter text.

pg. 2



Mobile Outreach Support Team (MOST)

Mobile Outreach Support Team (MOST)

Individual Engagement Form

Date of Engagement: Click or tap to enter a date.

Approximate Time: Click or tap here to enter text. AM/PM (circle one)

Staff Name: Click or tap here to enter text.

Estimated # of times you have interacted with this person prior to this engagement: Click or tap here to enter text.

Phone Number: (if available) Click or tap here to enter text.

Location of Engagement: Click or tap here to enter text.

Services you provided:

☐ Gave Supplies
☐ Listened to individual's 'story'
☐ Engaged in motivational counselling
☐ Supported referral to services directed to achieving individual's goal/stated needs: (ie. brought them to an agency or helped them make an appointment)

☐Drop in	☐Housing
☐TSC	☐Education
☐CMHA	☐Employment
☐WFHT	☐Drug/Alcohol Treatment
☐WECHC	☐Clinic/Medical
☐Shelter	☐Other (explain:)Click or tap here to enter text.

☐ Discussed family reconciliation issues
☐ Arranged a follow up call or meeting
☐ Other (please explain) Click or tap here to enter text.

Please complete any information you were able to get during the engagement:

Street Name/Alias: Click or tap here to enter text.

Full Name: First Click or tap here to enter text. **Second** Click or tap here to enter text.

Age: Click or tap here to enter text.

Age Group: (estimate if age not known)

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Mobile Outreach and Support Team (MOST)

Assembling a Team

4

- Steering Committee:
  - Leaders from 4 Partner Agencies
  - Research and Planning staff
  - Communications Professionals

- Project Team:
  - Operational Managers from agencies
  - Front line staff (Outreach Workers, Attendant Service Workers, CMHA Affiliates)

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Mobile Outreach and Support Team (MOST)

Launch!

5

- Launched Jan 31st, 2019
- Monday – Friday, 5pm – 9pm
- Currently operating across 5 main locations in the City of Windsor
- Locations publicized on partner websites, in the news and by using cards that are handed out
- Van largely staying in dedicated locations, but does move as needed
- Significant promotion in local media, throughout City, etc.

HÔTEL-DIEU GRACE HEALTHCARE

Mobile Outreach and Support Team (MOST)

Launch

Mobile outreach team hits streets to help homeless

The Mobile Outreach and Support Team (MOST) hit the cold streets of Windsor, Ont., on Thursda
Campbell / CTV Windsor)

Community services collaborate to launch mobile outreach unit

TAYLOR CAMPBELL Updated: February 2, 2019

From left, Tatum Dault, program coordinator at Family Services Windsor-Essex, Chynna Resendes, a social worker at the Canadian Mental Health Association, and Adrienne Payne, a housing outreach worker at Family Services Windsor-Essex, pictured Thursday, January 31, 2019, OST) that will head out in a van to help those that are vulnerable in the community.

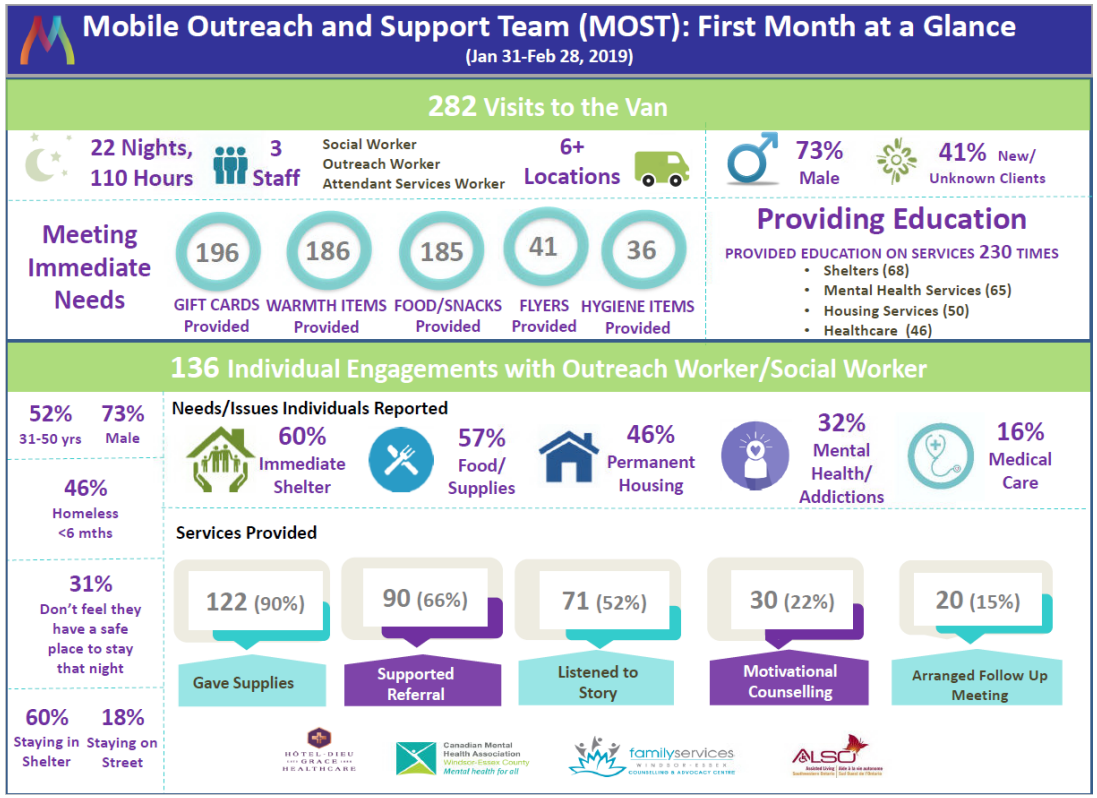
Hundreds helped by mobile outreach pilot project in first month

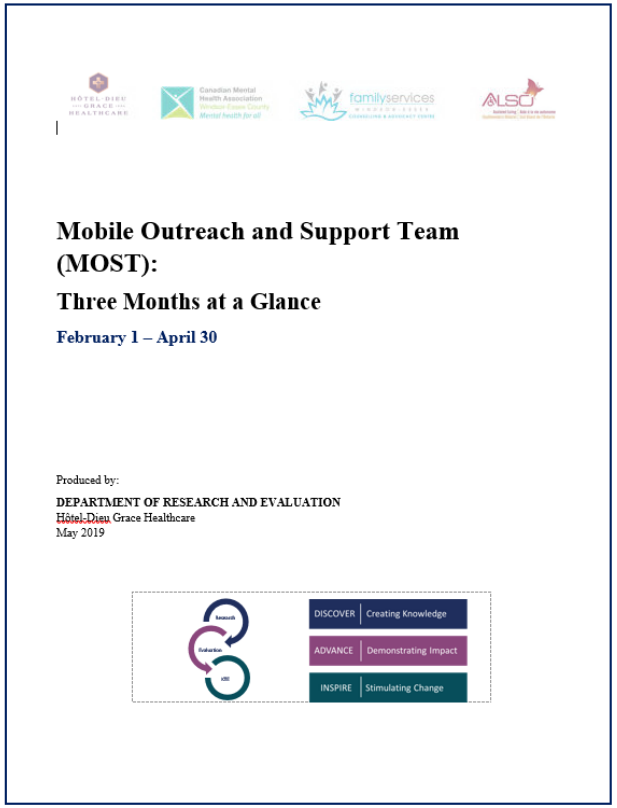
TAYLOR CAMPBELL Updated: April 5, 2019

Colleen Renaud, left, talks with members of the Mobile Outreach and Support Team (MOST), from left, Stephanie Hill, Shayna Samson, and Sue LaButte, that was parked at the corner of University Ave. East and Glengarry Ave., Wednesday, April 3, 2019. DAX MELMER /

Mobile Outreach and Support Team (MOST)

Results





Mobile Outreach and Support Team (MOST):

Three Months at a Glance

February 1 – April 30

Produced by:

DEPARTMENT OF RESEARCH AND EVALUATION
Hôtel-Dieu Grace Healthcare
May 2019

Mobile Outreach and Support Team (MOST): Three Months at a Glance

(January 31st – April 30th , 2019)

849 Visits to the Van

64 Nights | 3 Staff | 141 Stops | 10+ Locations

74% Male | 43% New/ Unknown Clients

Meeting Immediate Needs

564	430	719	180	243
GIFT CARDS Provided	WARMTH ITEMS Provided	FOOD/SNACKS Provided	FLYERS Provided	HYGIENE ITEMS Provided

Providing Education

PROVIDED EDUCATION ON SERVICES 586 TIMES

- Shelters (196)
- Housing Services (167)
- Mental Health/Addictions (147)
- Healthcare (76)

301 Individual Engagements with Outreach Worker/Social Worker

49% 31-50 years old

16% Homeless <6 mths

42% Staying in Shelter

20% Couch Surfing

13% Living on Street or Outdoors

Needs/Issues Individuals Reported

70% Food/ Supplies

48% Immediate Shelter

40% Permanent Housing

28% Mental Health/ Addictions

10% Medical Care

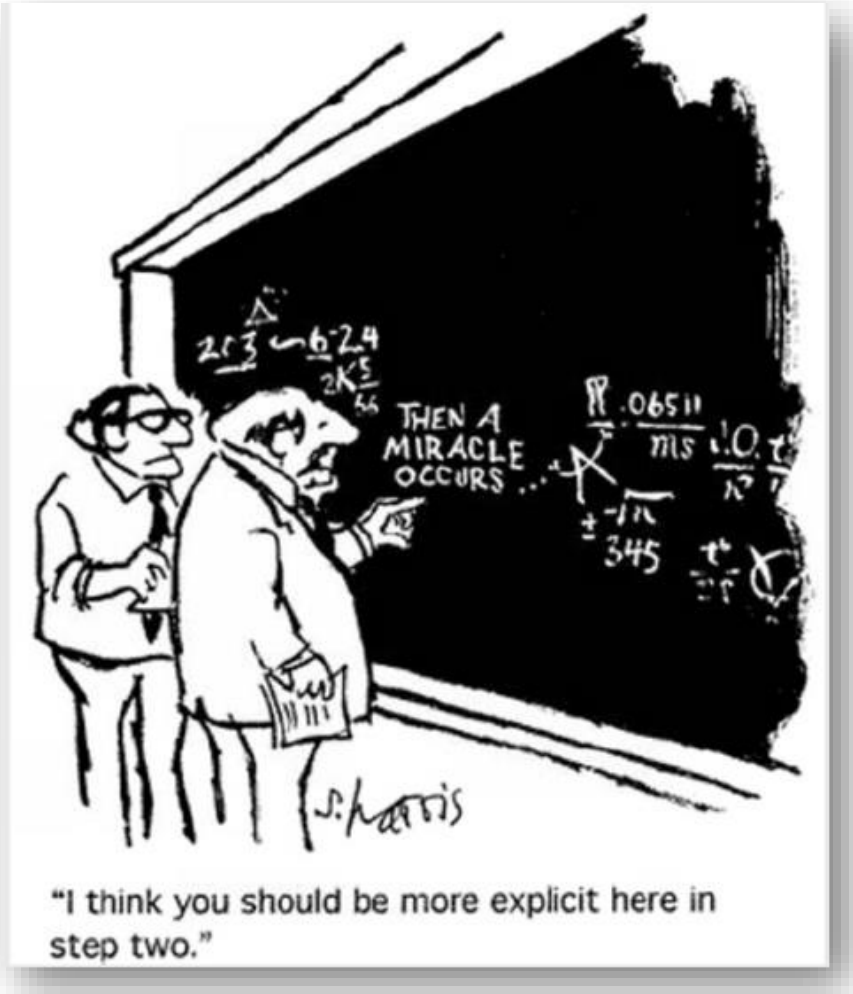
Services Provided

279 (94%)	174 (57%)	143 (48%)	78 (26%)	39 (13%)
Gave Supplies	Supported Referral	Listened to Story	Motivational Counselling	Arranged for Follow Up

Supported Referrals

Housing	57%
Shelter	51%
Drop In	45%
Mental Health	44%

KEY LEARNINGS



"I think you should be more explicit here in step two."

- Combine/link resources and services
- Start small and build
- Invest in solid planning and evaluation
- Go to where the people are
- Consistency is key

HÔTEL-DIEU GRACE HEALTHCARE