Mobile Outreach and Support Team (MOST):

Windsor, ON

OMSSA Conference
June 13th, 2019
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
Laying the Foundation

- 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
## Needs Based Planning

<table>
<thead>
<tr>
<th>Target Audience</th>
<th>Best Practice Review</th>
<th>Environmental Scan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who should we serve?</td>
<td>What does the literature show?</td>
<td>What else exists in our community?</td>
</tr>
<tr>
<td>What do they need?</td>
<td>What has worked elsewhere?</td>
<td>What are similar programs like elsewhere?</td>
</tr>
</tbody>
</table>
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

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?

49% Emergency Shelters

24% With Family or Friends

15% Other

10% Unsheltered

2% Housed

Source: City of Windsor 2018 Preliminary Point-in-Time Count
# City of Windsor - 2016 vs. 2018 Point in Time Count

## City of Windsor Profile

<table>
<thead>
<tr>
<th>Metric</th>
<th>2016</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>329,144</td>
<td>329,144</td>
</tr>
<tr>
<td>Unemployment rate</td>
<td>6.9%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Minimum wage</td>
<td>$14/hr</td>
<td>$14/hr</td>
</tr>
<tr>
<td>Total number of Shelters</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Total number of Beds</td>
<td>102</td>
<td>102</td>
</tr>
</tbody>
</table>

## Homelessness Indicators

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

*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

Main objectives are to improve:
- Quality of life
- Access to other services
Structured assessments and referral pathways to from/to formal partners

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

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

Mobile units can enhance the credibility of other providers by becoming a recognizable presence in high risk neighbourhoods.
Why do people use Mobile Units?

Most people who use a Mobile Unit are currently homeless

60% were defined as currently homeless, 92% had a 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

Once engaged, clients visit the Mobile Unit frequently

Median of 7 visits in 3 months

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

The majority of homeless people do not have a family doctor (59%)
29% have no usual source of care

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

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

**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.

- ✓ Windsor COAST
- ✓ CMHA Community Outreach
- ✓ Family Services
- ✓ Windsor Youth Center
- ✓ Windsor Essex Housing Connections (WEHC) Housing First Program
- ✓ New Beginnings
- ✓ Can Am Friendship Centre
- ✓ Street Health
- ✓ Street Health Outreach Van
- ✓ WECHC Mobile Health Clinic
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 populated housing

Staff: Healthcare professionals and outreach workers

Services: offers immediate care, direct link to ongoing health services

**Mobile Mental Health Clinic**
(Calgary)

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.
<table>
<thead>
<tr>
<th>Project Charter</th>
<th>Program Logic Model</th>
<th>Evaluation Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorizes the project, and provides authority to apply organizational resources.</td>
<td>A visual illustration of a program's goals, activities and expected outcomes.</td>
<td>Describes how you will monitor and evaluate your program.</td>
</tr>
</tbody>
</table>
Mobile Outreach and Support Team (MOST) Project Charter

**Project Overview**

<table>
<thead>
<tr>
<th>charter creation date</th>
<th>December 2018</th>
<th>Last Revision Date</th>
<th>Jan 23, 2019</th>
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</thead>
<tbody>
<tr>
<td>Charter Status (Pending/approved)</td>
<td>Pending</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Duration</td>
<td>August 2018 - August 2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Plan #</td>
<td>Not Applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HODH Executive Sponsor</td>
<td>Sonja Grabowski, VP Mental Health and Addictions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 (HODH), 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:
- Provide for basic needs by distributing essential goods
- Provide interactive mental health supports
- Establish connections to additional services

The program will launch by January 22nd, 2018 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 employees originate. 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

**Steering Committee Members**

- Serge Rebois (Executive Sponsor)
- Cecilia Don Brad (Executive Sponsor)
- Joanne Zab (Executive Sponsor)
- Lynn Calder (Executive Sponsor)
- Robert Morris (Operations)
- Eric Olovic (Communications)
- Maria Jackson (PMG / Evaluation)
- Terris Caden (PAS)
- Colin Matthews (PMG)

**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

**HODH**
- 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 inventory, including funding
- Arrange and manage Attendance Service Worker for 28 hours/week
- Order and maintain stock for program supplies
Program Logic Model

Objective: 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.

Goal: Most - Mobile Outreach Support Team (2018/2019)

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

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)

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

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 root
- Housing plan and disability applications
- Advocacy

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 outreach activities conducted
- #/type of people identified/engaged
- #/type of communication attempts
- #/type of essential items dispensed
- #/type of assessments completed
- #/type of needs identified
- #/type of goals set
- #/type of goals met
- #/type of interventions provided
- #/type of referrals made
- #/type of referrals supported
- #/type of referrals successful

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

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

## Short Term Outcome Evaluation

<table>
<thead>
<tr>
<th>Objective</th>
<th>Metrics</th>
<th>Data Source</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved awareness of population needs</td>
<td># of population needs</td>
<td>Outreach Encounter Summary Form Individual Engagement Form</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Increased trust and confidence in traditional services</td>
<td># of referrals made</td>
<td>Outreach Encounter Summary Form Individual Engagement Form</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Increased participation in treatment, services and recovery supports</td>
<td>Service Uptake</td>
<td>Individual Engagement Form</td>
<td>After each individual engagement</td>
</tr>
<tr>
<td>Demonstrate effectiveness of model</td>
<td>Outreach Team Feedback Participant Feedback</td>
<td>Outreach Team Interviews Participant Interviews</td>
<td>8 and 6 months</td>
</tr>
</tbody>
</table>

## Long Term Outcome Evaluation (TBD)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Metrics</th>
<th>Data Source</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced community capacity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced system fragmentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved functional outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduced crisis events/ED Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved housing status</td>
<td></td>
<td></td>
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</tbody>
</table>
Mobile Outreach Support Team (MOST)

Measurement Tools

Mobile Outreach Support Team (MOST)

Data Collection Procedures

Two forms have been created 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:
   - Include the # of individuals that you interact with each shift and your best estimate of how many you have seen before and how many were in each gender and age group.
   - All items were given out.
   - The information received was provided about a local service/agency.
   - The item(s) were given out.
   - Other comments are noted.

   Note: Please complete one OESF at each stop made, so there may be multiple OESFs 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 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 experienced (as reported by them).
   - Needs the individual expresses.
   - Summary of the individual’s situation.
   - Follow-up plan discussed.

Data Reporting Procedures (TBD)

- OESF to be completed by the ASO Driver and kept in the MOST Binder. Copies to be scanned and emailed to support@qld.gov on a weekly basis.
- IEF to be completed by individual providers (ASO, affiliate OFP/POR Outreach Workers) after each meaningful engagement is completed. Forms to be kept in the MOST Binder. Forms to be scanned and emailed to research@ MOST.org once per week.

Outreach Encounter Summary Form

This form is to be completed after leaving each outreach location. The form below may change over time depending on A of questions asked.

Street Outreach Data:
- Click or tag here to enter data.
- Approximately Time:
  - AM/PM (circle one)
  - Staff Memo:
    - Click or tag here to enter text.
  - Outreach Location:
    - Choose an item.
  - Total # of Individuals Encountered:
    - Click or tag here to enter text.
  - Estimated # of Individuals that were Unknown/Untried:
    - Click or tag here to enter text.
  - Estimated Total # of Adults Encountered:
    - Click or tag here to enter text.
  - Estimated Total # of Youth Encountered (under 18 years):
    - Click or tag here to enter text.
  - Estimated Total # of New Encounter:
    - Click or tag here to enter text.
  - Estimated Total # of Warnings Encountered:
    - Click or tag here to enter text.

Total # of individuals who gave the following items:

- Passes/Permits:
  - Click or tag here to enter text.
- Hygiene packs/Items:
  - Click or tag here to enter text.
- Clothing/warmth items:
  - Click or tag here to enter text.

- Other: (Please specify)
  - Click or tag here to enter text.

Total # of individuals educated about/provided information about:

- Drop-in:
  - Click or tag here to enter text.
- Meals:
  - Click or tag here to enter text.
- Cambodia:
  - Click or tag here to enter text.
- Togo:
  - Click or tag here to enter text.

Individual Engagement Form

Date of Engagement:
- Click or tag here to enter text.

Approximate Time:
- AM/PM (circle one)

Staff Memo:
- Click or tag here to enter text.

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

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

Location of Engagement:
- Click or tag here to enter text.

Services provided:
- (Circle all that apply)
- Listened to individual’s story
- Engaged in motivational counseling
- Supported referral services directed to achieving individual’s goal/stated needs:
  - [ ] brought them to an agency or helped them make an appointment
  - [ ] drop-in
  - [ ] drop-in
  - [ ] drop-in
  - [ ] drop-in

[ ] Discussed family reunification issues
- [ ] Arranged a follow-up call or meeting
- [ ] Other (please specify)

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

Street Address:
- Click or tag here to enter text.

Full Name:
- Click or tag here to enter text.

Age:
- Click or tag here to enter text.

Age Group:
- (circle if age not known)
Assembling a Team

• 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)
Launch!

- 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.
Launch

Mobile outreach team hits streets to help homeless

Community services collaborate to launch mobile outreach unit

Hundreds helped by mobile outreach pilot project in first month
**Results**

### Mobile Outreach and Support Team (MOST): First Month at a Glance
(Jan 31-Feb 28, 2019)

<table>
<thead>
<tr>
<th>282 Visits to the Van</th>
<th>Providing Education</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>22 Nights, 110 Hours</strong></td>
<td>PROVIDED EDUCATION ON SERVICES 230 TIMES</td>
</tr>
<tr>
<td><strong>3 Staff</strong></td>
<td>• Shelters (68)</td>
</tr>
<tr>
<td><strong>6+ Locations</strong></td>
<td>• Mental Health Services (65)</td>
</tr>
<tr>
<td><strong>73% Male</strong></td>
<td>• Housing Services (50)</td>
</tr>
<tr>
<td><strong>41% New/Unknown Clients</strong></td>
<td>• Healthcare (46)</td>
</tr>
</tbody>
</table>

**Meeting Immediate Needs**

- Gift Cards
- Warmth Items
- Food/Snacks
- Flyers
- Hygiene Items

<table>
<thead>
<tr>
<th><strong>Meeting Immediate Needs</strong></th>
<th><strong>Providing Education</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>196 Provided</td>
<td>• Shelters (68)</td>
</tr>
<tr>
<td>186 Provided</td>
<td>• Mental Health Services (65)</td>
</tr>
<tr>
<td>185 Provided</td>
<td>• Housing Services (50)</td>
</tr>
<tr>
<td>41 Provided</td>
<td>• Healthcare (46)</td>
</tr>
<tr>
<td>36 Provided</td>
<td></td>
</tr>
</tbody>
</table>

### 136 Individual Engagements with Outreach Worker/Social Worker

**Needs/Issues Individuals Reported**

- 52% Homeless <6 months
- 73% Male
- 46% Immediate Shelter
- 31% Don’t feel they have a safe place to stay that night
- 60% Staying in Shelter, 18% Staying on Street
- 60% Food/Supplies
- 57% Permanent Housing
- 32% Mental Health/Addictions
- 16% Medical Care

**Services Provided**

- 122 (90%) Gave Supplies
- 90 (66%) Supported Referral
- 71 (52%) Listened to Story
- 30 (22%) Motivational Counselling
- 20 (15%) Arranged Follow Up Meeting
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

Meeting Immediate Needs

- Gift Cards Provided: 564
- Warmth Items Provided: 430
- Food/Snacks Provided: 719
- Flyers Provided: 180
- Hygiene Items Provided: 243

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

- Food/Supplies: 70%
- Immediate Shelter: 48%
- Permanent Housing: 40%
- Mental Health/Addictions: 28%
- Medical Care: 10%

Services Provided

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

Supported Referrals

- Housing: 57%
- Shelter: 51%
- Drop In: 45%
- Mental Health: 44%
- Addictions: 39%

KEY LEARNINGS

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