

# Outreach to People Experiencing Homelessness



*2009 Best Practices Conference  
Richmond, VA  
Sept 24-25, 2009*

Ken Kraybill  
Center for Social Innovation  
kkraybill@center4si.com

Joseph Benson  
Center for Social Innovation  
jbenson@searchhomeless.org

## **Outreach to People Experiencing Homelessness**

- 8:30 Introduction to outreach**  
Seeing through new eyes  
Meaning of home – necessity of hope
- 9:00 Understanding the basics**  
What works: promising practices in homeless services  
Outreach and engagement – why, where, who, what, and how  
Relational outreach and engagement model
- 10:30 BREAK**
- 10:45 Taking it to the streets**  
Frameworks of engagement  
Engagement strategies  
Specific topics in outreach: safety, supervision, self-care, dilemmas,  
effective referrals, integrating service and advocacy
- 12:30 Adjourn**

## Three Homes

---

*Home: one's place of residence, domicile, house, the social unit formed by a family living together, a familiar or usual setting, congenial environment, the focus of one's domestic attention (home is where the heart is), habitat, a place of origin (salmon returning to their home to spawn), headquarters, an establishment providing residence and care for people with special needs, the objective in various games, out of jeopardy, in a comfortable position with respect to some objective, to a vital sensitive core (the truth struck home) **At home:** relaxed and comfortable, at ease (felt completely at home on the stage), in harmony with the surroundings, knowledgeable (teachers at home in their subject fields), on familiar ground*

---

Each of us “resides” in three homes.

The **first home** is the self – one’s primary home. This is the home of our very being and identity. The fundamental characteristics of this first home are physical, mental, emotional, social and spiritual in nature.

This home must be kept warm, dry, safe and in good working order. It needs exercise, rest, nutrition and proper maintenance. It also needs to be nurtured and maintained through intellectual stimulation, emotional support, behavioral regulation, time for reflection and development of a sense of purpose and meaning in connection to the outer world.

We receive our first home at birth. Early in our lives, others are given primary care-taking responsibility for our care and nurture. Gradually we come to claim more of this responsibility for ourselves.

Although we are wonderfully and complexly made with the ability to do great things, we are also created with considerable fragility and vulnerability. Even the strongest among us experience great frailty at times. Each of us requires the sustaining efforts of others in order to thrive. Despite our best self-care efforts, we still need the knowledgeable care, love and support that others can provide.

Our **second home** is that with which we are most familiar – the place where we live, our housing, where we “nest.” It refers not only to the physical structure in which we live but also to the kind of living environment we create within it.

Like the first home, this home possesses important physical, mental, emotional, social and spiritual characteristics. It offers safety and protection from the elements and the outside world. It provides an adequate, private space in which to properly attend to hygiene, rest, and nutrition needs.

This home serves as a base of operations and a place to keep and use one’s possessions. It offers a place of welcome, familiarity, and stability. In this home we can welcome guests, share in celebration and suffering, be creative and silly, be still and mindful, be intimate with loved ones, and find renewal of energy and purpose.

The very structure and design of typical housing in our cultural context points to these functions. For example, we construct a foundation (stability, grounding), walls (protection,

privacy), a roof (shelter, protection from the elements), doors (welcoming, shutting out), and windows (light, connection with the outside world).

Space is divided into a living room (relaxation, socialization, play), kitchen (hospitality, nutrition), bedroom (rest, intimacy), bathroom (hygiene), study (intellectual stimulation, meditation), closets (secrets), and a yard/garden (play, relaxation). This second home provides the necessary context for meeting the needs of the first home and an important foundation and link to the third home.

The **third home** in which we reside is the larger community, or more accurately, the multiple communities, from the local to the global, in which we are located. Here our interdependence with other people and organizations is fully evident. It is in the context of these various communities that we fulfill various roles and participate in the life around us. We give and receive, produce and consume, lead and follow, serve and are served.

There are numerous opportunities for participation and resources in this third home that permit us to meet the needs of our first and second homes. For example, it is in the context of the larger community that we are connected to health care, education, work, food procurement, transportation, socialization, purchasing goods, entertainment, the arts, politics, recreation and community service. This third home provides the social, economic, service and cultural context for our lives.

**What implications** does this notion of “three homes” have for outreach workers? People on the streets often do not feel “at home” in their own bodies, minds, and souls, have no housing to call home, and are disaffiliated from a meaningful role and purpose in the larger community.

It seems clear that if we are to help people resolve their home-less-ness, we are compelled to direct our efforts even beyond addressing basic survival, health, and housing needs. As the saying goes, a house is not a home. We must assist them in making their housing into a home. In addition, we must also help them be more attuned to their own personal conditions, needs and care. And we must help them find their “place” in the larger community.

Helping others move towards a greater sense of being “at home” in their lives begins with the very first outreach encounter. For example, by offering a hospitable presence – “creating a free and friendly space for the stranger” (Henri Nouwen) – one makes it possible for the other person to experience a taste of being “at home.” The seeds planted in such a relationship can go a long way to help someone take the necessary steps towards greater stability in all three homes of their lives.

*Ken Kraybill*

# What Works

These selected approaches and practices have been shown to be effective in addressing the needs of people experiencing homelessness and living with serious mental illness and/or substance use disorders.

## **Person-centered values**

Person-centered care prioritizes the self-identified needs and preferences of the individual. The helping relationship is collaborative and invitational. Support, information, and options are offered. Services are tailored to the individual.

## **Trauma-informed**

Homeless people report high levels of trauma, past and present. Viewing the lives of people through a “trauma lens” helps to understand their behaviors, responses, attitudes, and emotions as a collection of survival skills developed in response to traumatic experiences.

## **Belief in recovery**

People can and do recover from problems related to substance use disorders, mental illness, and homelessness. They experience recovery of hope, self-worth, and participation in meaningful relationships and activities.

## **Outreach and engagement**

Involves going out into the community and meeting homeless people where they are – on the streets, under bridges, in shelters and drop-in centers. Workers seek to develop trust with individuals and to provide or connect them with needed services.

## **Flexible, low -demand services**

Services are provided in an individualized manner, varying in frequency, duration, and scope depending on one’s changing needs and wishes. Participation in treatment is not required as a condition for continuing to receive services such as accessing entitlements or housing.

## **Housing first with appropriate supports**

Emphasis is on placing people as early as possible into permanent housing units with low-demand supportive services offered by an interdisciplinary team of health, behavioral health, and social service providers. Housing itself is seen as a form of treatment.

## **Interdisciplinary care teams**

Teams are composed of various health, behavioral health, and social service providers who work together to ensure that a homeless person’s needs are being addressed in an appropriate and coordinated manner.

## **Integrated treatment for co-occurring mental illness and substance use disorders**

Refers to concurrent, coordinated clinical treatment of both mental illnesses and substance use disorders provided by the same clinician or treatment team. Integrated treatment has been shown to be more effective than a parallel or sequential treatment approach.

**Motivational interventions**

Person-centered clinical strategies that seek to help people resolve ambivalence and move in the direction of change. Make ample use of open questions, affirmations, reflective listening, and eliciting change talk.

**Self-help programs**

Programs are typically based on the AA 12-step method. Focus is on developing personal responsibility within the context of peer support. Participation has been shown to decrease substance use and inpatient treatment, and improve self-esteem and community adjustment.

**Involvement of consumers and recovering persons**

Play important role in outreach, supporting peers in recovery, staffing agency programs, contributing as active members of planning councils, advisory boards, and community advocacy groups.

**Long-term follow-up support**

The recovery process from homelessness, mental illness, addictions, etc. is neither a linear nor a short-term process for most people. Individuals require long term follow up support from an interdisciplinary team of care providers.

**Prevention services**

Examples include appropriate discharge planning from institutions/hospitals/ treatment programs, short-term intensive support upon re-entry into the community, and provision of subsidized housing and adequate income support.

*Adapted from* Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Use Disorders, *DHHS Pub. No. SMA-04-3870. Printed 2003*

# Housing First

Housing First has been recognized as a promising practice by national researchers and policymakers. As a result, communities around the country are piloting projects that employ Housing First principles.

The National Alliance to End Homelessness (NAEH) defines the Housing First approach for addressing the chronic homelessness of disabled and vulnerable people as “a client-driven strategy that provides immediate access to an apartment without requiring initial participation in psychiatric treatment or treatment for sobriety.”



## **Housing First is based on two core convictions:**

1. Housing is a basic human right, not a reward for clinical success, and
2. Once the chaos of homelessness is eliminated from a person's life, clinical and social stabilization occur faster and are more enduring.

## **Housing First principles:**

1. Move people into housing directly from streets and shelters without preconditions of treatment acceptance or compliance.
2. The provider is obligated to bring robust support services to the housing. These services are predicated on assertive engagement, not coercion.
3. Continued tenancy is not dependent on participation in services.
4. Units targeted to most disabled and vulnerable homeless members of the community.
5. Embraces harm reduction approach to addictions rather than mandating abstinence. At the same time, the provider must be prepared to support resident commitments to recovery.
6. Residents must have leases and tenant protections under the law.
7. Can be implemented as either a project-based or scattered site model.

*Adapted from Downtown Emergency Service Center [www.desc.org/documents/DESC\\_Housing\\_First\\_Principles.pdf](http://www.desc.org/documents/DESC_Housing_First_Principles.pdf)*

## **Housing First/Permanent Supportive Housing**

Mr. Carlson became homeless at the age of 20. Little did he know at the time that he would spend the next 40 years of his life surviving on the streets of New York City. Through decades of cold winters, heavy drinking, and deteriorating health, Mr. Carlson spent countless nights in the city's emergency rooms and detoxes, and was frequently admitted to inpatient medical and psychiatric units. Mr. Carlson admits that he would often seek out these facilities as a means of survival from the cold.

During his years on the streets Mr. Carlson was befriended by members of a local church who supported and accompanied him in various ways. Mr. Carlson was regarded fondly for his resiliency and humor. Finally at the age of 60, he was connected to Street to Home, a new housing first program. Soon thereafter, Mr. Carlson became housed for the first time in 40 years. It was a memorable day for him and for all who knew him.

Mr. Carlson was clearly excited to finally have a place to call home, but after so many decades without one, he was also overwhelmed when the prospect became a reality. Both before the housing interview and on the first morning he woke up in his own bed, Mr. Carlson was tempted to walk away. Street to Home's team stayed alongside Mr. Carlson, listening to and supporting him.

He now has his own keys and signed his first lease. As Mr. Carlson continues to find new challenges and fears living inside, support staff work with him as he learns to cook his own meals, clean his own bathroom, and acknowledge when he needs help. Instead of walking around the streets looking for a meal or warm place to rest, he can be seen with a glowing grin sitting in the lobby of his new home in a renovated hotel.

*Kristin Barlup, Common Ground, NYC*

# Purpose and Principles of Outreach

## Purpose

“...contact with any individual who would otherwise be ignored (or underserved) ...in non-traditional settings for the purpose of improving their mental health, health, or social functioning or increasing their human service and resource utilization.”

*Morse, Gary (1987) Conceptual overview of mobile outreach for persons who are homeless and mentally ill, presented at APHA annual meeting in New Orleans, LA*

## Principles

- Friendly, non-threatening approach
- Services taken to individuals rather than waiting for them to come to the services
- Repeated contact over time
- Engagement of those who are reluctant or suspicious to receive help
- Prompt response to client’s basic survival needs
- Client’s overall needs assessed, services and strategies tailored to meet those unique needs
- Clients provided tools and resources to reduce or abstain from harmful behaviors
- Flexibility in the menu of services offered
- Patience in motivating clients to accept services
- Variable times for client contact, including non-scheduled contacts
- Team approach to outreach

*Adapted from Marsha McMurray-Avila in Organizing Health Services for Homeless People, 1997*

# Characteristics of Effective Outreach Workers

## Professional Characteristics

Given the range of services that can be provided through outreach, the staff involved can vary significantly – from medical providers and doctorate level professionals to masters or bachelors level counselors, social workers or case managers to paraprofessionals without degrees, including peers or consumers.

## Personal Characteristics

Effective outreach workers are:

- Flexible – able to readily change directions, literally and figuratively, as needed
- Non-judgmental – able to suspend or refrain from making judgments based on one’s own personal opinions, biases, or standards; involves accepting people “where they’re at” – different from approval
- Respectful – to regard as worthy; words and behavior must be congruent
- Relaxed – easy to talk with and able to initiate conversation in a non-threatening manner
- Tactful – e.g. able to help clients acquire services without alienating other service providers; able to treat law enforcement as allies while still defending the rights of clients
- Patient and assertive – both are required concurrently
- Resourceful – find creative ways to engage clients and meet their needs
- Centered, grounded –healthy sense of self and boundaries
- Calm and clear-headed in emergency situations
- Cautious and alert to possible danger
- Independent and able to take initiative, while being strong team players

*Adapted from Marsha McMurray-Avila in Organizing Health Services for Homeless People, 1997*

# Where Outreach Happens

**Fixed site outreach** occurs where programs have “set up shop” in a location where homeless people gather. **Mobile outreach** moves around and can be carried out anywhere that people experiencing homeless might be found.

## Fixed-site

Scheduled clinics in or near:

- shelters, missions
- drop-in centers, hygiene centers
- transitional housing
- medical respite programs
- soup kitchens
- other homeless facilities

## Mobile

Street locations:

- city streets, alleys
- bridges and overpasses
- subways
- parks, beaches
- vacant lots, abandoned buildings
- vehicles

Rural areas:

- “doubled up”
- along roads, vehicles
- wooded areas, riverbanks
- foothills, desert areas
- barns, garages
- camps, designated camping areas

Public facilities:

- libraries
- bus or train stations
- racetracks
- cafeterias, coffeeshops

Institutions (to make contact with ongoing HCH clients or potential clients):

- hospitals
- jails, prisons
- detox facilities, treatment programs
- some hotels/motels/SRO’s
- public welfare agencies

*Adapted from Marsha McMurray-Avila in Organizing Health Services for Homeless People, 1997*

# Services Provided Through Outreach and Case Management

## **Engagement**

- Create a safe “presence” – make non-verbal contact
- Initiate non-threatening conversation
- Offer sandwiches and coffee
- Offer a blanket, sleeping bag, hat, socks
- Offer sunscreen, condoms, hygiene articles

## **Information and Referral**

- Provide information about available services
- Facilitate effective referrals
- Accompany individual as needed

## **Direct Services**

- Assist with accessing shelter/housing, entitlements, ID, legal assistance
- Assist client in utilizing services linked to particular site – food, clothing, showers, laundry, phone, mail, etc.
- Assess a client’s medical, psychiatric and social needs and develop a treatment plan
- Provide direct medical care, mental health or chemical dependency services
- Screen for specific illnesses or disorders
- Make referrals to specialty care, dental care, mental health services, chemical dependency treatment, or other services not provided by HCH
- Provide case management
- Advocate with other agencies for client to receive necessary services
- Enhance motivation
- Facilitate support groups, life-skills training
- Provide health education/promotion
- Intervene in crisis situations making links to emergency medical, detox or psychiatric care

*Adapted from Marsha McMurray-Avila in Organizing Health Services for Homeless People, 1997*

# Relational Stages of Outreach and Engagement

Outreach and engagement is the process of coming along side of someone who is struggling with homelessness and related health and social concerns, and sharing the journey in a way that leads to healing, wholeness and stability in the community. Outreach and engagement activities can be seen as a movement through four overlapping, but distinct phases of relationship: approach, companionship, partnership, and mutuality.

## **Approach – Making a Connection**

The approach phase involves observation and introduction. It is helpful to spend time simply watching, to see how a person acts, how they relate to others, what kind of space they need, how they seem to be experiencing their environment and responding to the world. Careful observation helps to shape an introduction. One might simply pass by with a nod or greeting or introduce oneself in some manner. The key is to begin generally as someone who cares, and define your role more specifically as the relationship develops and trust builds between the two of you.

## **Companionship – Developing the Relationship**

At its simplest, companionship means sharing a little of the journey with another, standing or sitting with them, walking a little ways with another, listening, and hearing a person's story. Perhaps it may include suggesting some possibilities to assist someone along the way, maybe going with them to some destination, or arranging for another to accompany and help them.

## **Partnership – Enhancing Motivation and Linking**

The partnership phase of outreach and engagement involves providing information, enhancing motivation, and introducing the person to others who can help or assist. In partnering with others – case managers, medical providers, social service programs, family members – a widening circle of care is created upon which the individual can rely for support and care in various aspects of their lives.

## **Mutuality – Supporting Wellness and Stability**

In the mutuality phase, we recognize one another as fellow citizens and community members. The worker continues to encourage the other in making use of appropriate resources and supports the individual in becoming a stable part of the neighborhood and community. In time, it is recognized that the relationship has come to fruition and thus is brought to closure as appropriate.

*Adapted from unpublished paper, Relational Outreach and Engagement, by Craig Rennebohm*

## **Dilemmas: What would you do if...**

...a woman who is pregnant admits to you that her boyfriend sometimes punches her in the face and the stomach, but it doesn't happen too often and besides, she really loves him?

...a young man, who has tested positive for HIV, tells you he makes money to survive by having sex, usually unprotected, with various customers?

...your client, who has experienced multiple traumatic brain injuries, repeatedly asks the same questions, acts impulsively, and becomes agitated quickly to the point of threatening others, desperately wants to live independently in his own housing?

... a woman, who refuses to fill out paperwork or permit you to help her with it, says she's "very smart" and does not need any help, but you believe she is unable to read and write?

... the local police ask you to accompany them on their walking beats to help intervene with certain problematic homeless people?

... your promotion of needle exchange and handing out bleach kits to clients who inject drugs is criticized by co-workers as "enabling" clients to continue using drugs?

... your client who is terminally ill refuses any further treatment and says he just wants to die under the bridge where he has been staying for several years?

... you learn that your developmentally disabled client is running drugs for a dealer, who gives the client money, gifts, and special attention?

... you wish to testify at a local hearing on homelessness, but are told by your superior that you are not permitted to engage in advocacy?

... a client you've known for a long time who lives under the freeway and has a long history of PTSD and alcoholism, says it's only a matter of time until he's going to commit suicide, but not to worry, because he'll do it alone and no one else will ever know?

... you finally have gotten your client into permanent housing, but it seems to be more of a problem than a solution; he feels walled in, doesn't like being alone, and is getting more and more depressed?

... your client tells you that she's proud of herself because she's cut down from smoking crack daily to only five days a week?

... you like your work and are committed to it, but find yourself "taking it home with you" – you think about your clients, have a hard time being attentive to your loved ones, and sometimes feel guilty for enjoying simple pleasures

... (examples from your own experience)

# Professional and Ethical Guidelines for Outreach and Engagement

---

"Ethics is how we behave when we decide we belong together. "

*David Steindl-Rast*

---

The overriding philosophy of these guidelines is to treat others as you would want to be treated. At the very least, do no harm. This applies not only to how we interact with homeless people but also with co-workers, supervisors, administrators, other agency staff, policy-makers, and so forth. With clients, providers are expected to consistently provide competent, compassionate care in whatever forms that may take.

It is prudent for providers to anticipate and identify ethical dilemmas that arise in outreach and to discuss these issues with supervisors and peers. The guidelines below are intended to prompt such discussions so as to increase adherence to ethical practice. These guidelines are intended to serve as an adjunct to agency-specific codes of ethics and other relevant policies.

- Commit yourself to being well prepared physically, intellectually, emotionally and spiritually for doing this work.
- Develop an awareness of the causes, experience, patterns and politics of homelessness.
- Continually increase your knowledge about health, mental health, and substance use disorders, including social service needs and resources.
- Present yourself in a genuine, hospitable manner.
- Maintain a perspective of objectivity with clients. Avoid being judgmental.
- Be respectful of others' desire for privacy and need to keep secrets. Be assertive but not intrusive in your outreach.
- Maintain confidentiality in your relationships.
- Keep your word. Be trustworthy and reliable.
- Respect people as ends, not means. Never exploit clients for personal or agency gain.
- Educate others about behaviors that can enhance their health and well being. Also, inform them of behaviors that might cause them to be susceptible to disease and/or bring harm to themselves or others.
- Don't attempt to intervene in areas in which you are not trained or competent.
- Do not withhold information from clients about other resources and services from which they could benefit.
- Devote some part of your time, no matter how little, to use your knowledge and experience to inform public planning and policy-making processes.
- Refrain from imposing your moral or religious beliefs on others.
- Refrain from having social or emotional relationships with clients outside of work.
- Do not use your own home to shelter clients.
- Never engage in sexual activity with clients.
- Do not accept cash from clients. Accept gifts only when it is culturally appropriate.
- Refrain from giving personal gifts or cash to clients.
- With the possible exception of pepper spray, never carry weapons.
- Never use alcohol or illicit drugs on the job.
- Develop practices of self-care and renewal within and outside the work setting.

*Adapted from the California Association of Community Health Outreach Workers' Code of Ethics and other sources*

## Safety Guidelines for Street Outreach

These safety guidelines for street outreach are adapted from guidelines developed by outreach workers in the downtown skid row area of Los Angeles. They are designed solely to assist staff in avoiding trouble on the street. They do not address how to handle difficulties once they arise. The strength of these guidelines is that they address the needs of the street outreach worker who operates in a very different work environment than staff who are agency-based. The guidelines are intended as only one part of an agency's overall safety policies and procedures.

1. Your supervisor needs to know where you will be at all times.
2. Learn as much as possible about the situation before setting out to do outreach.
3. Do not plan outreach in areas that you have good reason to believe are inherently dangerous.
4. Be aware of gang areas and their colors. Avoid wearing those colors.
5. Always carry business cards and identification with you.
6. Inform collaborating agencies of your presence.
7. Introduce yourself and inform people of what you are doing and why.
8. Do not stand and argue with someone who does not agree with what you are doing.
9. Outreach is preferably conducted in two-person teams. No team member should conduct outreach activities alone unless receiving prior approval from their supervisor.
10. Do not approach those who are giving "signs" that they do not want to be bothered.
11. Do not be critical of your partner in public while conducting outreach. Always present yourselves as a team.
12. Wear comfortable clothes and shoes. Do not overdress.
13. Do not carry valuables or other personal possessions such as jewelry, large amounts of money, radios, laptops, etc. If carrying incentives, make arrangements to hold these in a secure place.
14. Do not remain in a spot where a drug deal is in process or is being set up to "go down." Leave the area immediately without drawing attention to yourself or others.
15. Do not linger with a person who you know is holding illicit drugs.
16. Do not interrupt the sale of sex or drugs for money. Leave the area immediately without drawing attention to yourself or others.
17. Maintain confidentiality with all clients you meet.
18. Do not accept gifts, food or buy any merchandise from clients.
19. Do not give or lend money to clients.
20. Do not accept or hold any type of controlled substance.
21. Never enter any clients' cars, homes or any enclosed area.
22. Tell clients approximately when you will be back and where you can be reached. Provide clients with a business card.
23. Develop a contingency plan for worst-case scenarios or dangerous situations with your partner and supervisor.
24. Keep your supervisor informed of any unusual developments.
25. In case of an emergency, call or have another person call 911. Do not separate from your partner unless you feel that staying would increase your danger.

## Fourteen Ways to Be an Effective Outreach Supervisee

1. Make sure you have a supervisor
2. Recognize that a supervisor's foremost responsibility is to ensure quality client care
3. Request regularly scheduled one-to-one meetings with your supervisor
4. Agree upon the format and expectations for supervisory sessions
5. Ask directly for what you need to do your work well, including how you will know how well you are doing
6. Inquire regularly about ways to improve your job performance
7. Inform your supervisor how you learn most effectively – e.g. listening, reading, watching demonstrations, discussion, doing simulations
8. Invite and accept constructive feedback:
  - Welcome it
  - Listen to the concern
  - Maintain eye contact and open body language as you listen
  - Restate the feedback to make sure you understand it
  - View the feedback as an attempt to solve a problem, not a personal attack
  - Focus on possible solutions to the concern
9. Give priority to exploring one clinical case in-depth in a supervisory session vs. superficially reviewing multiple cases
10. Be willing to bring up awkward or thorny issues in supervision and address them as thoroughly as possible
11. Ask your supervisor to assist in monitoring your stress level and finding ways to enhance your self-care
12. Discuss how the supervisory relationship is working for both of you and make changes as needed
13. Keep a written log of things you want to remember and follow up on from supervisory meetings
14. Learn from your experience – it will help you become an effective supervisor some day

## **This work...**

exhilarating  
*and* exhausting

drives me up a wall  
*and* opens doors I never imagined

lays bare a wide range of emotions  
*yet* leaves me feeling numb beyond belief

provides tremendous satisfaction  
*and* leaves me feeling profoundly helpless

evokes genuine empathy  
*and* provokes a fearsome intolerance within me

puts me in touch with deep suffering  
*and* points me toward greater wholeness

brings me face to face with many poverties  
*and* enriches me encounter by encounter

renews my hope  
*and* leaves me grasping for faith

enables me to envision a future  
*but* with no ability to control it

breaks me apart emotionally  
*and* breaks me open spiritually

leaves me wounded  
*and* heals me

*Ken Kraybill*

## Finding Resiliency and Renewal in Our Work

*“In the event that oxygen masks may be needed, place the mask over your own face before assisting others.”*

Individuals involved in outreach to people experiencing homelessness provide care under demanding circumstances, bear witness to tremendous human suffering, and wrestle with a multitude of agonizing and thorny issues on a daily basis. At the same time, we have the privilege of becoming partners in extraordinary relationships, marveling at the resiliency of the human spirit, and laying claim to small but significant victories. Such is the nature of this work that it can drain and inspire us all at once.

Despite the rewards inherent in the work, it inevitably exacts a personal toll. By listening to others’ stories and providing a sense of deep caring, we walk a difficult path. Yet we do so willingly, knowing that first we must “enter into” another’s suffering before we can offer hope and healing. It is interesting to note that the word *care* finds its roots in the Gothic “kara” which means “lament, mourning, to express sorrow.”

Caring can become burdensome causing us to experience signs and symptoms of what the literature variously calls compassion fatigue, secondary traumatic stress, or vicarious traumatization. This impact is compounded by the frustrations of trying to provide help in the face of multiple barriers to care, including inadequate resources and structural supports for homeless people such as housing, health care, and incomes. To feel weighed down by these circumstances is not unusual or pathological. It is in fact a quite normal response.

The “treatment of choice” for diminishing the negative impact of this stress is to seek resiliency and renewal through the practice of healthy self-care. Self-care is most effective when approached with forethought, not as afterthought. In the same manner that we provide care for others, we must care for ourselves by first acknowledging and assessing the realities of our condition, creating a realistic plan of care, and acting upon it. Though many providers practice self-care in creative and effective ways, we sometimes lose our sense of balance, and fail to provide the necessary care for ourselves with the same resoluteness that we offer care to others.

To better understand what self-care is, here are three things it is **not**:

**1) Self-care is not an “emergency response plan” to be activated when stress becomes overwhelming.** Instead, healthy self-care is an intentional way of living by which our values, attitudes, and actions are integrated into our day-to-day routines. The need for “emergency care” should be an exception to usual practice.

**2) Self-care is not about acting selfishly (“It’s all about me!”)** Instead, healthy self-care is about being a worthy steward of the self – body, mind and spirit – with which we’ve been entrusted. It is foolhardy to think we can be providers of care to others without being the recipients of proper nurture and sustenance ourselves.

**3) Self-care is not about doing more, or adding more tasks to an already overflowing “to do” list.** Instead, healthy self-care is as much about “letting go” as it is about taking

action. It has to do with taking time to be a human *being* as well as a human *doing*. It is about letting go of frenzied schedules, meaningless activities, unhealthy behaviors and detrimental attitudes such as worry, guilt, being judgmental and unforgiving.

The following A, B, C's of self-care can provide a useful guide in reflecting upon the status of your own practices and attitudes.

**AWARENESS** Self-care begins in stillness. By quieting our busy lives and entering into a space of solitude, we can develop an awareness of our own true needs, and then act accordingly. This is the contemplative way of the desert, rather than the constant activity of the city. Thomas Merton suggests that the busyness of our lives can be a form of “violence” that robs us of inner wisdom. Too often we act first without true understanding and then wonder why we feel more burdened, and not relieved. Parker Palmer in *Let Your Life Speak* suggests reflection on the following question: “Is the life I am living the same as the life that wants to live in me?”

**BALANCE** Self-care is a balancing act. It includes balancing action and mindfulness. Balance guides decisions about embracing or relinquishing certain activities, behaviors, or attitudes. It also informs the degree to which we give attention to the physical, emotional, psychological, spiritual, and social aspects of our being or, in other words, how much time we spend working, playing, and resting. Recently I heard it suggested that a helpful prescription for balanced daily living includes eight hours of work, eight hours of play, and eight hours of rest!

**CONNECTION** Healthy self-care cannot take place solely within oneself. It involves being connected in meaningful ways with others and to something larger. We are decidedly interdependent and social beings. We grow and thrive through our connections that occur in friendships, family, social groups, nature, recreational activities, spiritual practices, therapy, and myriad other ways. Often times, our most renewing connections can be found right in our midst in the workplace, with co-workers and with the individuals to whom we provide care.

There is no formula of course for self-care. Each of our “self-care plans” will be unique and change over time. We must listen well to our own bodies, hearts and minds, as well as to the counsel of trusted friends, as we seek resiliency and renewal in our lives and work.

*Fasten your seatbelts and enjoy the ride!*

*Ken Kraybill*

# Frameworks of Engagement

## Hospitality – Creating Space for the Stranger

Estrangement, a sense of not belonging, is common to the experience of homelessness. People living in shelters and on the streets often become separated from ordinary activities, relationships, and a sense of place and purpose in the world. Literally, one becomes a stranger. The longer homelessness persists, the more deeply ingrained this experience of disaffiliation becomes.

Offering the gift of hospitality is an antidote to estrangement. In his book *Reaching Out*, Henri Nouwen defines hospitality as “creating free and friendly space for the stranger.” As such, it is an invitation to relationship. A hospitable relationship provides a welcoming face and presence, and creates an interpersonal refuge from an often impersonal, hostile world. Thus, a person in the midst of homelessness can experience a bit of being “at home” in the context of a safe, friendly relationship.

Hospitality comes with no strings attached. It does not pass judgment or make demands. Instead, it provides space in which the other can freely explore personal needs, concerns, capabilities and hopes. It allows for self-reflection and restoration. It instills and renews hope.

Hospitality can be offered in many ways – sometimes by a simple gesture of acknowledgement, a warm smile, a cup of coffee, listening patiently without interrupting, offering information, a word of encouragement, or simply by being present with the other person in silence. Hospitality cannot be rushed. It requires time, patience and kindly persistence. It sees the “bigger picture” rather than seeking the “quick fix.”

*Ken Kraybill*

## Story

Everyone has a story. Sharing our stories creates a common ground on which we can meet each other as human beings. Our stories are neither “right nor wrong.” They are simply our stories. Some of us can tell our stories with an unclouded memory for our past, clarity about our present situation, and a realistic understanding of where our journey is heading in life.

Some of us find telling our story extremely difficult. Our past may be painful and deeply hidden from memory. Mental illness, intoxication, neurological disorders, developmental disorders, and brain injuries can deprive us of the capacity to tell our story and locate ourselves with others and the world. In the midst of illness the narrative of our lives may take on disjointed or bizarre dimensions. Difficulty in sharing a coherent story may be an indication of illness or disability, and thereby will require a patient, especially careful approach to working together.

Inviting another to share her/his story can be a non-threatening way to gain mutual trust, and develop a picture of a person's situation and needs. A willingness to share a little of our own story in the conversation helps build the common ground. We end, in a sense where we began. As we share our stories over time, hopefully we are both enriched. At best, I have been able to add a little something to another's story, some hope, some concrete help, some encouragement, and they have added something of their courage, their humanness, and their experience to my story.

*Craig Rennebohm*

## **Care**

The word "care" finds its roots in the Gothic "Kara" which means lament. The basic meaning of care is: to grieve, to experience sorrow, to cry out with. I am very much struck by this background of the word care because we tend to look at caring as an attitude of the strong toward the weak, of the powerful toward the powerless, of the haves toward the have-nots. And, in fact we feel quite uncomfortable with an invitation to enter into someone's pain before doing something about it.

Still, when we honestly ask ourselves which persons in our lives mean the most to us, we often find that it is those who, instead of giving much advice, solutions, or cures, have chosen rather to share our pain and touch our wounds with a gentle and tender hand. The friend who can be silent with us in a moment of despair or confusion, who can stay with us in an hour of grief and bereavement, who can tolerate not-knowing, not-curing, not-healing and face with us the reality of our powerlessness, that is the friend who cares.

To care means first of all to be present to each other. From experience you know that those who care for you become present to you. When they listen, they listen to you. When they speak, you know they speak to you. And when they ask questions, you know it is for your sake and not for their own. Their presence is a healing presence because they accept you on your terms, and they encourage you to take your own life seriously and to trust your own vocation.

Our tendency is to run away from the painful realities or to try to change them as soon as possible. But cure without care makes us into rulers, controllers, manipulators, and prevents a real community from taking shape. Cure without care makes us preoccupied with quick changes, impatient and unwilling to share each other's burden. And so cure can often become offending instead of liberating.

*Henri Nouwen, excerpted from Out of Solitude*

# Connecting with People in Distress

By Daniel Fisher, M.D., Ph.D. and Laura Prescott, B.A.

In this article we provide a brief overview of how to connect with people in distress, regardless of the source. Further, we describe how the underlying assumptions and principles of being person-centered, trauma-informed, and recovery-oriented can converge to support opportunities for healing.

Perhaps the most significant impact of trauma is the disruption of “control, connection, and meaning.” In an effort to re-assert a sense of control and equilibrium, people may develop a number of adaptations erroneously called symptoms.

For instance, many people will stay up all night because the evening reminds them of times they were vulnerable to prior perpetration. Some continually pace in order to throw off nervous energy and avoid being in any one place too long. Others create constant conversation in order to mitigate the loneliness or to respond to an inner dialogue others can’t hear.

Some people develop extreme startle responses and find themselves jumping at loud sounds, sudden moves, or persons coming up behind them. Others injure themselves or put themselves at risk to see if they can invoke feelings because they are no longer sure they are alive. These adaptations all reflect ways people attempt to find meaning and to reconnect.

Becoming trauma-sensitive means understanding the extensive impact of trauma in the lives of people experiencing homelessness and responding in ways that support people in

*Because trauma very often happens in the context of relationships, it is within relationships that healing must necessarily*

becoming the central directors of their lives and healing. In order to be successful in providing any kind of interventions and to avoid inadvertently re-traumatizing those we are attempting to help, it is imperative to remember, trauma first, diagnosis second.

In general, each person should be approached at the level of one human being to another, with an emphasis on connecting with the individual as deeply as possible, regardless of the person’s symptoms or diagnosis.

Workers are more likely to make this meaningful connection if they understand the ever-present role trauma plays in undermining the foundation of trust and shattering relationships in the lives of people who are homeless. Because trauma very often happens in the context of relationships, it is within relationships that healing must necessarily commence.

To understand what helps in connecting with people who are homeless, it is useful to examine what constitutes homelessness and recovery from it. The concept of home and therefore recovery from homelessness are multidimensional. The mere presence of a house does not constitute a home. Being “at home” means being comfortable in connection with oneself, with a spirit (however one defines it), and with others. The expression “home is where the heart is” certainly carries a great deal of wisdom.

Many people who are homeless and diagnosed with mental illness have spent time in jails, prisons, psychiatric facilities, and yet these institutions are the opposite of home. These buildings are usually isolated and segregated from communities, and are places where people are all too often referred to by their diagnosis in life and buried with only a number in plowed-over fields after they are gone.

This stands in stark contrast to home, where we feel fundamentally understood, appreciated, protected, and known at the deepest, most complex levels.

Ideally, home is the crucible of our sense of self and place, imprinting our individuality on it through collected items that remind us of our history there. It is the nest that nurtures our meaning and love. In this sense an essential aspect of recovery from mental illness and trauma is creating a home in the community that is both a physical manifestation of space as well as an emotional/spiritual internal world where we feel safe, connected, and accepted.

People tend to turn inward and away from the world, seeking refuge in the inner asylum of their minds, when the external world becomes too frightening, chaotic and unpredictable. The losses aren't static but rather live in dynamic relationship to one another, becoming compounded and cumulative over time. In other words, the strain of chronic dislocation can lead to physical illness, relationship loss, and exposure to physical and sexual assault, and vice versa.

Supporting recovery, therefore, is predicated on our ability to foster connection and environments that are safe, eliminating threats of force and coercion while increasing the level of control people have in determining the course of their own lives. The process of recovery is not likely to begin unless the external world or temporary connection in relationship is safe enough for people to take the risk to return from their inner refuge. Significant loss transforms people, making it impossible to go back, to return to the previous state of being. Thus, recovery is not so much a going back as it is a non-linear process of

### **Laura's Story**

I became homeless again later in life after running away from an institution. There were nights when I withdrew as far as I could into my coat, as far as I could retreat behind my eyes without disappearing altogether. I rocked back and forth to block out the cold that clawed at my fingers and feet, and repeated a series of words or sounds that filled my head with a constant hum to keep me company, to remind me I was still alive.

I had been coerced into treatment by people who said they were trying to help. I had been held down and forcibly disrobed when I refused to give people my clothes in emergency rooms. These things all re-stimulated the feelings of futility, reawakening the sense of hopelessness, loss of control I experienced when being abused. Without exception, these episodes reinforced my sense of distrust in people and belief that "help" meant humiliation, loss of control and dignity.

The more distressed I became, the more loudly the voices raged in my head taking up all the space. I wore my shame in thick layers of clothing, covering my body and sense of rawness I couldn't leave behind. I sweat heavily, but it was better than being exposed, having people know that I had no skin to live in anymore. I was given medication to decrease what people called paranoia. But it slowed down my reactions and made it harder to be alert and to protect myself.

No one ever thought to ask if someone was really pursuing me. It was assumed that those feelings and responses were symptoms of some psychological condition unrelated to being stalked. It took fourteen years before anyone thought to ask...

uncovering who we are in the context of our lives after having experienced significant loss, and discovering who we can be in the future.

In this context, the first contact workers make is critical. It can be an opportunity to begin the process at that moment of the person coming home in the relationship. The worker can begin to create the sense of safety and warmth that provides a glimpse of what a home might feel like.

The assumptions and principles that follow are crucial for workers to embody in attempting to foster genuine relationships and healing.

### **Believe in the person**

This is an essential first principle of recovery and trauma-based care. It may appear that there is no one there when a person is not sharing in our consensual reality. When someone is in severe distress and is mute or talking to an unseen person, they are still there, inside, at home. In fact, at that time they are more present than someone not in distress.

The most frequently cited factor among people who have recovered is that “someone believed in me.” This means that during the time when they had trouble believing in themselves, there was someone whose belief sustained them.

#### **Dan’s Story**

During my residency, a gifted teacher would conduct an interview with a consumer who was in their own reality. At the end he would say, “You see there is no one home.” When I tried to start a conversation with a consumer, another teacher said, “You can’t talk to a disease.”

I was too afraid of being discovered in those days, so I did not tell them that I knew that was not true. I wish I had told them that no matter how unusual a person’s appearance, behavior, or thoughts, there is always a person at home.

### **Invite story**

It is a basic human need to relate the stories of our lives, to find meaning in our experiences and to be valued for who we are. In having the opportunity to tell the story to one other human being in whatever language we use, the “I” becomes “we” and the exchange becomes its own story. And in the magic of those moments, we are no longer alone. An important aspect of providing care for someone is inviting them to tell their story.

### **Understand the meaning of metaphor**

In daily conversation, people relate on a superficial level, relying primarily on spoken words for meaning. When someone is in severe distress they yearn for a much deeper level of relating. This deep level of relating often takes place mostly at the emotional level. Therefore, the nonverbal elements of communication are the most crucial.

If the individual has experienced interpersonal violence, the words themselves will often cease to have meaning. For example, many survivors of violent sexual and physical attack relate that the word “no” only brought on more violation, so that conversely, they were

rejected, abandoned and sometimes left to die when asking for something they needed.

There was a time when I was convinced that everyone in the world was a robot. I was expressing from my heart the distress over how seldom people communicate on a feeling level as well as how little I was capable of doing so as well.

*Dan*

When this level of betrayal of trust occurs through violation, people will seek out other ways to communicate.

The use of metaphor is a particularly potent adaptation when direct expression has been forbidden or words have ceased to have meaning. It is important to assume that people are doing the best they can to communicate the truth of their lives even when it may seem obscure. They are telling us something important. If we assume the use of

metaphor is a “symptom” of mental illness and don’t ask about its meaning, then we miss important opportunities to connect.

## **Don’t give up**

One of the effects of interpersonal violence and trauma is a sense of foreshortened future. Chronic and prolonged crisis leads people to deal with only enough energy to trust the immediate moment. Survivors are often repeatedly told and shown that the future is unpredictable at best and the promise of tomorrow is tenuous.

This makes it even more imperative for workers to be persistent in their approach to people by being tenacious in supporting them and holding onto people’s strengths even when they don’t appear very strong. It is important to remind each other that there is renewed possibility as time silently moves one moment into the next, shaping a future previously unforeseen.

## **Support people in developing life purpose**

There is often a spiritual renewal that comes from being with and believing in another. Whether it is for a child, lover, pet, or person in need of help, there is deep meaning for people who can step outside of their own world to connect with someone else. This is one of the reasons twelve-step programs have been so successful over time. These programs are built on a spiritual foundation, encouraging those in recovery to reach out to others, to share their experience, strength and hope as part of a recovery process.

Many people with severe emotional distress are not seen as competent in their ability to give back. And yet, an important part of recovery from substance use, severe emotional distress, trauma and experiences of homelessness is the opportunity to find meaning and purpose – to feel one’s life is worth living, to share experiences with others, to pass on the messages of hope and that recovery is possible.

## Be honest and authentic

Almost always, severe emotional distress involves a loss of trust in important relationships. Building trust again is based on the person being able to believe you, especially at an emotional level. To build a foundation of trust, one must be honest and authentic. This may require re-examining the kind of training that defines professionalism in terms related to maintaining distance, boundaries, and objectivity, especially around the expression of feelings by the worker. For example, if someone tells you something that makes you feel sad, it is all right to show and share some of that sadness with them (while staying in touch with yourself and not becoming too lost in the sadness.)

Emotional reserve on the part of a listener can interfere with building trust, partly because the teller is often acutely aware of how the listener is feeling. In order to survive, many have developed a heightened sense of awareness. Rather than creating a safe space for traumatized persons to connect, emotional distance creates a sense of distrust and disconnection.

### The Power of Honesty

During one hospitalization, a nurse named Karen was assigned to be with me throughout the evening. I had been having a terrible time, struggling with extreme sadness, unbridled fury, dissociation, and self-injury. I couldn't tolerate being locked in or contained, touched, or crowded in any way.

Karen kept her back against the wall, looking up only to stare at me before returning to her notes. The more she observed at a distance, the more distressed I became. The voices of the past came crashing forth into the present. The experiences of being intruded upon and violated, watched while I dressed, showered, and changed, refused to be kept in the past...but rather blended into the person sitting at a distance with a clipboard.

I could feel the room prickle with unspoken electricity. I got up to pace. Maybe I could outrun the feelings, I thought, just walk so fast that they would be left behind. The more I paced, the more I sensed Karen's fear. So I sat down, but this only made my inner world more chaotic.

Realizing that something needed to shift, she took a deep breath, put down her notes, and changed positions so I could see her better. In a soft, direct, and quiet way, Karen took a risk to be authentic with me. She sat on the floor to make sure she wasn't standing over me or blocking any entries and exits, and then made eye contact. She told me she didn't understand what was happening when I went so far away and that watching the dissociation from the outside frightened her because it was so removed from her experience.

She asked me if I would be willing to describe it to her so she could better understand. "Perhaps," she said, "if I understand you won't be so alone." It has been fifteen years since then and her courage and honesty move me still. Because she took a risk to reach into my world, I began to trust her and to take a risk to come back into hers. Compassion knows no boundaries. It surpasses geography, language, age, culture, gender, space, and time to touch the spirit that resides in each human heart.

*Laura Prescott*

## **Listen with all your heart first and foremost**

All too often professionals are pressured to increasingly prove their work is valid and “scientific” in order to stay on the cutting edge. People are encouraged to compete with one another over scarce resources instead of working together. In this atmosphere, it becomes a challenge to remember some very important things we already know. We need to remember to pay attention to the wisdom of the heart and to the awareness that community, connection, validation, respect, and time are the ultimate healers.

When we open ourselves to another and listen deeply, we help the person in distress learn to listen to themselves as well. We actually experience another person’s heart with ours. This might be referred to as “tuning in” or “resonating” with the other person. This level of human connection includes a nonverbal language that allows us to converse across many artificial boundaries between people and cultures.

## **Minimize distractions**

Persons in acute distress depend on the people around them to keep them connected to themselves and the world. Anything that distracts you as a worker when connecting with someone will break the connection and send the person back into distress. Distractions can include external mechanical distractions as well as internal thoughts and worries that you carry into the relationship. This is why practicing some form of centering or meditation can be quite valuable. Meditation enables a person to let go of the intensity of feelings generated by thoughts, allowing the heart to open up to others in a much broader fashion.

## **Support self-determination**

Autonomy, the freedom to make one’s own choices and decisions, has been shown to be a stronger motivator than either external rewards or punishment. Therefore, any way that we can assist someone in (re)gaining control over their life will increase their motivation to be an active agent in that process.

*Dan Fisher, M.D., Ph.D. is the Executive Director of the National Empowerment Center in Lawrence, MA.  
Laura Prescott, B.A. is a Senior Associate at the Institute on Homelessness and Trauma in Newton Center, MA.*

# Reducing the Harm

## Definition

Harm reduction is a set of strategies and tactics that encourage individuals to reduce the risk or harm to themselves and their communities by their various behaviors.

## Goal

The goal of harm/risk reduction is to facilitate change by helping individuals become more conscious of the risks of their behavior and providing them with the tools and resources with which they can reduce their risk.

## Principles

- A humanistic, client-centered approach – meets people “where they’re at”
- Addresses the whole person with complex needs
- Provides an alternative and challenge to traditional disease model and/or moral criminal models
- Accepts that risk is a natural part of our lives
- Places risky behavior on a continuum within context of person’s life
- Looks at individual’s relationship to the behavior as defined by him/herself
- Accepts that behavioral change is often incremental
- Regards any positive change as significant
- Interventions are not rigid, require creativity and innovation reflective of person’s life situation
- Though commonly associated with substance abuse and HIV infection, harm reduction is applicable to any number of social welfare and public health issues

## Harm Reduction and Outreach

Outreach itself is harm reduction in action. Outreach activities are essentially a set of strategies and practices that encourage and assist individuals to reduce the risk or harm to themselves related to the conditions of homelessness and the disorders from which they may suffer. Reaching out, building trust, meeting survival needs, providing education and information, enhancing motivation, providing referral and advocacy all work together to diminish harm to individuals and thus enhance the quality of their lives.

*Adapted from "Recovery Readiness: Strategies That Bring Treatment to Addicts Where They Are" by R. Elovich and M. Cowing and National Harm Reduction Working Group Report from October 21-23, 1993 meeting*

## Checklist for Making Successful Referrals

- I have an adequate understanding of the client's situation and perceived needs.
- The client and I have talked about how to prioritize these needs and what options exist to help address them.
- He or she is willing and ready to be referred.
- "We have discussed what issues might make it difficult for him or her to follow through with the referral."
- I am familiar with the agency to which I am referring the individual, including its eligibility requirements and services?
- The agency has the *capacity* and *willingness* to serve people experiencing homelessness in a knowledgeable and respectful manner.
- I have a working relationship with at least one staff person at this agency who can provide useful information and help advocate for the client.
- I have considered whether or not to accompany the client based on the individual's:
  - Ability to negotiate complex social situations
  - Ability to provide and receive information
  - Ability to tolerate waiting
  - Level of ambivalence about seeking help
  - Interpersonal style (passive to argumentative)
- If the person is going alone, I have provided sufficient information and "coaching" to help make the referral successful?
- I have made a plan to follow up with the client to see how things went and to determine next steps?
- I have a backup plan if this referral fails to work out for any reason.

## Working Effectively in the Community

Through your attitude, actions and words, serve an “ambassador” for homeless people in your encounters with others in the community.

Promote a spirit of collaboration with shopkeepers, police, clergy, and “natural helpers” in the neighborhood. They are valuable “eyes and ears” to assist you in your outreach efforts.

Develop and maintain a strong working relationship with at least one staff person from key social service organizations.

Offer to provide education and training for other organizations about issues related to homelessness. Likewise, invite them to provide relevant training for your team/organization.

Consider setting up an inter-agency consortium to meet training needs. Each participating agency hosts and provides a workshop on a rotating basis. A representative planning group chooses topics.

Go out on outreach “rounds” at selected agencies on a scheduled basis. This provides an opportunity to maintain regular contact with agency personnel, to accept referrals, make follow-up contacts, and provide consultation.

Participate in developing formal interagency agreements to address issues specific to the care of homeless people. For example, ways to expedite referrals, homeless-specific admission criteria, discharge planning, and sharing of information.

Provide advocacy on behalf of other community programs that are part of the larger network of services for homeless people.

Invite others to open houses, celebrations, farewells, fundraisers, and other special occasions. Attend other agencies’ functions.

Make a special effort to reach out to organizations “on the fringes” of the human services community.

Set aside time at each staff meeting to discuss current and emerging advocacy issues at the local, state and national level.

Get involved in committees, boards, work groups and coalitions that are working to improve the lives of homeless people and to end homelessness.

Subscribe to listservs and periodicals working to end homelessness.

## Charity or Justice?

---

“Charity offends almost no one; at one point or another, justice offends practically everyone.”

*David Hilfiker*

---

Outreach workers are in a unique position to advocate authentically and powerfully on behalf of people experiencing homelessness. The experience of doing outreach work generates compelling first-hand observations, anecdotes, and analyses that beg to be imparted to a broader audience, especially to decision-makers from supervisors to legislators. Just as it is essential in outreach to listen to people’s stories, so it is imperative to “tell the story” of homelessness to the broader human community in which we live.

Outreach and advocacy are inseparable activities. Outreach itself is advocacy in action. Outreach workers are particularly skilled and experienced in “calling out for and on behalf of” individuals experiencing homelessness. But how far are we to take advocacy? Do we dare challenge the conditions and policies that deprive whole groups of people of health and home? Do we have the courage to call out for justice in our social structures, while still helping to restore what is broken in the lives of the individuals for whom we care?

Providers who work with homeless people encounter an uneasy tension concerning the difference between doing “charity” and “justice.” David Hilfiker (“The Limits of Charity” in *The Other Side* magazine, September and October 2000) describes this tension as such: “Justice has to do with fairness, with what people deserve. It results from social structures that guarantee moral rights. Charity has to do with benevolence or generosity. It results from people’s good will and can be withdrawn whenever they choose.”

Hilfiker argues that charity must be viewed as a limited response. It may be a necessary response in our current situation, but it is not enough. Charitable organizations, including government-sponsored programs, provide important services and care but are rightly seen as a “safety net” – not the *solution* to the concerns of poverty and homelessness.

Hilfiker argues that “charity does little to change the wider social and political systems that sustain injustice.” Instead, charity “acts out” inequality. It maintains the system of “*we* who are the givers and *they* who are the receivers.” It does not address the fundamental conditions of injustice – the inevitable result of the structures of our society – that are at the root of poverty and homelessness.

*Ken Kraybill*