Brantford Downtown Outreach Team

Summary of Evaluation

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BDOT Pilot – Summary of Evaluation

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About this evaluation

The City of Brantford and the BDOT Coordinating Committee engaged Dr. James Popham, Community Research Liaison, Centre for Research on Security Practices at Wilfrid Laurier University to conduct an arm's length evaluation of the BDOT pilot. Dr. Popham commissioned an evaluation team including Jocelyn Booton, MSSW and Lindsay Sprague, Ph.D. Leveraging inputs from the coordinating committee, the research team first developed a logic model for the BDOT pilot, identifying inputs and perceived outputs. The research team then designed a mixed-method evaluation framework in collaboration with all partners that included secondary data analysis, document analysis, and face-to-face interviews with individuals who contributed to or interacted with the BDOT.

The evaluation team collected data provided by St. Leonard's Community Services, the Brantford Police Service, Brantford Fire Service, Brantford-Brant Emergency Medical Services, Brant County Health Unit, and other materials from third parties. This information was used to inform descriptive and analytic analyses of the BDOT's impact in the community.

The evaluation team also conducted interviews with key informants familiar with the pilot, and also collected secondary qualitative data related to the BDOT's daily operations. This information was anonymized and processed to inform assessment of the BDOT's successes, challenges, and opportunities for future Brantford-specific outreach teams.

While this evaluation occurred during the unprecedent and socially disruptive public health response to the ongoing COVID-19 pandemic, the team was nonetheless able to compile a series of indicators that point to the BDOT's overall success. This accomplishment is grounded in the willing collaboration and partnership that was experienced when working with all partnering organizations.

BDOT Pilot – Summary of Evaluation

Executive Summary

- The BDOT recorded 5,269 service interactions with an equivalent service time of 4,554 hrs, with approximately 171 unique individuals
- BDOT made 2,066 referrals to community services (84 percent acceptance) and provided 1,282 units of preventative resources
- Clients had an average age of 41.5 years; 67 percent were male; 88 percent resided in Brantford more than 6 months; and most were encountered on the east side of downtown
- Treatment follow-through estimates suggest 35 percent of referrals led to program completion
- SROI estimates indicate a 3.5:1 ratio of Net Present Value of Benefits to Net Present Value of Investments; indicating that every $1 spent on BDOT netted $3.50 in services
- BDOT engaged in harm reduction activities throughout the duration of the program, which included safe needle collection among other activities. Granular data about these actions could not be collected; however, related actions were recorded as “harm reduction” (included in section 1[C][b]; referrals). Adaptations were made to harm reduction plans, like safe needle collection, to ensure good partner relations.
- Analysis of pre-COVID BPS calls for service indicated significant decreases in monthly disorder calls, from 164.5/month in July-December 2018 to 128.3/month in July-December 2019
- BDOT coordinated partnerships with 20 service agencies, including 12 warming/touchdown locations and eight supply donors
- Interviews indicated strengths, including: successful program leadership; diverse team makeup; flexible/adaptable design; client-centred care; building trust; and community advocacy
- Interviews indicated opportunities for growth, including: building clarity on overall mission; addressing staff turnover and service disruptions; and lengthening program funding time to address the needs of the intended clientele

BDOT Pilot – Summary of Evaluation

1. Summary of BDOT activities

This section provides a summary of BDOT activities through their entire operating year; providing indicators of inputs toward the outreach program.

1(A) - Interactions

a. BDOT recorded 5,269 service interactions between July 2 2019 and June 25 2020, from 1871 client interactions.
   - 171 registered clients accounted for 62.5 percent of interactions (n=62.5)
   - 38 registered clients interacted 10 times or more; top 3 were 65, 52, 41 times
   - Average number of BDOT members involved per interaction: 2.8
     - Initial contact: Peer Support Worker(PSW) = 427 (22.8%); NP = 14 (.7%); Concurrent Disorder Clinician(CDC) = 874 (46.7%); Coordinator = 556 (29.7%)
     - Others involved: PSW = 763 (40.8%); NP = 185 (9.9%); CDC = 1369 (73.2%); Coord. = 1083 (57.9%)
   - Average duration: 14 min 45 sec.
     - Range (minutes) = 1 – 300; interquartile range = 5 – 15
     - Mode (minutes) = 5
     - Most (n=1,391) were 15 min. or less
   - Gross service time: 77,630 min. / 1,293 hrs 50 mins
     - If OHIP minimum consultation times are applied (50 mins): 273,245 min. / 4,554 hrs equivalent service

1(B) - Referrals

a. BDOT provided 2,066 referrals total
   - Referrals were offered at 919 client interactions (49.11 percent)
   - Referrals were accepted at 772 client interactions (84 percent of offered)
   - Top 5 most common (accepted/total): Community Mental health (319/361); Ongoing housing (273/320); Community Addictions (229/256); Shelter (208/246); RAAM (177/212);

b. BDOT distributed 1,282 preventative resources
   - Resources were provided at 691 client interactions (36.93 percent)
   - An average of 1.6 items were provided per interaction; most clients (58.6 percent; n=405) received one item
   - Top 5 most common (accepted): Food (494); Harm reduction (316); Basic needs (129); Hygiene (107); Transportation (47)

1(C) – Harm Reduction

a. BDOT engaged in harm reduction activities throughout the duration of the program, which included safe needle collection among other activities. Granular data about these actions could not be collected; however, related actions were recorded as “harm reduction” (included in section 1[C][b]; referrals). Adaptations were made to harm reduction plans, like safe needle collection, to ensure good partner relations.
   - 316 occurrences of harm reduction were recorded (16.9% of interactions)

- Most (34.2%) occurred in zone 2 (108 events; 16.5% of interactions in zone) and zone 4 (33.5%; 106 events; 26% of interactions in zone).
- No harm reduction events were recorded at encampments
- Seven harm reduction events initiated by phone or external appointment

2. Profile of BDOT clients

This section provides a snapshot profile of the clients that the BDOT interacted with, using the basic demographic information that was provided.

2(A) - Summary – All clients

a. Average age = 41.5 years
b. Gender = 67.2 percent identify as male; 32.5 percent female; .2 percent other
c. 88 percent reported residing in Brantford for at least 6 months prior
d. 34 percent of interactions occurred in zone 2; cumulatively, zones 2,3, and 4 accounted for 63.5 percent of all interactions (BPS atoms 10045; 10026; 10036 – Generally south of Chatham; East of Market; North of Veterans Memorial; West of Alfred)
e. 20 percent of interactions did not occur "on the street;" 11.1 percent were phone calls; 9.9 percent were external appointments

2(B) - Summary – Pre-COVID

f. Average age = 39.7 years
g. Gender = 68.5 percent identify as male; 31.2 percent female; .3 percent other
h. 87.8 percent reported residing in Brantford for at least 6 months prior
i. 41.6 percent of interactions occurred in zone 2; cumulatively, zones 2,3, and 4 accounted for 75.6 percent of all interactions (BPS atoms 10045; 10026; 10036 – Generally south of Chatham; East of Market; North of Veterans Memorial; West of Alfred)
j. 6.2 percent of interactions did not occur "on the street;" 5.6 percent were phone calls; 0.6 percent were external appointments

2(C) - Summary – Post-COVID

k. Average age = 50.7 years
l. Gender = 60.5 percent identify as male; 39.5 percent female; 0 percent other
m. 90.3 percent reported residing in Brantford for at least 6 months prior
n. 2.3 percent of interactions occurred in all zones
o. 97.7 percent of interactions did not occur "on the street;" 39.7 percent were phone calls; 60 percent were external appointments

3. Flow-through projections

This section provides an experimental calculation of programmatic success for individuals based on acceptance rates. These figures can be used to identify the likely proportion of BDOT clients who completed programs to which they were referred.

3(A) - Method

a. The evaluation team conducted a literature review of treatment program engagement rates for individuals who were referred to these programs by warm handoff/assertive community treatment.
b. The team located 14 relevant publications, with an average acceptance rate of 49 percent and a standard deviation of +/- 18 percent, and a range of 27 to 87 percent.
c. Program completion rates were provided by St. Leonard's Community Services:
    - Withdrawal management planned/coordinated discharges = 85%
    - Residential/day treatment withdrawal rate = 18%

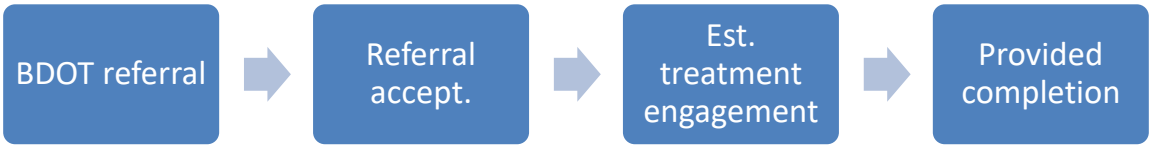

Figure 1 Summary of how follow-through was calculated

3(B) - Withdrawal Management:

a. BDOT referrals (gross count): 12
b. Accepted referrals (gross count): 10
c. Estimated follow-through (49% x b.): 5
d. Estimated completion (85% x c.): 4

3(C) - Residential/day treatment

a. BDOT referrals (gross count): 31
b. Accepted referrals (gross count): 29
c. Estimated follow-through (49% x b.): 15
d. Estimated completion (82% x c.): 12

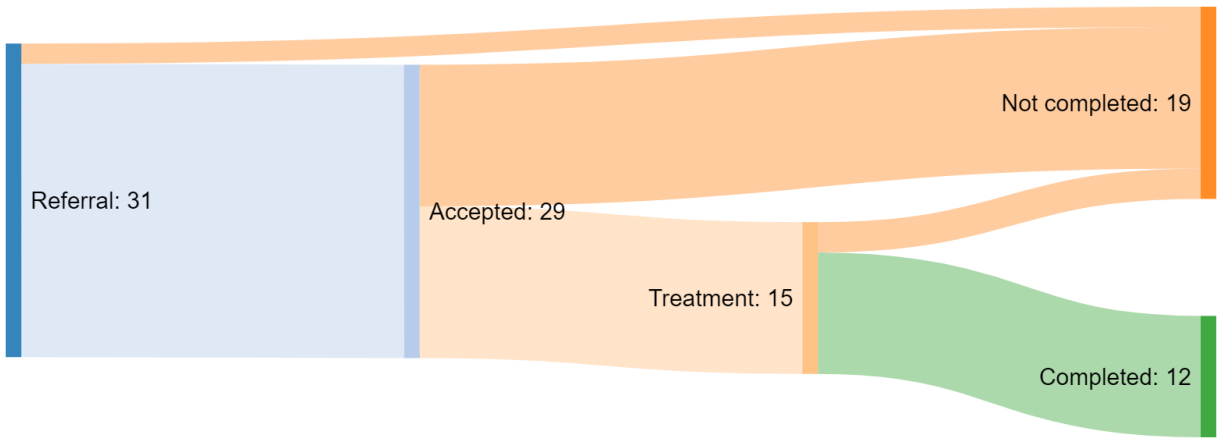

Figure 2 Sankey diagram of follow-through calculations

3(D) - RAAM

a. BDOT referrals (gross count): 212
b. Accepted referrals (gross count): 177
c. Estimated follow-through (49% x b.): 87
d. Estimated completion data unavailable

4. Social Return on Investment Analysis

This section provides details on the SROI for selected referrals, as well as the generalized net benefits derived from the Coordinated Care Program system. This information can be used to demonstrate the cost effectiveness of outreach/direct programming like BDOT.

4(A) - Methodology

The basic idea of SROI is to assess the net social/financial benefit of a program relative to the costs of achieving the benefit.[1]

$$SROI = \frac{Net\ present\ value\ of\ benefits}{Net\ present\ value\ of\ investment}$$

The net present value of investment is calculated from the costs associated with the initiative. In the case of BDOT, investment is represented as cost per referral. The net present value of benefits is a summation of costs (proxies) associated with equivalent treatment or services delivered through traditional means. This value is then divided by the net present value of investment to identify the SROI ratio.

[1] New Economics Foundation (2008). *Measuring value: A guide to social return on investment, 2nd ed.* Retrieved from https://commdev.org/pdf/publications/Measuring-Value-A-Guide-to-Social-Return-on-Investment.pdf

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4(B) - The SROI ratio for the top five referral groups is estimated to be 3.5:1

Table 1: SROI Values for selected referrals provided by BDOT

Initiative	Referrals	NPVB	NPVI	SROI Ratio	Net SROI
RAAM	177	$160,008	$23,010	6.95:1	$136,998
Community mental health	319	$412,786	$41,470	9.95:1	$371,316
Housing	481	$486,772	$214,045	2.27:1	$272,727
Community Addictions	229	$309,837	$115,187	2.69:1	$194,593
Withdrawal clinic referrals	12	$37,248	$6,036	6.17:1	$31,212
Nurse Practitioner	199	$28,855	$8,955	3.22:1	$19,900
TOTALS	1417	$1,435,506	$408,703		$1,026,746

*Estimate tables for each referral are available in Appendix A

4(C) - Coordinated Care Plan (CCP) estimates (Non-SROI)

a. An estimated 177 clients were presented with the opportunity to initiate or re-initiate a Coordinated Care Plan via RAAM referrals. Assuming full engagement, translates to:
b. Est. reduction of 407 ED visits
c. Est. reduction of 195 inpatient visits
d. Est. reduction of 53 30-day inpatient readmissions
e. Est. reduction of 35 inpatient visits for ambulatory care sensitive condition
f. Est. reduction of 18 OMHRS admissions
g. Est. reduction of 708 inpatient LOS days
    i. Est. BCHS-BGH cost per stay is $4,781 and average stay is 6.9 days for est. daily cost $693 = $490,644

5. Calls for service received by the Brantford Police Service.*

This section provides a comparative study of disorder calls received by the BPS in the zones where the BDOT was active. **Note: This data was not computed for Dec-July 2020 due to the introduction of confounding variables via human resources challenges and the global pandemic.*

5(A) - Monthly comparisons

a. The average number of disorder [2]calls per month to the downtown core decreased year-over-year (comparing July-December 2018 to July-December 2019).
    i. On average, a difference of 36 fewer calls per month in 2019.
    ii. The largest observed decreases occurred in the Suspicious Individual calls (16 fewer), Unwanted Persons group (14 fewer per month), Provincial Offence Notice stops (10 fewer per month)

[2] Disorder calls for service include unwanted persons, suspicious individuals, intoxicated persons, drug use/possession, wellbeing/compassionate checks, mental health, provincial offence notice stops (excluding traffic stops), and assisting Fire/EMS.

5(B) - Displacement

b. The average number of disorder calls per month to the areas surrounding downtown remained relatively stable (comparing July-December 2018 to July-December 2019).
    i. This indicates that "displacement" did not occur

6. Community Partnerships

a. The BDOT engaged in formal and informal partnerships with more than 20 service organizations and community members
    - This includes outreach supply donations from eight different community members or entities
    - Warming/Touchdown locations provided by twelve community organizations

7. Comparative summary of BDOT activities (pre/post pandemic)*

This section provides a brief summary of the changes encountered by the BDOT following the pandemic declaration

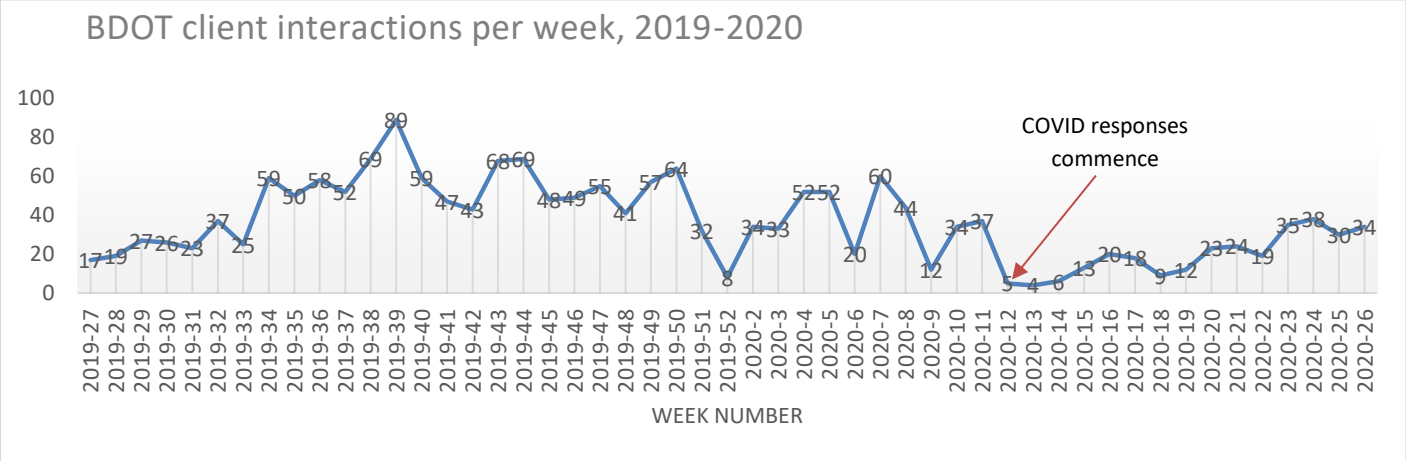

Figure 3 Chart depicting weekly BDOT interactions

Observed changes

a. Average interactions per week dropped from 43.6 to 19.3
    i. Estimated delta of 19.2 interactions (Avg. interactions previous 14 weeks = 38.5)
    ii. Despite this drop, weekly calls rose steadily under new parameters along a linear trajectory (2.25x + 1.33) from 5 interactions during week 12 of 2020 to 34 interactions during week 26 of 2020.
    iii. Most interactions were by phone (117) or external appointment at the Hampton Inn (172). One interaction was recorded in the downtown area.
    iv. The average number of referrals per incident dropped from 1.16 to .81. When excluding interactions that did not include referrals, the average dropped from 2.34 to 1.75 referrals.

v. Proportion of top five referrals per interaction dropped in most cases: Community Mental health 20.4% to 12.5%; Community Addictions 14.5% to 8.3%; Shelter 13.4% to 11%; RAAM 12.6% to 4.6%. Stable housing increased slightly 16.8% to 17.4%

8. Qualitative observations

Methodology & Demographics

Individual semi-structured interviews were held over Zoom video calls with BDOT Organizers and Frontline Staff from May to September 2020. A total of nine interviews were completed, five with BDOT Organizers from involved Organizations and Municipal Staff and four with BDOT Frontline Staff. While originally proposed, individual interviews with BDOT Service Users were not completed, as per WLU's continued moratorium on in-person data collection, research ethics guidelines for academic institutions, and logistical barriers to recruitment and interviewing with Service Users during COVID-19 restrictions.

All recorded interviews were transcribed, and memos are written during all stages of data collection and into analysis. Thematic coding and analysis are currently underway. The Review presented here reflects a broader understanding of the evaluation research participants' opinions. Forthcoming is the formal thematic analysis, reviewing and confirming themes with participants, and the final analysis of themes and comparison and confirming with other data sources.

Successes

a. *Strong Leadership and Oversight Committee*
Some participants noted that for the BDOT project, **city leadership has been important**, as explained by Participant 101: *"I think the city of Brantford really stepped up to the plate to do this."* By establishing a **Brantford-specific oversight committee**, collaboration was enhanced for BDOT now and for programs in the future, as Participant 101 also said, *"I look upon it as fantastic, that the police department, the city, St. Leonard's, Grand River [Community Health Centre], like we rolled up our sleeves…but there's a huge by-product benefit of that. The next collaborative venture with this population or otherwise will be so much easier given all the hard work and attention that went to this."* Participant 103 suggests that *"…having more hands in the pot than just us"* contributed to success. When asked **what makes the BDOT project Brantford-Specific**, Participant 103 noted that, *"I think the partnership piece, again. So…we were able to adjust and make the program wrap-around what Brantford services look like."*

b. *Varied BDOT Staffing Model Reaches Service Users and Other Service Providers*
The BDOT staffing model, based on a Coordinator with a crisis background, a Concurrent Disorder Clinician, a Peer Support Worker, and a Nurse Practitioner, covered many areas of needs important for the intended Service User. The **diverse street outreach team composition helped broker relationships with services beyond BDOT**. By these team members representing multiple professions, Participant 109 suggested that BDOT was "*able to help people kind of wrap their heads around a different conceptualization and*

reframe the past experience to be just a past experience and not what needs to define their present experience or the future experience with certain services." About the Nurse Practitioner specifically, Participant 101 said, *"…the function being brokering a relationship to ongoing primary care, perhaps at the health center or elsewhere, then then having a primary care practitioner, you know, involved in that brokering is helpful."*

According to several participants, one standout role on the Team was the Peer Support Worker. This **role focused the work on the Service Users' needs**, an important task that will be discussed later. While this role was unfilled for six months of operations, Participant 103 still spoke of its importance: *"Not having a peer support worker [throughout the service] has, I think, it's really impacted the program, and I think if that part is really important, it helps us... A lot of the role of peer support…it was just starting that initial engagement, and then building some trust, which our other two workers have been able to do as well but I think that peer support is really important because it's a different perspective."*

c. *The BDOT Model Facilitates Many Operational Benefits*

From the beginning, Frontline Staff wanted to, as Participant 109 states, *"…make sure that we were seen as something different from the get-go. And we wanted to ensure that, and we have a lot of conversations around ensuring that, our clients were very aware that we were coming if we were invited, we were coming if we were wanted, and we were only providing whatever anyone said that they desired, and we were really reinforcing that voluntary aspect all the way through."* By **highlighting how BDOT is a different type of service** to Service Users, the foundation for trusting relationships (discussed under **Impacts**) was laid.

To further meet Service Users' needs, **Frontline Staff needed to operate flexibly**, as Participant 109 states, *"And so what we found working with our clients was that we needed to be available to them in such a way that if we were working someone, we needed to be able to do it intensively if they needed it. And we needed to be able to flex the hours that we were working a little bit to be able to meet their needs…"*. **Partnerships facilitated nimble operations**, as described by Participant 113, "…*the flexibility of being able to go in and out of buildings and RAAM and Grand River Community Health Centre, it was really unique, and really, really needed, actually. Because not everyone can just open a door when they're struggling…"*.

The BDOT model was further enhanced by the **multi-sectoral benefit inherent in street outreach's connection to the health sector**. While BDOT employed a Nurse Practitioner, a role not consistently filled during the pilot, the partnership with Grand River Community Health Centre acted as a potential pathway to medical care. In future street outreach programs, Participant 104 stated that "…*this has to be a health system funded initiative …because it helps to ensure the connection with the broader continuum of services and supports and more continuity of care for individuals that are first interfaced with that outreach team."*

d. Impacts on Service Users

The BDOT's successes include important impacts for Service Users. While many of the longer-term impacts on Services Users – specifically those who are often as marginalized and stigmatized as those BDOT intended to reach – require a timeframe longer than one-year of service in order to crystalize and a more extensive evaluation framework to capture that change, those challenges will be discussed later.

BDOT Service Users included some who were not necessarily known to the service partners and were **disengaged from needed services**, as explained by Participant 104: "*So I think [BDOT] did an exceptional job in building a relationship with some folks that had never really had contact with the continuum of supports prior so that I think is a huge success."* BDOT also succeeded in **giving voice to marginalized populations**. Participant 103 explained that *"we're talking about the most vulnerable, marginalized population who are very unwell. And not connected to supports for a reason, because they're not able to connect. So, I think, these people don't typically have a voice. And that's been what BDOT has done."* Engaging these clients was attributed to the time BDOT spent on **building trusting relationships** and **providing client-centered care**. Trust-building with Service Users is seen as both a product of the time spent in "persistent engagement" and the basis for future work. Participant 103 says, *"So, I think our staff have done a really good job of building, taking the time that's needed to build those relationships, so that we can get somewhere. And we've seen, even in the last month, successes of that persistent engagement."* The story Participant 113 tells of where that trust-building can take an individual is considerable: *"We connected with [the service user] originally and he was living by the river. And through our daily interactions and confidence building and support, he ended up working on some relationships with family and friends, was able to get into…the community suppers, so he was eating, he had some shelter. And then he ended up getting a job in the type of work that he was doing before…. That's a lot to happen."* Participant 103 described what **providing client-centered** actually means in practice: *"It's all about the client journey, like what they need. What I think they need is not what they need. It's all about listening to where they're at."* BDOT's commitment to providing client-centered care is further explained by Participant 109: *"We, we honestly and truly did our, our utmost to be able to show people in the amount of time that we had that we just concerned about people and that whatever they wanted for their wellness would be up to them."*

e. Impacts on the Community

In addition to Service User impacts, participants mentioned the role of **advocacy to the service sector for marginalized populations** as a significant part of BDOT's work to impact the Brantford community. Participant 103 spoke about how *"the advocacy piece has been the majority of my job in this program, and the big focus of what some of our staff have been doing…. I think, I think it's probably the most important thing that I could have done in the last year,"* and that *"we had to have a lot of difficult conversations with people, but I think that the conversations that I wouldn't have had an opportunity to have or been aware of, without the BDOT program."* BDOT continued past the service sector to **impact the broader community to address needs of marginalized people**, as

Participant 103 also said, *"…at least people are aware of services, they're more aware of where we can refer people. They're more aware of what's available."*

Challenges

a. *Alignment of Street Outreach Philosophies Defines Team Operations*
Early on in operations, BDOT Organizers and Frontline Workers had to **align stakeholders' street outreach philosophies**. Participant 104 described this as the Oversight Committee working *"out some kinks around philosophical alignment in terms of what it was that that our BDOT team was doing…."* Specifically, *"what we're doing to support our clients"* (Participant 103) around engaging people about encampments and how social services are approached. Participants were clear that this "alignment" process led to greater understanding and ultimately more client-centered care.

b. *Advocacy to Services Difficult when the Right People are not at the Table*
Participants mentioned several community and social service organizations whose involvement in and work with marginalized members of the community were not included on the Oversight Committee. Participant 103 commented that when BDOT encountered barriers with one organization in particular, *"I think sometimes they saw us as the enemy, because we were going in there and challenging, challenging some of the ways the programs are being run and it created issues where, if they were part of the table, maybe they would have kind of seen what we were trying to do, and it wasn't a personal attack on any program."*

BDOT Composition and Staffing
BDOT encountered staffing challenges early in operations, specifically with the Nurse Practitioner position. While the **recruitment and retention of positions** for a one-year program can be difficult in a competitive market, Participant 102 commented that *"[we] never really did establish a nurse practitioner in the way that I felt a nurse practitioner should be…."* Later **staff turnover causing disruptions to services**, such as the Peer Support Worker in January, was soon overshadowed by quarantining measures undertaken to mitigate COVID-19 in March, leaving the two-person team to further redefine and operate BDOT for the remainder of the funding.

c. *Transportation for the BDOT Team and Services Users is a Consistent Challenge*
The BDOT model originally included a van where the Nurse Practitioner, in particular, could work with Service Users. The van did not materialize, and as Participant 102 states, *"…it would be a safe place for people to go, not that that's the lynching pin here of it not being successful."* Another participant (103) did mention that *"[Service Users] can't get to and from appointments. They need that support"*,for which a van could have been useful.

d. *Connection between Program Length and Outcomes*
Participants generally indicated that one year was not enough time to truly tap into and demonstrate the power and potential impact of a Street Outreach Program like BDOT.

The short program runtime **restricted the amount and quality of work accomplished**, *"we didn't get our hands in it enough, because it didn't last long enough." (Participant 103)*. For one, building **trusting relationships with marginalized people takes time and resources**. Participant 101 said, *"…once a client comes with a suite of needs, you know, we're not we're not necessarily doing counseling on the first day, we're going to help you with with food. We're going to help you with housing, we might help you get your OHIP card. So I think doing these providing these concrete, tangible supports builds that trusting relationship."* Participant 103 recounted one Service User with whom BDOT had been engaging for over nine months before connection was made. The frustration of creating an understanding about the issue within the community and with other service providers emerged for this Participant, who said that, *"…numbers are great, but you're talking very complex situations, and people who have no trust, and have been, quite frankly, burned a lot by people in the community. And it takes a long time to navigate all of those pieces and connect them to the right supports."*

Future Street Outreach Programs

a. *Leadership and Oversight: Properly Resourced, Representative of Service User Needs*
Participants generally commented that while the BDOT leadership functioned well, implementing another Street Outreach Team could consider that team leadership requires higher staffing resources. *"I think you need an identified lead…. We had the coordinator on the position, but like, that still was a frontline person that wasn't a supervisor or a manager on our end." (Participant 103)* Participant 102 tied this specifically to funding: *"So, I think money was a limitation. If we look at barriers…there needs to be money spent for a true manager of the program. Not fair to ask a frontline worker to be the coordinator, to be wearing five hats. Not fair because things fall through the crack. So there needed to be an identified leader that would be able to oversee the whole program, to say, 'this is where we're going'."*

b. *Defining Outcomes to Inform Processes*
Some Participants talked about how to define success and, in turn, inform how a Street Outreach Team would operate. For example, Participant 101 suggested that, *"If we got a dozen homeless people and connected to primary care, which then also becomes an interface point for all sorts of other supports that would to me, that would be a…if I could connect a dozen homeless folks who didn't previously connect with the system, I would look upon that as a huge accomplishment."* Using desired outcomes to inform objectives and operational processes would help create a long-range evaluation plan.

Using Data to Adjust Operations Creates a Better Program
Some Participants also mentioned using data to drive operations in real time. Participant 102 recommended that a direct link to statistics could help a Street Outreach Program manager to better know *"what the City was wanting, knowing what the business community was wanting. Are we meeting it? And having weekly meetings. Did we achieve our accomplishments? Did we achieve our objectives, not our accomplishments? Did we achieve our objectives?"* Participant 103 echoed a similar

sentiment: "So, *utilizing the data to really wrap our services around what's happening in the community at that point in time…."*

c. *Advocacy to Services to Better Address the Needs of Marginalized Populations*
Participants who discussed how the BDOT made important gains in creating stronger connections with other services also talked about how many services still have some work to do in understanding the population BDOT was created to serve. When asking what an extended BDOT program should do, Participant 101 suggested that they *"Make all the connections with and referrals that it has been doing and to spotlight this work so that all of all those other agencies who don't have marginalized persons front and centre in their mandate, that they expand the thinking of their mandate to include these clients."*