Community Ment Health J (2016) 52:56–65
DOI 10.1007/s10597-015-9963-4

ORIGINAL PAPER

Mental Health Outreach to Persons Who are Homeless: Implications for Practice from a Statewide Study

Michael Rowe[1] · **Thomas Styron**[2] · **Daryn H. David**[1]

Received: 10 November 2014 / Accepted: 8 November 2015 / Published online: 28 December 2015

Abstract In order to help states establish best practice standards for mental health outreach and engagement teams for persons who are homeless, this study aimed to identify key functional elements needed to effectively address the multiple needs of these persons. A statewide survey across six representative outreach programs was initiated in Connecticut. Focus groups with staff and clients, interviews with program administrators, shadowing of outreach workers on their rounds, and review of relevant written materials were conducted. Four main functional themes regarding optimal outreach work—constructive outreach team characteristics; availability of a wide range of services and resources for clients; navigation of multiple service systems; and favorable work demands and training opportunities—were identified through thematic analysis. The article concludes with recommendations for incorporating these four essential functional elements into mental health outreach and engagement practice to effectively meet the varied needs of the target group.

Keywords Homelessness · Behavioral health · Outreach · Engagement · Statewide standards · State mental health authorities

✉ Michael Rowe
michael.rowe@yale.edu

[1] Yale Program for Recovery and Community Health, Department of Psychiatry, Yale University School of Medicine, 319 Peck Street, Building 1, New Haven, CT 06513, USA

[2] Department of Psychiatry, Connecticut Mental Health Center, Yale University School of Medicine, New Haven, CT, USA

Introduction

In the assertive mental health outreach approach, case managers, clinicians, and others leave their offices to make contact with and provide a wide range of services to people who are homeless with behavioral health disorders. Outreach work emphasizes meeting people "where they are" both physically—on the streets, in emergency shelters, and in other sites—and existentially—acknowledging and respecting their experiences and stated needs and preferences (Rowe et al. 1996; Rowe 1999; Erickson and Page 1999). Outreach workers proceed at their potential clients' pace, accepting the wariness that many have of mental health practitioners due to their past negative experiences, difficulty balancing the exigencies of homeless life with the requirements of public service bureaucracies, or other reasons (Fisk et al. 1999; Rowe et al. 2001). Workers aim to make contact with individuals first and foremost as people not patients, emphasizing their strengths, including that of surviving homelessness (Erickson and Page 1999; Fisk et al. 1999; Ng et al. 2004; Rowe 1999; Rowe et al. 1996). Following initial meetings focused on building trust and/or helping people meet basic needs, the marker point for "engagement" is the client's willingness to accept some services such as case management focused on securing entitlement income, vocational training, housing, and behavioral health treatment (Rowe et al. 2002).

The practice of assertive outreach was developed in the early 1980s in response to the rise of a "new homelessness" characterized by the presence on the streets of single persons who were poorer and more likely to have a mental illness than in previous eras (Rossi 1989). During the 1990s, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) took the lead nationally on this outreach through Programs for Assistance in

Transition from Homelessness (PATH) and Access to Community Care and Effective Services and Supports (ACCESS) program. The latter was a nine-state research demonstration project of outreach and engagement services to people who are homeless. Systematic evaluation of the ACCESS program demonstrated the effectiveness of outreach teams in making contact with and providing services to people who are homeless with mental illnesses and engaging them into case management services (Lam and Rosenheck 1999).

At present, SAMHSA continues to provide direct-care funding to states through the PATH program, as well as training and informational resources through the Homelessness and Housing Resource Network. Apart from these initiatives, however, the coordination, administration, and funding for outreach programs largely falls to states, with local policies and practices that can vary from state to state and for programs within states.

The Connecticut Department of Mental Health and Addiction Services (DMHAS) was one of the original SAMHSA grantees under the ACCESS program and currently supports 27 homelessness outreach and engagement programs through PATH and DMHAS funds. These programs are operated by private non-profit agencies or state-operated facilities financed and overseen by DMHAS. In 2010, seeking a more comprehensive understanding of current outreach work being conducted through these programs, DMHAS convened a Homeless Services Committee composed of local mental health directors and other key stakeholders. With the Committee's endorsement, DMHAS elected to fund an evaluation of its outreach programs that would respond to three main questions: First, what do the terms "outreach" and "engagement" mean across these programs? Second, are there promising practices across programs that can be made available to other outreach teams in the state? And third, what are the relationships between outreach teams and local mental health systems of care?

DMHAS and the Homeless Services Committee selected six outreach teams for evaluation that, together, represented the geographical range of the state and included urban, small urban, and semi-rural service areas; programs run by state mental health centers or local mental health authorities, and programs run by private non-profit programs (PNP) with state funding. The six sites were located in Harford, Manchester, Meriden, Middletown, New Haven, and New London/Norwich. Listed below are specifics regarding each program.

- The Hartford program is based at a state mental health center, with assessment, clinical care and case management provided by clinical staff at the center, and outreach and engagement services provided by PNP paraprofessionals including volunteers, with assistance as needed from mental health center staff. The site is urban.
- The Manchester program is based at a PNP with professional and paraprofessional staff with linkages to a local shelter and case management agency. Contracted staff provide outreach, engagement, and referral services. The site is small and semi-urban/semi-rural.
- The Meriden site is based at a PNP with links to shelter and other PNP programs. The site is small urban.
- The Middletown program is based at a state mental health authority with professional and paraprofessional staff with links to clinical care at the parent agency and to a local shelter, soup kitchen, and other PNPs. The site is directed by a clinical psychologist and is in a small urban setting.
- The New Haven program is based at a PNP that serves as a large shelter and case management site. The program is directed by an MSW clinician and mainly paraprofessional staff and with links to case management at the parent agency, to the local mental health center for clinical care, and to other PNPs. The site is urban.
- The New London–Norwich program is a loose collaboration between the state mental health center with professional supervision by a clinical social worker and outreach and engagement services provided by PNPs including a few local shelters/day centers and referral to clinical care at the mental health center. This site is semi-urban, semi-rural.

Hartford, New Haven, New London/Norwich, and Middletown sites were assessed in 2010. Manchester and Meriden were assessed in 2011. The same procedures were used for all sites.

DMHAS contracted with the Program for Recovery and Community Health of the Yale School of Medicine Department of Psychiatry with which the authors are affiliated for this evaluation. After conducting relevant research (described below), the authors of this study submitted a report to DMHAS focused on the three key questions. The present manuscript focuses on key themes identified through the evaluation that are, in part, responses to DMHAS's original questions. However, this manuscript also contains elements that the evaluators believe to have broader significance for state responses to homelessness through mental health outreach. To our knowledge, no systematic guidelines are available to states for maintaining clear standards for outreach programs while allowing for local variations based on size, extent of homelessness, local service system characteristics and other factors. This article attempts to fill this gap in practice guidelines, with limitations and caveats as noted in the discussion section.

Methods

Following discussion with DMHAS and Homeless Services Committee members, it was agreed that a mainly qualitative and observational study would likely yield the most benefit to DMHAS in its efforts to better understand the range of outreach practices it funds, to identify promising practices, and to assess outreach team linkages to local systems of mental health care. This study was therefore exploratory and not hypothesis-driven, but rather oriented around the questions about which DMHAS sought information. Specific procedures included semi-structured key informant interviews with outreach team directors and supervisors; review of written policies, procedures, and other material; focus groups with outreach workers and clients at each site; and shadowing of outreach workers on their rounds.

Key informant questions to directors and supervisors concerned the organization, functioning, and history of the teams, scope of services provided, demographics of team clients, and barriers and challenges to conducting outreach work. Various interview questions focused on the target population, training and supervision, services provided on and/or outside the team, and local strengths and challenges of the team, parent agency and the local service system. Some sample questions for these informants included or concerned:

- What is outreach as a practice and what do you see as its basic principles? Are terms like recovery and community integration meaningful to you in your work?
- Do you work with people with primary substance use disorders and/or dual diagnosis as well as people with primary mental illness only?
- Is your team composed of staff of a single agency, or multiple agencies? (Questions on disciplines represented on and range of services and supports available in the local service system followed.)

Focus group questions to outreach workers concerned team composition, functioning, and effectiveness, needs of clients, barriers and opportunities to helping clients, and the experience of conducting outreach. Sample questions included:

- What is outreach and who is it for? What makes outreach work and what gets in the way?
- How does your outreach team collaborate with other agencies/service providers in your area?
- If you could do anything you wanted to make the work more effective, what would you do?

Focus group questions to current and past clients of the outreach teams concerned their experiences of homelessness and with receiving services from the outreach teams and other service providers. Individuals, who were recruited by the outreach team, were paid $20 for their participation. Sample questions included:

- What do outreach workers do? What kinds of contact do you have with outreach workers? Where?
- Are there things they do for you that are particularly helpful (or aren't so helpful)?… How so?
- What issues do you ask outreach workers for help with? Are there any you like to deal with on your own?

"Outreach shadowing" involved accompanying outreach workers on their indoor and outdoor rounds and reviewed written policies and procedures, chart forms, and other material from each site. Shadowing occurred once or twice at each site for a few hours each time. Times of day included morning, mid-day, and evening, in consultation with outreach team staff.

Eleven key informants were interviewed across six interviews, one at each site, preceded by review of relevant policies and procedures and related material for each site. A total of 28 outreach team staff, the large majority having at least 2 years' experience in outreach work, and 37 clients (most current) participated in focus groups across the 6 sites.

Focus groups and interviews were audiorecorded and then transcribed. Thematic analysis, a foundational approach for analysis of in-depth interviews, was employed for both individual interviews and focus groups. Thematic analysis involves five phases (prior to writing reports): (1) researcher familiarization with transcribed data, (2) generation of initial codes, (3) collating codes into potential themes, (4) reviewing themes in relation to coded extracts, and (5) defining and naming themes (Braun and Clarke 2006). The first and third authors independently reviewed the transcripts for key themes and then discussed their findings, along with their impressions of outreach round shadowing, in order to reach consensus on themes.

Permission to conduct the study was obtained from the human subjects' protection institutional review boards of the DMHAS and the authors' institution, the Yale School of Medicine Human Investigation Committee. The investigators had no conflicts of interest in regard to site selection or other aspects of the study, and their involvement in implementation of changes in oversight to and support of outreach teams in Connecticut is limited to the report submitted to DMHAS administrators and members of the Homeless Services Committee, with recommendations for action.

Results

Four main themes were identified as functional elements that were essential for the outreach teams studied. The authors believe that these themes can serve as guides for organizing and assessing outreach practice in Connecticut and, potentially, in other states as well. These included: (1) *constructive outreach team characteristics* including the demographic composition of workers, positive regard toward clients, commitment to outreach work and outreach philosophy, and teamwork; (2) *availability of services and resources* including but not limited to housing, medical and behavioral health care, case management, and vocational training; (3) *the capacity to navigate multiple complex service systems*; and (4) *clear and appropriate work demands and opportunities* including written policies, procedures, paperwork requirements, and appropriate staff training. A final consideration—differences between urban and rural or semi-rural sites—also deserves mention, as this contrast will be in play in many state mental health approaches to mental health outreach. We discuss each theme/functional element below.

Outreach Team Characteristics

Not surprisingly, outreach team administrators were particularly knowledgeable of the place of their outreach teams in the local services system while, as the discussion and quotes below demonstrate, outreach workers had strong core insights about the basic principles and outlook toward clients that drove the work. Outreach workers' and clients' views of their interactions and the motivations of outreach workers were quite consistent within and across sites, with the important caveat that the research team relied on outreach workers to recruit people for focus groups with their current or former clients.

Demographics

A mix of male and female workers and diversity of race and ethnicity are important, in general, for culturally respectful and competent outreach and engagement work. Likewise, bilingual capacity is important for outreach to and engagement of monolingual Spanish speakers (or speakers of other languages, if relevant). Employing peer outreach workers with a history of homelessness may also be helpful, as research has shown that peer staff working on intensive community-based teams have a unique capacity to engage persons who are most "disengaged" from treatment into treatment and self-help groups (Davidson et al. 2006; Sells et al. 2006, 2008).

Positive Regard for Clients and Strong Commitment to Outreach Work

In our study, outreach workers often expressed a sense of being 'called' to their work. Sometimes this sense stemmed from prior personal experiences with homelessness and the desire to help others similarly rehabilitate their lives. Other times, it was linked to a commitment to social justice and to empowering socially marginalized and disenfranchised individuals. In speaking of his clients, one outreach worker said, "Everybody has a right to start all over again…everybody has value and self-worth, no matter what happened in your life." Workers' attitudes toward their craft was also sometimes conveyed in spiritual or even supernatural terms:

> We're always where we're supposed to be, no matter how we deviate from our routes. We always end up in the right place. [To what do you attribute that?] The universe. [What makes the universe do that?] Because of what we do. And whoever's put us there to begin with, I don't know. But it's a factor. It's a real thing.

This faith in the process of outreach work was important for workers' engagement in their daily job.

Participants in client focus groups also overwhelmingly and spontaneously spoke of outreach staff as being "different" from many other service providers. They noted workers' fierce commitment to them, even during difficult times, and stressed that the respect received from outreach workers helped them to regain their self-respect. "Thank God for Mr. __," said one client. "He latched on and never let go." On a similar note, outreach workers consistently noted the importance of committing to the hard work of building trusting, respectful, and non-demanding relationships with clients whose lives on the streets made them physically and psychologically vulnerable and self-protective. Workers recognized that building such relationships can take time and effort. The importance of celebrating clients' "small growth and change that are taking place over time" was also noted.

Further, the ability to refrain from personalizing antagonism directed at them by their clients was also identified as a critical factor in successful outreach. Commenting on a racially insulting remark that a potential client made to him, one worker said, "This is not about me. He's reacting to a need he may have, or to an illness that he may have. So I don't take it personally."

Flexibility and Teamwork

Outreach workers noted the importance of evaluating and responding to their clients' needs quickly and creatively.

As one worker remarked about her rounds, "It's kind of like you're a MASH unit. You're prioritizing as you go along, every day. What's here this week, today. You just do your best."

At times, workers' adaptability to clients' changing needs also meant a willingness to stretch or even violate operating procedures—transporting clients in their own car if no agency vehicles were available, for example, or occasionally conducting outreach rounds alone if their usual outreach partner was otherwise occupied. Team leaders responded to this 'do what it takes' approach by demonstrating support for the commitment it represented while also requiring reasonable safety policies and procedures. Leaders also encouraged openness in talking through these 'judgment call' situations during team meetings and individual supervision.

Likewise, an *esprit de corps* among team members and the belief that one could honestly share frustrations, sadness, and joy during team supervision were vital for maintaining morale. One worker said of his team:

> We've bonded… We don't just come to the table and give a report and walk out the door, 'See you next week.' If I call these people at the table, they're going to call me back, and they're going to help me if they can. I trust them.

Outreach work can be stressful and workers do not earn generous salaries. Humor was a compensating strategy for outreach workers in our study. "We have to laugh and have a sense of humor about it," one remarked. "Sometimes we have stories…You couldn't make this stuff up!"

Availability of Services and Resources

The ability of outreach workers and/or case managers to both identify stated needs and desired services and to support and maintain communication with clients is essential for helping them make a successful transition from homelessness into housing with appropriate treatment, resources, and other supports. Once clients have agreed to receive services, outreach work expands in scope to provide these services directly or to connect clients to other appropriate providers. This phase of the work introduces new challenges, as client needs are often multiple and complex, and desired resources are often scarce. Outreach team case management is the primary means for identifying, providing, and securing access to needed services. As was true for the different sites evaluated in this study, case management for clients on outreach teams may be a function separate from, or combined with, outreach itself.

Outreach team administrators provided invaluable evidence of the overall "workings" of the local service system, which in turn suggested areas of strengths and weaknesses of the service system and local community. Outreach workers and clients generally provided a similar view of the each or difficulty of gaining access to certain services, supports, and resources, often with an emphasis on the difficulties of gaining access to these and to their short supply. This observation applies to the next theme—navigating multiple complex service systems—as well.

In focus groups, clients highlighted a broad range of services that they received from outreach teams. These included referrals to supported permanent housing, medical, and psychiatric care; help securing identification cards and security deposits; transportation to and from medical and court appointments; help applying for disability benefits; and help finding possible employment and filling out job applications. Two of the six outreach sites provided money management and legal assistance to clients. Clients also described outreach workers as portals to other resources in a behavioral health and social services system, access to which they otherwise found to be difficult, slow, and demoralizing. As one client noted, "There are so many things that [outreach workers] know. I don't know the system. They have a lot of access to the system that I don't."

The main domains of assistance for clients are discussed next. Bureaucratic complexities that outreach workers and case managers confront follow.

Housing

Workers noted that their clients' needs for housing outstripped supply. This limitation is a key factor with which services providers must contend. Some outreach teams employ housing specialists, while others work with agencies that provide supportive housing or connect with landlords with apartments or rooms for rent. In either case, outreach workers and case managers must be knowledgeable about housing types, availability, requirements, and wait lists.

In our study, outreach workers often found themselves in complex relationships with housing providers. One lamented that his clients are "forced to live in substandard conditions. Marginal neighborhoods and active buildings [i.e. with drug use] throw [clients] right back to where they came from." Frustrated with the shortage of affordable housing, however, workers had to consider a broad range of housing options for their clients. One remarked, "I never thought I would say I'm glad there's a slumlord in town… Sometimes they're the only people who are going to take our clients."

Not surprisingly, finding safe, affordable, and permanent housing, with or without support, was a prominent topic of discussion in client focus groups. Participants talked about

long waiting lists for supportive or public housing, the need for numerous references, rejection based on criminal histories, lack of funds for security deposits and furniture, and unaccommodating landlords in the few apartments they were able to secure. One participant described her inability to escape homelessness as, "I have…no credit. I had a job and couldn't get the house. I lost the job because I didn't have a place to sleep. The place closes and I work 3rd shift, so I have nowhere to sleep. It's hard."

Vocational Training

Team vocational specialists assess, counsel, develop a plan with, and support clients' efforts to find and keep work. Vocational specialists may also cultivate connections with employers that can give clients a foot in the door. Some outreach teams in our study offered vocational assessment, training, and placement, but most worked with separate vocational service providers.

Participants in the client focus groups talked about wanting to work but of confronting high barriers to it. Criminal records and bad credit were a problem for many, as was fierce competition for available jobs. Homelessness itself was also a barrier to employment, not only because of difficulty of maintaining one's personal hygiene and appearance but also because this status, if revealed to potential employers, could cast an applicant in an unfavorable light. As one focus group member remarked, "How can someone get a job if he's not clean, smells, has been wearing the same clothes for 2 weeks, and uses half a bottle of cologne hoping it will cover the smell?"

People who were homeless with whom we talked often settled for under-the-table work that no one else wanted, with low pay, security, benefits, or other protections available to employees in the legitimate job market. While some clients found value in less-than-fully-competitive work or in volunteer positions, frustration with the lack of consistently available living-wage employment was palpable.

Behavioral, Physical, and Dental Health Care

Outreach programs in Connecticut seek to provide access to mental health, primary health, and dental care through referral to public mental health centers, public clinics, or to federally qualified community health centers. Options for addictions treatment may include inpatient or residential detoxification programs, as well as outpatient individual and group treatment. Increasingly, integrated dual diagnosis treatment is being provided for persons with co-occurring serious and disabling psychiatric disorders and substance use disorders. It appears that provision of nursing care on homeless outreach teams, particularly when the nurse is directly associated with a community health or other public health clinic, can help facilitate access to primary health and, in some cases, dental care. In general, however, nursing care at this level is not available on the outreach teams and wait lists for appointments in primary and behavioral care settings can be lengthy. In addition, direct provision of behavioral health care, especially involving medication management, by outreach teams is an expensive and increasingly rare option.

Navigating Multiple Complex Service Systems

In Connecticut as elsewhere, outreach teams are coordinated with larger systems of care to greater and lesser extents. When outreach teams were integrated into larger behavioral health care practices, referral of clients to other in-house services often proceeded relatively smoothly. In less well coordinated systems, however, access to treatment and rehabilitation services was more difficult. As one outreach worker observed about trying to coordinate ongoing care and services for her clients:

> We are in bureaucratic fiefdoms of services. There's like a moat around some of our buildings and services, with crocodiles, saying, 'Forget it, you're not coming in here.' We need to do things differently.

The negative consequences of lack of coordination and communication among service providers are particularly relevant for people who are homeless, as they are among the most vulnerable to being effectively shut out of care. Likewise, there often is a poor fit between the cultures and organization of traditional behavioral health, medical, and addictions treatment and the realities of homeless life. Outreach teams pride themselves on their creativity and flexibility, and "meeting their clients where they are." In contrast, some service agencies are not well equipped, accustomed to, or comfortable working with individuals who may be homeless, unkempt, and/or unable or unwilling to maintain a regular appointment schedule. A lack of information about outreach and engagement services among staff in conventional behavioral health care settings can compound these problems. In describing her experiences trying to get medical services for her clients, one worker remarked:

> You…meet a resident who will look at your client, despite how psychotic he is, despite his history of alcoholism, and then you'll go to the next resident and they don't want to spend two minutes with your client…not even wanting to be in the same room with them.

Sensing this lack of positive regard and service availability, individuals who are homeless may view gaining access to

care as being too complicated and perhaps not worth the effort.

Clear and Appropriate Work Demands and Training Opportunities

Effective use of operational policies and procedures may be difficult to achieve in outreach work because of the range and fluidity of the work, workers' and teams' ongoing adjustments and adaptations to client needs, and external conditions. Workers were required to keep records and charts that detailed client contacts and status. Paperwork also included data required by funding sources. Some of these data, in theory, could provide useful information to outreach teams. However, workers noted that the range of outreach and engagement activities is often difficult to capture on standardized written statements. Because clients may not become part of one's official caseload until they accept and begin to receive actual services, outreach workers can feel that they do not get full credit for the work they accomplish with their clients. As a result, they may become frustrated both by the time they spend on paperwork and by their knowledge that the paperwork they are submitting does not capture either the full range or time spent on their work. In addition, the use of different data recording systems and requirements across different outreach and treatment agencies—sites that receive PATH funding must record certain types of data, for example— can complicate efforts to provide coordinated and integrated services for clients.

Outreach workers also spoke about the benefits they thought additional training could provide. Training could be specific to conducting outreach or could cover other aspects of behavioral care relevant to the competencies of outreach workers. Although outreach workers in Connecticut sometimes had access to online trainings, several observed that they felt ill-equipped to handle all the challenges that come their way, including identification of and assistance to clients with active psychotic or substance-abuse disorders, weather-related distress, or intimate partner violence. Further, overstretched workers experienced difficulty finding time to complete these trainings.

Differences Between Urban and Rural or Semi-rural Sites

We were surprised, although in retrospect perhaps should not have been, by what appeared to be differences between urban (Hartford and New Haven, the two largest of our sites) and the other four, small urban, rural or semi-rural sites (Manchester, Meriden, Middletown, and New London/Norwich). This additional observation came largely through shadowing the outreach teams in action and also from talking with outreach team leaders and staff. Outreach teams and parent agencies in rural sites seemed to have somewhat denser, varied, and more numerous contacts with non-service system community members, businesses, and other local resources than urban sites in which outreach teams, while still the "outliers" in their systems of care, appeared somewhat more dependent on and tied to the technical bureaucracies of such systems. At the same time, coordinated systems of care in urban sites could sometimes be tapped effectively for more streamlined care. Closer study of possible urban–rural sites for outreach work may be merited.

Discussion

Based on our extensive evaluation of outreach and engagement team work in Connecticut, we have identified four functional elements—outreach team characteristics, availability of additional services and resources for clients, navigation of multiple service systems, and appropriate work demands and training opportunities—that, we argue, are key to successful outreach work in this state. We also offer these functional elements as possible helpful guides to enhancing outreach work in other states. Below we provide recommendations on ways to implement and build upon these elements to develop and enhance outreach and engagement programs more generally.

Outreach Team Characteristics

Successful outreach can hinge on how constructive, open, and supportive the dynamic is among outreach workers on a given team. We recommend that in addition to making a conscious effort to ensure that outreach team workers are familiar with the backgrounds of their clients, administrators and team leaders should work to ensure a climate of trust and open, culturally-sensitive communication on the team and between team members and their clients. Likewise, efforts should be made to recognize and reward the professionalism of outreach work, fostering respect for the inventiveness and creativity that outreach workers bring to their jobs. Formal recognition of outreach workers who epitomize the values and practices of outreach and engagement might do much to maintain or enhance worker morale. Conferences in which workers from different outreach teams discuss their shared work, provide tips to each other on resources, share best practices, and hear from other leaders in the field could likewise provide a forum for brainstorming around shared concerns.

Availability of Services and Resources

Limited housing, employment opportunities, and health services perpetually challenge the capacity of outreach workers to help their clients make an exit from homelessness. Since solutions to this issue will necessarily involve many agencies and players beyond the outreach team proper, state-level administrators must also take active roles in addressing these concerns. For instance, administrators and others in influential positions in behavioral health systems of care could encourage, and pave the way for, the participation of local and regional outreach teams on planning bodies such as those creating 10-Year Plans to End Homelessness (National Alliance to End Homelessness 2015). Official endorsement could legitimate already-established collaborations and provide another venue for outreach teams to be included as full members in local systems of care.

Our evaluation of outreach programs in Connecticut revealed a trend—likely related to the economic downturn, an increase in supported employment, and a more recovery-oriented view of client capacities—toward a greater interest in paid employment among people with mental illnesses who are homeless than was the case in our work with them a decade and more ago. Our focus groups also revealed clients' frustrations with finding steady and living-wage work. Assuming these two elements—the desire to work and the barriers to doing so—are present in other states as well, a larger-scale reevaluation of how employment services are delivered may be in order. One option could be for teams and their state-level administrators to lobby supported employment programs to provide slots for people who are homeless. State officials and outreach team leaders might also assess the role of SAMHSA programs including PATH and SSI/SSDI Outreach, Access, and Recovery (SOAR), which supports increased and more timely delivery of SSI/SSDI benefits for people who are homeless (PRA Inc. 2014), in likewise addressing employment and income-related issues for their clients.

In an effort to expedite clients' access to behavioral and physical health care, initiatives to include psychiatrist or APRN time on outreach teams merit consideration. State mental health authorities could also, in theory, stipulate that state-employed psychiatrists and APRNs routinely make contact with soup kitchens and other hubs of homelessness activity to provide medication management to clients. Some outreach teams and soup kitchens in Connecticut have already forged voluntary connections with medical practitioners and are providing medical care, including HIV testing, in this manner. This approach can help clients avoid wait times and other bureaucratic delays they may encounter in standard community-based clinics. State authorities could also encourage social work schools, particularly those that are state-funded, to approve internships on outreach teams for their students, which would help facilitate earlier training of potential workforce participants as well. Finally, many states have arranged for Medicaid waivers to reimburse the work of peers in behavioral health settings. Such funded placement of peer workers on outreach teams would add to counseling and overall outreach capacities.

Multiple Service Systems

Both administrators and workers who participated in our study cited collaborations with other community agencies and stakeholders including health providers, law enforcement, non-profits, faith organizations, housing authorities, and landlords as critical for successful outreach work. They also noted the many challenges to coordinating and integrating client care across these, and other, providers. Enhancing outreach workers' exposure to the work of other agencies could foster collaboration among all programs and staff that provide services to people who are homeless. State authorities that oversee these agencies can promote the inclusion of outreach supervisors and workers at local mental health center grand rounds and relevant behavioral health training opportunities, while also giving them the opportunity to introduce their own work to non-outreach-focused colleagues. Also helpful would be organized meetings in which relationships with identified 'friendly' local employers could be nurtured.

With their broader view of the system, state authorities could also identify characteristic difficulties in referrals and gaps in services, as well as complementary opportunities for building new initiatives to address these problems. For example, encouraging the use of electronic records and universal consent forms, something that was not employed frequently across the Connecticut providers, can facilitate the quick and efficient sharing of client information across service providers. Another option is to stipulate that state-funded community mental health centers hold weekly clinics to which individuals who are homeless could come, with or perhaps even without an appointment, to receive psychiatric assessment and treatment.

Appropriate Work Demands and Training Opportunities

Much of the art and science of outreach work is learned on the job under an apprenticeship model. Still, outreach workers can benefit from additional, formalized training and job evaluations to help enhance necessary skills. Structured access to relevant online trainings, such as those sponsored by SAMHSA, should be provided to outreach teams and workers, as should protected time for completing these trainings.

Annual training on safety should also be mandatory for outreach staff. Team or agency leaders, with or without state requirements, should audit the training needs of their teams regularly, and follow up with appropriate training.

In the current climate, for instance, training could address the changing demographics of outreach team clientele by teaching staff how to work with people from a range of cultural and life backgrounds including previously-incarcerated persons, those with limited English, youth and young parents, women, individuals convicted of sexual offenses, undocumented immigrants, families, elderly persons, and people who have experienced various forms of trauma. Outreach workers could also benefit from exposure to clinical approaches including motivational interviewing, and from additional information about the signs and symptoms of mental illness, various medical conditions, and trauma. At the same time that they provide new tools, however, these trainings should also highlight the difference between a working knowledge of a given therapeutic technique and the potential drawbacks of using a technique without sufficient additional training.

Further, a range of core competencies can be addressed during scheduled job evaluations so that outreach workers understand the grounds on which their work is being reviewed. These core competencies, in turn, must be supported through staff training and supervision (Mullen and Leginski 2010). In Connecticut, and no doubt in many other states, academic-research support is available for different interventions and approaches. State authorities should draw on this expertise.

More broadly, standards of practice should be developed that build on and support the effective work of assertive mental health outreach to persons who are homeless with behavioral health disorders. These guidelines for practice will be most meaningful and effective to the degree that outreach teams have co-created them and thus have an investment in their implementation. Likewise, the development and evaluation of written policies and procedures should be explicitly linked to these standards of practice. Policies written in plain, specific language that capture and address the actual work of outreach from first contact to case management, recovery planning, and referral to additional care, will be most useful and most likely to be utilized by workers and teams.

Limitations

There are several limitations to the generalizability of this study and thus its potential to offer guidance to states in designing, contracting for, and assuring quality of care in mental health outreach. The study was conducted in a small state and thus the logistics of oversight and quality assurance may be more manageable than in larger states. Geographic variety, client demographics, role of different state authorities on overseeing outreach programs, and extent of homelessness varies across different states and thus our findings may need to be modified, or may be found wanting in some aspects, in different states. Finally, this was a mainly qualitative study limited to less than of third of the outreach teams in Connecticut. A more ambitious and highly resourced study using mixed methods, with in-depth study of a representative sample of sites (as with this study) but with additional survey or other data—such as that which all sites report to DMHAS in Connecticut—might have yielded additional and more generalizable data of additional relevance to other states.

Conclusion

Our findings and recommendations do not exhaust the rich contributions of outreach work and workers, the challenges they face, or the possibilities for enhancing the impact they can have within systems of care and communities. We hope the findings, themes, and recommendations presented in this article will prove helpful to state mental health and other authorities, to outreach teams, and to local systems of care in addressing the needs of people who are homeless with behavioral health disorders.

Acknowledgments The authors dedicate this paper to the memory of Barbara Geller, former Director of Statewide Services for the Connecticut Department of Mental Health and Addiction Services (DMHAS). We would also like to thank DMHAS and the Homelessness Services Committee for their commitment to and financial support of this project. Special thanks go to Alice Minervino.

References

Assessing the evidence: What we know about outreach and engagement. http://www.nrchmi.samhsa.gov/Resource/Assessing-the-evidence-What-We-Know-About-Outreach-and-Engagement-37555.aspx. Accessed July 12, 2011.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101.

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin, 32*(3), 443–450.

Erickson, S. & Page, J. (1999). To dance with grace: Outreach and engagement to persons on the street. In *The 1998 national symposium on homelessness research*. Washington, DC: Substance Abuse and Mental Health Services Administration.

Fisk, D., Rakfeldt, J., Heffernan, K., & Rowe, M. (1999). Outreach workers' experiences in a homeless outreach project: Issues of boundaries, ethics and staff safety. *Psychiatric Quarterly, 70*(3), 231–246.

Lam, J. A., & Rosenheck, R. (1999). Street outreach for homeless persons with serious mental illness: Is it effective? *Medical Care, 37*(9), 894–907.

Mullen, J., & Leginski, W. (2010). Building the capacity of the homeless service workforce. *The Open Health Services and Policy Journal, 3*, 101–110.

National Alliance to End Homelessness. (2015). http://www.endhomelessness.org/pages/ten-year-plan. Accessed May 2, 2015.

Ng, A. T., Mcquistion, H. L., & Hunter, L. (2004). Outreach to the homeless: Craft, science, and future implications. *Journal of Psychiatric Practice, 10*(2), 95–105.

PRA Inc. What is SOAR? http://www.prainc.com/soar/about/. Accessed November 2, 2014.

Rossi, P. H. (1989). *Down and out in America: The origins of homelessness*. Chicago: University of Chicago Press.

Rowe, M. (1999). *Crossing the border: Encounters between homeless people and outreach workers*. Berkeley: University of California Press.

Rowe, M., Frey, J., Bailey, M., Fisk, D., & Davidson, L. (2001). Clinical responsibility and client autonomy: Dilemmas in mental health work at the margins. *American Journal of Orthopsychiatry, 71*(4), 400–407.

Rowe, M., Frey, J., Fisk, D., & Davidson, L. (2002). Engaging persons with substance use disorders: Applying lessons from mental health outreach to homeless persons. *Administration and Policy in Mental Health, 29*, 263–273.

Rowe, M., Hoge, M., & Fisk, D. (1996). Critical issues in serving people who are homeless and mentally ill. *Administration and Policy in Mental Health, 23*(6), 555–565.

Sells, D., Black, R., Davidson, L., & Rowe, M. (2008). Beyond generic support: The incidence and impact of invalidation within peer-based and traditional treatment for clients with severe mental illness. *Psychiatric Services, 59*(11), 1322–1327.

Sells, D., Davidson, L., Jewell, C., Falzer, P., & Rowe, M. (2006). The treatment relationship in peer-based and regular case management services for clients with severe mental illness. *Psychiatric Services, 57*(8), 1179–1184.