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ENGAGING PERSONS WITH SUBSTANCE USE DISORDERS: LESSONS FROM HOMELESS OUTREACH

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Assertive mental health outreach emerged in the early 1980s as clinicians and researchers learned that many individuals who are homeless and have a mental illness shun community mental health centers for a number of reasons, including (1) the requirement of the centers that the homeless acknowledge having a mental illness before receiving help (Segal, Baumohl, & Johnson, 1977), (2) the drawbacks of stigma and medication side effects that can come with treatment, and (3) the exigencies of homeless life, which may force individuals to choose between eating at a soup kitchen and keeping an appointment with a clinician (Dennis, Buckner, Lipton, & Levine, 1991; Koegel, 1992).

Assertive mental health outreach (outreach) is an effective method of engaging mentally ill homeless persons into treatment and case management (Lam & Rosenheck, 1999) and is associated with good client outcomes in several domains (Rosenheck, 2000). Outreach is not an inexpensive practice, however (Rosenheck, Gallup, & Frisman, 1995; Rosenheck, 2000), since its practice spans the process of trust building, gradual engagement, and the individual's acceptance of mental health and other social services (Swayze, 1992; Brickner, 1992; Susser, Goldfinger, & White 1990; Morse et al., 1996). Policy makers and researchers will continue to evaluate the place and worth of outreach-based work in public mental health care when other individuals with serious mental illness are willing to come into clinics for treatment. However, our interest in this article is to examine two related questions. First, how can assertive mental health outreach be adapted to work effectively with persons who have "only" substance addictions? Second, how can outreach teams make a successful

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transition from working with one categorical group to inclusion of another group without losing focus or helping one group at the expense of the other?

In addressing these questions, we begin with an overview of assertive outreach and some lessons learned over the past two decades of outreach experience. We use our own experience in developing and managing an outreach team to discuss the challenges that face such teams as they expand their target population to include those with addictions. We then discuss emerging practice issues that are primarily responsible for bringing individuals with substance use disorders into the foreground of public policy and social service debates regarding the most efficient use of limited program resources. We end with a discussion of the challenges inherent in expanding outreach and some strategies that appear to be useful in this regard.

ASSERTIVE MENTAL HEALTH OUTREACH

One of the most important lessons learned from outreach is that it requires more than a method. Outreach involves delicacies, dangers both physical and moral, intricacies, and contradictions which, taken together, compel outreach workers (clinicians, case managers, and other specialists) to become artists of sorts, as well.

The delicacies of outreach are found in its insistence that the park bench is the homeless person's living room and that the ledge under the highway bridge is his bedroom. The delicacy of a certain aura clings to the encounters of homeless persons and outreach workers too—a delicacy that is flavored in part by physical danger and in part by a loosening of traditional boundaries between clinician and patient. The delicacy of humanistic values in outreach work is linked to workers' conviction that persons with serious mental illness are the most vulnerable of the homeless. When outreach workers see a spark of life in one who has been worn down from years on the streets, the satisfaction the workers feel is even greater because they know about that individual's double affliction of homelessness and mental illness. The notion of the individual "story" and of workers "crossing a bridge" with homeless individuals when they tell the workers their story is strongly associated with the suffering of mental illness, which is simultaneously the mask that hides the story and the wound that imbues it with richer meaning.

The encounters between homeless people and outreach workers take place at a physical border of homeless and housed worlds and at a border of cultural knowledge. These encounters are invested with a mutual and collective charisma for homeless persons and outreach workers, in the sense of a gift of grace or a quality that gives a person special influence over others. They are "homeless," not only in the sense that homeless persons are a party to these encounters, but also in the sense that they lack a foothold in the well-trod office-based meetings of patients and clinicians.

The dangers of outreach are physical. They include entering abandoned parking garages or buildings, although much outreach work takes place in soup kitchens, emergency shelters, and other such institutional way stations for the homeless and very poor. Its dangers are also moral, cultural and, implicitly, political. The lack of structure in boundary encounters suggests the possibility of transformation on both sides of the worker-client transaction, and even the possibility of partnerships to advocate for social change (although institutional and professional influences shape outreach work to blunt its more radical tendencies).

The intricacies of outreach work involve the process of helping homeless persons gain access to both tangible resources such as housing and income, and access to affective resources such as belonging and socially valued roles. With the important qualification that homelessness can be a

"sometimes" thing, alternating with substandard housing, psychiatric hospitalization, and incarceration (Hopper, Jost, Hay, Welber, & Haugland, 1997), we can say that when homeless persons contemplate workers' offers of tangible services and help in finding housing, they weigh the reality of giving up the non-citizenship of homelessness against a package that may give them the second-class citizenship of the barely housed (Rowe, 1999).

The contradictions of outreach work involve what we call the "outreach worker's dilemma." Outreach workers are advocates, but they are also gatekeepers who operate under the aegis of institutional rules and processes geared toward rationing limited services (Lipsky, 1980). In addition, encounters with the homeless involve loosening strict staff-client boundaries, yet the actors have unequal power—there are workers who can dispense services and homeless individuals who can accept them. Finally, workers talk about slowly "persuading" persons with mental illness to accept the services they offer, yet persuasion can verge on coercion, since outreach teams have the power of the state—a psychiatrist who can commit individuals to involuntary hospitalization.

SHIFTING THE FRAME FROM MENTAL ILLNESS TO ADDICTION

Since we draw on our experience with an assertive mental health outreach and case management project to identify key issues and strategies in the discussion section that follows, we offer a brief history to begin this section. The New Haven homeless outreach team was formed around its members' prior participation in the ACCESS (Access to Community Care and Effective Services and Supports) national research demonstration of direct services and systems integration strategies for the care of mentally ill homeless persons (Randolph, 1995; Randolph, Blasinsky, Leginski, Parker, & Goldman, 1997). Eligible clients were homeless, had a mental illness, or were dually diagnosed with mental illness and substance abuse, and were not engaged in treatment at the time that outreach workers made contact with them. From May 1994 though November 1999, New Haven ACCESS provided outreach and case management services to more than 500 individuals. Outcome data showed that clients reported fewer psychiatric symptoms, reduced drug and alcohol use, improved quality of housing and quality of life, and increased income from public sources at 3 and 12 months after baseline interviews (Kloos, 2000).

In 1999, at the close of the federal ACCESS Project, the Connecticut Department of Mental Health and Addiction Services provided funds for a newly titled Outreach and Engagement Project (Outreach Project). The new name reflected a charge of expanding the ACCESS target population to include individuals who were homeless and had "only" substance use disorders; that is, they did not have a co-occurring major mental illness. The decision to fund the Outreach Project was, in turn, part of that state agency's attempt to move public behavioral health care toward greater integration of what, historically, had been administratively and culturally separate mental health and substance abuse fiefdoms. At the service-system level, key administrators looked to the Outreach Project as a locus of new efforts to reach out to homeless and at-risk persons with substance use disorders who refused, or were seen as unmotivated for, traditional substance abuse treatment. New local initiatives included a "sober" or "safe" house and a vocational program that proposed use of the slow engagement and motivational techniques of assertive mental health outreach. While the local system of behavioral health care looked to outreach as the service-system "glue" for work with substance-using individuals, the Outreach Project administrators and staff were themselves struggling to incorporate their new mission. Some of that struggle is reflected in the discussion section below.

Assertive mental health outreach has

commonly included individuals with co-occurring psychiatric and substance use disorders as part of its target population, and research supports its effectiveness with this subgroup (Blankertz, Cnaan, White, Fox, & Messinger, 1990; Meisler, Blankertz, Santos, & McKay, 1997). Some writers discuss outreach methods generically, without making distinctions between its efficacy for those with mental illness and those with substance abuse disorders (Erickson & Paige, 1999). One contemporary study reported on the specific application of assertive outreach to primary substance users (Tommasello, Myers, Gillis, Treherne, & Plumhoff, 1999). In addition, we should note that outreach to substance users has been practiced in various guises for many years, from Victorian-era alcoholics who roamed urban slums and police courts looking for men who could benefit from their message of salvation and the resources of jobs and housing at their disposal (Boyer, 1978), to Alcoholics Anonymous, needle exchange programs, and other contemporary forms of outreach work (Thompson et al., 1998). However, in this article, the form of outreach of concern to us has not yet taken hold in the contemporary addiction-treatment community, where the philosophy that individuals must "hit bottom" and "choose" abstinence before treatment can begin remains a powerful paradigm.

Despite the continuing influence of the "bottoming out" model, however, the use of assertive outreach for persons who have substance use disorders and who are not benefiting from conventional services appears to be a logical next step in substance abuse treatment and practice. There is no *a priori* justification for limiting outreach work to homeless persons with mental illness. The argument that mental illness among homeless persons is a social problem that involves not only treatment but attention to systems of care, which enhance or impede individual recovery (Goldman & Morrissey, 1985), applies equally well to individuals with primary substance use disorders who do not gain access to conventional care. This argument becomes particularly persuasive from a policy point of view when one considers the health care, productivity, and broader social costs that can be attributed to untreated substance use disorders, including repeated hospital emergency room visits, multiple inpatient and detoxification admissions, treatment of associated medical conditions, criminality and incarceration, increased family burden, and lost work productivity.

Broadening the scope of outreach teams to include individuals with substance use disorders would eliminate the need, for purposes of program eligibility, to sort out on the street whether individuals' substance use is their primary behavioral health problem or one that masks an underlying mental illness. Teams that are already deployed to conduct outreach to shelters, hospital emergency rooms, detoxification centers, day labor agencies, soup kitchens, and other sites presumably could, with proper resources and additional training, expand their efforts to include individuals with primary substance use disorders whom they routinely encounter on their rounds. The legacy of success of outreach teams, then, including a basic humanistic imperative to offer people alternatives to life on the streets, which its practitioners have fought for and modeled, is likely to lead to increased pressure on those teams to expand their admission criteria.

Some recent innovations in substance abuse treatment bear a strong family resemblance to outreach. The "motivational interviewing" approach, for example, recognizes that people with substance use disorders often are ambivalent about treatment, and thus need to be persuaded to change their behavior through a gradual process that includes the phases of precontemplation, contemplation, determination, action, and maintenance (Miller & Rollnick, 1991; Prochaska, DiClemente, & Norcross, 1992). This treatment framework shares kinship with the phases of brief but repeated contact, trust building,

acceptance of treatment, and on-going clinical stability employed in outreach. The recognition that legal problems, family needs, physical health, threats from drug dealers, or an abrupt loss of customary income, rather than the wish to turn away from drug abuse, are often what send people to treatment, is akin to the recognition that homeless individuals with mental illness may use treatment and ancillary services for refuge and recuperation rather than for improvement in lifestyle (Segal & Baumohl, 1985). The recognition that most individuals with substance use disorders rarely achieve abstinence in the first round of treatment (Pollack, Otto, & Rosenbaum, 1996) is similar to outreach workers' understanding that their mentally ill clients may have periodic relapses on the way to, or even after achieving, clinical stability. Finally, the "contingency management" approach to substance abuse treatment, in which clients receive immediate rewards for achieving behavioral targets and no rewards for faltering (Higgins & Silverman, 1999), resembles outreach workers' use of housing and access to entitlements to entice persons with mental illness into treatment and other services.

Despite these similarities, however, there are reasons to hesitate before casting a wider outreach net. Categorical services and practices not only ration limited resources, but they also focus the efforts and skills of practitioners and shield them from being overwhelmed by the demands of yet another desperately needy population. In addition, the traditional wisdom that people need to hit bottom before being able to use treatment effectively, combined with the difficulties of placing people in stand-alone treatment programs that demand a high level of motivation or "clean time," can make outreach workers and teams shy away from people with substance use disorders even when funding agencies are shifting to accommodate them. Finally, outreach workers are likely to lack rigorous training in substance abuse treatment, to be unfamiliar with components of the addiction treatment community that do not focus on co-occurring disorders, or to be unprepared for a sudden expansion of their target population.

DISCUSSION

We have asked two related questions in this article: First, how can assertive mental health outreach be adapted to serve persons with primary substance abuse? Second, what are the key issues that administrators and staff of outreach programs face when they take on this task? Our response to these questions, which we consider together in this section because they overlap, involves assessments of both individual client characteristics and service-system issues. In the first category, we consider the sub-topics of early contacts and treatment trajectories. In the second, we consider outreach team capacity and service-system readiness. In addition to our 7-year experience with the New Haven Outreach Project, we draw on our review of 100 consecutive "first contacts" with individuals on whom outreach workers in New Haven reported in the team outreach log for a 9-month period (December 1999 through August 2000). For each individual, we reviewed both the service needs they or their outreach workers identified and what, if any, referrals or direct services they received from the Outreach Project.

Individual Characteristics and Responses to Outreach Efforts

Early Contacts. Our analysis of initial outreach contacts confirmed a rule of thumb, formulated during our experience with the ACCESS Project, about a distinction between outreach to individuals with primary mental illness and outreach to individuals with primary substance abuse. This rule states that severely mentally ill persons often are reluctant to ask for, or entertain workers' offers of help, while individuals with primary substance abuse

disorders often will approach workers for help in obtaining housing, work, or treatment. With the latter group, then, outreach workers frequently find themselves the objects of pursuit and may feel overwhelmed by the urgency of the requests they receive. We were astonished, for example, to find that of the 100 individuals contacted during the 9-month period noted above, when the Outreach Project was only tentatively beginning to work with its new target group, 54 individuals were identified as having primary substance use disorders.

The eagerness of these individuals raises a special set of difficulties for outreach workers because either complying with or denying their requests is problematic. Small items that workers may be able to offer (backpack or sleeping bag) can be sold for drugs. Complying with individual's requests for large items such as housing, before addressing their substance use, if only at an early motivational stage, may result in their loss of housing due to drug use and failure to pay rent, and loss of housing for others when landlords feel that outreach workers and their drug-using clients have "burned" them. Yet a flat-out rejection of these individuals' requests will not accomplish the outreach goal either, because they are likely to conclude that, once again, service providers, whether sitting in their office or out on the streets, have no intention of helping them.

Engagement into treatment for this population may involve offering small items such as coffee or small food vouchers that are not likely to be converted into cash. Some individuals' interest will flag quickly when workers do not immediately offer to house them, but workers should continue to be available to these individuals, offering assistance with placement in emergency shelters, encouraging them to attend 12-step meetings, or making referrals to substance abuse detoxification or treatment. Drawing on the principle that work may be a motivator to start or stay in treatment, rather than a long-term goal following successful treatment, outreach workers should also consider job training and placement programs as outreach tools. Even when individuals reject the offers, workers give the message that they take them seriously, even when they will not comply with their requests. In this way they can begin to build trust with individuals and negotiate with them around their short- and long-term goals while assessing where they stand on the motivational continuum.

Treatment Trajectories. When outreach workers identify a goal (referral to substance abuse treatment, access to medical insurance, job training, or other needs) with the client, they have an opportunity to use motivational interviewing to thoroughly assess their clients' strengths, interests, and needs, and to begin negotiating an individual treatment plan with them. In motivational interviewing (Miller & Rollnick, 1991; Prochaska et al., 1992), which is an empathic, supportive, and directive counseling style, clinicians see their relationship with the client as a working alliance to which both parties bring expertise. They see their clients' ambivalence about treatment as normal, an obstacle to recovery that can be overcome by working with their intrinsic motivations and values.

It is important to note, however, that in spite of the kinship between motivational enhancement and interviewing techniques and the engagement techniques of outreach workers, substance abuse assessment and treatment represent a distinct discipline and expertise. Outreach workers often are paraprofessionals who lack the training, experience, or confidence to conduct a thorough substance abuse assessment. Even trained clinicians on outreach teams generally have expertise in mental health assessment and treatment and, when they address their clients' substance use, do so within the context of their primary mental illness. However, when outreach workers are given the training they need, it is possible for them to develop relationships with substance-us-

ing clients who live on the streets or in shelters. Issues, such as how money can trigger a relapse if the client returns to work, can be addressed in the context of this ongoing relationship. Outreach workers can support individuals' progress, be involved in ongoing treatment planning, monitor compliance with treatment, and nurture the development of sober social supports and internal changes in self-perception that support sobriety as the client's motivation to maintain these gains ebbs and flows.

Before moving on to program- and systems-level considerations, we will conclude this section with some reflections on the ways in which our experience with individuals with primary substance use disorders has modified our initial assumptions and beliefs. First, before we had worked extensively with this population, we reasoned that the stigma of mental illness carried a more lasting and deeply ingrained sense of otherness, for those who hold the label, than for those with substance addictions. The addict can become an ex-junkie or recovering alcoholic at worst and a model citizen at best, we thought; but the person with mental illness is often seen as being stuck with it. His illness carries a special shame and a more indelible otherness (Rowe, 1999). Second, we thought that many recovering substance users were in a better position to reintegrate into mainstream society, regaining jobs and social and romantic relationships, than individuals in recovery from mental illness who continue to exhibit symptoms that interfere with their economic and social reintegration.

There is partial truth to these observations, and that part can bear practical consequences for members of both the client group and for the outreach workers who must modify their approaches with each client. Individuals with primary substance use disorders may need to grieve the loss of a marriage or the loss of children of their relationship; but with clean time they may have more potential to recoup other losses such as jobs and self-sufficiency, than many of their counterparts among the severely mentally ill. By contrast, persons with schizophrenia will grieve a loss of friends or housing due to substance use; yet, with clean time under their belts, they may continue to grieve the loss of a sense of self that they had (or that others attributed to them) before the onset of schizophrenia. Such differences have important consequences for the worker-client relationship and the negotiated vision of what help, progress, and recovery mean for individuals in each group.

Our third assumption was that the engagement aspect of the outreach worker-homeless person relationship, which emphasizes the worker's relationship with the *person* rather than the patient, is better suited to work with persons who have severe mental illness than those with substance addiction who might be relatively more focused on the practical issues of housing, jobs, and treatment on the way to their reintegration into mainstream society. Given this, we expected that workers would tend to engage in relatively early negotiation with their primary substance-using clients about entering treatment, compared with longer periods of trust building with clients who have primary mental illness, before bringing up the issue of treatment. Our outreach data partly confirmed this assumption and the hypothesis that flowed from it. Of the 25 (of 54) individuals with whom outreach workers had enough contact to make formal referrals to substance abuse treatment, they made 23 of those referrals within 3 outreach contacts or fewer. Only 8 of the 25 clients had ongoing contact with outreach workers, compared with more than 60% each for dually diagnosed and mentally ill outreach clients who were referred for ongoing treatment and other services. However, from the data available for our retrospective analysis, we cannot tell how much the referral of substance users to other services reflects outreach workers' lack of training in working with primary substance-using clients at an early stage of target population expansion, nor how much

the relative lack of ongoing contact reflects their lack of knowledge about how to track individuals' movement through relatively unfamiliar programs and systems of care.

Overall, we do not find that the partial truths contained in our assumptions hold up as obstacles to broadening the target population of outreach projects to include persons with primary substance use disorders. In the early stages of outreach and engagement, the "citizenship" potential of these individuals is largely theoretical and, as a group, they appear to be about as marginalized and disenfranchised as those with primary mental illness. In addition, our own experience with this population has taught us that most individuals do not come to us with substantially better histories of functional competence and skills than their counterparts with primary mental illness. Moving to the practice level, the model of motivational interviewing and assessment, along with other recent innovations in substance abuse treatment, make a good fit with the values and practice of assertive outreach to homeless persons. The fault in expanding outreach, it seems, lies more squarely in our expectations, the resources we supply to our community-based teams, and our systems of care, than it does in an inherent "better fit" with persons with severe and persistent mental illness.

Service-Level and Systems-Level Issues

Outreach Team Capacity and Readiness. Much as the mentally ill and substance-using populations have in common, and much as current innovations in mental health and substance abuse treatment resonate with each other, expansion of outreach teams is no simple matter. Outreach workers and teams that are trained to work with mentally ill and dually diagnosed homeless persons will be ill-equipped to add substance abuse treatment to their repertoires without a thoughtful process of project planning and staff training. Absent this, staff may resist change in various ways, including a retreat from outreach. In New Haven, the Outreach and Engagement Project's transition to work with homeless substance abusers was complicated by the fact that the team was also asked to begin serving individuals who were not literally homeless, but at risk of it. Over time, one clinical supervisor noted that outreach workers seemed "paralyzed" in rounds because almost anyone they encountered was eligible for their help. Workers' tentativeness in working with substance-using individuals, while exacerbated by the "non-homeless" addition to the target group, appeared also to reflect their sense that their outreach and engagement tools did not quite match the needs and responses of substance using individuals who did not have a primary mental illness.

Service-system pressures may also push workers to move substance-using clients out of shelters and into treatment or housing. After they have accomplished this task, workers may be under pressure to move on to the next client, rather than follow through with the one just referred for treatment. In New Haven, the municipal government awarded funds to the Outreach Project for a special "treatment access" program geared toward placing substance using "guests" of city-funded shelters in detoxification centers; but, in the City's plans for the program, little attention was given to the need for placing these individuals in residential treatment or follow-up case management. Outreach workers, then, may find themselves juggling many requests for assistance from clients as well as systems pressures to engage in bureaucratic "people processing" (Lipsky, 1980). The outreach values of developing relationships with clients, conducting thorough needs assessments, and staying with clients until they are ready to move on may not be priorities under such systemic pressures. (We should note that such pressures may well apply to work with homeless individuals with primary mental illness, unless outreach projects have established a strong tradition, with

service-system acceptance, of extended outreach, engagement, and follow-through with individuals until they make a comfortable transition to ongoing treatment.)

Assertive mental health outreach teams that aim to expand their target population to include primary substance abusers must address at least four key issues that involve assessing, timing, training, and specializing: They must *assess* the team's overall capacity, the local homeless populations' need for outreach and case management for substance abusers, and the resulting capacity of the team to include individuals from the new target group. They must then address the issue of *timing*, gradually expanding their capacity to serve the primary substance-using population and adjusting that timetable as the circumstances of implementation warrant. Next, they must implement systematic and ongoing *training* programs for direct care staff and supervisors. Such training will also help to guide decisions about how to modify outreach and engagement techniques to meet the needs and characteristics of the new group and of the agencies that cater to it. Finally, supervisors must make decisions about when or whether to *specialize*, developing sub-teams to provided outreach, case management, and referral to substance users based on staff training, interest, and skill.

Local and State Service-System Characteristics and Resources. Local outpatient substance abuse treatment clinics may require a higher degree of motivation than many homeless persons possess as they contemplate the possibility of treatment and recovery. Clinic requirements may at times appear to present "catch-22" barriers to homeless persons. One supervisor with the New Haven Outreach Project reported her frustration with outpatient treatment programs that variously denied services to individuals whom she referred because they were "too motivated, not motivated enough, not clean from substances, clean for too long from substances, had missed too many appointments in the past, or had kept appointments for an extended period of time and therefore could receive a lower level of care than the clinic provided." Such difficulties in gaining access to care will be exacerbated if substance abuse and mental health treatment systems are under the auspices of separate state authorities, or if these local systems operate under a *de facto* segregation of philosophy and practice. In Connecticut, mental health and substance abuse authority has been integrated at the state level for several years, but only recent efforts by the local mental health authority and an emerging regional authority for substance abuse services has begun to move the behavioral health care system toward greater coordination of, and access to, care in New Haven. These efforts were fueled in part by the example of the ACCESS Project and the belief that its successor, the Outreach Project, could serve as a linking mechanism, or glue, for integrating behavioral health services at the street level for homeless and other poor and marginalized persons.

Systemic and practice barriers, then, may impede the integration of substance abuse services into assertive mental health outreach teams, but we are struck by the similarity between the mental health system of care in place at the time that the ACCESS Project was implemented in our service area 8 years ago, and the behavioral health system (or non-system) of care that is in place now. Then, homeless persons with mental illness were considered a doubtful investment of service-system resources when many of them had already proven themselves to be "treatment failures," and when others with more motivation were queued up at the public mental health center for treatment. Now, the treatment system as a whole is divided between the *hope* that homeless and at-risk persons with substance abuse disorders can be outreached, engaged, and persuaded to accept treatment and become contributing members of society, and the *skepticism* that any program approach can

help these individuals before they hit bottom and reach the point of solid motivation for treatment. Then, the outreach team confronted a mental health system that was hostile to the team's clientele; but the team discovered its capacity to effect change and greater integration of services from the bottom up, pushing the local system of care to accept their clients through advocacy and education (Rowe, Hoge, & Fisk, 1998). Now, the Outreach Project finds a local system of care divided between mental health and substance abuse service camps that are slowly and uncertainly moving toward integration. We anticipate that current efforts at the service level and systems level will lead to acceptance of this new target population as part of service-as-usual, as is now the case for homeless persons with mental illness. However, we also recognize that outreach team efforts, here and elsewhere, must be accompanied by local and statewide systems initiatives. Such initiatives include the need for extensive staff training in substance abuse outreach, assessment, and increased availability of detoxification and sober-housing services. They include support for individuals' return to competitive employment as a reason for entering and staying in treatment rather than the end goal of recovery, and social integration efforts to help individuals with substance use disorders establish, or re-establish, productive ties to the community that they lost due, in part, to their disorders. Finally, they include systems of care in which people can gain access to, and receive, the services most appropriate to their phase of recovery.

CONCLUSION

Assertive outreach is a proven intervention for homeless persons with mental illness and dual diagnosis, and its extension to homeless persons with substance abuse disorders seems both a reasonable and humane project for local communities and systems of care. Outreach teams can serve an essential function as points of entry into local systems of treatment and rehabilitation, and as integrating mechanisms to bridge gaps in those systems. Problems of training and provision of adequate resources must be addressed, and some differences in client characteristics and treatment trajectories must be taken into consideration. Ultimately, this transition represents a challenge that appears no greater to us than that involved in addressing the unmet needs of mentally ill homeless persons; but it is one, like work with that population, which requires as much political will as it does training and program modification.

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