

Outreach and Engagement in Homeless Services: A Review of the Literature

Jeffrey Olivet^{*1}, Ellen Bassuk^{1,2,3}, Emily Elstad¹, Rachael Kenney¹ and Lauren Jassil¹

¹Center for Social Innovation, 200 Reservoir Street, Suite 202, Needham, MA 02494, USA

²The National Center on Family Homelessness, 181 Wells Avenue, Newton, MA 02459, USA

³Department of Psychiatry, Harvard Medical School, USA

Abstract: Outreach and engagement are regarded by many who work in homeless programs as essential services. Outreach on the streets and in shelters is often the first point of contact for people who are not served by traditional site-based services and is often the first step in engaging homeless people in services. While outreach and engagement are critical components of the response to homelessness, consensus is lacking about the nature and effectiveness of these services. The purpose of this paper is to examine what is known about outreach and engagement for people experiencing homelessness. The authors review quantitative studies that examine outcomes and augment this understanding with information from qualitative studies and non-research literature. The latter provides information about the goals of outreach, assumptions and values, staffing issues, and consumer involvement. The paper concludes with implications for practice, policy, and research.

Keywords: Homeless/homelessness, outreach, engagement, review.

INTRODUCTION

At a recent discussion among outreach workers in Washington, DC, one participant described the reasons for providing outreach to people experiencing homelessness: "Waiting for people to come to us didn't work...so what we're doing is going to where people are comfortable, to where they are right now, because that's probably most effective." This description highlights three essential aspects of outreach. First, outreach and engagement means "going to where people are," rather than waiting for them to seek services at a specific place. Second, traditional approaches to site-based social services may not be accessible for people who are marginalized, such as homeless individuals and families. Finally, workers provide outreach because it is "probably most effective."

Homeless service providers, advocates, and consumers have viewed the process of outreach and engagement as critical components of homeless service delivery. Yet outcomes-based quantitative research demonstrating the effectiveness of outreach is limited. Outreach workers are then left with the belief and hope that what they are doing is effective.

The purpose of this paper is to examine what is currently known about outreach and engagement for people experiencing homelessness. We reviewed the quantitative studies on outreach and engagement and supplemented this review by examining qualitative research as well as colloquial literature that includes case studies, manuals, training curricula, and other descriptive literature. This approach of including qualitative, quantitative, and

colloquial literature builds on the work of the Canadian Health Services Research Foundation [1]. It provides a more complete understanding of issues such as definitions, key ingredients, and outcomes of outreach and engagement. This information can then guide service providers, policy makers, and researchers.

METHODS

We used the search terms "homeless" or "homelessness," and "outreach" or "engagement," to comprehensively search the following databases: MEDLINE, PsycINFO, Psyc EXTRA, and SAMHSA's Homelessness Resource Center knowledgebase. The team of authors also conducted web searches using Google and Google Scholar utilizing the same search terms. To ensure nothing was missed, we also used outreach bibliographies developed by the Health Care for the Homeless Information Resource Center and the National Resource Center on Homelessness and Mental Illness. This search process identified 202 articles.

Through a review of titles and abstracts, we applied the following inclusion criteria:

1. Outreach/Engagement must be the primary focus of the article.
2. The principle population served must be homeless.
3. The article must be published within the past 15 years.
4. The article must be print literature. Presentations, video, and other media are excluded.

These criteria yielded the following:

- Quantitative studies (including mixed methods) n=19
- Qualitative studies n=6
- Colloquial literature n=41

*Address correspondence to this author at the Center for Social Innovation, 200 Reservoir Street, Suite 202, Needham, MA 02494, USA; Tel: 617-467-6014; Fax: 617-467-6015; E-mail: jolivet@center4si.com

Sixty-six articles were included in this review. Other articles identified in the initial search were excluded primarily because either the practice of outreach and engagement or the homeless population was not the primary focus of the study.

We then reviewed each of these bodies of literature to extract outcomes from the quantitative literature, key insights from qualitative research, and common themes from the colloquial literature. These findings are described below.

FINDINGS

Review of the literature suggests that although there is a lack of generalizable outcomes-based quantitative research supporting the effectiveness of outreach and engagement, much is known about the practice. Quantitative research focuses on what specific interventions work for specific population (e.g., people who are homeless and have mental health or substance use problems) to achieve specific outcomes (e.g., improved health, decrease in psychiatric hospitalization, improved housing status). Several qualitative studies explore consumer satisfaction and describe the experience of consumer/peer outreach workers, while others address public attitudes towards homeless individuals. Finally, the colloquial literature synthesizes a vast body of clinical knowledge and experience, providing context for the research findings and offering practical guidance on staffing, safety, and ethics.

Defining the Terms

There is no common agreement in the literature about how to define outreach. When people use the term “outreach,” they mean many things. For some, outreach can mean “going out” into the waiting room of a shelter or clinic. For others, outreach takes place on the streets, in camps, and in abandoned buildings. Outreach can mean efforts to educate the community about available services or it can be a place where other services are offered (e.g., “I see this person *on outreach* and provide intensive case management”). Many view outreach as a service in itself—a process of building a personal connection that may play a role in helping a person improve his or her housing, health status, or social support network.

The term “engagement” is equally problematic. Engagement is most commonly used in one of two ways: 1) engagement in services, or 2) the process of building a trusting relationship. The former is more easily quantified: someone who has been contacted through outreach participates in an intake process and is assigned a case manager, psychiatrist, counselor, or medical provider. She is “engaged” in services. Relationship-building is more difficult to describe and evaluate. Engagement involves creativity, flexibility, may take months or years, and involves establishing a relationship [2].

Outreach and engagement refer to a variety of activities driven by different goals. Table 1 demonstrates the range of definitions that exist for outreach and engagement.

Outcomes

While there are limitations to the research on outreach and engagement to people experiencing homelessness, the results suggest that outreach improves housing and health

outcomes for various subgroups of homeless persons. As Table 2 demonstrates, the sample sizes tend to be small and generally refer to specific subgroups. It is therefore difficult to generalize the findings to other populations in different outreach settings. Recognizing these limitations, the research literature suggests various positive outcomes associated with homeless outreach programs.

In reviewing these studies, several limitations must be borne in mind:

1. The majority of research studies on homeless outreach (74% of those reviewed in this paper) are quasi-experimental in design. There are no randomized controlled studies in the literature to date.
2. Most research focuses on people with mental health and/or substance use problems. Among studies reviewed for this paper, populations studied include (percentages equal >100% because some studies include more than one subpopulation):
 - 63% homeless individuals with mental health problems
 - 21% people with substance use disorders
 - 16% both substance use and mental health problems
 - 16% single adults (with no behavioral health issues specified in the study, although many individuals in the samples may have mental health and substance use issues)
 - 11% homeless veterans
 - 8% HIV+ individuals
 - 5% homeless children and their families (1 study)
3. The voice of consumers is significantly represented in the research, but is often limited to consumer satisfaction surveys. Of the 25 quantitative and qualitative studies reviewed, 12 (48%) included some consumer perspective.
4. Cultural and linguistic competence is not adequately addressed in the research. Although racial and ethnic demographic data is described in 11 (44%) of the 25 studies, cultural and linguistic competence is not addressed explicitly in any of the studies.

Although the quantitative literature tends to be quasi-experimental and focused primarily on single adults with mental health and substance use issues, the findings suggest that outreach is effective in supporting access to stable housing and reducing medical and mental health symptoms. However, the literature under-represents various subgroups of homeless people such as families and youth, tend to use small samples in specific settings, and lack control groups. Thus, the outcomes may not be generalizable.

Qualitative Studies

Findings from outcomes-based research are augmented by a small body of qualitative research that gives texture and depth to our understanding of outreach and engagement.

Table 1. Definitions of Outreach and Engagement

Definition	Source
“Outreach can be broadly defined as sending social services or health delivery personnel away from a facility into the arena where people live or congregate” (27-28).	Able-Peterson & Bucy [3]
Engagement is crucial: “It is described as the process by which a trusting relationship between worker and client is established” (2). Engagement provides context for assessing needs, defining service goals, and agreeing on a plan for delivering these services. The main goals of outreach are to care for immediate needs, develop trusting relationships, and connect clients to mainstream services.	Erickson & Page [4]
Engagement involves linking individuals to services and outreach is helping consumers develop a sense of personal control.	Jones & Scannell [5]
“Outreach seeks to establish a personal connection that provides the spark for the journey back to a vital and dignified life” (10).	Bassuk [6]
Outreach workers “identify persons in need and enter into some relation with them” (8); “find and link”; “find and serve” (8-10).	Wasmer [7]
“The overarching goal of outreach is to help break the bonds imposed by homelessness. Outreach, at its best, helps people move toward a life of greater health and personal stability. In so doing, they are able to discover more fully their own sense of identity and purpose, find meaningful work and activity, and establish a sense of place and belonging in the larger community” (1).	Kraybill [8]
“Outreach is the entryway to services and safety that otherwise might not be available for some homeless people. It serves as the crucial link between the streets and HCH services” (174).	McMurray-Avila [9]
“A successful engagement program helps the clients to view the treatment facility as an important resource” (18). Engagement means getting people to participate in services.	Sacks, Skinner, Sacks, & Peck [10]
The goal of outreach is to create and maintain rapport and trust. The goal is to eventually engage individuals in services. Outreach can be a treatment modality for engagement in services; engagement can mean enrollment in services.	Ng & McQuiston [11]
“Engagement in the context of Safe Havens refers to establishing interest and encouraging involvement” (40).	NRCHMI [12]
“The mission of outreach is to engage the individual who is literally homeless—living on the streets, in parks, transportation terminals, and other public places—and to encourage acceptance of a referral for the next service” (12).	Tsemberis & Elfenbein [13]
Outreach is “a service that increases the access of a homeless mentally ill individual to other needed treatments and services.” This definition, however, narrows the concept to a particular function, namely referral/linkage/liaison. However, in practice, outreach programs “typically provide a number of services beyond this function, although they do vary in the specific types of services provided” (262).	Morse <i>et al.</i> [14]
“When we use the term <i>outreach</i> , don’t only think about teams of people hitting the street with backpacks full of supplies or driving around in mobile health clinics pulling up in parking lots. Picture also “working the waiting room or the floor of the shelter,” seeking ways to connect with people, recognize their needs, and lay the foundation for healing. Likewise, <i>engagement</i> should not be viewed as a technical concept for use only by those who have clinical training. It is what we all do when we meet people where they are and offer them some support, solutions, or kindness that help in that moment” (143). Outreach is “... contact with any individual who would otherwise be ignored (or underserved)... in non-traditional settings for the purpose of improving their mental health, health, or social functioning or increasing their human service and resource utilization” (148, adapted from [14]).	Kraybill & Olivet [15]
“Outreach services generally take one of two approaches. Traditionally, these emergency-based services offer food, material goods (blankets, clothing), and advice (i.e. counseling about housing, access to benefits), with outreach workers visiting homeless people on the streets [16, 17]. However, demand and harsh circumstances facing this population mean that outreach programs have also established bases where homeless people can go for assistance. Such facilities often provide meals (or groceries), shower and laundry facilities, clothing, and drop-in or advice services. Overall, outreach programs fulfill three main goals (a) they assist homeless people by providing food or other material needs, (b) they offer a point of contact for homeless people with mainstream society (i.e., social support), and (c) they provide assistance for those seeking housing tenancies” (170).	Christian & Abrams [18]
“Outreach and engagement are not easily accomplished. The HOP [Hostel Outreach Program] workers have developed good relationships with [shelter staff]...This is critical to the way service is ultimately perceived by the individuals who are referred. Contact with a client is generally initiated by the HOP workers and is continued on a regular basis. Instead of lengthy or intrusive intake interviews, client assessments are made over a lengthy period and include all aspects of the clients’ lives; during this time, the worker is also assisting with the clients’ basic survival problems. Thus, a trusting relationship is gradually developed. This engagement process can be slow and can entail frequent visits over a period of weeks or months. It requires a creative and flexible approach involving brief contacts that may have no other purpose than just being with the client in an attempt to get to know him or her” (609).	Goering <i>et al.</i> [2]

Although the body of qualitative literature on outreach and engagement is small (six in this review), these studies explore several important issues. For example, one study documents positive changes in public perception of

homelessness after nurse practitioner students have contact with people who are homeless, suggesting that one way to combat stigma and stereotypes is to provide students hands-on opportunities to work with people who are homeless [36].

Table 2. Key Findings from Quantitative Research on Outreach and Engagement

Authors	Title	Purpose of Study	Description of Intervention	Sample	Key Findings
Buhrich & Teesson [19]	Impact of a Psychiatric Outreach Service for Homeless Persons With Schizophrenia	To evaluate the impact of outreach services on hospitalization rates for homeless persons with schizophrenia	Regular weekly outreach clinics were established and assertive case management provided on site, including medication supervision, counseling about the management of mental illness, regular review of side effects and symptoms, and help in obtaining public assistance, employment, and public housing.	n=415 homeless men with schizophrenia Control group: n=91 individuals who did not attend outreach services	<ul style="list-style-type: none"> The psychiatric outreach service in the refuges (shelters) significantly reduced the rate and duration of psychiatric hospitalization among clients. In contrast, there was no change in this rate among those who were referred but those not to attend the clinics.
Bybee, Mowbray, & Cohen [20]	Short <i>Versus</i> Longer Term Effectiveness of an Outreach Program for the Homeless Mentally Ill	To examine results of 4-month and 12-month follow-up to determine short-term and longer-term effectiveness of homeless outreach	<p>The Mental Health Linkage intervention model aimed to house persons in independent residences of their choice in the community, provide them with support and assistance necessary to maintain a residence, and then transition them to ongoing community service systems.</p> <p>Outreach workers offered clients a variety of services; conducted a comprehensive assessment of functionality, housing preferences, and needs; assisted clients in obtaining temporary or permanent housing; provided mental health clinical service; and provided short term intensive case management (184).</p>	n=139 mentally ill homeless or potentially homeless persons No control group	<ul style="list-style-type: none"> 4 variables are significant predictors of residential outcomes at 12 months: recruitment source, project service duration, community mental health (CMH) service duration, and client age “The project achieved a relatively high success rate in engaging clients screened eligible for services”; 73% accepted some form of project assistance. At 12 months, more than half of the participants were in permanent independent settings—most living alone, some with relatives or with others. One quarter lived in supervised dependent settings The remainder were in treatment facilities or homeless or correctional settings Overall, 76% were not homeless at 4 months, 71% were not homeless at 12 months Intensity of service contact (hours of contact per month) showed no significant impact on the odds of any of the permanent housing settings at 12 month follow-up. Age has a significant impact on residential status, with older clients more likely to be in permanent housing settings at 12 months.

(Table 2) contd.....

Authors	Title	Purpose of Study	Description of Intervention	Sample	Key Findings
Bybee, Mowbray, & Cohen [21]	Evaluation of a Homeless Mentally Ill Outreach Program: Differential Short-Term Effects	To determine the impact of outreach services on housing status after 4 months	Mental Health Linkage intervention model was used; eligible clients offered a number of services, <i>in vivo</i> , by outreach workers: a comprehensive assessment of functionality, housing preferences and needs, assistance in obtaining temporary or permanent housing in independent settings (matched to needs and preferences), help in establishing income supports including payee services, training or rehab, mental health clinical services, and short-term intensive case-management.	n=163 homeless or near homeless mentally ill individuals No control group	<ul style="list-style-type: none"> • 3 variables were significant predictors of residential stability at 4 months: 1) recruitment source (shelter, psychiatric hospital, or community mental health agency); 2) client functioning; and 3) hours of service from the homeless project. “The latter finding suggests that project interventions contributed to positive changes in clients’ residences” (13). • Of the 163 individuals in the follow-up cohort, 81% had a permanent residence for some portion of the 4 months following intake • There is a relationship between recruitment source and housing outcomes—clients recruited from inpatient psychiatric settings were more likely than long-term CMH clients to be residing independently alone
Chen, Rosenheck, Kaspro, & Greenberg [22]	Receipt of disability through an outreach program for homeless veterans	To identify factors associated with receipt of VA pension and compensation benefits among homeless veterans after their initial contact with the VA national homeless outreach program	The Health Care for the Homeless (HCHV) program is a community outreach program that provides outreach by linking vets with VA health and benefit services, time-limited contract residential treatment in community-based halfway houses, and supported housing arrangements in either transitional or permanent apartments.	n=5,731 veterans with psychiatric and/or SA disorders who are not current patients at VA medical centers. Study participants were divided into 2 groups—those who received benefits and those who did not	<ul style="list-style-type: none"> • A limited number of veterans (15%) were subsequently awarded benefits (67% pension benefits, 33% compensation benefits) • Veterans who received benefits were more likely to have reported use of VA services and greater number of medical and psychiatric problems at the time of outreach • Vets who received benefits were more likely to have served during wartime and to have experienced hostile fire in combat. • Vets who had used the VA medical system for medical and/or psychiatric care in the past 6 months were more likely to receive benefits

(Table 2) contd.....

Authors	Title	Purpose of Study	Description of Intervention	Sample	Key Findings
Christian & Abrams [18]	A Tale of Two Cities: Predicting Homeless People's Uptake of Outreach Programs	“This research has two main aims. One aim was to assess the utility of the Theory of Planned Behavior (TPB) framework within the setting of service provision for the homeless...our second aim was to examine the relative weighting of each element of the TPB in different contexts” (171-172)	The research intervention interviewed homeless individuals then tracked their utilization of outreach services 4 weeks later.	Homeless people in New York (n=103) and London (n=100) Study compared the two groups	<ul style="list-style-type: none"> • “On average, participants had an unfavorable view towards outreach programs” (174) • “Sociodemographic characteristics were not significantly related to TPB variables of behavior” (174) • “Both attitudes and intentions were strongly correlated with behavior” (177) • “It was participants’ feelings about using services, and their sense that they had control over whether to make use of the services, that accounted for a large proportion of the variance in uptake behavior” (179) • In London intentions and behavior were most affected by perceived control and subjective norms. In NY they were most affected by perceived control and attitude.
Christian & Abrams [23]	The effects of social identification, norms and attitudes on use of outreach services	To examine how aspects of identity and the normative social framework are related to the uptake of outreach services by homeless people	Outreach services not clearly described	n=126 homeless individuals seeking housing and support assistance No control group	<ul style="list-style-type: none"> • The role of social identity and social norms is of central importance in understanding uptake of outreach services among homeless people • “For the theory of planned behavior our results offer mixed news...intention was affected by subjective norm and perceived control. However, participants’ evaluations of using the outreach services did not affect intention” (152) • “The present study also revealed the potentially substantial impact of homeless people’s attitudes to formal authority, consistent with the theorizing that those who use outreach services are likely to have a better articulated position (opposition) toward official institutional frameworks” (152)

(Table 2) contd.....

Authors	Title	Purpose of Study	Description of Intervention	Sample	Key Findings
<p>Dixon, Stewart, Krauss, Robbins, Hackman, & Lehman [24]</p>	<p>The Participation of Families of Homeless Persons with Severe Mental Illness in an Outreach Intervention</p>	<p>To describe how an Assertive Community Treatment (ACT) team which employs a family outreach worker (FOW) interacts with homeless persons with severe mental illness and their families</p>	<p>PACT model—outreach, crisis intervention, social work, nursing, substance abuse and psychiatric services in the community and at the hospital, and access to a family outreach worker. Family Outreach Worker worked with clients to contact family members, provide education and support regarding mental illness through telephone and face-to-face contact.</p>	<p>n=67 homeless and seriously mentally ill (SMI) No control group</p>	<ul style="list-style-type: none"> • 73% of clients had contact with their families • ACT worked with families of 61% of clients • ACT had less contact with families of men and substance users • Client days in stable housing were associated with increased ACT family contact • The work of the ACT team with families appeared to be associated with higher levels of satisfaction with family relations and housing • The role of the FOW should be explored further • Family contact was rated extremely or moderately important in 42% of cases • Mothers and siblings were the most frequent family member with contact • Number of days client spent in stable housing was significantly associated with staff ratings of increased family contact
<p>Fisk [25]</p>	<p>Assertive Outreach: An Effective Strategy for Engaging Homeless Persons with Substance Use Disorders into Treatment</p>	<p>To examine substance abuse treatment referrals that were made by outreach workers in a homeless outreach project (the Outreach and Engagement Project, New Haven, CT)</p>	<p>Intensive, community-based clinical case management and rehabilitation services</p>	<p>n=73 homeless persons who have been diagnosed with substance abuse, mental illness, or a combination of the two No control group</p>	<ul style="list-style-type: none"> • There was a statistically significant relationship between clients' motivation level and completed referral, and between referrals made and program acceptance • Of 73 clients who were referred to substance abuse treatment in a one-year period of time, 41% successfully entered treatment • "This study provides evidence that assertive outreach is effective in engaging and linking homeless persons with substance abuse disorders to substance abuse treatment services" (479)

(Table 2) contd.....

Authors	Title	Purpose of Study	Description of Intervention	Sample	Key Findings
Goering <i>et al.</i> [2]	Process and Outcome in a Hostel Outreach Program for Homeless Clients with Severe Mental Illness	To assess outcomes and their relationship to program elements	<p>“The Hostel Outreach Program (HOP) in Toronto is an assertive case management service for homeless mentally ill clients. It is linked with two men’s and four women’s hostels” (608)</p> <p>The intervention is described as proactive outreach & extended availability</p>	<p>n=55 homeless SMI</p> <p>No control group</p>	<ul style="list-style-type: none"> • The number of weeks clients spent in hostels decreased, as did transiency • Total and sub-scores for social functioning scale improved • Housing satisfaction improved • Total psychiatric symptoms decreased, as did anxiety and depression • The use of medical and psychiatric services was related to social functioning but not to symptom outcome • Stability in housing can be achieved by those with chronic histories of transiency and shelter use
Lam & Rosenheck [26]	Street Outreach for Homeless Persons with Serious Mental Illness: Is it Effective?	To examine case management clients who are homeless and have a severe mental illness to determine how those contacted through street outreach differ in their socio-demographic characteristics, service needs, and outcomes from those clients contacted in shelters and other health and social service agencies.	Street outreach is one phase of the ACCESS demonstration project. The other phase is case management. In the outreach phase, workers would initially meet basic needs and work on building a relationship, then over time, “the outreach worker and client worked toward a mutual agreement that the client would accept case management services” (895)	<p>n=11,857</p> <p>homeless persons with severe mental illness</p> <p>Study compares those contacted through street outreach and those contacted in shelters and other agencies</p>	<ul style="list-style-type: none"> • Clients contacted on the street, as opposed to being contacted in shelters and service agencies, were generally worse off. They were more likely to be male, to be older, to spend more nights literally homeless before the contact, to have psychotic disorders, and took longer to engage in case management. • These people expressed less interest in treatment and were less likely to enroll in the case management phase of the project. • Three month outcome data showed that enrolled clients contacted through street outreach showed improvement that was equivalent to those enrolled clients contacted in shelters and other service agencies on nearly all outcome measures.

(Table 2) contd.....

Authors	Title	Purpose of Study	Description of Intervention	Sample	Key Findings
Lyons, Cook, Ruth, Karver, & Slagg [27]	Service Delivery Using Consumer Staff in a Mobile Crisis Assessment Program	To investigate consumer service delivery in a mobile assessment program designed to assist homeless people with severe psychiatric disorders; to identify similarities and differences in the nature and amount of services delivered by consumer <i>versus</i> non-consumer staff	<p>“Mobile crisis assessment is a recently devised form of mental health service delivery intended to help persons with serious mental illness and problems of homelessness find linkage to needed services” (34)</p> <p>The Mobile Assessment Unit (MAU) has three basic forms of service delivery: 1) routine calls on shelters and other social service agencies, 2) emergency dispatches when someone calls requesting on-site crisis services, and 3) street outreach</p>	<p>n=9</p> <p>(4 consumer staff, 5 non-consumer staff)</p> <p>Consumer staff are homeless or formerly homeless mentally ill individuals</p> <p>Study compares the two staff groups</p>	<ul style="list-style-type: none"> • Consumer staff engaged in more street outreach and were less often dispatched for emergencies • There was a trend for consumer staff to be more likely to certify their clients for psychiatric hospitalization. • Consumer staff can be a valuable addition to a mobile assessment program • “Mobile assessment staff with personal consumer experience were more likely to do street outreach than were non-consumer staff. This is consistent with the hypothesis that consumer staff are more willing and better to engage mentally ill people on the street” (38)
McGuire, Rosenheck, & Kasproff [28]	Health Status, Service Use, and Costs Among Veterans Receiving Outreach Services in Jail or Community Settings	To compare client characteristics, service use, and health care costs of two groups of veterans who were contacted by outreach workers: a group of veterans who were contacted while incarcerated and a group who were contacted in community settings.	<p>Healthcare for Homeless Veterans (HCHV) program focuses on delivering three kinds of service: outreach and case management in community locations, linkage with medical and psychiatric services, and community contract residential rehab.</p> <p>Veterans were contacted on the street and in jail to do face-to-face interviews and assess characteristics and service use.</p> <p>Initial outreach contact in the jails was limited to assessment and planning for post-release community treatment—no formal VA services were delivered in the jail setting.</p>	<p>n= 8236</p> <p>Homeless veterans (1676 [jail] and 6560 [community settings])</p> <p>—one group contacted while incarcerated, the other group contacted in community settings. Both groups were mostly middle-aged men. The study compared the two groups.</p>	<ul style="list-style-type: none"> • Veterans who were contacted in jail obtained higher scores on several measures of social stability (marital status and homelessness status) but had higher rates of unemployment. • Vets in jail had fewer medical problems but higher levels of psychiatric and substance use problems, although the rate of current substance use was lower among these vets than among the community homeless vets. • One year service access for the jailed vets was half that of the community homeless vets • Total health expenditures for the vets who received outreach contact in jail were \$2,318 less, or 30% less than those who were contacted through community outreach.

(Table 2) contd.....

Authors	Title	Purpose of Study	Description of Intervention	Sample	Key Findings
Morris & Warnock [29]	Effectiveness of a Mobile Outreach and Crisis Services Unit in Reducing Psychiatric Symptoms in a Population of Homeless Persons with Severe Mental Illness	To use a time-lag design to evaluate the effectiveness of a mobile outreach and crisis services unit in remitting psychiatric symptomatology, improving global functioning, and decreasing homelessness	Mobile outreach and crisis services (MOCS) unit utilizing a Program for Assertive Community Treatment mode; "once located, individuals are provided individualized treatment targeted at utilizing available services to <i>meet all</i> aspects of client needs (housing, financial aid, medical care). The goal of the treatment team is to effectively outreach, stabilize, rehabilitate and assimilate into community support those individuals unable to do so without assertive intervention" (343)	n=50 SMI homeless 25 before receiving services (pretreatment or control group), 25 after receiving service (post-treatment or experimental group)	<ul style="list-style-type: none"> • "A mobile outreach and crisis services (MOCS) unit utilizing a Program for Assertive Community Treatment mode was effective in significantly decreasing psychiatric symptomatology, reducing homelessness, and increasing global functioning" (343) • Subjects in the post-treatment group manifested significantly lower levels of psychiatric symptomatology and displayed higher levels of global functioning. • Subjects in the post-treatment group reported significant reductions in instances of homelessness and significantly fewer days homeless in the past six months than pretreatment group
Nuttbrock, Rosenblum, Magura, & McQuiston [30]	Broadening Perspectives on Mobile Medical Outreach to Homeless People	To describe a tension between an emergency medicine model of outreach and that of primary care	Mobile medical outreach based on two differing approaches—the emergency medical (EM) model and the primary care model (comprehensive outreach/treatment or COT)	n=1042 homeless adults	<ul style="list-style-type: none"> • People have varying reasons for visiting the medical van, with less than half presenting acute symptoms: 44% sought evaluation and/or medical treatment for an acute condition; 20% sought a preventive checkup or medications; 18% sought help for a chronic medical condition; and only a few sought help for non-medical reasons, trauma, or psychiatric or substance use issues • Almost all the van clients reported physical symptoms during the past 30 days • A significant minority (40%) experienced some type of physical trauma (e.g. broken bone, cut or wound), although only 2 clients were seeking help for trauma. • Almost all of the van clients would be found positive for substance use if evaluated diagnostically, and the majority suffer from depressive or psychotic symptomatology • More than one fifth of the van clients were HIV positive • There are high degrees of comorbidity of medical and behavioral health problems in the population served by the van

(Table 2) contd.....

Authors	Title	Purpose of Study	Description of Intervention	Sample	Key Findings
Park, Tyrer, Elsworth, Fox, Ukoumunne, & MacDonald [31]	The Measurement of Engagement in the Homeless Mentally Ill: the Homeless Engagement and Acceptance Scale (HEAS)	To produce a concise instrument which could be utilized for all categories of clients who are homeless and mentally ill to measure the individual's degree of engagement with others and their attitude toward interventions.	Staff from "an established program for the homeless mentally ill helped to identify relevant questions used to develop a five-item rating scale." The practice intervention is not clearly described.	Homeless mentally ill n=21 pilot group n=72 existing case group n=40 new case group	<ul style="list-style-type: none"> HEAS score was shown to be a significant predictor of accommodation status and adequacy of support network at 12 months HEAS is "likely to be a useful tool in assessing engagement status" (855)
Rosenblum, Nuttbrock, McQuiston, Magura, & Joseph [32]	Medical Outreach to Homeless Substance Users in New York City: Preliminary Results	To conduct a medical, drug user treatment and social needs assessment survey, and to conduct a process and outcome evaluation of the mobile medical outreach clinic with the addition of intensive case management (ICM) as an experimental enhancement	"An innovative, experimental, medical outreach initiative, using a fully-equipped mobile medical van"	n=250 "Mostly male, minority group, high-level, homeless NYC substance abusers with infectious disease" Control group self-referred to social worker for services. Experimental group received ICM	<ul style="list-style-type: none"> Both groups saw reductions in drug use, homelessness and health complaints Experimental group experienced increased rates of subjects receiving public benefits and decreased number of emergency room visits ICM clients compared to controls had more contacts with the social worker, and received and completed more referrals. Four-month outcomes show that all study subjects, regardless of condition, reported past 30 day reductions in crack use, days homeless, and number of health complaints
Tischler, Vostanis, Bellerby, Cummella [33]	Evaluation of a Mental Health Outreach Service for Homeless Families	To describe the characteristics of homeless children and families seen by the mental health outreach service (MHOS), to evaluate the impact of this service on the short term psychosocial functioning of children and parents, and to establish perceptions of and satisfaction with the service	Assessment and brief treatment of mental health disorders in children; liaison between agencies; and training of homeless centre staff	Homeless children ages 3-16 years with mental health problems and their families Experimental group (n=23), Control group (n=31) 27 children from 23 families who received MHOS and 49 children from 31 families in control group	<ul style="list-style-type: none"> Children in the experimental group had a significantly higher decrease in total scores on a questionnaire. Having received the intervention was the strongest predictor of improvement in SDQ total scores. There was no significant impact on parental mental health scores Families and staff expressed high satisfaction with the MHOS

(Table 2) contd.....

Authors	Title	Purpose of Study	Description of Intervention	Sample	Key Findings
Tommasello, Myers, Gillis, Treherne, & Plumhoff [34]	Effectiveness of Outreach to Homeless Substance Abusers	To describe a substance abuse treatment program conducted by a medical care provider for homeless persons in Baltimore and compare characteristics of recipients to those of walk-in clients; and to examine the differences in drug abuse pathology and selected treatment outcomes among homeless and non-homeless clients	Outreach teams formed based on the indigenous leader model. Two outreach teams sought out clients during the day and two evenings per week, providing outreach to streets, shelters, and soup kitchens with the purpose of engaging clients in substance abuse treatment	Homeless street dwelling substance users n=4428 outreach clients Control group: n=4380 walk-in clients	<ul style="list-style-type: none"> Homeless persons demonstrate a shorter length of stay in non-residential substance abuse treatment than non-homeless individuals Composite scores on Addiction Severity Index for homeless individuals are significantly higher (reflecting more serious problems) on every measure as compared with non-homeless individuals Outreach clients reported significantly higher levels of substance abuse than walk-in clients 42.3% of outreach contacts became service recipients “Our findings indicate that outreach can be a successful method of targeting and engaging a segment of homeless substance abusers who are otherwise difficult to engage in treatment” (295) Homeless patients are dramatically undercounted by state substance abuse data collection systems
Tommasello, Gillis, Lawler, & Bujak [35]	Characteristics of Homeless HIV-Positive Outreach Responders in Urban US and Their Success in Primary Care Treatment	To describe characteristics of homeless HIV+ substance users who responded to outreach and enrolled in integrated treatment services and to describe street outreach methods undertaken to bring this population into treatment	“The intensive outreach component was based on the indigenous leader model to engage individuals, build relationships with them, and, when necessary, provide personal items such as food and blankets to meet immediate needs. The teams also assessed for HIV risks, mental illness, and substance use disorders in the outreach environment. Referrals to Health Care for the Homeless (HCH) and/or other community resources were made as appropriate” (912)	N=110 urban homeless HIV+ persons with persistent mental illness and substance abuse No control group	<ul style="list-style-type: none"> 47% of all those contacted through outreach visited the clinic 25% reported an unmet need for drug treatment at baseline The sample improved on 6 of 8 measures. Three of these were statistically significant: general health, mental health, and vitality Improvements were seen in all mental health and substance use symptom clusters---depression, psychosis, drug abuse, recent drug use, and PTSD 85% of subjects interviewed at 12 months had at least one clinical contact at HCH during the study period Clients who visited the clinic less than 10 times during the study declined on most measures Clients who visited the clinic 10-29 times during the study showed improvement in general health, physical functioning, and physical role High utilizers (30+ visits) showed the largest gains on mental health and vitality scores Over the service period, the self-reported need for services declined in every area Respondents reported heavy street drug use and unmet service needs particularly for housing and financial assistance

Another study offers insight into the practice of hiring consumers as outreach workers [37]. Critical issues in hiring consumer staff members include:

- disclosure of disability status;
- client-staff boundaries; and
- workplace discrimination [37].

Kryda and Compton [38] support the findings of Fisk *et al.* [37], also suggesting the importance of hiring homeless or formerly homeless individuals as outreach workers. The authors of this study also explore why some individuals who are homeless refuse services, even when outreach workers go out on the streets to where they are living. The authors report a pervasive lack of trust and lack of confidence in traditional services and conclude that outreach may increase people's trust and confidence. Strategies include: "using an empathetic listening approach, minimizing stereotyping, providing greater choices, and employing formerly homeless people as outreach workers."

Two qualitative studies examine outreach programs for people living with HIV/AIDS who are homeless or at risk of homelessness [39, 40]. Cameron *et al.* found that people accessing outreach services valued the flexibility of outreach workers. The study also found that the role of the outreach worker incorporates two roles—networker/navigator and advocate. Both are "important in determining the effectiveness of the service."

Finally, people receiving outreach services identify being treated respectfully and feeling valued as the most important aspect of these services [40]. This finding emphasizes that it is not simply *what* is being offered, but also *how* it is being offered.

Table 3 demonstrates key findings from the qualitative research on outreach and engagement.

Colloquial Literature

The quantitative and qualitative research is supplemented by a large body of colloquial literature that explores characteristics of effective outreach workers, describes the importance of relationship building, and demonstrates that outreach and engagement is a process requiring creativity and flexibility. This body of literature includes manuals, descriptive essays, outreach handbooks, training curricula, and non-research articles. This literature describes how to conduct outreach. It addresses questions of ethical boundaries, personal safety, and self-care for outreach workers. It also provides the context for why outreach, engagement, and the process of building trust are critical to the success of homeless programs and to the lives of homeless individuals.

This literature explores key ingredients of outreach that are not clearly defined in the research literature. Several articles, for example, describe the relationship between outreach worker and individuals who are homeless as the foundation for the process of outreach and engagement [6, 11, 14, 15]—a relationship not easily quantified in research methodologies. Several sources describe outreach and engagement as a process rather than an outcome [9, 42, 43]. Additionally, other authors address the importance of teams

as opposed to individual clinicians in providing outreach services [13, 43-45]. Rowe *et al.* describe "the outreach team, as a repository of the staff's collective wisdom and values, supports the workers' passion and moral imperative... and channels their enthusiasm into an emerging "best practice" model of clinical care for this population" [44]. Finally, similar to several of the qualitative studies described above, the colloquial literature focuses on consumer involvement in outreach [4, 13, 45]. Erickson and Page state that "the benefits of such peer models [of outreach and engagement] allow for effective outreach, sharing of their personal expertise, fostering of partnerships between consumers and non-consumers, increased self-esteem of the working peers, and the evolution of consumers becoming active in changing services throughout the country" [4]. Table 4 summarizes this literature.

DISCUSSION

Our review of the literature on outreach and engagement indicates that although there is no single definition of outreach, experts agree that outreach is a process designed to contact individuals in non-traditional settings who might otherwise be ignored or underserved. Its purpose is to improve physical and mental health and social functioning, increase use of human services, and re-integrate people into the community [4, 14, 15]. The outcome-based quantitative literature suggests that outreach is effective for improving various housing and health outcomes, although almost three-quarters of the quantitative studies were focused on homeless individuals with mental health and substance use issues.

Outreach programs are designed to "meet people where they are" [46], both geographically and emotionally. This means not only contacting people in non-traditional settings, but also meeting their need for connection, reassurance, and support through empathic listening, minimizing stereotyping, and providing greater choices [38]. Various authors also emphasized the importance of addressing basic needs to ensure the survival of individuals living on the streets [9, 46]. Others discussed the salutary effect of employing formerly homeless people as outreach workers [4, 37, 38, 45].

Although outreach and engagement are coupled in the literature, their relationship has not been fully explored. Outreach refers to the overall process of contacting people wherever they are [6, 9, 46], while engagement refers to the process of establishing rapport and forming a trusting relationship that provides the context for assessing needs, defining service goals, agreeing on a plan and linking people with services [4].

For engagement to occur, outreach workers must attempt to establish a relationship with people who are often mistrustful of service providers and reluctant to make contact. In *Crossing the Border: Encounters Between Homeless People and Outreach Workers* [49], Rowe explored the importance of relationship in the process of outreach, suggesting that people who are homeless often experience a "pervasive sense of negativity and alienation" [49]. "[Outreach workers] believe," Rowe concluded, "that connection with a caring human being, not tangible resources alone, is necessary to pull people out of a sea of

Table 3. Key Findings from Qualitative Research on Outreach and Engagement

Author	Title	Purpose of Study	Description of Intervention	Population Served	Key Findings
Cameron, Lloyd, Turner, and Macdonald [39]	Working across boundaries to improve health outcomes: a case study of a housing support and outreach service for homeless people living with HIV	To report the findings of an evaluation of an 'Housing Support, Outreach and Referral' service developed to support people living with HIV who were homeless or at risk of homelessness	The service was set up as part of the Supporting People Health Pilot programme established to demonstrate the policy links between housing support services and health and social care services by encouraging the development of integrated services.	People living with HIV who were homeless or at risk of homelessness	<ul style="list-style-type: none"> ○ Those using services placed most emphasis on the flexibility of the support worker role. ○ The role of support worker incorporates two dimensions <ol style="list-style-type: none"> 1. networker/navigator 2. advocate ○ Both dimensions are important in determining the effectiveness of the service
Cavacuiti and Svoboda [41]	The use of electronic medical records for homeless outreach	To assess the features of Electronic Medical Records (EMRs) used by North American homeless outreach organizations	Twenty-eight homeless outreach agencies throughout North America were contacted. Nine used EMRs for homeless outreach. Service providers from these nine agencies were interviewed to learn more about their EMRs.	People contacted on homeless outreach	<ul style="list-style-type: none"> ○ Two of the most frequently cited essential features were: <ol style="list-style-type: none"> 1. ability of different sites and providers to access medical information; and 2. capacity to collect client data such as numbers of clients served, services provided, and outcomes ○ EMR available at multiple locations to multiple providers is a powerful tool with the potential to improve the coordination, safety, efficiency, and quality of care to people who are homeless
Daiski [40]	The Health Bus: Healthcare for Marginalized Populations	To evaluate program effectiveness, and to identify unmet needs and areas for improvement	Health outreach with mobile bus; staff gives out toiletries, clothing, vitamins, condoms, clean needles, medications	People with HIV/AIDS, people living on the street	<ul style="list-style-type: none"> ○ Most important for client to feel valued, be provided services but also treated respectfully ○ Clients wanted: mental health services, addiction counseling, preferential treatment for people with serious illness, facilitating transportation to referrals, client involvement in running the Bus, longer hours, more publicity
De La Cruz, Brehm, & Harris [36]	Transformation in Family Nurse Practitioner Students' Attitudes Toward Homeless Individuals After Participation in a Homeless Outreach Clinic	To determine attitudes of family nurse practitioner students towards homeless individuals before and after participation in a homeless outreach clinic	FNP students participated in homeless outreach clinic conducting episodic health assessment and implementing nursing, medical, educational, and supportive therapies, in addition to referring homeless patients to a nearby community health center and other community agencies and resources for follow-up care.	FNP students	<ul style="list-style-type: none"> ○ Significant positive change in attitudes towards homeless individuals after participation in the outreach clinic ○ Compassion fatigue can be a problem in the general American public ○ Attitudes are significant predictors of behavior
Fisk, Rowe, Brook, and Gildersleeve [37]	Integrating Consumer Staff Members into a Homeless Outreach Project: Critical Issues and Strategies	To describe the experiences of consumer staff members and to propose strategies to ease the integration of consumer staff members into their work positions	The intervention is hiring consumers as outreach workers. Outreach team visits community sites to identify potential clients and introduce these people to a range of clinical and support services that include mental health and substance abuse services, case mgt, medical care, housing support, vocational rehab assessment and support	Consumers of homeless services who are now staff members	<ul style="list-style-type: none"> ○ Critical issues in hiring consumer staff members are: <ol style="list-style-type: none"> 1. disclosure of disability status 2. client-staff boundaries 3. workplace discrimination

(Table 3) contd.....

Author	Title	Purpose of Study	Description of Intervention	Population Served	Key Findings
Kryda and Compton [38]	Mistrust of Outreach Workers and Lack of Confidence in Available Services Among Individuals who are Chronically Street Homeless.	To explore how individuals who are homeless perceive outreach practices and available services	Interviews conducted with 24 individuals who had been homeless for longer than one year	Individuals currently living on the streets of midtown Manhattan	<ul style="list-style-type: none"> ○ Reasons why these individuals refuse services include a pervasive mistrust of outreach workers and the agencies that employ them, as well as a prominent lack of confidence in available services. ○ The findings suggest a need for an approach to outreach that incorporates giving individualized attention from outreach workers, using an empathetic listening approach, minimizing stereotyping, providing greater choices, and employing formerly homeless people as outreach workers.

negativity” [49]. These conclusions have been echoed throughout the literature. Bassuk [6], for example, described “a personal connection that provides the spark for the journey back to a vital and dignified life” [6]. Outreach and engagement, then, do not simply involve providing concrete resources or improving housing status or physical and mental well-being. They also focus on helping people find dignity, hope, and reconnection with others. The human connection between outreach worker and client is the linchpin of this process.

To meet the difficult challenge of engaging homeless clients, outreach workers must be flexible, empathetic, respectful, non-judgmental, committed, and persistent [13, 15]. Strong outreach workers also must have specialized knowledge of the issues facing the people they serve, availability of services, and systems of care such as housing, medical, mental health, and substance use treatment [9].

Because outreach involves work in non-traditional settings with people who may have complex needs, the risk of staff burnout is high. Additionally, outreach workers face many challenges related to safety, ethics, and boundaries. For example, they may witness the sale of drugs or sex, be exposed to potentially violent situations, or be asked for money, cigarettes, or a ride. While agency policies may address some of these dilemmas, outreach workers constantly make judgment calls about balancing their own safety and ethics with client needs. Various authors suggested that outreach teams were a good strategy for addressing these challenges [24, 34, 44]. Teams can ensure quality of services by bringing additional skills to the process, such as primary health care expertise, skills in working with people experiencing mental illness or addiction, and knowledge about community resources. Teams also have the potential to provide outreach workers emotional support and mentoring, thus preventing burnout.

Various authors also emphasized the importance of employing people who are currently and formerly homeless as outreach workers [4, 37, 38, 45]. Kryda and Compton [38] reported that people who have been homeless for more than one year tended to be mistrustful of outreach workers and the agencies that employed them. The authors argued that one way to increase trust, and therefore people’s willingness to

access services, is to utilize formerly homeless individuals as outreach workers.

To provide high quality outreach and engagement services, outreach workers could benefit from training and technical assistance on topics such as staff self-care, teamwork, boundaries and ethics, and personal safety. Other topics mentioned in the literature include relationship-building skills, motivational interviewing, cultural competence, effective referral and linkages, basic medical care, conflict de-escalation, and strategies for supporting consumer-providers [8, 15].

In addition to the need to train staff and organizations, the literature suggested other strategies for improving practice. Outreach programs should:

- Consider using handheld smart phones to access electronic records. This might improve coordination of services and prevent duplication of efforts [41];
- Utilize consumers as outreach workers; and
- Train and orient new outreach workers to understand the central importance of relationship building.

At the policy level, Federal, state, and local leaders can integrate outreach into their services and programs. Strategies might include:

1. Incorporate outreach and engagement in community and state-level plans to end homelessness.
2. Facilitate eligibility for Medicaid reimbursement for outreach services.
3. Develop dedicated Federal, state, or local funding streams for outreach services linked to rapid rehousing and housing first programs.
4. Build outreach activities into programs for people with mental illness, addictions, and co-occurring disorders.

Although the body of research about outreach and engagement has grown, various questions remain unanswered. Future directions for research in this area might include:

Table 4. Information from the Colloquial Literature on Outreach and Engagement

What the Literature Tells Us	Source
Outreach is a process rather than an outcome	McMurray-Avila [9]
“Outreach seeks to establish a personal connection that provides the spark for the journey back to a vital and dignified life” (10-3)	Bassuk [6]
“The homeless persons outreach is designed for those who are unserved or underserved by existing agencies and who aren’t able or willing to seek services from those agencies” (1)	Erickson & Page[4]
“Interventions need to take place where the person lives: in a doorway, park, under a bridge or in a train station” (10-3)	Bassuk [6]
It is important to meet basic needs such as food, clothing, emergency shelter and housing”	Fisk <i>et al.</i> [46]
“Engagement is continual and does not end when the individual accepts some type of formalized service” (30)	Anchorage [47]
“The time period during which engagement occurs must be fluid. It is probably best to think of it as a continuing process as staff and residents interact” (40)	NRCHMI [12]
“The outreach process focuses on creating and maintaining rapport and trust. The goal is eventually to engage individuals in necessary services” (95)	Ng & McQuiston [11]
“Outreach can be more than just a first step when the outreach efforts also offer immediate access to permanent housing and other necessary services; it can then be a transforming step in the individual’s search for a better way to live” (17)	Tsemberis & Elfenbein [13]
It is important to “meet clients where they are, both geographically and existentially” (223)	Fisk <i>et al.</i> [46]
“The outreach team aims to build a relationship in which even the most fragile and disaffiliated homeless persons may feel trust and respect from the team members” (142)	Cohen [43]
“The therapeutic connection does not happen accidentally. It only happens through a commitment to effective, compassionate communication” (141)	Kraybill & Olivet [15]
“The relationship that the outreach worker forms with the person living on the street provides the foundation for the intervention. Only within the context of a trusting relationship can help be successfully provided and accepted” (10-8)	Bassuk [6]
“A painstaking process of building a bond of trust with human beings who are profoundly distrusting. Such a relationship is, of course, the necessary foundation upon which all other outreach activities are based”	Kraybill [8]
“The most critical ingredient in providing such help is not resource brokering or even advocacy, but the establishment and maintenance of a trusting and meaningful relationship between outreach worker and client. This ongoing relationship is often necessary to gain a client’s cooperation and participation in seeking needed social resources (income assistance, housing, etc.) and psychiatric services; it is also a therapeutic instrument that allows the client to develop a healthier self image and better interpersonal relationships” (263)	Morse [14]
“The work is extremely labor intensive, often involving two or more staff members’ spending entire days with one individual. The teams must be flexibly designed to provide those services that a particular group or individual is missing” (142)	Cohen [43]
“The outreach team, as a repository of the staff’s collective wisdom and values, supports the workers’ passion and moral imperative... and channels their enthusiasm into an emerging “best practice” model of clinical care for this population” (492)	Rowe <i>et al.</i> [44]
“Successful outreach teams are flexible, tolerant, persistent, and highly creative in their use of engagement strategies” (17)	Tsemberis & Elfenbein [13]
“Outreach and engagement are the first steps involved in connecting with street homeless people, bringing them off the streets, and linking them with other portions of the service system.” (20)	Burt <i>et al.</i> [48]
“Some of the best teams include homeless persons as team members or adjuncts. They tend to be more knowledgeable about the social context and to be perceived as less threatening than other staff” (129)	Susser <i>et al.</i> [45]
Outreach programs are successful when they use consumers as outreach workers. “The benefits of such peer models allow for effective outreach, sharing of their personal expertise, fostering of partnerships between consumers and non-consumers, increased self-esteem of the working peers, and the evolution of consumers becoming active in changing services throughout the country” (6)	Erickson & Page [4]
“Ultimately, the goal is to successfully phase or integrate persons into the community and/or into a social service agency which would assume the task of promoting community integration. Just as clients are phased into outreach services from the streets, they are phased into the community from outreach” (7)	Erickson & Page [4]

- Exploring the feasibility and ethics of conducting randomized controlled trials.
- Designing studies with larger sample sizes to improve the generalizability of the findings.
- Describing how outreach services work in conjunction with site-based services can achieve positive outcomes. For example, as more communities develop housing first or rapid re-housing models, new research can explore the

connections among outreach, housing, and supportive services.

- Conducting more research on the effectiveness of outreach and engagement for various subgroups, such as families and youth.
- Examining the costs and benefits of providing outreach services.

In sum, the current literature suggests that outreach and engagement should be viewed as a mainstay of services for people experiencing homelessness. By “meeting people where they are,” the process of outreach increases the likelihood of improving housing and health outcomes. Only by integrating these services with other best practices and investigating their impact will homeless people be optimally served.

DISCLAIMER

This paper was developed under Contract No. HHSS280200600029C from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

REFERENCES

[1] Lomas J, Culyer T, McCutcheon C, *et al.* Conceptualizing and combining evidence for health system guidance. Ottawa 2005. Canadian Health Services Research Foundation.

[2] Goering P, Wasylenki D, Lindsay S, *et al.* Process and outcome in a hostel outreach program for homeless clients with severe mental illness. *Am J Orthopsychiatry* 1997; 67: 607-17.

[3] Able-Peterson T, Bucy J. The streetwork outreach training manual. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center 1993.

[4] Erickson S, Page J. To dance with grace: outreach and engagement to persons on the street. In: Fosburg LB, Dennis DL, Eds. Practical Lessons: The 1998 National Symposium on Homelessness Research Washington, DC: U.S. Department of Housing and Urban Development; U.S Department of Health and Human Services 1999.

[5] Jones A, Scannell T. Outreach interventions for the homeless mentally ill. *Br Dent Nurs J* 1997; 6: 1236-43.

[6] Bassuk EL. Community care for homeless clients with mental illness, substance abuse, or dual diagnosis. Newton, MA: The Better Homes Fund 1994.

[7] Wasmer D. Engagement of persons who are homeless and have serious mental illness: an overview of the literature and review of practices by eight successful programs. Chicago, IL: De Paul University 1998.

[8] Kraybill K. Outreach to people experiencing homelessness: a curriculum for training health care for the homeless outreach workers. Nashville, TN: National Health Care for the Homeless Council 2002.

[9] McMurray-Avila M. Outreach. In: McMurray-Avila M, Ed. Organizing health services for homeless people: a practical guide 2001; pp. 166-80.

[10] Sacks S, Skinner D, Sacks J, Peck A. Manual for engaging homeless mentally ill chemical abusers in a modified TC shelter program. New York, NY: National Development and Research Institutes, Inc 2002.

[11] Ng A, McQuiston H. Outreach to the homeless: craft, science, and future implications. *J Psychiatr Pract* 2004; 10: 95-105.

[12] National Resource Center on Homelessness and Mental Illness. In from the cold: a tool kit for creating safe havens for homeless people on the street. Washington, DC: U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development 1999.

[13] Tsemberis S, Elfenbein C. A perspective on voluntary and involuntary outreach services for the homeless mentally ill. *New Dir Ment Health Serv* 1999; 82: 9-19.

[14] Morse GA, Calsyn RJ, Miller J, *et al.* Outreach to homeless mentally ill people: conceptual and clinical considerations. *Commun Ment Health J* 1996; 32: 261-74.

[15] Kraybill K, Olivet J. Communication and connection. In: Kraybill K, Olivet J, Eds. Shelter health: essentials of care for people living in shelter. Nashville, TN: National Health Care for the Homeless Council 2005; p. 141-56.

[16] Jahiel RI. Homelessness: a prevention-oriented approach. Baltimore, MD: Johns Hopkins Press 1992.

[17] Randell G, Brown S. Outreach and resettlement work with people sleeping rough. London: Department of Environment 1995.

[18] Christian J, Abrams D. A tale of two cities: predicting homeless people's uptake of outreach programs. *Basic Appl Soc Psychol* 2004; 26: 169-82.

[19] Buhrich N, Teesson M. Impact of a psychiatric outreach service for homeless persons with Schizophrenia. *Psychiatr Serv* 1996; 47: 644-6.

[20] Bybee D, Mowbray CT, Cohen E. Short *versus* longer term effectiveness of an outreach program for the homeless mentally ill. *Am J Commun Psychol* 1994; 22: 181-209.

[21] Bybee D, Mowbray CT, Cohen EH. Evaluation of a homeless mentally ill outreach program: Differential short-term effects. *Eval Program Plann* 1995; 18: 13-24.

[22] Chen JH, Rosenheck RA, Kaspro WJ, *et al.* Receipt of disability through an outreach program for homeless veterans. *Mil Med* 2007; 172: 461-5.

[23] Christian J. The effects of social identification, norms and attitudes on use of outreach services. *J Commun Appl Soc Psychol* 2003; 13: 138-57.

[24] Dixon L, Stewart B, Krauss N, *et al.* The participation of families of homeless persons with severe mental illness in an outreach intervention. *Commun Ment Health J* 1998; 34: 251-9.

[25] Fisk D. Assertive outreach: an effective strategy for engaging homeless persons with substance use disorders into treatment. *Am J Drug Alcohol Abuse* 2006; 32: 479-86.

[26] Lam JA, Rosenheck R. Street outreach for homeless persons with serious mental illness: is it effective? *Med Care* 1999; 37: 894-907.

[27] Lyons JS, Cook JA, Ruth AR, *et al.* Service delivery using consumer staff in a mobile crisis assessment program. *Commun Ment Health J* 1996; 32: 33-40.

[28] McGuire J, Rosenheck RA, Kaspro WJ. Health status, service use, and costs among veterans receiving outreach services in jail or community settings. *Psychiatr Serv* 2003; 54: 201-7.

[29] Morris DW, Warnock JK. Effectiveness of a mobile outreach and crisis services unit in reducing psychiatric symptoms in a population of homeless persons with severe mental illness. *J Okla State Med Assoc* 2001; 94: 343-6.

[30] Nuttbrock L, Rosenblum A, Magura S, *et al.* Broadening perspectives on mobile medical outreach to homeless people. *J Health Care Poor Underserved* 2003; 14: 5-16.

[31] Park MJ, Tyrer P, Elsworth E, *et al.* The measurement of engagement in the homeless mentally ill: the homeless engagement and acceptance scale- HEAS. *Psychol Med* 2002; 32: 855-61.

[32] Rosenblum A, Nuttbrock L, McQuiston H, *et al.* Medical outreach to homeless substance users in New York City: preliminary results. *Subst use Misuse* 2002; 37: 1269-73.

[33] Tischler V, Vostanis P, Bellerby T, *et al.* Evaluation of a mental health outreach service for homeless families. *Arch Dis Child* 2002; 86: 158-63.

[34] Tommasello AC, Myers CP, Gillis L, *et al.* Effectiveness of outreach to homeless substance abusers. *Eval Program Plann* 1999; 22: 295-303.

[35] Tommasello AC, Gillis LM, Lawler J, *et al.* Characteristics of homeless HIV-positive outreach responders in urban US and their success in primary care treatment. *AIDS Care* 2006; 18: 911-7.

[36] De La Cruz F, Brehm C, Harris J. Transformation in family nurse practitioner students' attitudes toward homeless individuals after participation in a homeless outreach clinic. *J Am Acad Nurse Pract* 2004; 16: 547-54.

[37] Fisk M, Rowe M, Brooks R, *et al.* Integrating consumer staff members into a homeless outreach project: critical issues and strategies. *Psychiatr Rehabil J* 2000; 23: 244-52.

- [38] Kryda AD, Compton MT. Mistrust of outreach workers and lack of confidence in available services among individuals who are chronically street homeless. *Commun Ment Health J* 2009; 45: 144-50.
- [39] Cameron A, Lloyd L, Turner W, *et al.* Working across boundaries to improve health outcomes: a case study of a housing support and outreach service for homeless people living with HIV. *Health Soc Care Commun* 2009; 17: 388-95.
- [40] Daiski I. The health bus: healthcare for marginalized populations. *Policy Polit Nurs Pract* 2005; 6: 30-8.
- [41] Cavacuiti C, Svoboda T. The use of electronic medical records for homeless outreach. *J Health Care Poor Underserved* 2008; 19: 1270-81.
- [42] McQuiston HL, D'Ercole A, Kopelson E. Urban street outreach: using clinical principles to steer the system. *New Dir Ment Health Serv* 1996; 52: 17-27.
- [43] Cohen NL. Outreach intervention models for the homeless mentally ill. In: Lamb HR, Bachrach LL, Kass FI, Eds. *Treating the Homeless Mentally Ill* Washington, DC: American Psychiatric Association 1992; pp. 141-58.
- [44] Rowe M, Fisk D, Frey J, *et al.* Engaging persons with substance use disorders: lessons from homeless outreach. *Adm Policy Ment Health* 2002; 29: 263-73.
- [45] Susser E, Valencia E, Goldfinger SM. Clinical care of homeless mentally ill individuals: Strategies and adaptations. In: Lamb HR, Bachrach LL, Kass FI, Eds. *Treating the Homeless Mentally Ill* Washington, DC: American Psychiatric Association 1992; pp. 127-39.
- [46] Fisk D, Rakfeldt J, Heffernan K, *et al.* Outreach workers' experiences in a homeless outreach project: issues of boundaries, ethics, and staff safety. *Psychiatr Q* 1999; 70: 231-46.
- [47] Anchorage Community Mental Health Services. *Crossover house homeless project: an outreach intervention for homeless adults experiencing severe mental illness and substance abuse disorders*. Anchorage, AK 1994.
- [48] Burt MR, Hedderson J, Zweig J, *et al.* *Strategies for reducing chronic street homelessness*. Washington, DC: U.S. Department of Housing and Urban Development, The Office of Policy Development and Research 2004.
- [49] Rowe M. *Crossing the border: encounters between homeless people and outreach workers*. Berkeley: University of California Press 1999.

Received: August 18, 2009

Revised: September 20, 2009

Accepted: September 28, 2009

© Olivet *et al.*; Licensee *Bentham Open*.

This is an open access article licensed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/3.0/>) which permits unrestricted, non-commercial use, distribution and reproduction in any medium, provided the work is properly cited.