An evaluation study of the homeless chronically mentally ill program

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ABSTRACT

Social Work

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AN EVALUATION STUDY OF THE HOMELESS CHRONICALLY MENTALLY ILL PROGRAM

Advisor: Dr. Gale Horton

Thesis dated May, 1997

This is an summative evaluation of the Homeless Chronically Mentally Ill program which examined the impact of case management and the outcome of the program on participant’s substance abuse usage. Twenty-six participants’ participated in the study. Participants were evaluated by two scales, the Client Satisfaction Questionnaire and the Reid-Gundlach Social Service Satisfaction Scale. Participants were sampled from those who were admitted into the HCMI program.

The result of the study revealed that the majority (73.1) of those surveyed were satisfied overall with the program and 73.1 percent felt they could count on their social worker in times of trouble. This indicates that the HCMI program is meeting its goal to serve those veterans who are homeless and chronically mentally ill in order to help them reconnect into society.
AN EVALUATION STUDY OF THE HOMELESS CHRONICALLY MENTALLY ILL PROGRAM

A THESIS

Submitted to the faculty of Clark Atlanta University

in partial fulfillment of the requirements for

the degree of Master of Social Work

by

Tousha Terrell West

School of Social Work

Atlanta, Georgia

May 1997
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I would like to acknowledge all those who have supported me throughout this experience. First I would like to thank God for providing me this opportunity and blessing me with the knowledge patience, and endurance to make it through. I would also like to give thanks to my family, the Brown family, Dr. Horton for his guidance and never ending humor, Professors, and friends. I dedicate this paper to my mother and he who watches over me from above.
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CHAPTER ONE

Introduction

The past ten years have brought a substantial amount of public attention and opinion to the problem of homelessness. Studies show that as many as one third of the homeless are American Veterans. In order to correct this travesty the Department of Veteran Affairs (VA) began an aggressive outreach program whose primary goals are to seek out, identify, treat, and rehabilitate veterans who are homeless, and/or chronically mentally ill.¹

The Homeless Chronically Mentally Ill (HCMI) program was first established as a six month pilot project in 1987 by Public Law 100-6. As a result of the success of the pilot project, funding was extended and continues to operate as one of the components of the Health Care for Homeless Veterans Programs. The Heath Care Homeless Veteran operates under the guidance of the Strategic Health Care Group for Mental Health Sciences in the Department of Veterans Affairs Central Office. The program is located at 43 Veteran Adminstration facilities throughout the nation.

As a result of social alienation and multiple health care issues, homeless mentally ill people were found to require a more aggressive outreach and treatment services.² The purpose of the Homeless Chronically Mentally Ill Program is to provide health care, and

outreach services in community locations in order to engage homeless veterans who have been undeserved and/or disenfranchised.

The Homeless Chronically Mentally Ill program defines homelessness as: (1) an individual who lacks a fixed, regular, and adequate nighttime residence; (2) an individual who has a primary nighttime residence that is: (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (b) An institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. ...Exclusion: For purposes of this act, the term “homeless” or “homeless individual” does not include any individual imprisoned or otherwise detained pursuant to an Act of Congress or a State law.³

The Homeless Chronically Mentally Ill program provides seven key services to homeless veterans with psychiatric and substance abuse problems. Services include: outreach, intake assessment, community case management, psychiatric and medical examination, initiation of treatment, residential treatment and continuing case management.⁴


⁴Ibid.
Although many of the veterans receive care in the VA medical centers, domiciliaries, or nursing homes, most are not. To reach this group, VA treatment teams were established to conduct direct outreach to homeless veterans and to collaborate with existing homeless coalitions, task forces, and other service providers in the communities.\(^5\)

Outreach also encompasses the HCMI workers to go out into the community locations such as shelters and soup kitchen in order to identify veterans. Intake assessment involves the clinical evaluation of the veteran and determination of eligibility for services, in many cases' assessments are done right on the spot. Community case managers assist veterans who do not enter residential or inpatient care, but who need supportive services in the community. The Atlanta VA has established treatment and support groups in order to help those who fall within this particular category. Psychiatric and medical examinations are conducted at the VA medical center, on an inpatient or outpatient basis. Initiation of treatment focuses on the immediate needs of the veteran and often involves stabilization of his or her psychiatric and/or medical condition. Once the veteran has been stabilized he or she may be contracted into a community-based halfway house, for brief to intermediate periods. Once the veteran has been established into the program he/she will receive follow up by the staff in order to support the veterans re-entry into the community.

During the 1995 fiscal year 23,681 veterans were assessed by HCHV teams across the country. All but 2.3% of these veterans were male, and their average age was 43.7 years. Approximately 51% of those assessed were African American. About 50% of those seen had served in the military during the Vietnam era. Over three-quarters of the veterans seen were living in shelters or in outdoor locations at the time of first contact, and one-third had been homeless for six months or more.\(^6\)

In order for veterans to qualify for the HCMI program, they must first be diagnosed with a mental illness (including drug and alcohol abuse), be defined as homeless (according to established definition) or be an imminent risk for homelessness. Eligible veterans also include those who on a limited basis, are being furnished hospital, domiciliary or nursing home care for a chronic mental illness.\(^7\)

Priority service is given to veterans who are seen through the outreach programs, and those who did not initiate contact for services. Priority status is also given to veterans with a service-connected chronic mental illness disability, veterans with any service-connected disability, and veterans with nonservice-connected disability unable to defray the expenses of necessary care.\(^8\) It is believed that these veterans do not seek out services because of limited knowledge of services, distrust of government services, and negative experiences in the past. Priority status is also determined by: Chronicity of


\(^7\) Ibid.

\(^8\) Ibid.
homelessness: the number of times a veteran has been homeless, and the duration of homelessness; and Vulnerability: The risk of serious debilitating effects of homelessness if homelessness continues, if the veteran does not receive adequate treatment.9

The overall objectives of treatment in the HCMI program are to return the homeless veteran to mainstream community housing; to enable the veteran to live without dependence on alcohol and illegal drugs; to improve the veteran's overall physical and mental status; to increase employability; and to improve psychosocial functioning.10

The HCMI programs do not use a specific treatment modality. However, the program does rely on the flexibility of its staff and their willingness to change in order to meet the needs of the specific client population. Treatment is provided through the joint cooperation of the contract residential treatment center, the HCMI team, community providers, and VA outpatient clinics.

The HCMI program is monitored through the HCHV program by VA's Northeast Program Evaluation Center (NEPEC) at the West Haven, CT, VA medical center. NEPEC tracks the work of HCHV teams through assessment data collected at the time of screening, and discharge summaries conducted at the conclusion of residential treatment.11 A series of indicators were selected as “critical monitors” of site

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9 Ibid.
11 Ibid.
performance because these indicators reflect goals that were either specified in the
program’s authorizing legislation or that have been given priority by the Strategic Health
care Group for Mental Health Sciences.\textsuperscript{12} Generally, the performance of all HCHV sites
is used as the norm for evaluating the performance of each individual site.

The HCMI programs are federally funded through the Mental Health and
Behavioral Sciences department of the Veteran Administration.\textsuperscript{13} The Atlanta VA
receives 52,000 a quarter to run its program.\textsuperscript{14} This money is used to pay for the halfway
houses, bus tokens, supplies and food vouchers.

This study will contribute vital information in terms of participants perception of
the impact of the HCMI program on substance abuse and case managers impact on the
participate. This information will be useful to supervisors and case managers as they
continue to work with and develop programs geared for the homeless veteran population.

Further, the purpose of this study will be to evaluate the impact of case
management and the outcome of the program on participant's substance abuse usage.

\textsuperscript{12} Ibid.
\textsuperscript{13} Depart of Veterans Affairs, Clinical Affairs, Homeless Chronically Mentally Ill Program Guide (Washington
\textsuperscript{14} Ibid.
CHAPTER TWO

Review of Literature

The number of veterans who are homeless and suffer from substance abuse and psychiatric problems are increasing. Studies show the number of these veterans have more than doubled over the past ten years. Research indicates that intensive case management and an aggressive outreach program is vital.\(^1\) Given the large number of veterans in the homeless population it is necessary to gain a working knowledge of not only treatment programs that work, we must also understand what causes homelessness and what factors relate to successful treatment for this population.

The review of literature revealed a variety of programs and treatment modalities aimed at helping homeless veteran. Although varies tools were used in order to bring about change, I felt it was imperative that we also examine the characteristics, and the indicators of this unique population.

The literature suggests a consensus among researchers that homeless veterans suffer from a mixture of ailments. In a study conducted by Steven Applewhite, veterans reported a high incidence of health and mental health problems, limited resources, negative public perceptions and treatment, insensitive service providers, dehumanizing policies and procedures, and high levels of stress and frustration with service delivery systems among their complaints.\(^2\) As a result of these impediments many became

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depressed and exhibit symptoms of a loss of hope such as an inability to seek or receive assistance, set goals, or work toward breaking out of their homeless state.³ Tollett and Thomas agreed with Korner who wrote that hope is the vital life force in humans.⁴ With this in mind, they sought to determine whether or not a specific nursing intervention to instill hope would positively influence the level of hope, self-efficacy and self-esteem and depression in homeless veteran. Their study found some support for the homelessness-hopelessness theory as evidenced by a high level of depression and low levels of hope, self-efficacy among veterans who did not receive the intervention, and decrease depression in veteran who received the nursing intervention.

One of the most studied subgroup of the homeless population is the American veteran. Homeless veterans are a subgroup of the homeless population that appears to be uniquely suited for empirical examination. They are more homogeneous than the homeless population at large and they constitute a large segment of the homeless.⁵ It has been found that between 30% and 50% of the homeless population are veterans.⁶ Of

⁴Ibid.
these, nearly 50% are Vietnam era veterans with a median age of forty years.\textsuperscript{7} This seems to suggest that the greater risk of homelessness to be among men age 30-44.\textsuperscript{8}

Rosenheck, Gallup, and Leda found that the proportion of veterans exposed to combat fire were similar to those of non-homeless veterans. Homeless combat veterans who were not white were found to be more likely to have psychiatric, alcohol, and medical problems than homeless non-combat Vietnam veteran who are not white.\textsuperscript{9} These findings seem to contradict Rosenheck and Leda findings in a 1995 study that used a multi-site descriptive outcome study to examined the differences between black and white veterans. In this study they found that during admissions, blacks were younger and had more problems with drugs and violent behavior, but were less likely than whites to have clinical diagnoses of alcohol abuse or a serious psychiatric disorder, and had few suicide attempts.\textsuperscript{10} They also had more social contacts and had more frequently experienced a recent disruption in an important relationship.\textsuperscript{11} There was little if any, differences found between the two groups concerning program participation. However, one year after discharge, black veterans showed greater improvement in medical


\textsuperscript{10}Suzanne L. Wenzel and others, eds., “Predictors of Homeless Veterans Irregular Discharge Status from a Domiciliary Care Program,” \textit{Journal of Mental Health Administration} 22 (Summer 1995): 245-260.

symptomatology, social contacts, and violence, while white veterans showed a greater increase in outpatient health service use.\(^{12}\)

Some research suggests that there are no factors that separate homeless veterans, from non-homeless veterans. While trying to determine exactly what caused veterans to become homeless Rosenheck and Leda found that compared with non-veterans, homeless veterans were older, more likely to be white and better education. In general, these veterans did not differ from non-veterans on any indicator of residential instability, current social functioning, physical health, mental illness, or substance abuse.\(^{13}\)

Although homeless veterans were found to be better educated and had been married in the past, these advantages did not appear to protect them from homelessness. Factors that place veterans at risk for homelessness appear to be about the same for the general population, what is unique to homeless veteran is his military service. Military service introduces other factors such as combat stress and psychosocial adjustment, these factors may play a role in causing homelessness among servicemen. Clinical data was gathered on 627 homeless Vietnam veterans evaluated in a Department of Veterans Affairs clinical program for homeless mentally ill veterans. It was found that more than


\(^{13}\) Robert Rosenheck and Paul Koegel, "Characteristic of Veteran and Non-Veterans in Three Samples of Homeless Men," *Hospital and Community Psychiatry* 44 (September 1993): 858-863.
two-fifths (43%) of the 627 veterans showed evidence of combat stress that was associated with more severe psychiatric and substance abuse problems.14

Homeless mentally ill Vietnam veterans appear to be significantly undeserved and in need of specialized services directed at both their combat-related psychiatric problems and their severe housing, financial, and social difficulties. Military service appears to predispose individuals to psychiatric stressors due to “isolation from the larger society, centering life around the military milieu, and organizing around work, sports, drinking, use of illegal substance, or various sorts of sexual experimentation as well as war-related stressors”15

Homeless veterans with combat stress were more likely to use VA outpatient services than homeless veterans without it.16 Vietnam veterans diagnosed with PTSD also suffer from substance abuse disorders as well as other problems more frequently than those without PTSD.17

In determining characteristics of homeless veterans, one study used data gathered from 163 individual who applied by telephone to a residential rehabilitation program for homeless veterans and compared these data with general veteran and homeless


17 Ibid.
populations. Their subjects were found to have a mean age of 40.82 years and had attended 13.34 years of school. High levels of substance abuse, psychiatric, medical and legal problems were also observed. Although these homeless veterans appeared to be reasonably capable and seemed to have significant habitation potential relative to the typical stereotypes of the homeless population, they still had high rates of pathology.

Homelessness among veterans appears to be a severe and chronic problem. Homeless coupled with substance abuse and psychiatric problems only serve to escalate the problem. According to an 1989 assessment of the HCMV programs it was found that almost two-thirds had previous been hospitalized for either a psychiatric or a substance abuse problem.

Why does treatment fail? Miller finds that a lack of proper motivation as the reason for addict's failure to enter, continue in, comply with, and succeed in treatment. This research suggests that a reliability tool for assessing motivation for treatment be utilized when working with chronic populations.

Motivation appears to play a key role in determining if treatment will be successful. The treatment outcome of sixty chronic mentally ill patients who received services at a private-sector residential care program was analyzed. Research found

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19Ibid.


patients with good participation in program and who maintained contact with the outpatient support network had a 95% probability of good outcome.\(^{22}\)

In 1990, the Department of Veteran Affairs initiated a comprehensive homeless center in the Dallas-Fort Worth Area. This center served as a model for public and private partnerships that developed a range of specialized programs for homeless mentally and physically ill veterans.\(^{23}\) The emergence of managed care and the rising cost of inpatient care has forced the Department of Veterans Affairs to seek assists from community sources in areas where they traditionally handle alone.

Various modalities have been employed in order to bring about change in the lives of homeless veterans. With the assistance of 110 veterans in a residential rehabilitation center, one group of researchers used cognitive-behavioral and therapeutic community techniques to treatment their homelessness and substance abuse problems. During admission, all reported multiple psychosocial problems, and all had drug alcohol abstinence as a treatment goal.\(^{24}\) Data obtained at 3, 6, 9, and 12 months post discharge revealed a substantial proportion had positive outcomes with respect to housing, substance abuse abstinence, employment, and self-rated psychological symptoms.\(^{25}\)

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\(^{22}\)John F. Hofmeister, Valerie E. Weiler and Lynn M. Ackerson, “Treatment Outcome in a Private-Sector Residential Care Program,” *Hospital and Community Psychiatry* 40 (September 1989): 927-932.


According to the authors this technique may be viable for other populations with similar clinical characteristics.

Studies evaluating residential rehabilitation effectiveness among homeless veteran found a significant difference between subjects who successfully completed treatment and subjects who did not. Subjects who completed the program were more likely to have improvements in areas such as finances and vocation. As a result of the chronic and multiple problems of homeless veterans, a conservative effort is needed in order to reach this hard to reach population.

In one inner-city area a continuous care team was studied to determined the effects of ongoing treatment on chronic mentally ill patients in an outpatient setting. A continuous care team consists of a nurse-social worker, a psychiatrist, four clinicians, and an addiction's counselor. The care teams are responsible for the treatment of the patient whether they are hospitalized or not. This form of aggressive outreach revealed increased rate of treatment compliance, decreased frequency of crises, and decreased frequency and duration of hospitalization. Although substance abuse was negatively correlated with improvement in this study, the successful outcomes in the other area show continuous care to be a noteworthy concept.

In measuring case management activity it was found that usual work load effects are seen in case management as in other areas, when case loads are large or contain many

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difficult cases, the overall quality of case management is judged to be lower. What seems unclear in the literature is whether or not the continuity of case management or specific case management strategies are more effective than other, more traditional approaches in the care of the chronically mentally ill.

A review of the literature concerning assertive outreach revealed mixed findings as to the cost and effectiveness of such programs. One study demonstrated that assertive community treatment programs were highly effective in reaching the need for psychiatric hospitalization of chronically mentally ill patients. The authors of this study believed that the costs of these programs were higher than traditional outpatient care.

Dr. Olfson of the Payne Whitney Clinic at Cornell Studied assertive community treatment programs based on the Training In Community Living Model. His research revealed assertive community treatment reduced hospital utilization across settings and patient population. Previous research had revealed evidence that the approach was more effective than conventional treatment, however recent studies has not duplicated these results.

An outreach program for homeless veterans with substance abuse or other psychiatric problem and an intensive case management program for severely mentally ill

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29 Carl A. Taube and others, eds., "New Directions in Research on Assertive Community Treatment," Hospital and Community Psychiatry 41 (June 1990): 642-646.

high hospital users were compared at two multi-sites VA hospitals. Comparisons were made using both periodic patient-specific progress summaries and a one-time clinician questionnaire, Jerrell and Hargreaves’ Community Program Philosophy (CPPS) Scale.\textsuperscript{31}

Program differences were considered to be substantial only when data from patient-specific progress summaries and from thematically related CPPS scores both revealed statistically significant differences between the two programs.\textsuperscript{32} This study shows that the CPPS is able to discriminate between different programs. It also reveals a greater diversity in the operation of community-oriented mental health programs, when they are applied to different populations.\textsuperscript{33}

A study conducted by Rosenheck and Gallup found that admission to residential treatment appears to be the strongest determinant of clinical engagement of the homeless mentally ill.\textsuperscript{34} While levels of involvement in the program were modest those who were admitted to residential treatment were 5.4 times more likely to be involved in the program than those not admitted.\textsuperscript{35} This data seems to contradict research by Hiday and Cooks who conducted a state wide study of psychiatric patient involved in civil commitment hearings. Their research found patients who were committed to out-patient treatment


\textsuperscript{32} Ibid.

\textsuperscript{33} Ibid.


\textsuperscript{35} Ibid.
were significantly more likely than patients with the other dispositions to utilize after care services and to continue in treatment.\textsuperscript{36}

While the majority of the research shows significant improvement in treatment and access to treatment through outpatient services, the costs of these programs appear to be quite high. A study conducted to evaluate the impact of an outreach and residential treatment program for homeless mentally ill veterans found an increase of 35 percent per veteran per year to run its services.\textsuperscript{37}

Although only a handful of outcome studies have been published, all have suggested that participation in specialized clinical programs can facilitate movement of the chronically mentally ill out of homelessness.\textsuperscript{38} This supports Leda and Rosenheck conclusion that homeless mentally ill veterans derive clear benefits from participation in a multi-dimensional residential treatment program. However, improvements in mental health problems were weakly linked to improvement in other areas.\textsuperscript{39} This suggests that treatment programs may have to attend separately to multiple domains of life adjustment if they are to be truly successful.


\textsuperscript{39}Catherine Leda and Robert Rosenheck, “ Mental Health Status and Community Adjustment After Treatment in a Residential Treatment Program for Homeless Veterans,” \textit{American Journal of Psychiatry} 149 (September 1992): 1219-1224.
A study conducted to assess the impact of changing patterns of societal substance use on a general psychiatric unit of an inner-city veteran, found no difference between substance users and nonusers in length of stay. However, younger age and axis II pathologies were associated with irregular discharge, and younger age was associated with shorter length of stay. While it is suggested that treatment is more successful with patient who were older and had been in treatment longer, attention should also be focused on those who tend to drop out early and are younger.

A study conducted on predictors of homeless veterans irregular discharge status from a domiciliary care program found other important characteristic. The authors of this study found that irregular discharge from treatment was more likely among veteran who were black, who had poor employment histories or who had problem with alcohol. This suggests that further attention needs to be focused on minorities in order to maintain these veterans in treatment programs so that they can achieve maximum benefit from available programs.40

The Department of Veterans Affairs is committed to eliminating the threat of homelessness among its all veterans. A Preliminary evaluation of the effects of a veterans hospital domiciliary program for homeless person revealed statistically significance’s for

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the program. The intense focus on individual and group counseling can reduce homeless veterans feelings of anxiety, depression, and loneliness.41

Although the literature suggests that intensive outreach and client participates make a difference in the effectiveness of treatment for patients who are chronically mentally Ill.42 The research also indicates that treatment can be costly. While residential treatment was far more costly than other treatments more research needs to be conducted in order to provide more concrete findings.


Theoretical Orientation

The theoretical framework utilized for this program appears to be an Eclectic approach with behavioral, ecological, and systems theory as its major theories. The eclectic framework espouses the thought that no one theoretical framework is sufficiently comprehensive in order to meet the multi-complex problems of today's clients. An eclectic practitioner adheres to models and theories that best matches a given problem situation and accords highest priority to techniques that have been empirically demonstrated to be effective and efficient.

Primary objectives of behavioral theory centers around the behavior of people and what they actually do and say. Using techniques such as conditioning, consequences and reinforcement it is believed that one could be "re-trained" or re-taught a different behavior. The central premise of behavior theory is that behavior is maintained by its consequences. Therefore, it is conceivable to believe that behavior will resist change unless more rewarding consequences result new behavior. This is a key issue for veteran within the HCMI program. As a consequence of their behavior with drugs and alcohol, many veterans have burned their bridges with their families, lost jobs, and have had run-in's with the law.

Many of those who seek treatment from the program found that living on the streets or in shelters, and using drugs to be counter-productive to their lives. One of the

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44 Ibid.
goals of HCMI is to help veterans to explore alternatives independent of alcohol and illegal drugs. Thereby, helping them establish more productive behavior patterns.

The Ecological model is an extension of the “person-in-environment” perspective. Two main concepts of Ecological theory are habitat and niche. Habitat refers to the place where organism live, for humans it consists of the physical and social settings within particular cultural contexts. When one’s habitat has the necessary resources for growth and development, human beings tend to thrive. When habitats lack the necessary resources ongoing functioning may be adversely affected causing severe depression, alcohol or drug abuse, and engagement into violent behavior or activities.

The concept of niche refers to the statues or roles occupied by members of the community. One of the tasks in the course of human maturation is the find one’s niche in society which is essential to achieving self-respect and a stable sense of identity. The Ecological theory supports the literature that finds veterans in particular Vietnam veterans having severe readjustment problems when returning to mainstream society.

Those who served in times of war differ immensely from attitudes and perceptions of those who may have disagreed with the United States in its involvement in foreign affairs. Once the soliders returned many were unprepared for the onslaught of negative Feelings directed towards them. Facing high unemployment and constant public

46 Ibid.
redicule many felt betrayed and abandonment by the government. As a result, many withdraw from the society at large and use alcohol and drugs as means of coping.

Systems theory as describe by Bertalanffy is the idea that human systems are ecological rather than mechanistic. Therefore, people affect and are affected by numerous interactions within the greater society. With this in mind, the HCMI program not only addresses issues such as homelessness and substance abuse, they also attempts to assist the veteran with their mental and medical problems, housing, employment, and reconnection to social supports.

The Eclectic approach appears to be an effective modality in working with homeless chronically mentally ill populations. The use of various models and theories demonstrate not only a diverse approach to treatment but also ensure the client of the best possible treatment available.

Terms and Definitions

VA- Veterans Affairs

HCMI- Homeless Chronically Mentally Ill

HCHV-Health Care for Homeless Veterans

SPSS - Statistical Package for the Social Sciences

Veteran- One who has been in the armed forces.

Chronically Mentally Ill is defined as an individual who suffers from psychiatric or substance abuse problems.

Case Manager- Provides ongoing support and treatment to veterans in the HCMI program by the way of assistance into halfway houses, individual, and group therapy.

Satisfaction- The degree to which participant feels the program is beneficial to him/her.

Substance abuse usage- The degree to which one uses alcohol or drugs to the point where their lives become unmanageable.

Homeless (1) an individual who lacks a fixed, regular, and adequate nighttime residence; (2) an individual who has a primary nighttime residence that is: (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (b) An institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a
accommodation for human beings. ...Exclusion: For purposes of this act, the term “homeless” or “homeless individual” does not include any individual imprisoned or otherwise detained pursuant to an Act of Congress or a State law.48

CHAPTER THREE

Methodology

This is a summative program evaluation study. Its purpose was to evaluate the effectiveness of the homeless Chronically Mentally Ill Program administered by the Department of Veterans Affairs. It is summative because it seeks knowledge that can be generalized and applied to decision making that affect this program and other programs working with homeless veterans. This study used self-reported data provided by subjects through the form of questionnaires.

A nonprobability sampling procedure based on the availability of the participants was employed for this study. The sample was drawn from the participants of the HCMI program administered by the Department of Veteran Affairs in Decatur Ga. A total of twenty six participants responded to the survey.

Data Collection

The Client satisfaction questionnaire (CSQ-8) and the Reid-Gundlach Social Service Satisfaction Scale was used to collect data for this study. The CSQ-8 consists of eight items with a range of scores from 8-32 it’s purpose is to measure client satisfaction with services. The R-GSSS consisted of thirty-four items with a range of scores from one to five. The R-GSSS provides an overall satisfaction-with-service score plus three subscales dealing with consumers reactions to social services regarding the following: (1) relevance (the extent to which a service corresponds to the client’s perception of his or her problem and needs); (2) impact (the extent to which services reduce the problem);
and (3) gratification (the extent to which services enhance the client’s self-esteem and contribute to a sense of power and integrity). Five questions related to demographics were included.

Before administering the questionnaire preliminary tasks were completed. The letter of intent was read and confidentiality and anonymity were ensured. The questionnaire took appropriately fifteen minutes to complete. According to Fischer and Corcoran the CSQ-8 has excellent internal consistency, with alphas that range from .86 to .94. Test-retest correlation’s were not reported. The CSQ-8 has very good concurrent validity. Scores were correlated with clients’ ratings of global improvement and symptomatology, and therapists’ ratings of clients’ progress and likeability. Scores were also correlated with drop-out rate (less satisfied client had higher drop out rates). The R-GSSS reliability has very good internal consistency with a total alpha of .95. The scores showed high face validity however, no other forms of validity were reported.

Data Analysis

The results were interpreted and analyzed by the researcher. The collected data was coded into the computer and analyzed using the Statistical Package for Social Sciences (SPSS) software. Descriptive statistics were used along with frequency distributions and percentages to analyze data.
CHAPTER FOUR

Presentation of Results

TABLE 1

Frequency distribution of the demographic data from the Homeless Chronically Mentally Ill (HCMI) Program, Atlanta VA Medical Center, February 1997.

(N = 26)

<table>
<thead>
<tr>
<th>Race</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>26</td>
<td>100%</td>
</tr>
<tr>
<td>White</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-29</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>30-39</td>
<td>11</td>
<td>42%</td>
</tr>
<tr>
<td>40-49</td>
<td>12</td>
<td>46%</td>
</tr>
<tr>
<td>50-59</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100%</td>
</tr>
</tbody>
</table>

The data of the demographic variables showed that the questionnaire was completed by twenty six males. The race all of the participants were black. The age range from 19 to 55. 46% of the clients ages ranged between 40-49.
TABLE 2

Frequency distribution of the branch of service in which veteran served. (N=26)

<table>
<thead>
<tr>
<th>Branch of Service</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Army</td>
<td>16</td>
<td>61%</td>
</tr>
<tr>
<td>Navy</td>
<td>8</td>
<td>31%</td>
</tr>
<tr>
<td>Air Force</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Marines</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100%</td>
</tr>
</tbody>
</table>

Participants surveyed 61% had served in the army, 31% served in the Navy, while the Air Force and the Marine both had a percentage of 4%.

TABLE 3

Frequency distribution of combat experience (N=26)

<table>
<thead>
<tr>
<th>Combat</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>7</td>
<td>27%</td>
</tr>
<tr>
<td>No</td>
<td>19</td>
<td>73%</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100%</td>
</tr>
</tbody>
</table>

Of the men surveyed 27% reported seeing combat while in service, 73% did not.
TABLE 4
Frequency distribution of the length of stay in the Homeless Chronically Mentally Ill (HCMI) Program.
(N=26)

<table>
<thead>
<tr>
<th>Program Length</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 weeks</td>
<td>11</td>
<td>42%</td>
</tr>
<tr>
<td>1-2 months</td>
<td>6</td>
<td>23%</td>
</tr>
<tr>
<td>3-4 months</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td>5 month or more</td>
<td>6</td>
<td>23%</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100%</td>
</tr>
</tbody>
</table>

The results of the participants length in program revealed 42% had been in the program for four weeks or less, 23% of the participants had been in the program for 1-2 months, 12% had been in the program for 3-4 months; while 23% reported participation as long as 5 months or more.

TABLE 5
Frequency distribution of how the participants rated the HCMI programs quality of services.
(N=26)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>65.4%</td>
</tr>
<tr>
<td>Good</td>
<td>25.9%</td>
</tr>
<tr>
<td>Fair</td>
<td>8.7%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The majority (65.4%) of the sample rated the quality of the HCMI service to be excellent while 25.9% considered the program service to be good; with 8.7% rated the programs quality of service as fair.
TABLE 6
Frequency distribution of whether or not the participants felt they received the kind of service they wanted.
(N = 26)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>15</td>
<td>57.7%</td>
</tr>
<tr>
<td>Yes, generally</td>
<td>11</td>
<td>42.3%</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table three revealed that 57.7% of the participants survey felt that they were definitely receiving the kind of service they wanted. The remaining 42.3% felt that they were generally receiving the kind of service they wanted.
TABLE 7
Frequency distribution of to what extent has the HCMI program been instrumental in meeting your needs.
(\(N=26\))

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>only a few</td>
<td>4</td>
<td>15.4%</td>
</tr>
<tr>
<td>most of my needs</td>
<td>11</td>
<td>42.3%</td>
</tr>
<tr>
<td>almost all of my needs</td>
<td>11</td>
<td>43.3%</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table four show that an equal percentage of participants (42.3%) felt the program was either meeting all their needs or at least most of them. While 15.4% felt only a few of their needs were being meet.
TABLE 8

Frequency distribution of whether or not the participant would refer a friend to the HCMI program if they were in need of similar help. (N = 26)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>21</td>
<td>80.8%</td>
</tr>
<tr>
<td>Yes, I think so</td>
<td>6</td>
<td>19.2%</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100%</td>
</tr>
</tbody>
</table>

According to table five 80.8% of the participants said that they would definitely recommend the program to a friend in need. While 19.2% said they felt they would recommend it.
TABLE 9

Frequency distribution of satisfaction with the amount of help received through the HCMI program.

(N = 26)

<table>
<thead>
<tr>
<th>Satisfaction Level</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>very satisfied</td>
<td>15</td>
<td>57.7%</td>
</tr>
<tr>
<td>mostly satisfied</td>
<td>11</td>
<td>42.3%</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table nine shows that 57.7% of the participants were very satisfied with the help they received to deal with their substance abuse problems, while 42.3% were mostly satisfied.

TABLE 10

Frequency distribution of the effectiveness of the program on substance abuse problems.

(N = 26)

<table>
<thead>
<tr>
<th>Effectiveness Level</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, they helped a great deal</td>
<td>15</td>
<td>57.7%</td>
</tr>
<tr>
<td>Yes they helped</td>
<td>11</td>
<td>42.3%</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100%</td>
</tr>
</tbody>
</table>

Of those survey 57.7% of the participants felt the program helped them a great deal, while 42.3% felt the program was helpful.
TABLE 11

Frequency distribution of the overall satisfaction with the services of the HCMI program (N= 26)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quite</td>
<td>1</td>
<td>3.84%</td>
</tr>
<tr>
<td>Mostly satisfied</td>
<td>6</td>
<td>23.08%</td>
</tr>
<tr>
<td>Very satisfied</td>
<td>19</td>
<td>73.08%</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table eight revealed that 73.1% of the participants were very satisfied with the program; 23% were mostly satisfied and 3.8% felt the program was all right.
TABLE 12

Frequency distribution of whether or not the participant would return to the program for help
(N=26)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, I don’t think so</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Yes, I think so</td>
<td>7</td>
<td>26.9%</td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>18</td>
<td>69.25%</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>100%</td>
</tr>
</tbody>
</table>

According to table nine 69.2% of those surveyed said that they would come back to the program if they needed help again, 26.9% responded that they probably would and 3.8% would not.
According to the bar graph the following scores were computed: overall (2.65), Relevance of the program (2.05), impact of the program (2.94), and Gratification (3.17).
CHAPTER FIVE

Summary and Conclusions

With the arrival of the managed care system many organizations and programs have been required to produce and justify measurable outcomes in order to continue receiving funding. As a result, many programs have implemented evaluation components into their programs in order to meet this requirement. The HCMI program is monitored and evaluated through the Northeast program evaluation center in West Haven CT. For the purposes of this study an evaluation was conducted that measured the participants perception of impact of the program on their substance abuse usage and satisfaction with the program/case manager. In regards to the outcome of the program on participant substance abuse 57.7% of these survey felt the program helped them a great deal while 42.3% felt it was helpful. This appears to suggest that all of those surveyed felt that programs was helpful to some degree. According to the results of the program satisfaction questionnaire, 65.4% of those surveyed felt the HCMI program was an excellent program and 73.1% was very satisfied with the overall services of the program. This evidence seems to imply that the program is meeting the needs of those who seeks it’s services.

The second survey which dealt with the impact of case managers on participants showed that 73.1% (cumulative percent) felt they could count on their social worker in times of trouble. However, the overall satisfaction and the impact of the program revealed that participants were fairly satisfied with the social worker. The relevance
scores showed the participants felt the social worker’s knowledge of substance abuse was fairly relevant to their problems. Although the other scores seemed to range at the midway point the gratification scale was fairly higher, participants reported a 3.17 overall score which seems to suggest the participants received a substantial amount of gratification from the program.

In conclusion, the HCMI program according to the participants, appears to be an effective and much appreciated program. This study shows that programs such as the Health Care for Homeless Veteran’s which administers the HCMI program is a vital tool in helping this population in dealing with homelessness and substance abuse issues.

Limitations of the Study

The major limitation of this study was that many of those surveyed (42%) had been admitted into the program for less than a month. Therefore it can not be generalized to all participants who participate in the HCMI programs.

Suggested Research Directions

A more extensive evaluation needs to be conducted to determine the lasting effects of the program on client substance abuse usage and how social workers can better tap into that variable that will increase the likelihood of sobriety once the client has been discharged from the program.

Implications for Social Work Practice

This research has added to the field of social work in two major areas, the importance of evaluation in assessing program effectiveness and the importance of client
participation in the evaluation process is vital. The analysis of the data in this study demonstrates how important the client is in continuing or discontinuing certain aspects of a program when it appears to be ineffective. In order for the agencies and programs we work in to survive the merciless hand of managed care, we as a profession must be able to implement and justify methods and techniques through evaluational processes. With the assistance of the client and appropriate measuring tools we can not only ensure our survival as a profession but continue to bring the best possible treatments available to our clients.
Appendix A
Questionnaire

(Program Satisfaction)

1. How would you rate the HCMI program’s quality of service?
   4  3  2  1
   Excellent  Good  Fair  Poor

2. Did you get the kind of service you wanted?
   1  2  3  4
   No, definitely  No, not really  Yes, generally  Yes, definitely

3. To what extent has our program met your needs?
   4  3  2  1
   Almost all of my needs have been met
   Most of my needs have been met
   Only a few of my needs have been met
   None of my needs have been met

4. If a friend were in need of similar help, would you recommend our program?
   1  2  3  4
   No, definitely not  No, I don’t think so  Yes, I think so  Yes, definitely

5. How satisfied are you with the amount of help you have received?
   1  2  3  4
   Quite dissatisfied  Indifferent or mildly dissatisfied  Mostly satisfied  Very Satisfied

6. Have the services you received helped you to deal more effectively with your substance abuse problems?
   4  3  2  1
   Yes, they helped a great deal  Yes, they helped  No, they really didn’t help  No, they seemed to make things worse

7. In an overall, general sense, how satisfied are you with the service you have received?
   4  3  2  1
   Very Satisfied  Mostly Satisfied  Indifferent or mildly dissatisfied  Quite dissatisfied
8. If you were to seek help again, would you come back to our program?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No, definitely not</td>
<td>No, I don’t think so</td>
<td>Yes, I think so</td>
<td>Yes, definitely</td>
</tr>
</tbody>
</table>
Appendix B
Service Satisfaction

Using the scale from one to five describe below, please indicate on the line at the left of each item the number that comes closest to how you feel.

1 = Strongly agree
2 = Agree
3 = Undecided
4 = Disagree
5 = Strongly disagree

--- 1. The Social Worker took my problems very seriously.
--- 2. If I had been the social worker I would have dealt with my problems in just the same way.
--- 3. The Worker I had could never understand anyone like me.
--- 4. Overall the agency has been very helpful to me.
--- 5. If a friend of mine had similar problems I would tell them to go the agency.
--- 6. The social worker asks a lot of embarrassing questions.
--- 7. I can always count on the worker to help if I’m in trouble.
--- 8. The social agency has the power to really help me.
--- 9. The social worker tries hard but usually isn’t too helpful.
--- 10. The problem the VA tried to help me with is one of the most important in my life.
--- 11. Things have gotten better since I’ve been going to the HCMI program.
--- 12. Since I’ve been using the HCMI program my life is more messed up than ever.
--- 13. The VA is always available when I need it.
--- 15. The social worker loves to talk but won’t really do anything for me.
16. Sometimes I just tell the social worker what I think they want to hear.

17. The Social worker is usually in a hurry when I see him/her.

18. Do you feel your social worker was knowledgeable about substance abuse issues.

19. No one should have any trouble getting some help from the VA.

20. The worker sometimes say things I don’t understand.

21. The social workers are always explaining things carefully.

22. I never looked forward to my visits to the VA.

23. I hope I’ll never have to go back to the VA for help.

24. Every time I talk to my worker I feel relieved.

25. I can tell the social worker the truth without worrying.

26. I usually feel nervous when I talk to my worker.

27. The social worker is always looking for lies in what I say.

28. It takes a lot of courage to go to the VA.

29. When I enter the VA I feel very small and insignificant.

30. The VA is very demanding.

31. The social worker will sometimes lie to me.

32. Generally the social worker is an honest person.

33. I have the feeling that the worker talks to other people about me.

34. I always feel well treated when I leave the VA.

Y or N 35. Do You Know who your caseworker is?
Demographics

1. What Branch of services did you serve?

2. Did you see combat?

3. age ----

4. Race ----- 

5. Education level ------

6. How long have you been in this program ------
Appendix C
Dear Participant,

This survey is designed to measure whether or not the HCMI program has been useful in helping you with your substance abuse problem and the impact of the programs case managers on participants. The results of this survey will be used for educational purposes, with a copy of the final results being forward to the supervisors of the HCMI program and its staff.

Thank you in advance for your participation and cooperation.

Sincerely,

Tousha West
Social work Intern
References


Rosenheck, Robert, Gallup, Peggy, Astrachan, Boris, Milstein, Robert, Leaf, Philip, Thompson, Dennis, and Errera, Paul, 1989. Initial Assessment Data From a 43-Site Program for Homeless Chronic Mentally Ill Veterans. Hospital and Community Psychiatry 40: 937-942.


