

Getting To Outcomes[®] in Services for Homeless Veterans

10 Steps for Achieving Accountability



July 2011

Acknowledgments

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Preface

All of us working to serve homeless Veterans want to know: *Are we making a difference?* Do Veterans who receive our services achieve greater levels of self-sufficiency and independence? This question takes on added significance with the Veterans Administration's (VA) new plan to end Veteran homelessness in five years. Progress towards this ambitious goal will only be successful if programs at the local level are implemented with quality and outcomes for Veterans are monitored. This manual represents an effort to help those working with Veterans use an evidence-based approach to how they set goals, consider and plan homeless programs, develop and conduct process and outcome evaluations of programs, and learn how to improve and sustain programs that reach outcomes.

Knowledge about evidence-based programs is a necessary but not sufficient condition to achieve outcomes. If you are in the everyday world of implementing programs, you have probably heard that you should do the following: a needs and resource assessment, have clear goals and objectives, use evidence-based practices, be culturally competent, build your capacity to deliver services with quality, have clear and thorough program plans, implement your plan and do a process and outcome evaluation, continually improve your work, and sustain your work. These are essential ingredients for effective service delivery.

However, the question remains: how can you incorporate all of these tasks into your day to day work? This guide describes the Getting To Outcomes® (GTO) model that puts all of these steps together with the knowledge base of evidence-based homeless services in one comprehensive approach. GTO integrates the process and guidance offered by the 10-step, Getting To Outcomes process (Wiseman, Chinman, Ebener, Hunter, Imm, & Wandersman, 2007) with identified best practices in the homelessness field and the experiences of practitioners in the VA who work hands-on providing assistance to homeless Veterans.

This GTO manual draws from two other completed GTO books in other areas of public health:

Wiseman, S., Chinman, M., Ebener, P. A., Hunter, S., Imm, P., & Wandersman, A. (2007). *Getting To Outcomes: 10 steps for achieving results-based accountability*. Santa Monica, CA: RAND.

Lesesne, C.A., Lewis, K.M., Moore, C., Fisher, D., Green, D. & Wandersman, A. (2007). Promoting Science-Based Approaches using Getting To Outcomes: Draft 2007. Centers for Disease Control and Prevention, Atlanta, GA.

The GTO model has been shown to improve individual capacity and program performance to facilitate the planning, implementation, and evaluation of human service programs (Wiseman et al., 2007). In that research, the GTO manual was supplemented with training and technical assistance. Similarly, it is recommended that this manual be supplemented with training and technical assistance, where possible, to achieve the maximum impact in eliminating Veteran homelessness.

Introduction

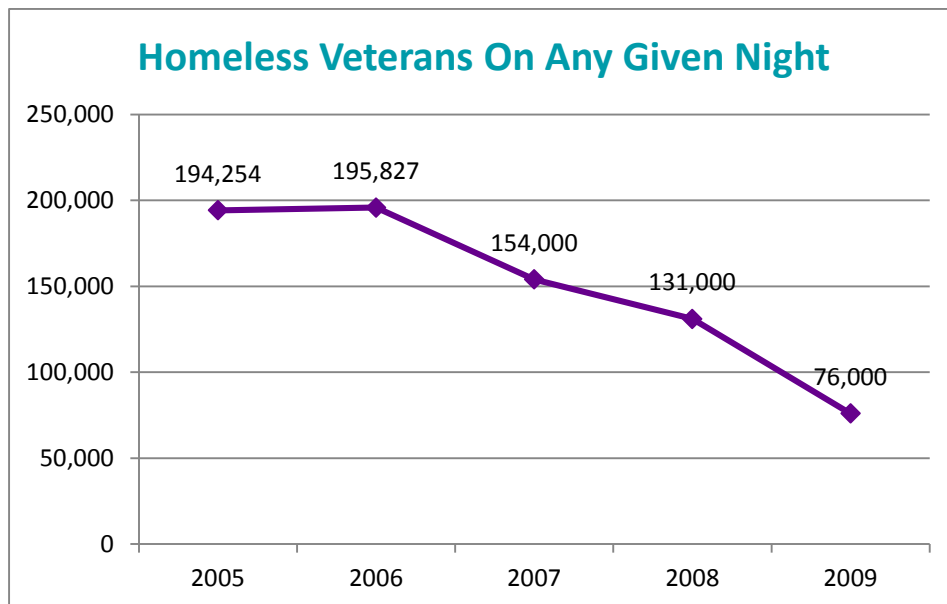
Getting To Outcomes in Services for Homeless Veterans

Getting Started

Glossary

Getting To Outcomes in Services for Homeless Veterans

About one-third of the adult homeless population have served their country in the Armed Services. Current population estimates suggest that about 76,000 Veterans (male and female) are homeless on any given night (<http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2053>) and perhaps twice as many experience homelessness at some point during the course of a year. Many other Veterans are considered near homeless or at risk because of their poverty, lack of support from family and friends, and dismal living conditions in cheap hotels or in overcrowded or substandard housing. Right now, the number of homeless male and female Vietnam era Veterans is greater than the number of service persons who died during that war -- and a small number of Desert Storm Veterans are also appearing in the homeless population (United States Department of Veterans Affairs, 2010). Although the number of homeless Veterans has been on the decline in recent years, it remains a substantial problem and addressing and preventing homelessness is one of the VA's top priorities. The VA has adopted a "no tolerance" policy towards Veteran homelessness and has created a 5-year plan to end homelessness among Veterans.



The factors that place Veterans at risk for homelessness are similar to the risk factors for non-Veterans. Social isolation is one of the primary risk factors for homelessness. Many homeless Veterans, similar to the rest of the homeless population, also suffer from mental illness and (with considerable overlap) from alcohol and other substance abuse problems. There are differences, however, between homeless Veterans and homeless non-Veterans. Homeless male Veterans are more likely to be chronically homeless than homeless male non-Veterans. On the positive side, homeless Veterans tend to be better educated and more likely to be working for pay than homeless non-Veterans.

Demographic	2008 Statistics
Mental Health Diagnosis	78% Serious Psychiatric or Substance Abuse 51% Serious Psychiatric 61% Substance Dependence 35% Dually Diagnosed
Length of Time Homeless	22.0% Greater than 2 years 9.0% 1 - 2 years 11.0% 6 months - 1 year 26.0% 1 month - 6 months
Employment	19.6% full time 27.4% part time, irregular 26.4% unemployed 25% disabled, retired

What is Getting To Outcomes (GTO)?

Getting To Outcomes (GTO) is a user-friendly process for comprehensive planning, implementation, and evaluation of programs and services. It's designed to help programs and services do exactly what it says: get to desired outcomes. Many of the steps in this GTO process will look familiar because this is just a structured way of approaching the work you're already doing.

The original Getting To Outcomes manual was written in 1999 for community-based organizations trying to reduce youth drug use to help them implement evidence-based programs developed by researchers (Wandersman, Imm, Chinman & Kaftarian, 2000), then updated in 2004 to broaden its scope and applicability to a wider range of programs and organizations (Getting To Outcomes 2004: Promoting Accountability through Methods and Tools for Planning, Implementation and Evaluation, Chinman, Imm & Wandersman, 2004). Based

on established theories of traditional evaluation, empowerment evaluation, results-based accountability, and continuous quality improvement, GTO represents a collaborative effort to make it easier to turn evidence-based *knowledge* into evidence-based *practice*. To accomplish this task, this guide offers you a practical, powerful set of tools which you can use to plan, implement and evaluate new programs or fine-tune and refine existing ones.

The Ten Accountability Questions

The primary purpose of this guide is to help you improve the quality of your programs aimed at serving homeless Veterans. This guide’s planning, implementation and evaluation process is organized by ten accountability questions that correspond to GTO’s 10 steps. Following these ten steps can increase your chances of getting better outcomes as well as help you meet accountability requirements such as the VA’s performance indicators, VA’s Uniform Mental Health Services Handbook or CARF accreditation.

THE 10 GTO ACCOUNTABILITY QUESTIONS

Goal Setting		
1.	Needs/Resources	What are the needs of homeless Veterans and what resources are available to meet these needs?
2.	Goals	What are the goals and objectives of your homeless program?
Planning		
3.	Best Practices	Which evidence-based programs and best practices can be useful in reaching the goals?
4.	Fit	What actions, if any, need to be taken so the selected best practice(s) “fits” your local context?
5.	Capacities	What capacities are needed to implement the program?
6.	Plan	What is the plan for your program?
Evaluating		
7.	Process Evaluation	How will the quality of implementation be assessed?
8.	Outcome Evaluation	How well did the program work?
Improving and Sustaining		
9.	CQI	How will continuous quality improvement strategies be incorporated?
10.	Sustainability	If the program is successful, how will its success be sustained?

The term accountability is basic to an understanding of GTO. We define “accountability” as the systematic inclusion of critical elements of program planning, implementation, and evaluation in order to achieve results. In GTO, program development and program evaluation are integral to promoting program accountability. Asking and answering the ten questions begins the accountability process. This guide will assist you in answering each question and direct you to

other resources that may aid in the process when appropriate. We believe that systematically linking together all of these critical elements through the ten questions increases the likelihood of programs achieving their desired outcomes and demonstrating accountability for their services.






How to Use This Guide

The guide is divided into four major parts:

- **Part I: Goal Setting (Steps 1 – 2)**
- **Part II: Program Planning (3 – 6)**
- **Part III: Program Evaluation (7 – 8)**
- **Part IV: Improving and Sustaining (9 – 10)**

There is a table of contents at the beginning of the guide showing the steps, major topics, and tools as well as a glossary which includes all the terms used.

These icons call your attention to definitions, examples, resources, and tools throughout the guide:

	<p>Ideas provide more on sustainability, integration, or other important information</p>
	<p>Online/Resources Link points toward online resources and links</p>
	<p>Tool Box identifies an important tool with instructions</p>
	<p>Tips offer specific ideas for applying a step if you already have a program</p>
	<p>Checklist is a check-off list provided at the end of each step</p>

This document is organized by each of the 10 GTO steps. Included within each step is

- A brief summary of content
- Why the step is important
- Ideas for integrating GTO into your everyday work
- Specific instructions for carrying out each step including relevant tools
- Sidebars which illustrate specific points, stories or refer you to other resources such as Web sites or additional tools in the Appendix
- A checklist to help you finish up each step
- A summary of what you'll have when you've completed the work in that step and how it applies to the next step in the sequence
- A section on how to use the step if you're already implementing a program in your organization or local community

In Appendix A, there is a fictional example of a GTO project in a Veterans Homeless Center that shows what the 10 GTO Steps might look like in a realistic scenario.

If you already have a program: We know many of you using this guide have been working in the homelessness field for some time and you may want to jump to Step 7 about implementation and process evaluation. We want to encourage you to go through each step as though you're starting fresh. Using this guide to revise steps you've already done work in such as needs assessment, goal setting, or planning can help refocus and strengthen your program. Reviewing these steps can also help you avoid selecting or continuing on with unproductive strategies which do not achieve your desired outcomes. The GTO process is cyclical and ongoing, so using the full process will be more beneficial to your programs in the long term. Each step is an important link in the GTO process and critical to using an evidence-based approach in your work.

Getting Started

GTO works best when people work through the ten steps together. There are many colleagues, stakeholders, and other participants who may be eager and able to assist you and your program in this effort. Before moving ahead, we recommend that you:

Establish a team or workgroup to help you work through this process – This group should include both program managers and service staff from your program. If you already have an existing work group, you could modify it or form a sub-workgroup to concentrate on working through the process.

Get the right people at the table – Your work group should represent all relevant stakeholders. If you have an evaluator or evaluation team, having them join you right from the very beginning of your process will be very beneficial. When considering the overall makeup of your team, look for a good mix of thinkers and doers while keeping the size manageable; you may be able to create ‘sub-groups’ for specific tasks. Also, don’t be afraid to invite folks that you haven’t worked with before as diversity is good. Lastly, don’t forget to get some “clout” on your team if you anticipate needing some people in influential roles who can obtain access to difficult-to-get information or partnerships.

Develop an agreed-upon-plan for working together – Keep this simple, but hammer out these important details early on to keep your process on track. Your plan can include such elements as a meeting schedule, the design for your work process, assumptions about roles and responsibilities of the participating individuals, identifying available technical assistance, and developing a desired timeline for your work together.

Use GTO as a common framework – This guide is full of tips, templates, tools, forms, and checklists that will help you plan and keep track of your work. Encourage everyone to use the same forms as you work through the various steps. This will make it easier for everyone to work together and communicate more clearly. This will also help you more easily integrate the GTO process into your everyday work.

Glossary

Accountability – the systematic inclusion of critical elements of program planning, implementation, and evaluation in order to achieve results.

Activities – all of the broader actions needed to prepare for and carry out a program which includes such things as preparation, training, and staff debriefings among others.

Adaptation – the process of making changes to a evidence-based program to make it more suitable to a particular population or organization's capacity without compromising or deleting the core components.

Best practices – techniques or processes that have been identified through research and/or consensus among experts to be the most effective for accomplishing a particular task.

Capacities – the types of resources (staff, skills, facilities, finances, and other resources) an organization has to implement and sustain a program (see also cultural competence, human capacities, technical capacities).

Continuous quality improvement (CQI) – a systematic assessment using feedback from evaluation information about planning, implementation, and outcomes to improve programs.

Core components – the essential elements of an evidence-based program believed to make it effective which should be repeated or replicated to maintain program effectiveness.

Cultural competence – a specific kind of human capacity defined as a set of congruent skills and attitudes that can enable a person to work effectively with diverse groups and in diverse situations. This could include adapting services or approaches to meet diverse needs.

Desired outcomes – the specific changes you expect as a result of your actions; these should reflect the changes in knowledge, skills, attitudes, and behaviors that you desire. Desired Outcomes statements are also known as objectives.

Evidence-based programs – programs that have strong research evidence demonstrating repeated success at reaching specific outcomes across a variety of settings or locations.

Fidelity – the faithfulness with which an evidence-based program is implemented. This includes implementing a program without removing parts of the program that are essential to the program's effectiveness (core components).

Fit – compatibility between a program and the local context in which it is delivered.

Human capacities – staff with appropriate credentials, training and experience as well as commitment to the program; leaders who understand and support the program.

Needs and resources assessment – a systematic way to find out about the current conditions that underlie the potential “need” for a program or service and to identify resources available to help meet that need.

Outcome evaluation – the process of determining whether or not a program caused an improvement among its participants in specific areas of interest (e.g. housing, employment, etc.) and by how much.

Process evaluation – assesses the degree to which your program is implemented as planned. It includes monitoring the activities, who participated and how often, as well as the strengths and weaknesses (quality) of the implementation.

Promising programs – programs that have some quantitative data showing positive outcomes, but do not have enough research or replication to warrant confidence that such outcomes would be seen if these programs or strategies were widely used.

Qualitative data – answers the questions “why” and “how” which usually involve talking to or observing people in focus groups, forums, in-depth interviews, observation (participatory or non-participatory), key informant interviews, or case studies.

Quantitative data – answers “who, what, where and how much” and can be expressed in numerical terms, counted, or compared on a scale. These data involve the counting of people, behaviors, conditions, or other events, through written surveys, telephone interviews, structured, in-person interviews, observing and recording well-defined events, experiments or clinical trials.

Sustainability – the ability of a program to maintain high quality performance (as demonstrated through process and outcome evaluation) over time despite potential threats (e.g. staff turnover, cuts in funding, etc.).

Technical capacities – expertise needed to address all aspects of program planning, implementation and evaluation; access to special materials needed to deliver the program; technology appropriate to the implementation of the program such as computers.

Part I: Goal Setting

Step 1 – Identify The Underlying Needs And Resources Of Homeless Veterans.

Step 2 – Identify The Goals And Objectives For Your Homeless Program.

Step 1: Identify The Underlying Needs And Resources Of Homeless Veterans.

Overview of Needs and Resources Assessment

A useful needs and resources assessment is the first step in developing a fully informed plan for implementing effective programs. Conducting an assessment of the needs of homeless Veterans' and the resources available in your service area to meet these needs will help you decide what you want to accomplish and how you will accomplish it. This step walks you through the process of identifying and collecting the right amount of information you need to develop effective programs for homeless Veterans.

Why?

A needs and resources assessment is a systematic way to find out about the current conditions that underlie the potential “need” for a program or an intervention. Assessments are usually done within the specific geographic area a program would serve. Doing a needs and resources assessment will help you get a clearer understanding of the problems or issues in your location. Additionally, it's important to examine the existing assets and resources in a local area that can be tapped to help meet the needs of homeless Veterans. Collecting even very basic data can be important to help you shape the services you provide and eventually the outcomes you design and measure.

A needs and resources assessment leads you to:

- Identify where homelessness among Veterans is most prevalent in your service area.
- Identify which groups are most likely to be homeless among Veterans in your service area and adapt your program to meet the specific needs of these groups.
- Identify which risk factors are most associated with homelessness in your local service area.
- Identify strengths among homeless Veterans in your service area that could be drawn upon to help address identified problems.
- Learn more about suspected needs among homeless Veterans and uncover new ones.
- Assess community resources that exist to help serve the homeless.
- Obtain baseline data that can be monitored for changes over time.

- Gather support from stakeholders and assess the readiness of your organization to embrace action to address the issues you identify.

This step is important to do even if you feel you already know what the needs and resources assessment in the past. Needs and resources may have changed since you started your work or the available resources may have shifted. You may not have achieved your intended outcomes and working through this step can help you clarify your outcomes as well as ensuring you've selected the right programs or strategies for the right group you aim to serve. The right information will help you focus your efforts so you know who will use your programs, how you should use your resources most effectively. Doing so will help you be more successful. Your successes will help you better sustain your programs and strategies.

How?

It does not have to take a lot of resources – money or time – to conduct a meaningful needs and resources assessment. Even programs with small budgets can find cost-effective ways to get the information needed to plan effectively. This step will offer some practical suggestions for how to find useful existing data at no cost, for example.

At this stage, you are striving to get the right type as well as the right amount of information on which to base your goals and outcomes. Asking the right questions are just as important as getting the right information so your efforts are not wasted.

Establish a work group to manage your assessment

Whether you're conducting a needs assessment for the first time, or you're already running a program and want to update your data and fine-tune your work, it may be helpful to start your process by setting up a small assessment committee or work group of individuals to help you collect information. There may even be an existing group you could use or expand. Seek assistance from your Mental Illness Research, Education, and Clinical Center (MIRECC), Systems Redesign Committee, or other local technical assistance groups if you need it (see Appendix B Appendix B Appendix B for a list of helpful contacts).

You don't need to have a whole team of professionals in this area, but it might be useful to have a few experienced data crunchers. It's also important to include key stakeholders, such as program directors and managers, program staff, VA facility leadership, VISN leadership, Veteran service organizations, Vet Centers and also involve homeless or formally homeless Veterans.

Once your group is established:

Identify leadership – Designating a leader for the workgroup can help keep the process moving as well as facilitate clearly defining everyone's roles, responsibilities and the work plan.

Set a reasonable time limit – As in any worthwhile endeavor, this process may take some time but you want to put a reasonable time limit on it so it doesn't go

on forever. Participants could be easier to recruit if they know in advance what the time commitment will be.

We recommend taking about three months to accomplish this task. You can take more or less depending on your needs but we caution folks not to get stuck in the needs assessment and never move on to your programming. Make your needs assessment realistic and time-limited so you don't get stuck.

Make it easy to get going – You may want to start the work group off with some preliminary data or information to help launch your efforts, such as basic information on homelessness in your area. And ask someone to be the group's official recorder so that someone is responsible for capturing important information and next steps.



Sustainability Tip: Whether you are starting a brand new effort or refining an existing one, relationships are always important to your success. The relationships you establish at this stage can be extremely valuable as you move forward. Getting buy-in from a diverse group of participants now will help strengthen your efforts later. One way to get buy-in is to offer to share the results of your assessments with all the participants in exchange for their help in gathering the data you need.

Determine what types of data and information are needed

What do you want to know? In short, what are the needs of homeless Veterans in your area and what resources are available to meet these needs? It may be useful to have your workgroup brainstorm a list of what they feel they need to know to get the ball rolling, but we recommend you start by gathering as much of the following information as possible:

Census data

Number of homeless

The most common risk factors associated with homelessness in your local area

The cultural, economic, and socio-political factors unique to your community which may have an impact on homelessness

The number of homeless Veterans served by your specific program, clinic, or organization

Existing programs which are already targeting homeless issues in your community

Existing community strengths and resources in your community or VA center which could help address homelessness

Potential levels of readiness among your stakeholders to address homelessness

There are two basic ways to get the information you need -- search for existing data or develop new data. You will most likely need both types of information to give you the complete picture you need to move forward.

Finding and Using Existing Data

The first area to review for potential answers to your questions is existing data already available within the VA or out in your local community. There's a wide variety of information already compiled or collected by others that you could use to help answer your questions, such as CHALENG reports, national VA program progress reports and annual reports, data from the Computerized Patient Record System (CPRS), CARF review reports, and annual homeless censuses. These data may exist inside or outside your organization. This type of regularly collected information is generally easily accessible and starting by mining this area can save you a lot of time and money.

The information you need to collect for your review will depend on several things, but start with a clear understanding of the scope of what you want to know. National or state data on homelessness may be readily available but you may need to know what the rates are within your local area. The scope of your work will define the scope of data and information you'll need.

These tips may help you find what you need at little or no cost and with relative ease:

Look for existing assessments – Have other local agencies recently completed a needs assessment you can use? If so, make sure it addresses the issues relevant to Veterans.

Look for the most current data – Are existing data current enough to meet your needs? It's always best to have the most current data available, but determine how you might update or confirm the data, or what limitations might be associated with using the data as is.

Look for the data most relevant to your needs – What are the pros and cons of the various types of available existing data and the benefits of using one data source over another? You can probably zero in on some very useful resources that address your specific questions and ignore others.

Your organization's resources will also determine how wide-ranging your assessment will be. Depending on what you want to know, one staff person may be able to pull together the key information you need in an afternoon on the Internet. Do you have staff that can concentrate on getting the information you want? Do you have trained individuals and the computer capacity with which to conduct your research? Do you have student interns who can help get the

data you need? Once you have what you need from existing sources, you can determine if the data is comprehensive enough to meet your needs or if you need to supplement your assessment by collecting new data.

TIPSHEET: EXISTING DATA SOURCES/RESOURCES TIP SHEET

Source	Data	Location
CHALLENG Reports	Perceptions of homeless Veterans’ needs, the degree of VA/community cooperation and collaboration in serving homeless Veterans, and progress on local homeless Veterans program initiatives.	http://www1.va.gov/homeless/page.cfm?pg=17
Homeless Program Annual Reports	Data on the operation and monitoring of VA homeless programs.	http://vaww.nepec.mentalhealth.mcd.va.gov/PHV/description.htm
CARF Review Reports	Quality of Comprehensive Homeless Veterans Centers, Domiciliary Residential Rehabilitation Treatment Programs, and Compensated Work Therapy (CWT)–Transitional Residence Programs.	CARF Review Reports are sent to VA Center administration and program directors. Speak to your local program director or administrator to obtain a copy.

Collecting New Needs and Resource Data

The second area to review for potential answers to your questions is what new data you may need to collect. You may need to conduct some of your own surveys, interviews or focus groups to get the specific information you need. You may want qualitative or quantitative data or both.

Qualitative data are presented in narrative form, answering the questions “why” and “how” which usually involve talking to or observing people. These data include detailed, verbal descriptions of characteristics, cases, situations, and settings and usually involve answers to open ended–questions. Some examples include information taken from focus groups, meetings and forums, in–depth interviews, observation, key informant interviews, or case studies.

Qualitative data can yield rich, personalized stories from knowledgeable sources, but the disadvantage is that this type of information can be difficult to measure, count, or express in numbers or generalize to a larger group.

Quantitative data are data that can be expressed in numerical terms, counted, or compared on a scale. These data answer “who, what, where and how much?” These data involve the counting of people, behaviors, conditions, or other events, then classifying those events into categories, and using math and statistics to answer key questions. Gathering quantitative data usually involves answers to closed-ended questions. Some examples include written surveys, telephone interviews, structured in-person interviews, observing and recording well-defined events, experiments or clinical trials.

Quantitative data tends to target more people than using qualitative methods which can make data gathering more expensive, but it is also more structured and standardized because the same procedures are used with everyone surveyed and the results are more generalizable.

One VA in a large metropolitan area partnered with city government to complete a needs assessment in order to inform the design of a new service system for homeless Veterans (Henderson et al., 2008). This needs assessment involved the examination of existing quantitative data from the city shelter system and a recent survey of street homeless people, the collection of new data through a survey of Veterans placed in a variety of housing programs, and qualitative data from Veteran focus groups. By using a variety of data sources, this assessment was able to paint a more complete picture of the needs of homeless Veterans and by “triangulating data” from multiple sources — meaning putting multiple types of data together to tell one story — was able to have more confidence in their findings. For example, both the quantitative data from the surveys and the qualitative data from the focus groups identified employment barriers as a major impediment to moving Veterans from transitional to permanent housing.

If you decide you need new data or information, here are some tips to help you focus your efforts:

Decide from whom you will collect the new data – Develop ideas about what you want to know from homeless Veterans, other program partners, and/or community leaders so you can be clear about what you’re asking for.

Decide what method(s) you will use to collect the information – Make sure you understand what kind of information you get from different data-gathering techniques. It will be important to consider the pros and cons of one data collection technique over another. This will help you develop the right format for data gathering, such as developing interview questions or a leader’s guide for focus groups, as well as determine how you’ll input the data to a database. You may need to use more than one technique.

Be sensitive when gathering information from Veterans – If you plan to gather data and information directly from Veterans, it’s very important to protect their privacy as well as ensure the integrity of your data collection. This is particularly

important when collecting sensitive information on drug use or mental illness. You want to collect data from all sources in a sensitive, appropriate manner.

Get informed consent if necessary – If there is any possibility that you may present or publish any of the data that you collect on your program, the collection of this data may be considered research and require informed consent from Veterans. If you have any questions as to whether informed consent may be necessary for the data you are collecting, it is best to ask your institutional review board (IRB) as early on in the process as possible.

Now that you know what kind of data and information you want, you can develop a simple plan for gathering it.

Create and implement a data collection plan

At this stage, you may have already collected the most readily available data and information you want and determined what else you need. Organizing your next steps into a clear plan will help you stay on track. Remember – you want data and information that matches the scope of your planned work in your local area.

You'll find a simple Data Collection Plan Tool on page 20 to help you get organized. It may be possible for your work group to sit down and summarize your plan in an afternoon's work.

Here are some ideas to keep in mind as you prepare your plan:

Tie the specifics of your data collection plan to your key concerns – Make sure you're gathering information relevant to the issues at hand. This will make it easier to focus your efforts and then more quickly narrow down the results of your data gathering to identify priorities for your attention.

Find creative ways to get the information you need – Some of what you're after might take some negotiation with different agencies, organizations or individuals who have the information you want. If they're not already a part of your work group, you'll want to negotiate for their participation and explain clearly what it is you need.

Be realistic – Make every effort to clearly define what information you're after, where it is, who will get it and when you'll be done. Being clear up front will help you stay true to your plan. If you must deviate from your plan, have a logical reason for doing so.

Get help – Engage individuals from local VA research centers (e.g., Mental Illness Research, Education, and Clinical Centers (MIRECCs); Centers of Excellence) and universities to provide assistance (see Appendix B for contact information). They

may be able to provide limited assistance to your team at no cost or in exchange for a research opportunity.



Instructions for Using the Data Collection Plan Tool

Make as many copies as you need for your workgroup to complete this task. The process for completing the Data Collection Plan Tool is as follows:

1. In column 2, write down what kind of information and data you need to get to answer the question in column 1 for the homeless Veteran population in your local area.
2. In column 3, note whether this is existing data or if you'll have to collect new data.
3. In column 4, describe where this data can be found (e.g. local homeless census, VA records, focus groups with homeless Veterans, human service resource guide).
4. In column 5, specify who will be responsible for collecting the data and by when.

Fill in all the information you can. Feel free to add additional rows to accommodate other questions which you would like to find answers to. Proceed even if you don't have all information to fill in the plan that you need. Gaps may reveal what you need to fill in to get what you want.



DATA COLLECTION PLAN TOOL

Assessment Questions	What kind of data can we get to answer these Assessment Questions?	Existing or New data?	Briefly describe where we will get this information?	Who will be responsible for data collection / by when?
1) How would you describe the demographics of the homeless Veterans in your local area?				
2) What is the prevalence and incidence of Veteran homelessness in your local area?				
3) What are the most important risk factors associated with homelessness in your local area?				
4) What cultural, economic, and socio-political factors impact homelessness in your local area?				
5) What existing programs, services, and resources in your community address homelessness, housing, and employment?				
6) What potential collaborations or partners might you leverage to support your efforts?				



Look for an existing relationship between someone in your group and a trusted individual from whom you need to gather information. Or tap informal channels for getting what you need. Reminder – offer to share the final results of your data gathering with participants in exchange for their help.

The more thorough you are in completing your data collection, the more effective and accurate you'll be in eventually designing and implementing your programs and evaluations to meet the needs of those you wish to serve.



Integration Tip: Have everyone in your workgroup or on staff start using copies of the worksheets or tools in this chapter. This helps in a couple of ways. If everyone is using the worksheets and tools, it will help them work more on common ground and encourage them to talk common language. You can also start using the worksheets and tools as the formats for reporting back to your participants, stakeholders and community. This cuts down on paperwork, too. This tip works for developing a new program or updating your data, needs and resources assessments while running an existing program.

Assessing Community Resources

The third area of information gathering is determining what resources already exist in your medical center or community. A good resource assessment will show you a wide variety of existing programs, organizations and initiatives in your local area. You want to know who's already working on the problems you want to solve so you can avoid duplication of effort and not waste resources.

For example, find out what agencies operate in your local area that are either already working on homelessness. You may find that as you go about gathering data through focus groups and interviews, it's easy to also ask about resources at the same time.

Understanding the resources available in your local area – and assessing how effective they are – will help you see what gaps may exist, what's already working, and spark some ideas about who you might partner with to solve problems, save time and money, and avoid duplicating services.

When preparing to do a resource assessment, think of a wide range of existing programs and institutions both within the VA (other programs that address homelessness like MHICM or local Veteran Service Organizations and Vet Centers) and in the community such as shelters, faith communities, local governments, service groups, and cultural organizations.

Again, look for existing materials or connect with partners or other individuals who may be willing to collect data for your organization such as graduate students at a local university,

paraprofessionals, or volunteers from your local VA's Volunteer Services. Even if you don't have a lot of resources and staff, there are still ways to get data and information you need.

To help you conduct your resource assessment, we've provided a Resource Assessment Tool on page 23.



Instructions for Using the Resource Assessment Tool

Make as many copies of the tool as you and your work group need to complete this step. The process for completing the Resource Assessment is as follows:

1. Starting at the top of the tool, in row 1 (Name of Resource), write down the name of the resource, program or organization you're describing.
5. In row 2 (Location), if relevant, note the location of the resource or where it's delivered.
6. In row 3 (Contact Information), provide contact information, such as phone, email, fax, and contact person's name and position, if available.
7. In row 4 (Hours of Operation), describe how often the resource is available including hours of operation or how often it operates. It's important to be specific here because this information helps you identify the frequency and intensity of the resource which helps make conclusions about the appropriate "dosage" of the services.
8. In row 5 (Who Served?), describe what you know about who uses the program or resource. This goes beyond eligibility requirements and gets more at demographic information about who is served.
9. In rows 6 (Services Provided), describe the specific programs or services offered by this resource.
10. In row 7 (What's Working), collect any information you can find on what the successes are associated with this resource or program.



RESOURCE ASSESSMENT TOOL

	Resource 1	Resource 2	Resource 3
Name of resource			
Location			
Contact Information			
Hours of operation			
Who served?			
Services provided			
What's working?			

Interpret and analyze the data

Once you've gathered all the relevant data, it's time to make sense of what the data is telling you so you can use it wisely. This step is difficult to describe since organizations and communities face a wide variety of unique, complex situations that cannot all be covered within the scope of this document. The complexity or simplicity of this task will depend, in part, on how you've formed your assessment questions and how much data you've collected. As you move forward, you want to ensure the information you've gathered is clear, simple, understandable and useful to those who'll be seeing and using it.

A good analysis will help you adapt programs to meet any unique needs of homeless Veterans in your local area, target your interventions, and use your resources wisely. This means sometimes going beyond just homelessness statistics in your area.

Here are some tips that will help you do the best job of analyzing and summarizing:

Use the most recent data available – Archival data may not be current enough for your needs, so try to find the most recent data or use other kinds of data to corroborate archival data.

Choose people over data – When you're presented with conflicting information between older, existing data and recent local data, such as what people tell you in focus groups, lean toward placing greater emphasis on what local people say. They're likely to know the area better and have the most recent, personal information.

Look for patterns – Interpreting data can be tricky and difficult. As you go through this process, spend a lot of time asking “why” and “how do you know” questions to help you determine why the data might be suggesting certain patterns. Where data sources do not suggest similar patterns, such as Veterans' perceptions of a problem vs. health data, then it's important to give credibility to the Veterans' perception because data sometimes doesn't tell the whole story or is not as up-to-date as it could be.



At this point, you could consider hiring or recruiting an expert to assist you in data analysis and interpretation to help you make sense of the data.

To keep your efforts current, you'll probably want to regularly update and reassess your data and information. For example, you can set up a simple system for keeping track of your data gathering efforts noting the dates of your surveys. You could also indicate on your data collection plan when you plan to redo your surveys.

Use the data to select priority needs

If you have not already done so, now use the results of your data collection to select the priorities you want to address concerning homeless Veterans in your local area. The information you've collected in the assessment process should provide you with a clear road map, guiding you toward the choice of the most appropriate interventions. This will, in turn, help you develop clearer measurable outcomes. For example, the needs assessment mentioned earlier in this chapter found that 37% of homeless Veterans in their service area had previously been in supported housing but eventually lost it (Henderson et al., 2008). This led VA providers to realize that the intensity of case management provided in conjunction with supportive housing was insufficient for helping Veterans retain their housing. This also highlights the importance of measuring length of housing stays as an outcome, rather than just the percentage of Veterans in housing at a particular point in time.

For every strategy you eventually choose to implement, you should be able to point to the data in your needs and resource assessment that led you to choose that strategy.

If you have not yet reached a point where you are confident about the priorities you want to establish, then you can use the tools we've given you in this chapter to help you develop them. Convene any combination of your workgroup, staff, volunteers, Veterans or community members to go over the results of your assessment and decide which priorities are the most important to address homelessness among Veterans in your community.

There is no single answer or strategy to solving the problem of homelessness so your conclusions should reflect multiple approaches.

Think about these questions as you work on developing your priorities:

What factors contribute to Veteran homelessness?

What have you learned about what the research says influences these factors?

Which of these factors can be altered?

Altering which factor will result in the greatest improvements in the lives of Veterans?

It's important to be clear about not only those factors which can be changed, but those which you think your program can change. For example, it would not be a good use of your resources to try and reach or measure the impact of your interventions on substance abuse if your program is focused solely on employment.



Instructions for Applying This Step When You Already Have a Program

Whether you have already selected a program to implement or have been running one for awhile, you could use the tools provided in this chapter to help you review your program as if looking at it through a fresh set of eyes. Try these ideas:

Review your basic information – Perhaps you’ve never done a complete data or resource assessment. Even if you have, now may be the time to update the data and information on which your interventions are based.

Review your assumptions and priorities – You could convene a work group for an afternoon’s review of the major questions in this step. The workgroup could be just the members of your staff or you could include program volunteers and Veterans. You could also convene a workgroup that includes other people from programs similar to yours or stakeholders drawn from the larger medical center and community. A review could reveal specific areas to explore or fine-tune. It could also reassure you that your work is right on target.

Change your focus – If your work has been largely deficit focused, now may be the time to emphasize a focus on Veteran strengths. Using the data you collected, you may generate ideas for more fully utilizing the strengths of Veterans themselves.

Find new resources and partnerships – A review of your data and assessments at this time could help you identify new sources of support, or partnership. New programs or interventions may have started since you began your work and developing relationships with other effective programs will help not only address issues in your local area but help you strengthen and sustain your work.



Checklist for Step 1

When you finish working on this step, you should have:

- Established a diverse assessment committee or work group to collect data if needed.
- Developed and carried out a data collection plan which included gathering data on homeless rates among Veterans in your local area.
- Conducted a resource assessment to identify resources that may be already available to help you address homelessness among Veterans.
- Identified the critical data connected to homelessness specific to your local area.
- Analyzed the data you collected.
- Selected priorities which emerged from your assessments.
- Identified important demographic groups among homeless Veterans in your local area which may impact the design of services (e.g. ethnicity, age, gender, OEF/OIF, etc.).
- Used the tools in this step to review your work if you already have a program.

Before Moving on to Step 2

Now you'll move on to using the information you've gathered and the priorities you've identified to help you develop specific goals and desired outcomes. The priorities from Step 1 and the goals and desired outcomes you develop in Step 2 will form the basis for selecting the programs and strategies you plan to implement as well the outcomes you eventually plan to measure.

Step 2: Identify The Goals And Objectives For Your Homeless Program.

Overview of Goals and Objectives

Having chosen the top priorities you want to address and the specific groups of homeless Veterans you want to serve, you're now ready to get more specific about what your goals and desired outcomes will be for your program. Goals reflect what impacts you hope to achieve in the future. Goal statements provide the overall direction of the program and state what is to be accomplished. They provide the foundation for specific objectives and activities that will ultimately define the program. Objectives and/or outcome statements are changes that occur as a result of specific programs. Typically, objectives are related to changes in:

Knowledge: What people learn or know about a topic (e.g., how to use hygiene products, how to use the Internet to locate resources)

Attitudes: How people feel toward a topic (e.g., attitudes toward alcohol and drug use, attitudes towards work)

Skills: The development of skills (e.g., resume writing, interviewing, job searching, money management)

Behaviors: Changes in behavior (e.g., reduced use of alcohol, increased participation in employment, education, or volunteering)

This step will help you decide what you want to accomplish and how you want the lives of Veterans in your local area to change as a result of the programs you plan to implement.

The first step in developing clear goals and desired outcomes is to use the results of your needs assessment to identify what needs are greatest among homeless Veterans and where your program can have the biggest positive impact on their lives. By identifying these early in planning, it's easier to keep focused on your desired outcomes as you select program activities, deliver and evaluate your efforts.

In essence, Step 2 will help you lay the groundwork for showing the logic behind your program and, later, how specific program activities will be linked to desired outcomes. Also, by doing this early-on, you will make it easy to demonstrate to others how and why your program should work.

Why?

It's important to articulate clear goals and desired outcomes so you know where you're headed and can articulate and measure your impact. Clear goals and desired outcomes will help you identify the appropriate programs and activities to use to reduce and prevent homelessness as

well suggest which evaluation methods to use. These conclusions will form the basis of the desired outcomes you'll evaluate in later GTO steps.

How?

Create Goals

A goal indicates the overall direction your program will take and describes the impact you hope to have in the future. Your goals should be built upon the priorities you identified in Step 1, be consistent with your organization's mission and be achievable given the resources you have. And remember – you don't need a lot of goals. One or two good, clear goals will help you stay focused.

At this point, you should get more specific about your program's goals. For example, your goal may be very specific to the Veterans in your city or it may cover a wider geographic area such as your entire VISN. It may also specify specific groups of homeless Veterans, such as potentially employable homeless Veterans or dually diagnosed homeless Veterans.

In identifying goals, it may be useful to address questions such as the following:

- What are we trying to accomplish?
- What are the desired results we expect?
- How would we like the conditions to change?

If it is decided to implement an evidence-based program, it may be that the goals are already identified for you. That is, most program developers have already worked out, through their own evaluation studies, which goals are appropriate to expect that the program achieve.

Here are some examples of goals:

- Reduce substance abuse among homeless Veterans in VISN 4.
- Increase employment among Veterans placed in supportive housing.
- Reduce the number of Veterans becoming homeless after release from prison.

Create Objectives or Desired Outcomes

An objective is a statement that makes goals more concrete. To develop useful objectives (or outcome statements), remember to describe what specific change(s) you expect to occur as a direct result of your program. Keep these in mind:

- An objective should be specific and measurable.



Don't phrase a goal statement as an activity. To implement a vocational program is NOT a useful goal statement; it does not describe how homeless Veterans lives will improve.

- An objective should specify what will change (e.g., knowledge, skills, attitudes, behaviors); for whom (e.g., enrolled homeless Veterans) by how much (e.g., average income will increase to 200% of poverty level, stays in homeless shelters will be reduced by 50%); by when (e.g., by the end of your program, at a six-month follow-up).
- There is likely to be more than one objective for each goal.
- The objectives statements should be logically linked to support the attainment of the goal(s).

In specifying objectives, it is useful to address questions such as the following:

- What should be the immediate changes in our target population as a result of our program?
- What changes are reasonable to expect?
- What measures—tests, surveys, or other measuring tools—will be needed?
- Do we have access to these measures (or know someone who can help)?



Instructions for Using the Goal and Objective Tool

This tool uses a series of questions to help you identify the content details of what should go into your objectives.

The process for completing the Goal and Objective Worksheet is as follows:

1. Make as many copies of each of this worksheet as you and your workgroup need to complete the task.
2. Starting at the top of the tool, write your first program goal.
3. Moving down the page, answer the details of each of the five objective questions for your first objective related to the above program goal. Don't worry if you don't have all the answers. Working through this task may reveal some of the gaps in your information you need to fill so you can develop more specific objective statements.
4. If you plan to track progress towards this goal with more than one objective, answer the five objective questions for the other objectives below. If you have more than three objectives linked to this goal you will need to attach another copy of the tool for the remaining objectives.
5. Repeat the above steps for all of your program goals.



GOAL AND OBJECTIVES TOOL

Goal. (Goals are broad statements that describe the desired longer-term impacts of what your program is intended to accomplish. Please describe each program goal in the box below using one page per goal.)

Objectives are specific, measurable changes expected in your target population that indicate progress towards a goal. Each goal should have at least one objective.

Objective 1.

What will change?	
For whom?	
By how much?	
When will the change occur?	
How will it be measured?	

Objective 2.

What will change?	
For whom?	
By how much?	
When will the change occur?	
How will it be measured?	

Objective 3.

What will change?	
For whom?	
By how much?	
When will the change occur?	
How will it be measured?	

Objective 4.

What will change?	
For whom?	
By how much?	
When will the change occur?	
How will it be measured?	



Instructions for Applying This Step When You Already Have a Program

Whether you have already selected a program to implement or have been running one for awhile, you should use the tools provided in this chapter to help you review your program's goals and outcomes or explain the logic of your program. Try these ideas:

Start new conversations – Convene a workgroup, staff group or subcommittee for an afternoon's discussion about your program's goals and outcomes using copies of the tools from this step to help you think about your work.

Review and revise your existing goals and desired outcomes – Use the information in this step to review your program's goal(s) and desired outcomes and see if they need to be clarified or fine-tuned. (You may have called these objectives; we use these words interchangeably.)

Fill in the gaps – Revise objective statements using the Goal and Objectives Tool (see page 32).



Checklist for Step 2

When you finish working on this step, you should have:

- Program goal(s) that are clearly stated and not phrased as activities.
- Program goal(s) that are realistic and identify the expected results.
- Clearly defined the target population(s) or participants.
- Objectives (e.g., desired outcomes) that are linked to your goals.
- Specified the amount of change expected in each objective.
- Specified by when you expect the objectives to occur.
- Clarity about how the objectives will be measured.
- Access to the information needed to measure the goals and objectives.

Before Moving on to Step 3

All the information you've developed so far should be collected in your Goal and Objectives Tool. Now you're ready to take this material and use it to help you develop more of the details of your program planning and implementation.

The next four GTO steps work well as a unit to lead you through researching the best evidence-based approaches to use to achieve your goals and desired outcomes, as well as reviewing your program choices for the best fit in your local area, and to make sure you have the organizational capacity you need to actually deliver your chosen activities.

Part 2: Program Planning

Step 3 – Find Existing **Best Practices** That May Be Useful In Achieving Your Goals.

Step 4 – Modify The Best Practices To **Fit** Your Local Context.

Step 5 – Determine What **Capacities** Are Needed To Implement Your Program.

Step 6 – Make A **Plan** For Implementing Your Program.

Step 3: Find Existing Best Practices That May Be Useful In Achieving Your Goals.

Overview of Best Practices

Your needs and resource assessments have helped you form your initial goals and desired outcomes. You have a better idea of what you want to accomplish; now we'll begin to explore how you will achieve your goals. Although the VA Uniform Mental Health Services Handbook provides some guidance on homeless programming, the handbook is deliberately non-prescriptive in most programming areas in order to allow each VA Center to choose programs that are most appropriate for their local circumstances (i.e. identified needs, available resources, target populations, etc.). This step will introduce you to programs and practices that have been successful at achieving goals for homeless individuals. Familiarity with what programs and practices have demonstrated success elsewhere will help you select, design, or modify your own program so that it is most likely to reach your chosen goals given your local circumstances.

Levels of evidence

Whether you will be starting a new program or are looking to change your program, your efforts should be informed by evidence of what has worked previously to reach the goals and outcomes you've selected. The amount, type, and quality of evidence available to make decisions about your program will vary depending on the goals you have selected. In this manual, several terms are used to describe the level of evidence for homelessness interventions:

Evidence-based programs (EBPs) – Evidence-based programs represent the highest level of evidence. These programs:

1. are designed around a clear theory
2. include clear instructions for how to implement the program
3. have demonstrated through high-quality research success at achieving specific outcomes across multiple settings.

Promising programs – Promising programs are similar to evidence-based programs. They have some research demonstrating success at reaching specific outcomes, but the level of evidence is not sufficient to classify them as “evidence-based”. This may be because the program has not yet been tested across multiple settings, locations, or with diverse populations, or it may be that confidence in the research is not as high because of issues with how the research was conducted.

Best practices – In some areas of work with homeless individuals (such as outreach), there may not yet exist well-articulated programs with documented success at achieving your goals. You may need to design your own program. However, even in this case, there is typically knowledge available in the field about what techniques and processes are likely to contribute to success. Such knowledge may come from research looking at the common characteristics of successful programs, consensus panels of experts, or the accumulated experience of practitioners in the field. Such techniques and processes are known as “best practices” and ought to inform the design and implementation of any program that is not classified as an evidence-based or promising program. Best practices for implementing specific evidence-based programs are also often identified in the documentation for these programs.

The tasks in this step will help you:

- Understand the key characteristics of successful evidence-based programs
- Review available evidence-based programs and best practices you may be able to use to achieve your goals and desired outcomes
- Select one or more candidate programs to explore further

This step will guide you through connecting your goals and desired outcomes with the evidence-based programs you identify in this step for further exploration. Maintaining a clear connection between goals, desired outcomes and evidence-based programs not only helps focus your work but increases your overall chances of success. It’s important to note that although implementing evidence-based programs are your best opportunity to achieve outcomes, they are not a guarantee of success. You should still evaluate your program to make sure it’s achieving the desired outcomes.

Why?

Many programs aimed at preventing or alleviating problems among homeless Veterans have been rigorously researched, and have been shown to improve outcomes for these Veterans. These programs are available for you to draw on so you can build on what’s already known to increase your programs’ chances of success. Taking some time to learn more about existing evidence-based programs can help you focus your program planning and avoid wasting resources on ineffective interventions. While some research is complex and presented in scientific journals, there are materials available that put concepts and results into friendlier language. Using these resources will make it easier for you to communicate with your staff, participants and community about key program components that lead to success. When planning to start a new evidence-based program together with staff, it is important to:

- *Increase communications and confidence* – Involving staff in understanding and developing successful interventions creates an environment where concerns can be openly expressed or changes made. You can address concerns or resistance and tackle uneasy subjects while deepening an understanding of exactly how a program should work to meet your goals.
- *Help staff understand new demands* – It often takes just as much time to do a program that doesn't have a proven track record as it takes to do one that does. The good news is that implementing evidence-based programs increases your chances of success and makes everyone's job easier. Going through a process with staff so they understand the way that a new program changes behavior—i.e., reduces Veteran homelessness—may help them adhere more strictly to the program design.
- *Clarify appropriate adaptations* – Not all evidence-based programs will meet all of your participants' needs. Sometimes a new EBP seems too complex and staff may not want to implement it as it was originally designed. Understanding what can be adapted and more importantly, what can't be adapted, will help you maintain program effectiveness.
- *Use resources wisely* – Some evidence-based programs require a lot of resources to implement. Understanding available proven programs may help you feel more confident about investing your time and money in something you know will work.

How?

This step involves the following tasks:

1. Learning about potential evidence-based programs and best practices.
2. Considering which programs will work best for you.
3. Narrowing down your options to one or more programs to research further.

If you are already running a program, we will also show you how to use tools and ideas for making sure your work is in line with the latest best practices in homelessness.

There are two important questions to keep in mind as you move forward with researching potential programs to use:

1. Can you simply copy and use an existing evidence-based program as-is? Faithfully copying an evidence-based program is referred to as implementing with “fidelity”.
2. Do you need to change an evidence-based program in some way to make it fit more appropriately with your target population, your level of resources, or the philosophy of your organization? Needing to change some components of a program so that it works well for your participants is referred to as “adaptation”.

It may not be possible to simply replicate all the components of an existing program. A program which has been proven effective for urban Vietnam Veterans will not automatically translate into success with OEF/OIF Veterans in a rural community without some changes. But neither can you arbitrarily pick and choose the components you want to copy and change. If adaptations must be made, you need to understand which ones are acceptable to make without undermining the effectiveness of the program.

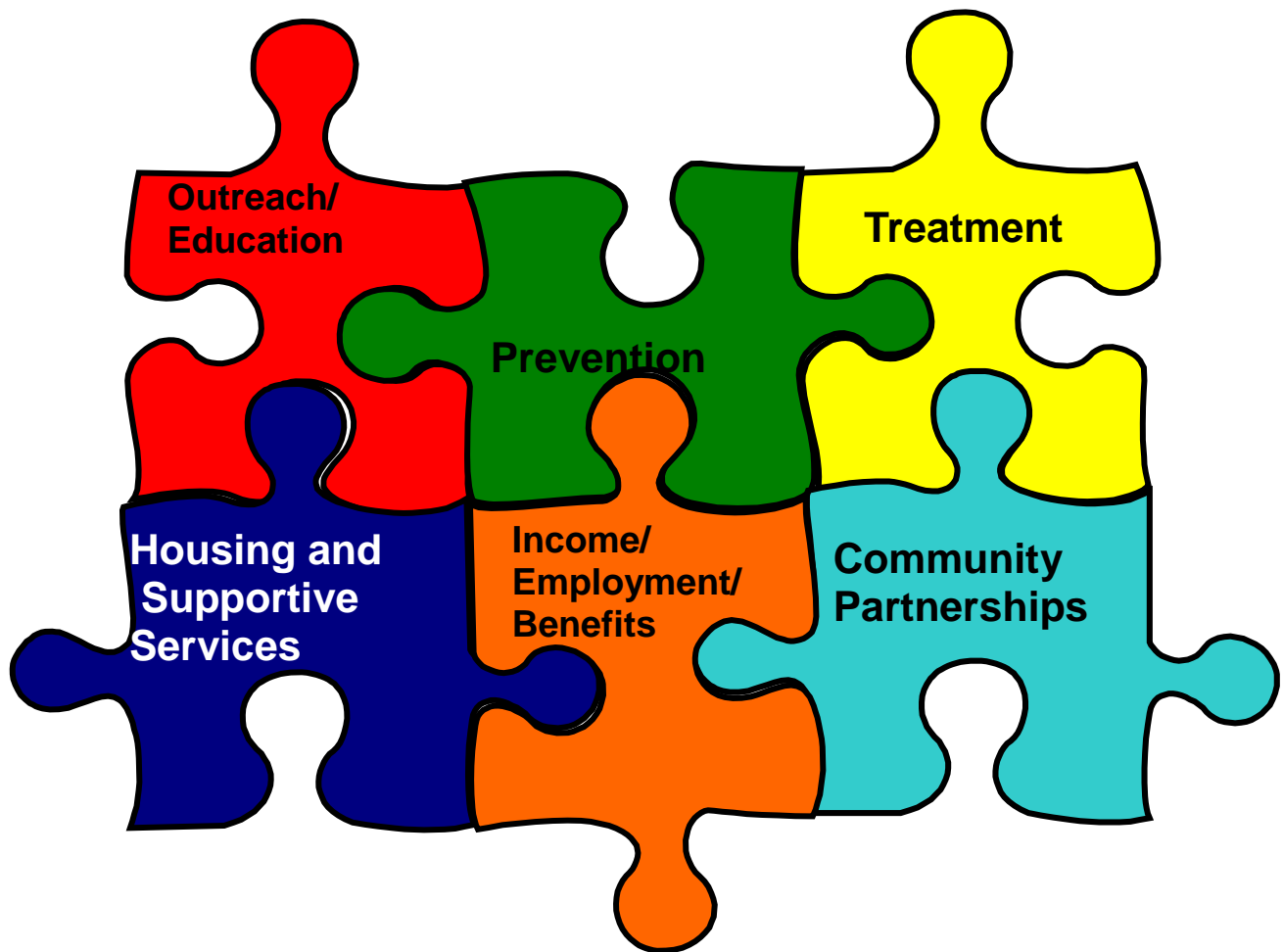
The core components of a program must be implemented with fidelity to ensure that the desired outcomes are reached. More guidance about adaptation of evidence-based programs is provided in Step 4.

Learn about potential evidence-based programs

Once you’ve looked at a variety of programs, we’ll help guide you toward narrowing down your choices of possible programs. In Steps 4 and 5 you’ll go into a more in-depth review of your short list.

We recommend you begin your look at these potential programs with your goals and objectives in mind (developed in Step 2). Use them to remind you which desired outcomes and target populations you’ve chosen. Your examination will reveal successful programs that have reached similar goals, outcomes, and participants.

There are many research resources, some of which you may already be using, but to help you get started, we provide a library of evidence-based programs, promising programs, and best practices regarding homelessness in Appendix C. The library is organized by the six interlocking components that make up the VA’s strategy to eliminate homelessness among Veterans identified in the VA’s five-year comprehensive plan. A summary of this library starts on page 42.



Some of the six components in this plan have received more attention in the research literature than others. Evidence-based and promising programs are listed in the library for those components in which they exist. These programs were identified through two major sources, both from SAMHSA. The first is a report done in 2003 called Blue Print for Change (<http://mentalhealth.samhsa.gov/publications/allpubs/sma04-3870/default.asp>). The second is a registry created by SAMHSA to document and report on evidence based programs and practices. This registry, called the National Registry of Evidence-based Programs and Practices (NREPP) identifies several programs specifically helpful in working with homeless populations (<http://www.nrepp.samhsa.gov/>). We also attempted to identify additional promising practices in the research literature for those components for which programs were not found in the above two resources. Since the purpose of this manual is to improve the quality of care for homeless Veterans, those programs that are already well established throughout the VA, such as HUD-VASH and Grant and Per Diem, are not separately listed in the library, although these programs have been shown to positively influence outcomes for Veterans and could be considered evidence-based practices. Instead there is a brief summary of these programs in the “Established VA Programs and Services” section for each of the six components from the five-year plan. Best practices are described for all six components and also for specific evidence-based and promising practices where available.

Consider which programs will work best for you

As you look over the library, focus on programs which best match the age, ethnicity, and gender of your intended participants. You want a program that has been shown to be effective in achieving goals and desired outcomes similar to yours. There will probably not be an exact match. This doesn't mean the program may not be a good fit.

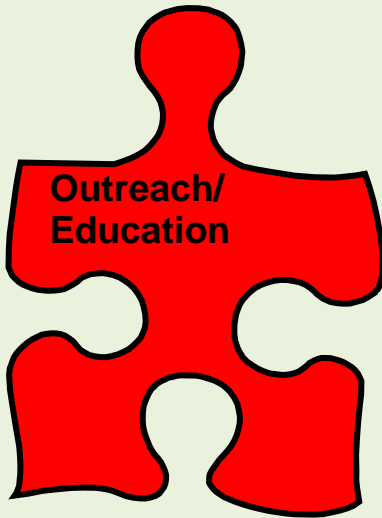
It's important to identify programs you think you can deliver with a relatively high level of fidelity, but we realize the best choice for you may be to adapt an evidence-based program to make it work for you. It's important to know, however, that anytime you change an activity in an evidence-based program, you potentially change the effectiveness of the program. If you omit critical program elements, you may risk cutting out the factors that made the program work in the first place.

You'll need to remain open minded and creative when thinking about whether to adapt a given program. Will you need a lot of changes or just a few in order to make the program work for your staff and Veterans? Generally you'll want to maintain:

- *Program dosage* – Reducing dosage (e.g., reducing a 12-session curriculum to only 4 sessions) will most likely seriously compromise the program's content.
- *Consistent number of facilitators* – Using fewer facilitators may make it harder to achieve results in the recommended timeframe or make sessions less effective.
- *Format* – A program based on interactive activities probably won't work as well if changed to a lecture format.
- *Similar priority populations* – What works for one age group or ethnic community will not automatically work well for a different group.

It's important to consider the resources that are required to carry out the program and determine whether the materials costs or special training needs are feasible for your organization. You should also work to completely understand how the program works, including the link between specific activities, behaviors, and outcomes.

If possible, talk to others who have implemented the same program or similar programs in your content area. Contact your Mental Illness Research, Education, and Clinical Center (MIRECC), Systems Redesign Committee, or other local technical assistance group or the program developer who might help you identify others who have implemented this specific program. You can ask questions about their experience and gain a fuller understanding of what the program is really like when implemented. This will help you anticipate challenges as well as opportunities the program can provide.



Outreach and Education

Overview: Outreach is a broad term to describe activities which increase the likelihood of the homeless engaging in services over time. Education, in this case, involves educating both homeless Veterans and the VA and non-VA providers who serve them about the services available to meet the needs of homeless and at-risk Veterans. With outreach, the outreach worker meets the homeless where they are, bringing services into their world rather than expecting the client to come to their agency. Quite aside from this practical element of outreach, there is a personal connection that develops over time, and results in a trusting relationship between worker and client. Over time, and based on this relationship, the client may choose to use the services available to move from homelessness into housing, recovery or employment. Skilled outreach teams in the Access to Community Care and

Effective Services and Supports (ACCESS) program have proven effective in reducing involuntary commitment and increasing enrollment in services (Lam & Rosenheck, 1999). When outreach workers develop a genuine relationship with homeless individuals who abuse substances, close to half will engage in treatment services voluntarily (Fisk, Rakfeldt, & McCormack, 2006). Outreach has been especially successful in reaching those homeless individuals with mental health issues, who may be most in need of services, but unlikely to seek them out (Rowe et al., 2002). Homeless Veterans experience a high level of frustration and stress while accessing traditional health care delivery systems (Applewhite, 1997), and are more likely to access care through outreach services (O'Toole et al., 2003). The ultimate goal of outreach services for the homeless is to integrate individuals back into the community and create the highest level of functional independence possible for the individual.

Established VA Services and Programs:

Although *Healthcare for Homeless Veterans (HCHV) Programs* initially served as a mechanism to contract with providers for community-based residential treatment for homeless Veterans, many HCHV programs now serve as the hub for a myriad of housing and other services which provide VA a way to outreach and assist homeless Veterans by offering them entry to VA care. Outreach is the core of the HCHV program. The central goal is to reduce homelessness among Veterans by conducting outreach to those who are the most vulnerable and are not currently receiving services and engaging them in treatment and rehabilitative programs.

Stand Downs are one part of the Department of Veterans Affairs' efforts to provide outreach to homeless Veterans. Stand Downs are typically one to three day events providing services to homeless Veterans such as food, shelter, clothing, health screenings, VA and Social Security benefits counseling, and referrals to a variety of other necessary services, such as housing, employment and substance abuse treatment. Stand Downs are collaborative events, coordinated between local VAs, other government agencies, and community agencies who serve the homeless.

The *National Call Center for Homeless Veterans hotline* (1-877-4AID or 877-424-3838) is another program that increases the accessibility of VA homeless services and provides information and assistance regarding these services to VA Medical Centers, federal, state and local partners, community agencies, service providers and others in the community. The hotline provides homeless Veterans or Veterans at-risk for homelessness with free, 24/7 access to trained counselors.



Prevention

Overview: Most VA homelessness services are designed to help Veterans who have already lost their housing to find and keep new housing. No matter how effective these services are these services will never end homelessness among Veterans, as long as new Veterans continue to lose their housing. Programs to prevent loss of housing in the first place are just as important if the goal of ending homelessness among Veterans is to

be realized.

The typical route to homelessness is well documented, and usually starts long before an individual or family arrives at shelter care. The National Alliance to End Homelessness suggests imagining a sequence of events from a crisis to shelter care, and thinking of them like a bus route to homelessness. People can get on at different points, and they can exit whenever they can find a solution to their crisis (NAEH, 2009). Early intervention and assistance is the key to preventing homelessness. Keeping existing housing is often the least expensive and least traumatic solution to homelessness, and may involve financial assistance or negotiations with the landlord or host family. If this does not occur, later intervention can still prevent homelessness if those seeking shelter can be diverted to safe temporary housing. A systematic and comprehensive system of prevention that can be accessed at any point in an individual's "bus route to homelessness" is recommended for optimal prevention of homelessness.

Preventing homelessness is an effort that involves community wide participation. Current homeless programs at the VA are well positioned to use their community contacts to approach homelessness from a prevention perspective. However, some experts suggest an overall redesign of the current model. A model of prevention recommended by Culhane and Metraux (2008) requires that programs move away from a continuum model based on shelter, and move towards a model based on stabilizing or sustaining housing, and then providing individualized services as needed. While the current model provides everyone with shelter and services, Culhane and Metraux (2008) argue that many could be better served with early interventions to maintain existing housing.

Established VA Programs and Services: The *Veteran Justice Outreach Initiative (VJO)* is a program that prevents homelessness by assisting incarcerated and justice involved Veterans with their reentry into the community. Incarcerated Veterans are at substantial risk of homelessness at the point of community re-entry (Mumola, 2000). VA Medical Centers have been strongly encouraged to develop working relationships with the court system and local law enforcement and must now provide outreach to justice-involved Veterans in the communities they serve. Each VA medical center has been asked to designate a facility-based Veterans' Justice Outreach Specialist, responsible for direct outreach, assessment, and case management for justice-involved Veterans in local courts and jails, and liaison with local justice system partners.



Critical Time Intervention

Level of Evidence: Evidence-based program

Description: Critical Time Intervention (CTI) is a case management model. It is designed specifically to prevent homelessness for individuals with mental illness as they are being discharged from institutional settings. CTI works in two ways: by providing practical and emotional support during the transition time, and by intentionally strengthening the individual's ties to services, family and friends. Unlike other assertive or intensive

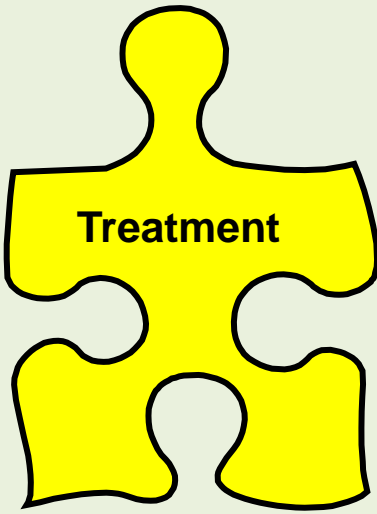
case management strategies, CTI is time limited, and lasts for nine months following discharge or placement into housing. The goal is to help the client establish community supports, and then keep these supports in place, with a specific goal being to prevent homelessness.

CTI involves three distinct phases, carried out over nine months. In the first phase, during the first 3 months, the case manager makes home visits, and meets with the client and new community providers. The case manager provides support and guidance for both the client and the new care givers. In the next four months, a second "tryout" phase is devoted to testing and adjusting the system of support. The case manager works to increase the client's problem solving skills, and observes how the client's support network is operating. Finally, in the last two months, the final "transfer of care" phase occurs, where a gradual process allows a total transfer of care to the new community providers. This phase often includes a party or formal recognition of the transfer of care.

Goals:

1. To prevent homelessness among individuals being discharged from shelters, hospitals, and other institutions into the community.
2. To strengthen individual's long-term ties to services, family, and friends.

Target Population: Individuals being discharged from shelters, hospitals, and other institutions into the community.



Treatment

Overview: Homeless Veterans often have significant treatment needs (Dougherty & Smits, 2009):

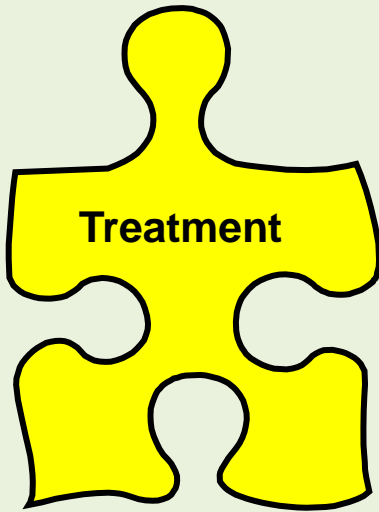
- 66% Alcohol abuse
- 51% Drug abuse
- 54% Serious psychiatric diagnosis
- 39% Dual diagnosis
- 58% Health/physical

Homeless Veterans with serious mental illnesses and/or co-occurring substance use disorders have complex problems that require comprehensive treatment. Although their need for treatment is often higher than Veterans with housing, they face more difficulties accessing the services they need. Some of the barriers to engaging homeless Veterans in treatment

include: social isolation, distrust of authorities and service providers, geographic instability, and multiplicity of treatment needs (Zerger, 2002).

Established VA Programs and Services: The *Domiciliary Care for Homeless Veterans* (DCHV) Program provides biopsychosocial treatment and rehabilitation to homeless Veterans. The program provides residential treatment to approximately 5,000 homeless Veterans with health problems each year and the average length of stay in the program is 4 months. The domiciliaries conduct outreach and referral; vocational counseling and rehabilitation; and post-discharge community support.

The *Homeless Veteran Dental Program* was established by the Veterans Administration in 1992. In surveys listing and ranking the 10 highest unmet needs for homeless Veterans, dental care was consistently ranked by homeless Veterans as one of their top 3 unmet needs, along with long-term permanent housing and childcare. Dental problems, such as pain and/or missing teeth can be tremendous barriers in seeking and obtaining employment. Studies have shown that after dental care, Veterans report significant improvement in perceived oral health, general health and overall self-esteem, thus, supporting the notion that dental care is an important aspect of the overall concept of homeless rehabilitation.



Assertive Community Treatment

Level of Evidence: Evidence-based program

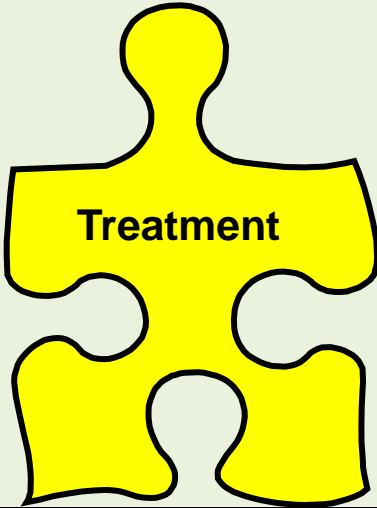
Description: Assertive community treatment (ACT) got its start over 30 years ago in Wisconsin. A group of mental health professionals designed the program to address the needs of seriously mentally ill clients who were being discharged from inpatient treatment, only to find themselves right back in care a short time later. These repeated hospitalizations were an initial focus of ACT, a program that aimed to keep people in the community and address their needs without extensive inpatient care. In the ACT model, service is delivered by a team of professionals, who provide care to the consumer for as long as needed. The goal is to provide services 24 hours a day, 7 days a week, and to provide these services in the community. The team members collaborate to provide services, and adapt and change their approach as the client's needs change. The team is not established to broker

services, but to deliver services directly to the client. An ACT team usually consists of 10-12 people, from psychology, psychiatry, nursing, and social work. Many teams have a substance abuse counselor. The goal is to make the team large enough to provide coverage 24/7, while keeping the team small enough that each professional is familiar with all the consumers served by the team. Generally, a 1-10 ratio is recommended, although this can change slightly if the consumers have especially intensive needs, or are located in rural areas where extensive driving is necessary to reach consumers. ACT has been well researched since its creation and has established standards and protocols in which its fidelity can be assessed. The VA has adopted this model at most of its Centers, calling it Mental Health Intensive Case Management or MHICM.

Goals:

1. To allow individuals with severe mental illness to remain in the community and avoid institutionalization.
2. To decrease symptoms from mental illness
3. To decrease substance use

Target Population: Individuals with co-occurring severe mental and substance use disorders who are at high risk of institutionalization and other adverse outcomes.



Motivational Interviewing

Level of Evidence: Evidence-based program

Description: Motivational Interviewing (MI) is a counseling style, designed to create behavior change by exploring and resolving ambivalence in the client. Ambivalent feelings and attitudes towards a behavior lead to a lack of resolve that is a primary obstacle to behavior change. This approach was first described by Miller in 1983, and has been developed into a coherent theory by Miller and Rollnick (1991, 2002). Motivational interviewing has been used to bring about behavior change in many areas, including many that are closely associated with homelessness, such as substance abuse, mental health treatment compliance, and job seeking.

Goals:

1. To help people overcome ambivalence and commit to change.
2. To increase treatment engagement.

Target Population: Individuals who are ambivalent about making behavioral changes in areas such as substance abuse, mental illness treatment, and employment.



Housing and Supportive Services

Overview: The solution for ending homelessness is ultimately housing. However, a large portion of homeless Veterans face multiple barriers to independent living, such as mental illness, substance abuse, and physical disabilities. These Veterans are likely to need multiple supportive services over an extended period of time in order to maintain housing.

Housing programs vary widely in their philosophies, design, and provided support services. Careful consideration should be given when designing housing programs to

make sure that they meet the needs and preferences of the intended tenants. Segregated group homes have often been used to provide housing to people with serious mental illness, although people with serious mental illness prefer integrated, regular housing (Carling et al., 1987; Brown et al., 1991). Veterans with substance use disorders may initially require low-demand housing (see Housing First program below) in order to encourage them to engage in services. Providing housing to homeless individuals has been shown to increase retention in substance abuse treatment, but these individuals will not do as well when housing requires participation in high intensity services (Orwin et al., 1999). Programs that combine affordable, independent housing with flexible, supportive services have been shown to be most successful at establishing housing stability, and improving mental health and recovery from substance abuse (SAMHSA, 2003).

Established VA Programs and Services: The Department of Housing and Urban Development and the Department of Veterans Affairs Supported Housing (*HUD-VASH*) Program, through a cooperative partnership, provides long-term case management, supportive services and permanent housing support. Eligible homeless Veterans receive a voucher from HUD to offset most of the cost of housing and VA provided case management and supportive services to support stability and recovery from physical and mental health, substance use, and functional concerns contributing to or resulting from homelessness. The program goals include promoting maximal Veteran recovery and independence to sustain permanent housing in the community for the Veteran and the Veteran's family.

VA's Homeless Providers *Grant and Per Diem Program* is offered by the Department of Veterans Affairs Health Care for Homeless Veterans (HCHV) Programs to fund community agencies providing services to homeless Veterans. The purpose is to promote the development and provision of supportive housing and/or supportive services with the goal of helping homeless Veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. Only programs with supportive housing (up to 24 months) or service centers (offering services such as case management, education, crisis intervention, counseling, services targeted towards specialized populations including homeless women Veterans, etc.) are eligible for these funds.



Supportive Housing

Level of Evidence: Evidence-based program

Description: Supportive housing is a broad term used to refer to independent housing where the tenant has access to a flexible array of services, including medical, mental health, substance use and vocational assistance programs. Other services may include case management, life skills, money management, and tenant advocacy. The use of these programs may or may not be a condition for continued occupancy. Supportive housing is appropriate for anyone who is facing or experiencing homelessness,

and also has chronic mental or physical health issues, substance abuse issues, or multiple barriers to housing access.

Historically, supportive housing emerged as a response to several emerging issues including a greater desire for independent housing by clients with mental illness, and a realization that affordable, permanent housing, with supports, was a path to decreasing homelessness.

In supportive housing, the tenant typically pays between 30%-50% of their income towards rent, ideally not more than 40%. The tenant in supportive housing has a lease or occupancy agreement, and the housing is considered permanent, as long as the conditions of the lease are met. Supportive housing often involves a working partnership between the service providers and the property managers.

Goals:

- 1. Increase housing stability
- 2. Decrease symptoms of mental illness
- 3. Decrease substance use

Target Population: Individuals with serious mental illness in need of housing



Housing First

Level of Evidence: Evidence-based program

Description: The Housing First approach was developed in 1999 by the National Alliance to End Homelessness (NAEH). The approach represents a shift away from providing shelter and transitional housing, and a move towards prevention and immediate re-housing. Housing First has few requirements for those who participate, and does not require treatment for mental health or substance use issues prior to or after housing is secured. The Housing First model has several important principles:

- Homelessness is first and foremost a housing problem and should be treated as such
- Housing is a right to which all are entitled
- People who are homeless or on the verge of homelessness should be returned to or stabilized in permanent housing as quickly as possible
- Issues that contribute to homelessness can best be addressed once housed

(Adapted from NAEH, 2009)

The Housing First model has several important delivery components. These include providing emergency services when needed and a complete assessment of housing needs, resources, and services necessary to sustain housing. Housing placement services are also provided, including financial assistance, and advocacy and assistance in facing barriers to housing. In many cases, time limited case management is also a part of Housing First programs. The Housing First approach has been used extensively with populations with severe mental illness and substance abuse histories.

Goals:

1. Decrease the time people are homeless
2. Increase housing stability

Target Population: Chronically homeless individuals with severe mental illness



Income/Employment/Benefits

Overview: Employment and government benefit programs are the two primary potential sources of income to help homeless people secure permanent housing and basic needs. Forty-two percent of homeless individuals identify employment as a primary need and 24% identify lack of employment as a primary reason for their homelessness (Burt et al., 1999). However, serious mental and physical disabilities, and substance abuse are major barriers to employment for many homeless individuals in addition to a mobile lifestyle and limited work experience.

Although many homeless individuals qualify for Federal income and entitlement programs, such as SSI, many are not enrolled. Benefits counseling can help with enrollment by providing information about benefits and eligibility, helping gather required documentation, filing applications, and mounting appeals, if necessary.

For those who want to work, offering employment at the earliest stages of engagement may be effective to develop trust, motivation, and hope (Cook et al., 2001; Min, Wong, &

Rothbard, 2004). Fear of losing public entitlements, especially healthcare and Social Security Administration (SSA) cash benefits, can inhibit people from seeking work. Many Federal benefit programs have changed policies to remove barriers to work, but eligible recipients remain largely unaware of these changes. Benefits counseling can help homeless individuals navigate employment opportunities without sudden loss of needed benefits.

Integrating employment services with clinical treatment through multidisciplinary teams has been found to be superior to providing services separately, especially in regards to consumer engagement and retention (Bond, 2004). Integrating these services can be difficult, however, due to conflicting staff perspectives on treatment priorities, the importance of employment, and how services should be integrated. Cross-training in mental health and employment issues, creating protocols for communication among staff, and providing opportunities for program planning can help address these barriers (Quimby et al. 2001).

Established VA Programs and Services: In VA's *Compensated Work Therapy/Transitional Residence (CWT/TR)* Program, disadvantaged, at-risk, and homeless Veterans live in CWT/TR community-based supervised group homes while working for pay in VA's Compensated Work Therapy Program (also known as Veterans Industries). Veterans in the CWT/TR program work about 33 hours per week, with approximate earnings of \$732 per month, and pay an average of \$186 per month toward maintenance and up-keep of the residence. The average length of stay is about 174 days. VA contracts with private industry and the public sector for work done by these Veterans, who learn new job skills, relearn successful work habits, and regain a sense of self-esteem and self-worth.

VA's *Supported Employment (SE)* program consists of competitive employment with therapeutic supports integrated into treatment. The focus of SE as currently implemented in the VA is to assist Veterans with psychosis and other serious mental illness gain access to meaningful competitive employment. The principles of SE have been found to be broadly effective. A full description of SE follows on the next page, so consideration can be given to how SE principles may be integrated into other employment programs or used with other populations.

VHA has provided specialized funding to support Veterans Benefits Counselors as members of HCMI and Homeless Domiciliary Programs as authorized by Public Law 102-590. These specially funded staff provide dedicated outreach, benefits counseling, referral, and additional

assistance to eligible Veterans applying for VA benefits. VBA has also instituted new procedures to reduce the processing times for homeless Veterans' benefits claims.



Supported Employment (SE)

Level of Evidence: Evidence-based program

Description: "Supported Employment (SE) is an approach to vocational rehabilitation for people with serious mental illnesses. SE emphasizes helping people obtain competitive work in the community and providing the supports necessary to ensure success in the workplace. SE programs help consumers find jobs that pay competitive wages in integrated settings (i.e., with others who don't necessarily have a disability) in the community.

In contrast to other approaches to vocational rehabilitation, SE de-emphasizes prevocational assessment and training and puts a premium on rapid job search and attainment. The job search is conducted at a pace that is comfortable for consumers and is not slowed down by any programming prerequisites.

People with serious mental illnesses differ from one another in terms of the types of work they prefer, the nature of the support they want, and the decision about whether to disclose their

disability to the employer or coworkers. SE programs respect these individual preferences and tailor their vocational services accordingly.

In addition to appreciating the importance of consumer preferences, SE programs recognize that most consumers benefit from long-term support after successfully attaining a job.

Therefore, SE programs avoid prescribing time limitations on services. Instead employment specialists help consumers become as independent and self-reliant as possible.

The overriding philosophy of SE is the belief that every person with a serious mental illness is capable of working competitively in the community if the right kind of job and work environment can be found. Rather than trying to sculpt consumers into becoming "perfect workers," through extensive prevocational assessment and training, consumers are offered help finding and keeping jobs that capitalize on their personal strengths and motivation. Thus, the primary goal of SE is not to change consumers but to find a natural "fit" between consumers' strengths and experiences and jobs in the community." (SAMHSA Evidence Based Practices Kit for Supported Employment, Module 1, 2009, pp. 2-3)

Goals:

1. Increase consumers participation in competitive employment
2. Increase consumers self-esteem

Target Population: Individuals with severe mental illness and individuals with co-occurring substance use disorders



Community Partnerships

Overview: The VA Uniform Mental Health Services Handbook requires each medical center to develop and maintain relationships with community agencies and providers to support them in working together to allow appropriate placement for veterans together with their families when they are homeless or at risk of homelessness. Community partnerships allow VA Centers to combine resources (human, fiscal, and technical) with other community agencies and stakeholders to accomplish tasks in overcoming homelessness that a VA Center alone would

be unable to accomplish. Community partnerships can help avoid unnecessary duplication of services, mobilize resources that otherwise would remain underutilized, and create a critical mass needed to raise community awareness and build political support for homelessness initiatives.

When building partnerships VA Centers should consider three questions (Lasker & Weiss, 2003):

1. *Who is involved in the partnership?* Partnerships with a broad and diverse array of participants have a greater variety of knowledge, skills, and resources with which to work than partnerships with a few homogeneous partners. This helps partnerships understand problems from multiple perspectives and develop unique solutions.
2. *How are partners involved in the partnership?* Partnerships only benefit from the knowledge, skills, and resources of partners, if partners are given the ability to influence plans and actions. If a "lead organization" assumes all the control over an initiative, little benefit may be gained by including other partners.
3. *How will management and leadership of the partnership support the interactions of the partners?* Leaders who have backgrounds and experience in multiple fields, understand and appreciate different perspectives, can bridge diverse cultures, and are comfortable sharing ideas, resources, and power tend to be more effective in leading partnerships. Leaders must be able to inspire and motivate partners, facilitate collaboration among partners, and create an environment where differences of opinion can be voiced.

Partnerships are not without their costs, and they do not guarantee success. Some studies have shown that efforts of partnerships to integrate systems lead to improvement in the system's organization and performance but little or no improvement in clinical outcomes and quality of life for clients (Randolph et al., 2002). Partnerships can be time consuming for staff and involve a loss of autonomy and control over programs and initiatives. The decision to enter into partnerships must, therefore, be made carefully weighing both the costs and potential benefits.

Established VA Programs and Services:

The Community Homelessness Assessment, Local Education, and Networking Groups (*CHALENG*) for Veterans is a nationwide initiative in which VA medical center and regional office directors work with other federal, state, and local agencies and nonprofit organizations to assess the needs of homeless Veterans, develop action plans to meet identified needs, and develop directories that contain local community resources to be used by homeless Veterans.



Circles

Level of Evidence: Promising program

Description: Circles™ is an innovative model based on a body of research suggesting that in order for individuals with low income to improve their situation, they must have bonding social capital within the community, bridging social capital to access the resources contained by higher income networks, and linking social capital that connects the first two with community institutions. In Circles, low-income individuals receive support from community volunteers, increase their ability to access community resources and opportunities, and develop

hope for the future. First, bonding social capital is created through peer relationships with other participants. This occurs primarily through required weekly meetings and leadership tasks the participants share. Second, bridging social capital is created through the relationships across class lines that are contained within Circles, where each participant is mentored by at least three middle or upper income community volunteers called "allies". Third, linkage social capital to institutions is created through the involvement of human service agencies, educational institutions, faith communities, and businesses in the Circles initiative. Circles is initiated by a lead organization, such as a VA facility, community action agency, or faith community. The lead organization facilitates the engagement of other human service organizations, faith communities, businesses, and community volunteers through the formation of a "Guiding Coalition" which is ultimately responsible for the ongoing operation of the initiative. One of the big advantages of Circles over other support programs for low income individuals is its systematic approach to leveraging other community resources which otherwise would not be directed towards alleviating poverty. Retention is a major problem with many programs for homeless and low income individuals. Circles directly addresses transportation, childcare, and other barriers to program participation and has very high retention rates compared to other programs.

Goals:

1. Move participants completely out of poverty.
2. Increase the social support of participants.
3. Raise awareness in the community of barriers faced by low-income people.

Target Population: Low income individuals who are motivated to leave poverty. Circles is not appropriate for individuals with active substance-abuse problems or with unmanaged mental health disorders. It is most appropriate for individuals capable of employment and in need of additional social support.

Narrow the list of options to one or two programs

After reviewing the available research on effective programs, looking for programs that match your goals, desired outcomes and participants, and making a preliminary determination about whether you'll need to adapt a program to fit your needs, you're ready to narrow your choices. Unless you're really confident you've found just the right program, don't focus on a single selection yet.

Here's what you should do next:

- We recommend you narrow your choices down to one or two programs which seem like the best match for your goals and desired outcomes.
- If you have selected more than one, decide which one you'd like to investigate further.
- In Step 4 on Fit, we're going to walk you through seeing if there's a good fit between each of the potential programs you've selected and your Veterans and community. We'll also provide more information about how to adapt a program.
- In Step 5 on Capacities, you'll assess whether you have the organizational capacities to deliver each of the chosen programs.
- Before moving onto Step 6 in which you begin to develop your implementation plan, you'll make a final decision about the program that best fits your participants and organization.

You may find after reviewing your initial set of likely programs that none of them really fits with your Veterans, VA facility or other existing programs. You could decide to adapt or come back to this step and do a little more exploration. Taking the time to find the best program fit now will pay off later in making it easier to achieve your goals and desired outcomes with the resources you have available.

Two final precautions:

Should you develop your own program? If you're unsure about selecting a program, don't automatically assume you should develop one of your own instead. Developing a program from the ground up is hard work. Running a program that hasn't yet been proven effective increases your risk of investing time and resources in a program that may not work.

What if you can't pick an evidence-based program right now? There may be reasons why an evidence-based or promising program can't be selected right now. Your organization might have a lot of time already invested in a program you've been using for awhile or you may have other partners like a homeless shelter committed to your current program. If you want to continue using a program you're already running, but it's not considered an evidence-based or promising program, you could use some of the tips and tools in the following section on "Tips

for Applying This Step If You Already Have a Program” to help you strengthen your practices. Now may be a good time to involve your stakeholders in finding creative ways to improve the program based on some of the best practices identified in the library.



Applying This Step If You Already Have a Program

If you already are using an intervention program and it is not considered an EBP, or you are using pieces of different programs but are not using an entire EBP as it was intended, then try these ideas:

1. *Document the logic of your program* – How do the activities in your program lead to the achievement of the programs goals and objectives (improvements in the lives of Veterans)? Clearly documenting the links between program activities, specific objectives, and long-term goals can help clarify and refine existing programs. Such documentation is often achieved through the creation of logic models or a theory of change.



The Community Tool Box created by the Work Group for Community Health and Development at the University of Kansas contains information and tools for creating logic models and theories of change which can be found here:

http://ctb.ku.edu/en/tablecontents/section_1877.htm

2. *Find new ideas and ways to improve your program* – Learn about the evidence-based programs and best practices in this chapter and elsewhere to glean ideas for improving or updating your work. Ask yourself, what best practices in these programs can be applied to your programs?
3. *Evaluate your work* – Take steps to have your program evaluated or use some of the material coming up in this guide to find ways to begin evaluating your program.



Sustainability Tip: Using as many characteristics of proven programs as possible will help you build a structurally sound program. You will increase staff competence and confidence as well by giving them a strong program with clear tools to use to deliver the program. It will also help you deliver a program that is more likely to produce the results you’re hoping for. Getting good outcomes and really changing Veteran’s lives is one of the surest ways to have a sustainable program. Demonstrate you’ve done your research and know what works by including some of your findings in your communications with staff, administrators, and stakeholders.



Checklist for Step 3

When you finish this step, you should have:

- A basic understanding of evidence-based programs, promising programs, and best practices in homelessness.
- Conducted a review process to find the programs with the best evidence for success to use to achieve your goals and desired outcomes
- Made a preliminary determination as to whether you can adopt an existing program or adapt one to your needs
- Selected one or more candidate programs to research further for your work and participants -OR—identified ways to improve an existing program

Before Moving on to Step 4

Now you're ready to move on to the next step in the GTO process - making sure your program fits for your Veterans, your VA facility, and other existing programs. You may already have chosen effective programs to explore further with fit in mind or you've been running a program for awhile and have done it what it takes to make sure there's a good fit between the Veterans in your area and the activities you're offering.

Steps 4 on Fit and 5 on Capacity can help you fine-tune your work in a way that helps maximize your resources and increase your chances of success. Spending time on finding the right program and making sure it's going to yield the results you're after will also make it easier as you look ahead to planning your program implementation and evaluation.

Step 4: Modify The Best Practices To Fit Your Local Context.

Overview of Fit

In the last few steps you've used data from your needs assessment to set program goals and develop desired outcomes. Based on these goals and outcomes, you've also examined the research on evidence-based programs, narrowed down your options to 2 – 4 candidate programs to further review, or you've decided to go with another program. No matter what type of program you've chosen or even if you are already implementing a program, it's important to assess its fit with the Veteran population, your organization, and the context in your local area. You'll now consider the fit of the programs you're thinking about or already doing. You may find that some of the material you gathered during your needs assessment will help you make some decisions about how to tailor your program, too.

Remember – this selection isn't your final one yet. As you work through the next two steps, you may realize the program doesn't match your Veterans or organizational capacities very well. You might either need to adapt the program in some way or choose another potential program to explore further.

This step is about making sure your chosen program is right for your Veteran participants and is compatible with your local context. For example, you wouldn't use a program developed for young adults with Vietnam-era Veterans. This compatibility is what we call fit.

The exact meaning of local context depends, in part, on the service area of your VA facility. Are you serving homeless Veterans across your entire VISN or primarily serving homeless Veterans from a particular metropolitan area? Whatever the scope of your local context, there are a number of levels on which to think about fit, including the:

- Values and practices in your local area
- Characteristics and contexts of the Veterans you're serving (e.g., age, gender, ethnicity, language, urban/suburban/rural, level of need, etc.)
- Mission and philosophy of your organization
- Culture of your target population
- Your VA facility's level of readiness for the program
- Priorities of the key stakeholders including program directors, VA facility leadership, VISN leadership, Veteran service organizations, Vet Centers, and homeless Veterans
- Other VA or community programs and services that already exist which may be doing some of the same activities with some of your Veterans

You probably already have a good idea about the Veterans you will be serving, so assessing fit will help you pick the right program for them. You might already be working with Veterans using an established program and feel the urge to by-pass this step, but we recommend not skipping it.

Taking time to make sure you understand how your work really fits with your Veterans could help strengthen and improve your program.

At this point, you might also have concerns that an identified program does not fit your Veterans or local context because it wasn't developed specifically for Veterans. Don't automatically dismiss it as a possibility. There are some program aspects that can be adjusted to make it work for you. We'll give you tips later in this chapter to help you make some preliminary decisions about that.

The tasks in this step will help you:

- Understand what fit means
- Consider the most important aspects of your program, Veterans and local context to assess to make sure there's a good fit
- Decide if the selected program fits the local context
- If adaptations are needed, determine the right adaptations to make so your program does fit
- If needed, further narrow your choice of programs to implement

Why?

It's important to understand the context in which your program will operate. If your program doesn't fit with the culture and values of your Veterans, organization, and local area, it will be harder to implement and probably less effective.

Understanding fit also helps you decide whether you could improve the fit of a potential program by making some adaptations. Often small changes to an evidence-based practice can and should be made to increase fit, especially when it comes to working with your Veteran participants. Thinking about these things now will help you implement with fidelity rather than making changes to the program on the spur of the moment which might make your program less effective.

Understanding fit can help you:

- Ensure your program and strategies work for participating Veterans
- Reduce duplication by complementing what others in your VA center and community are already doing

- Use the process of assessing fit to build stronger relationships with other agencies and stakeholders
- Make sure you'll have sufficient participation in a program meaningful to those that attend
- Choose and adapt the right program that increases your chances of making the changes you want to see

How?

There's no single magic solution for how to make your program fit perfectly. You may have to first understand, then balance competing interests such as a program's fit with the Veterans involved versus fit with other community agencies. However, it is important to at least consider the fit ideas presented in this chapter while knowing they don't include all of the answers you might need. Fit is sometimes an evolving process.

As we briefly covered in Step 3, the first thing to consider is how well you can implement your program with fidelity. Fidelity is the faithfulness with which an evidence-based practice is implemented. This includes implementing a program without removing parts of the program that are essential to the program's effectiveness – its *core components*.

Implementing with fidelity also means that the core components and activities were implemented in the proper manner which will lead to better outcomes. We always encourage you to implement an evidence-based program with fidelity. You can still maintain fidelity to the core components while tailoring the programs to better meet the needs of your Veterans. This tailoring is called *adaptation*.

Before moving too far ahead into examining the fit of your program, it's important to generally understand what you should and should not change about evidence-based programs. This information will help you determine if the potential changes you want to make to achieve fit will maintain or destroy the integrity of the program. Obviously, if the changes are too substantial, you should consider selecting another program.

Which program components can be adapted?

Once you have a clear understanding of how the program you're considering works and its core components, you're in a better position to assess how any potential changes could compromise the integrity of the program. Evidence-based programs have a recipe of activities to address specific problems or risk factors among participants. By changing parts of the recipe you might be losing the impact you'll have.

Think of it like making cookies. To make cookies, you need flour, eggs, oil, and sugar. If you take out one of these core ingredients you won't get cookies. These are like the core components of program. If you take out a core component, you're not implementing the evidence-based program with fidelity and it's unlikely you'll get the results you expect.

Now think about different types of cookies. There are cookies with raisins, chocolate chips, nuts, etc. Whether or not you add these things to the basic recipe, you'll still get a cookie. These are like the things that can be changed in an evidence-based program such as introducing memory enhancement techniques or increased use of repetition when presenting concepts or instructions to enhance retention among Veterans with cognitive impairments.

To illustrate this point further, let's look at Therapeutic Communities. A Therapeutic Community uses a culture of affiliation and self-help to foster change in its members. Some of its core components include community meetings and activities, psychoeducational classes, community management by a board including senior members and graduates, and vocational programs. Drawing on our cookie recipe example, psychoeducational classes are a core ingredient in Therapeutic Communities. If you remove this component, it is no longer a Therapeutic Community. However, the psychoeducational classes may increase the number of breaks, present information more gradually, or use more social modeling in order to enhance learning among homeless Veterans with dual diagnoses.

While there is no single standard for making decisions about adapting evidence-based programs, we offer this simple model for determining appropriate levels of adaptations:

Green Light changes – those which should be made, as long as they don't change or diminish the core components, to fit the program to the Veteran's culture and context. This does not include changing the risk factors addressed in a program, but changing things like the wording of program material to better match the reading level of the Veterans you serve. Most programs can be improved by tailoring elements, scenarios, names, or other aspects of program activities to better reflect the population you plan to serve. You should feel comfortable making these types of changes for most programs.

Yellow Light changes – those which should be made with the help of a skilled curriculum developer and someone who understands behavioral health and health education theory such as researcher or professor. Some of these changes, such as changing the sequence of activities or adding activities, are more substantial and require expert assistance so alterations don't compromise the integrity of the program.

Red Light changes – those which substantially compromise the core components of the program. These changes, such as reducing or eliminating activities, are highly discouraged because they compromise the integrity of the original program. For example, often programs will provide a chance for Veterans to practice new skills. This is a critical step in changing behavior and these skills should be practiced for the full amount of time that the program states.

One important thing to consider is the cost and feasibility of any adaptations you're considering. If it looks like the program requires a lot of time, money and effort to adapt, perhaps you can find a more suitable one to use with fewer required changes.

Starting on page 63, we've provided a brief Green, Yellow, Red Light Adaptation Guide. Go through this tipsheet and use it in the next set of tasks to help you identify and make the right adaptations. If you're unsure whether the adaptation compromises the fidelity of the program, contact your Mental Illness Research, Education, and Clinical Center (MIRECC), Systems Redesign Committee, or other local technical assistance group or the program developer and ask questions (see Appendix B for contact information).

How do I use the Adaptation Guide?

Green, Yellow, and Red Light Adaptations are described below in three separate sections marked by the color of the traffic light. Green light adaptations are those you should feel fairly comfortable making. Yellow light adaptations are those that require more skill and expertise to make. Lastly, red light adaptations should not be made because they will likely change the core components of an evidence-based program. Practitioners should consult and use this brief guide as they think about and make adaptation to an evidence-based program.

TIPSHEET: GREEN, YELLOW, RED LIGHT ADAPTATION GUIDE

Green Light Adaptation
Using more factually up to date materials. ¹
Changing learning activities and instructional methods so that they are appropriate to the Veteran's culture and cognitive abilities. ²
Changing wording of behavioral messages so that they are more appropriate to the Veteran's culture and cognitive abilities. ²



Yellow Light Adaptation
Substituting the video recommended by a program for one that more closely fits the priority population.
Changing the sequence of activities. ²
Adding activities to address additional risk factors.



Red Light Adaptation
Substantially shortening programs may reduce impact.
Reducing or diminishing activities that allow Veterans to personalize information. ²
Reducing or diminishing activities that allow Veterans to practice skills. ²
Eliminating material that addresses targeted risk factors. ²
Contradicting or competing with the intent of the program. ²
Failing to repeat and reinforce key behavioral messages as prescribed in the curriculum. ²



2007, ETR Associates and CDC Division of Reproductive Health

¹ Kirby D. (2006). Power Point Presentation.

² Kirby D, Laris B, Roller L. (2006). Sex and HIV Education Programs for Youth: Their Impact and Important Characteristics. Washington DC: Healthy Teen Network.

Determining levels of fit

Now we're going to discuss some ideas about what fit means in the following areas:

- Program fit with Veterans
- Program fit with your VA facility
- Program fit with existing programs and services

This next section will help you complete the following tasks:

- Understand fit at a variety of levels.
- Use the Assessing Program Fit Tool found on page 68 to help you examine each of the 2–4 programs you're considering.
- Use the Green, Yellow, Red Light Adaptation Guide as you assess your potential programs to determine the appropriate changes you could consider to help you select the right one.
- Narrow your list of program choices before moving onto Step 5.



If you are already running a program, the concepts and fit tool could help you review your program to see if there's room for improvement.

Program fit with Veterans

First, you want to know if the program you've selected will work for the Veterans you'll be offering it to. Have Veterans similar to yours been helped by the same program? Are the planned activities suitable for your participants? The assessment you do here will really help you identify the right program or the appropriate Green Light changes you could make to improve the program's fit with your Veterans. Remember – you don't want to make changes that compromise the intent or internal logic of the program.

You want to know if and how the program fits with your Veterans in the following ways:

Characteristics – age, gender, ethnicity, literacy and/or education level, geographic location and setting such as rural, suburban or urban. Determine whether the program activities and methods of delivery are suitable for your priority population.

Culture of the priority population – culture includes values, practices, beliefs, customs, religions, rituals, language and pop-culture. Determine whether the proposed program is appropriate for the given cultural context of the priority population.

Special needs of a priority population – substance abuse, cognitive deficits, or mental illness. Determine how best to tailor a program, if needed, to issues involved when working with a special population.

Will the program fit the cultural context of your Veterans? Talk with different cultural groups in your community and learn about their values and beliefs, especially those that are relevant to your program. What do people believe are the most appropriate ways to communicate and provide helping services? For example, using formerly homeless peers in outreach may facilitate connecting with and earning the trust of other homeless Veterans.

Once you know more about the cultural context in which your Veterans live, you can determine whether modifications or adaptations are needed to help the selected program more appropriately fit that cultural context. You can identify ways to increase the cultural sensitivity and relevancy of your program with various cultural groups and beliefs in your community by appealing to common interests across groups.

You may not have found a program that matched the characteristics of your population exactly, but often, you won't have to change much to achieve fit. One factor in your decision will be the potential cost of making changes in the curriculum, providing staff training, or buying materials as well as the feasibility of any adaptations you think will be needed. Will the modifications change the intent or internal logic of the program? Not all changes have the same effect. For example, giving a presentation on job interviewing skills is not the same as role playing a job interview.

Program fit with your VA facility

The next level of fit to consider concerns the compatibility between the program you're considering and your VA facility. Obviously it's important that the goals of a program are congruent with your facility's philosophy and values. Staff will be much more likely to deliver the program with fidelity if they believe it fits with their facility's vision and mission.

You want to know if and how the program fits with your VA facility in the following ways:

Mission of the facility – a strong connection between organizational mission and the programs delivered contributes to the efficient use of resources and increases the confidence of those involved in implementing the program. Determine if the program is compatible with the core values of your organization.

Staff and leadership support – the next level of key support involves your staff and leadership all being on board to support your chosen activities. Involving staff and volunteers in the process of actually selecting or adapting a program creates an opportunity to foster and strengthen these connections.

Program context/setting – the original setting in which the program was developed is often an important ingredient in its success. If a program was developed in a community agency but you plan to operate in a VA facility, will it still work in the new setting? Determine which changes should be made to the program to work in the new setting. Is there another program that better meets your population’s needs?

Program dosage – The number of times and the duration of program sessions and activities contributes to its overall success. To implement the program with fidelity, it should be implemented with the same dosage as the original program. Shortening programs or reducing, diminishing or eliminating activities are all potential Red Light changes that could significantly compromise a program’s outcomes. Determine how realistic dosage for the planned program is within the scope of your facility. For example, it may not be possible to do a 20 session program when you only have one month allotted to implement the program.



Assessing and building organizational capacity for program delivery can be found in Step 5.

Program fit with existing programs and services

The next level of fit involves how your program complements and collaborates with other programs and services, both within the VA and within the local community:

Other VA programs – Review existing efforts in the community which may be similar to yours. Determine if there are other programs or organizations doing something similar to what you’ve planned. Does your program add to or compliment theirs? Does your program conflict with existing programs? The information you collected in Step 1 (Needs and Resources Assessment) should help here. Can you join with their efforts or have them join with you? Doing so will avoid duplication of services and use everyone’s resources more wisely. It will also provide opportunities for productive partnerships!

Other local programs – Review existing efforts in the community which may be similar to yours. Determine if there are other programs or organizations doing something similar to what you’ve planned. Does your program add to or compliment theirs? Does your program conflict with existing programs? The information you collected in Step 1 (Needs and Resources Assessment) should help here. Can you join with their efforts or have them join with you? Doing so

will avoid duplication of services and use everyone's resources more wisely. It will also provide opportunities for productive partnerships!



Instructions for using the Assessing Program Fit Tool

You can use this tool to help you examine the more important aspects of fit for the program(s) you're considering or, if you are already running a program, you can use the tool to see if there are ways to improve what you're doing.

Make as many copies of the tool as you need for your workgroup to complete this task. You can make a fresh copy for each of the candidate programs you're considering.

The process for completing the Assessing Program Fit Tool is as follows:

- Assemble the basic information about each of the programs you're considering before you start work on assessing fit. Highlight the information that answers the questions posed above regarding levels of fit.
- Have a copy of the Green, Yellow, Red Light Adaptation Guide also on hand to help you answer questions in the fit tool about each of the programs you're considering.
- Starting with question 1, work through the questions in the fit tool for each program.
- Answer yes or no first, then go back and discuss the details of what you think it will take to increase fit for the program you're reviewing. Write down the conclusions you come make about what steps should be taken.
- In the final column on the right, answer whether you think any adaptations you've identified are green, yellow or red light adaptations.

ASSESSING PROGRAM FIT TOOL

Does your program fit with your Veterans'...	Program Design	Yes or No	What steps can be taken to increase program fit?	Green, Yellow or Red Light?
Literacy and/or education level?				
Age?				
Gender?				
Culture?				
Special Needs?				

Does your program fit with your VA facility...	Program Design	Yes or No	What steps can be taken to increase program fit?	Green, Yellow or Red Light?
Mission?				
Staff support?				
Leadership support?				
Context/ setting?				
Program dosage?				

Does your program fit with existing programs...	Program Design	Yes or No	What steps can be taken to increase program fit?	Green, Yellow or Red Light?
Within the VA?				
Within your local area?				



Applying This Step When You Already Have a Program

Don't take fit for granted, even if you've been running your program for awhile. Circumstances change. Your program will likely be more relevant and effective if you consider new ways to make it fit better, especially with your priority population. Think about your current program, then try these ideas:

Talk things over – Bring together a small workgroup and go through the levels of program fit together. In an afternoon's conversation, you may discover several creative ideas for updating your work.

Take a fresh look – Use the Assessing Program Fit Tool to give your program a fresh look. Can you find things related to fit that you can do to improve your program?

Update adaptations – If you're using an EBP, use the Green, Yellow, Red Light Adaptation Guide to review changes you may have made. Were these changes green light changes? In other words, do they retain the original meaning of the curricula?



Sustainability Tip: Taking time before you implement a program to make sure it fits for your Veterans and VA facility will increase the likelihood that your VA facility and administration will support it.



Checklist for Step 4

When you finish working on this step, you should have:

- An understanding of what fit means
- Considered the most important aspects of your program, Veterans and community to assess to make sure there is a good fit
- Decided if the selected program(s) fits for your participants, organization and stakeholder community
- Determined if adaptations are needed
- Determined the right adaptations to make so your program does fit
- Further narrowed your choice of programs to implement

Before Moving onto Step 5

After reviewing your prospective programs with fit in mind, you might have a clearer idea which programs are still good possibilities. If none of the 2–4 potential programs have weathered the fit test, you may need to go back to Step 3 and do some more research to find a new set of programs to consider. Knowing more about fit now may also help you more quickly zero in on potential programs if you do circle back to Step 3 for more research.

In Step 5, we'll show you how to examine the current capacities of your organization to make sure you can do a good job in implementing your chosen program. Step 5 will be the final reviewing step before moving onto planning and implementing your program as well as establishing your evaluation criteria.

Step 5: Determine What Capacities Are Needed To Implement Your Program.

Overview of Capacities

Assessing the fit of your top program choices in Step 4 has helped you better understand if your plans are compatible with your VA facility. Next, you want to consider if you have the organization, staff, skills, facilities, and other resources to carry out the program or programs you're considering. We call all of these organizational structures, skills and resources *capacity*.

It's important to know whether you have the variety of capacities needed to implement the program you're considering. Having the right capacities ensures your implementation with sufficient quality to produce the changes you're after and then get measurable outcomes. A capacity assessment will show you what you have to work with as well as what you might need to improve before you select and launch a program.

This step is about making sure your organization and your key partners have the capacities necessary to carry out your selected program and evaluate its impact. While we won't be able to tell you in-depth exactly which capacities you'll need to implement a specific program or how you'll build those you need, you should be able to find the specific capacity requirements you need from the developer materials associated with the program you're considering. If the resources you need aren't clearly spelled out in the materials, you may need to do some additional investigation, including Internet searches, talking to program designers or others using the program, to get answers to your questions.

This step lays out key capacity areas which are important for you to assess. The tasks in this step will help you:

- Understand the key capacities you need to support your work
- Assess whether you have the right levels of capacity needed to implement your potential program(s)
- Determine which capacities need to be further developed so you can move ahead with your work
- Further narrow your choice of candidate programs to implement

Throughout this step, we point out additional resources where you can go and find out more information on the different capacities we list including how to develop them.

Why?

It's important to assess capacities before launching a program because capacity affects how well the program will be implemented. For example, if staff is not trained well in how to deliver

a particular program, or there are not enough staff to deliver a program's components, then the quality of the program will be reduced.

This step can help you even if you are already implementing a program. You can use the Capacity Assessment Tool which begins on page 81 to re-examine your resources and make sure you have the right staffing and other capacities to sustain or improve your program's performance.

You may be wondering if the program you're thinking about requires more resources than you have to implement. This step can help you:

- Check to make sure you have the capacities to deliver the program you've chosen
- Develop a clear plan to grow the additional capacities you need
- Decide to examine another program which will better match your capacities
- If you discover you don't have adequate capacity to deliver your top-choice program and can't build it soon, you may need to revisit Step 3 to choose another candidate program to explore from your initial selections.

How?

It will probably be fairly straight forward to figure out whether you have the technical and resource capacities to deliver the program you're considering. You can easily determine, for example, if you have enough funding to purchase the program or if you have a computer in the office on which to track your work. The resources that may be harder to quantify and yet are crucial to the success of your program are the people you involve – your staff and volunteers, your leadership, and your community partners. Let's briefly look at what some of these important people capacities are.

Human capacities: staff and volunteers

You will need different people to carry out your program. This might include your staff, peer mentors, and community volunteers to deliver your program, other support staff such as drivers or child care workers, and evaluators to help you evaluate your program.

Skilled facilitators among your staff are very basic to your success because they will be responsible for actually delivering your program. Generally, they will need:

- Facilitation skills
- Knowledge of homelessness
- Knowledge of Veteran issues

- Skills specific to your program such as training in the curriculum, knowledge of the content, and instructional methods.

A program may require certain experience or educational qualifications to run effectively which we recommend you follow to maximize your chances of success. Under-qualified staff, even those who've been trained in a program's specifics, may make the program less effective.

It's also especially important to make sure all staff and volunteers are always working in culturally sensitive ways. The program you're considering should have specific materials related to relevant cultural issues but additional knowledge and training will also help you understand how best to deliver a program specifically to Veterans.

For example, staff should be familiar with language related to military service, generational differences between Vietnam-era Veterans and OIF/OEF Veterans, and clinical issues regarding combat related PTSD.



Sustainability Tip: Training is important to ensure your staff and volunteers know how to deliver a program. This not only improves program delivery, but increases the confidence of your staff, making it more likely that they will stay. Studies show that teacher or staff training increases knowledge, attitudes, intentions, and comfort level with a new program. Ongoing training and training more than one staff are useful approaches to keep current staff up-to-date and for those occasions when you have staff or volunteer turnover. This can help quickly orient and connect new personnel to the work.

Veterans may not just be participants in your program, but teachers and leaders as well in some cases. For instance, in the program Vet-to-Vet, peer facilitators run educational meetings for Veterans receiving psychosocial rehabilitation (Barber, Rosenheck, Armstrong, & Resnick, 2008). One important resource to consider is simply whether you'll have the time available to work with the Veterans you recruit.



LINKS TO HUMAN CAPACITY DEVELOPMENT SITES

All programs require different human capacities to implement them with fidelity. To find out more, we recommend:

The Community Toolbox also has lots of useful information about enhancing cultural competence including a plan for conducting a cultural audit of your organization or community. <http://ctb.ku.edu/tools/en/#PartH>

Both the Community Toolbox and the Conflict Resolution Network are good places to get information about building staff capacities common to all programs such as a 12 Skills Trainers Manual you can use to construct lessons to train staff in conflict resolution. <http://www.crnhq.org/>

Leadership capacities

All programs and organizations benefit from having strong leadership, but it's important to think about leadership in a variety of ways. You will want to get support from leadership within your VA facility. They can help find the resources you'll need as well as help continue to promote and maintain the successes of your program. You'll need leaders to help you get started, but you'll also need the kind of leaders who'll stay involved over the long haul. You will also want leaders among your staff and volunteers.

Cultivating diverse leadership is an important way to build your capacity and strengthen both your program and your organization. You want to recruit and involve people with different cultural and professional backgrounds and of different ages. Consider looking for different kinds of thinkers because you need people with a variety of perspectives and skills. You also want to get people involved who are not necessarily thought of in the traditional leadership sense such as homeless Veterans themselves. Leadership helps build sustainability, especially shared leadership so that a variety of people feel ownership of the work you're doing. This also includes Veterans.



LINKS TO LEADERSHIP DEVELOPMENT SITES

To find out more about developing leadership capacities and group facilitation skills, look at The Community Tool Box: <http://ctb.ku.edu>

Or the Free Management Library: http://managementhelp.org/ldr_dev/ldr_dev.htm

Partnership and collaboration capacities

Partnerships and collaborations are important for many reasons. For example, collaborating with community agencies can facilitate outreach to Veterans averse to seeking help through VA medical centers, identify gaps in homeless services in the community, facilitate referrals for emergency shelter and other services not provided by VA facilities, build coalitions needed for community-wide homelessness prevention efforts, and leverage additional resources to help homeless Veterans that otherwise would not be available.

Partnerships and collaborations also help us use available resources wisely and help us be more effective and build support for our work by involving more people. Cultivating partners and developing collaborations take time and often involve significant changes in everyone's thinking about how your work gets done. Generally there are four levels of collaboration, each with certain requirements and benefits (Chinman, Imm & Wandersman, 2004; Himmelman, 1996). The four levels are described below with an example based on a VA homeless center and a community agency.

1. *Networking* – the exchange of information for mutual benefit. The most informal type requires little trust or time, although these factors may be create barriers to expanded collaboration. An example: the VA homeless

center provides information about its programs to the community agency to facilitate referrals.

2. *Coordinating* – the exchange of information and change in activities for mutual benefit and common purpose which requires fewer turf issues as well as more trust and time. An example: the VA homeless center and community agency coordinate the times when their programs are offered to enable Veterans to take advantage of programs at both locations.

3. *Cooperating* – the exchange of information, change in activities and sharing of resources for mutual benefit and a common purpose. This requires:

- More organizational commitment than networking and coordinating
- Shared resources such as human, technical or financial capacities
- High amounts of trust, time and access to each other's turf

An example: the community agency provides office space to allow a staff member from the VA homeless center to be on-site to provide outreach to homeless Veterans and the VA homeless center provides space on its property for the community agency to operate a homeless shelter to serve both Veterans and non-Veterans.

4. *Collaborating* – a formal, sustained commitment by several organizations to enhance each other's capacity for a common missions by sharing risks, responsibilities and rewards. An example: the VA homeless center and community agency provide professional development to each other's staff to better meet the needs of the homeless populations they both serve.

It's important to acknowledge some of the potential barriers you could face -- like turf issues and limited resources. You may have to slow down and take some time to build relationships. Use the capacity assessment to determine who from your program or organization knows someone from another organization you want to partner with, and then reach out to start developing a good working relationship with that key person. Be specific about what you want—specific commitments are sometimes easier to negotiate than open-ended ones—and consider how you may be able to help them in return.



LINKS TO PARTNERSHIP AND COLLABORATION SITES

To find out more about how to develop partnership and collaboration capacities, we recommend:

The Resource Center for the Corporation for National and Community Service

<http://nationalservicerresources.org/program-management/partnerships>

Fiscal, resource, and technical capacities

You'll need basic tools to help you do your work no matter what the program is – computers, Internet access, and spreadsheet programs. You'll want original copies of the program materials. The original purchase price of materials may be expensive so if you borrow a copy from a partner, make sure it is a complete one!

Don't forget to think about all the specific, practical things you might need to conduct your activities, e.g., meeting space, food, supplies, transportation, notebooks, videos, and TV/DVD/video players.

When considering how much money it's going to cost to run the program, think ahead. Staff turnover may require additional staff training down the line. Increased participation in a new program may result in increased needs and costs in other areas, such as transportation, janitorial services, or utilities. For specific segments of your work, you may also need to consider hiring an evaluator with the technical expertise to help you. Some ideas are listed below to help you identify one.



RESOURCES FOR HIRING AN EVALUATOR

To find out more about how to hire an evaluator, we recommend:

The W.K Kellogg foundation has an online toolkit about evaluation with a section on developing an evaluation budget as well as how to hire and manage an evaluator which includes a free, one-page hiring checklist:

<http://www.wkkf.org/default.aspx?tabid=75&CID=281&NID=61&LanguageID=0>

To find an evaluator, go to the Web site for the American Evaluation Association: www.eval.org

Before considering hiring an evaluator, you should check to see whether evaluation expertise is available to you through your Mental Illness Research, Education, and Clinical Center (MIRECC) or Systems Redesign Committee.

How to Determine Program Capacities

Starting on page 81, we've provided a Capacity Assessment Tool to help you capture information about the key capacities described above you'll need to implement and evaluate your program. Materials describing the program you're considering should help you determine the following basic information:

- Requirements for each type of capacity
- Whether your organization has the ability to meet those requirements

Once you have filled in these important pieces of information, you can determine what you could do to improve your capacity if it's insufficient.

You may find that it's going to be very hard to improve your capacity in some areas. This is the reality for many organizations. Don't be discouraged. You can think of creative ways to get what you need or your assessment may help you see more clearly that the program you're considering is not the right one for you. If you can't achieve sufficient capacity for the program you are considering, you can return to the short list of evidence-based programs you created in Step 3 and select another one to consider that might work better with your capacities.

You may also find the Capacity Assessment Tool helpful as a planning instrument. For example, filling it out may show you what types of staff you need to hire or what kinds of expertise you need to recruit in the future.



Sustainability Tip: Building and maintaining the various capacities described in this step helps sustain your efforts. You'll have enough resources, a well-trained staff, a group of supportive volunteers, and the right leaders helping you stay connected to partners or developing new relationships and collaborations that keep you going. Also don't wait until you've finished your program – think now about how you can find or develop new resources to support your work.

Instructions for Using the Capacity Assessment Tool



Make as many copies of the tool as you need to complete this task. There are separate capacity worksheets for each of these areas:

- Program specific staff capacities
- General staff capacities
- Technical (expertise) capacities
- Fiscal capacities
- Collaboration/Partnership capacities

The process for completing the Capacity Assessment Tool is as follows:

1. Gather together information describing what is required to implement the program you're considering including costs, staffing levels and requirements, training needs, materials, facilities and other fiscal and resource capacities.
2. For each of the programs you're considering, go through each of the capacity worksheets and answer the questions about capacity requirements, whether you think your organizational capacity is adequate in each area and what your plan is to increase the capacity if you need to.
3. If filling out all the worksheets for several programs seems like a lot of work, you might consider splitting the tasks up among several people. You could divide the task by each program you're reviewing or have one person responsible for finding out all about one capacity area such as technical expertise for all of the programs you're considering.

Once you complete the Capacity Assessment Tool, you'll have a better idea about whether you can implement the program you're considering with enough fidelity to achieve your desired outcomes. The most revealing part of this task may be the gaps that appear. These gaps may be capacities you can build to achieve your goals or they may indicate that you need to select another program.

If you don't have the necessary capacities, it's important to think through how you can get them. If you can't deliver the program well because of capacity challenges, perhaps you should consider selecting a different program (identified in Step 3) or stepping back to build up your capacity.



CAPACITY ASSESSMENT TOOL

PROGRAM SPECIFIC STAFF CAPACITIES

Program Name: _____ Name of person completing form: _____
Date: _____

Capacity assessment item	Requirements	Is the capacity sufficient?	Plan to enhance the capacity
Staff training needed			
Staffing level required			
Staff qualifications (e.g., minimum degree needed; years of prevention experience)			



CAPACITY ASSESSMENT TOOL

GENERAL STAFF CAPACITIES

Program Name: _____ Name of person completing form: _____
Date: _____

Capacity assessment item	Requirements	Is the capacity sufficient?	Plan to enhance the capacity
Commitment			
Feeling supported by leadership			
Feelings of ownership			
Leadership			
Communication			
Conflict resolution			
Decision making			
Meeting facilitation			



CAPACITY ASSESSMENT TOOL

TECHNICAL (EXPERTISE) CAPACITIES

Program Name: _____ Name of person completing form: _____
Date: _____

Capacity assessment item	Requirements	Is the capacity sufficient?	Plan to enhance the capacity
Access to program materials			
Access to personnel with appropriate evaluation skills			



CAPACITY ASSESSMENT TOOL

FISCAL CAPACITIES

Program Name: _____ Name of person completing form: _____
Date: _____

Capacity assessment item	Requirements	Is the capacity sufficient?	Plan to enhance the capacity
Full costs			
Transportation			
Special trips			
Printed materials costs			
Participant incentives			
Food costs			
Baby sitting			
Volunteers			
Equipment costs			
Space (e.g., # of rooms)			
Evaluation costs (data collection, entry)			



CAPACITY ASSESSMENT TOOL

COLLABORATION / PARTNERSHIP CAPACITIES

Program Name: _____ Name of person completing form: _____
Date: _____

Capacity assessment item	Requirements	Is the capacity sufficient?	Plan to enhance the capacity
Collaboration with key partners			
Buy-in of local stakeholders			



Applying This Step When You Already Have a Program

It's important to periodically reassess what you're doing and whether or not you have all the capacities needed to continue the quality of your work. Consider these questions:

- Have you hired new staff since you started your program that need to be trained?
- Have your facilitators been to a refresher course or updated their skills in the last several years?
- Are there additional training resources that you need?

We suggest you use the Capacity Assessment Tool which begins on page 81 to help you revisit the capacities you have for a current program or for any new program you're planning to implement.



Checklist for Step 5

When you finish working on this step, you should have:

- An understanding of the key capacities you need to support your work
- Assessed whether you have the right levels of capacity needed to implement your potential programs
- Determined which capacities need to be further developed so you can move ahead with your work
- Further narrowed your choice of programs to implement

Before Moving onto Step 5

You've now completed a cycle of evaluating an evidence-based program for its potential to meet your goals and desired outcomes, its fit with your Veteran population, and your capacity for implementing the program. You may have repeated this cycle to examine several potential programs.

In Step 6, you will pick the program that best fits your Veterans and which you believe you can effectively deliver. Step 6 will outline the details of developing a plan to deliver your program.

Step 6: Make A Plan For Implementing Your Program.

Overview of Planning

After testing several potential evidence-based programs for fit and capacity, now it's time to finalize your program selection if you haven't already done so. Step 6 will show you how to create a detailed plan for implementing your chosen program. When you finish the tasks outlined in this step, you'll be ready to launch your program.

Your plan should bring together all the decisions you've made in the first five steps and help get your team ready for implementing, monitoring and evaluating the program you selected.

This step helps you decide who does what and by when so that no details are forgotten. The tasks in this step also ensure that the aspects of cultural fit you considered in Step 4 become fully operational.

The tasks in this step will help you:

- Finalize your program selection
- Develop a work plan
- Confirm that have done all you can to make sure your program is culturally appropriate

Here's what you'll need to get started:

- Previously completed assessments or tools from all prior steps
- Copies of program materials (curriculum)
- Copies of the tools provided in this step

Why?

Detailed plans are important to the success and careful implementation of a program. Without them, details can fall through the cracks, reducing the effectiveness of your work. Although planning takes time, it's important. The time you spend on creating a clear plan saves time and resources later while also increasing your chances of reaching outcomes. You can also use a detailed plan to help you monitor what's working or not working well so adjustments can be made to improve your program's functions.

How?

Finalize Your Program Selection

In Steps 3, 4, and 5, you identified a short list of evidence-based programs to consider implementing, then assessed them for fit with your priority population and local context, and

lastly, considered your organization's capacity to implement the various choices. You may have quickly discovered a top-choice program or you may have repeated the steps with several candidate programs before a clear choice emerged. If you haven't already identified the program you want to implement, now it's time to finalize your selection before moving ahead.

If you're still not ready to finalize a choice, or have other programs yet to consider, then you need to revisit Steps 3, 4, and 5 and work through the tasks again. In both cases, you may need to do some additional exploration to find other potential programs.

Finalize Adaptations

If you've selected an evidence-based program, do the following:

- Have a copy of the Green, Yellow, and Red Light Adaptation Guide from Step 4 to help you finalize appropriate adaptations.
- Document the adaptations you plan to make. As discussed in Step 4 on fit, your goal here should be to only make those green light adaptations that are really necessary to improve the fit of the program to your youth participants and community context.
- When you're done with these tasks, you're ready to go on to the next section, *Develop Implementation Plan*.

Remember – If you believe you need to make yellow light adaptations, you should talk first with someone with expertise in curriculum development, evidence-based program implementation, and health education theory such as a university professor. Do not make red light adaptations to a science-based program.

Develop Implementation Plan

To develop your program implementation plan, you will make a detailed list of all the activities for your chosen program. We've provided a Work Plan Tool which begins on page 90. Putting on a program requires a lot of preparation such as securing space, having necessary policies and procedures in place, recruiting participants, developing a budget, hiring facilitators, etc. If you plan to use peer volunteers, you will need plans to recruit, train, and supervise these volunteers. You may also need to factor in transportation arrangements for participants, as well as whether you're providing food for them. Creating a work plan now can help you cover all your bases and ensure that you're ready to implement. The work plan makes sure you're staying on track. The details of a work plan include:

- Describing all types of activities needed to effectively prepare for implementation such as administrative, policies and procedures, facilitation, location and materials, recruitment and retention, and implementation

- When activities will be done
- Who is responsible for each activity
- What resources are needed and where will they come from
- Date activities are completed

Remember – Include your collaboration partners as people potentially responsible for activities. Describe the roles each will play in the implementation of your program. This could include such things as a local organization coordinating shared staff training or a partner involved with identifying and making referrals.



Integration Tip: A good work plan can do more than help you implement your program. You can also use it to train new staff and volunteers about your work and their roles in it. Using the work plan as a common framework puts everyone on the same page. You can use the work plan to apply for new funds or to tell VA facility administration about the program. You can also integrate your work plan into your facility’s larger strategic planning efforts.



Instructions for Using the Work Plan Tool

Make as many copies of this tool as you and your workgroup need to complete the task. You may want to do rough draft of the plan as you gather the needed information, then prepare a final draft to distribute to everyone involved when you are done.

The process for completing the work plan is as follows:

1. Gather together all of the materials you’ve developed in previous GTO steps you need to complete the work plan such as assessments, outcome statements, adaptation guide, and program descriptions. You may also find the Capacity Assessments from Step 5 useful.
2. Fill in the basic program information at the top of the form.
3. Starting on the left-hand side of the form, under the Activities column, work your way through filling in the details of what it will take to implement your program. List program activities sequentially where you can to help you plan them out.

Don’t worry if you can’t fill in all the details. Working through this tool may help you see where there are gaps that need to be filled. Also consider your work plan a living document; update as new tasks arise.



WORK PLAN TOOL

Program Name: _____ Name of person completing form: _____

Date: _____

Program Name and Summary

Briefly provide the title and summary for this program or strategy.

Title:

Summary:

Identifying Program Components

What components will be implemented for this program or strategy? Which of the objectives (completed in GTO Step 2) are linked to each activity?

Program Component	Which objectives are linked to each component?	If using a model program, what is the adaptation plan (or none needed: will be implementing as intended)	If building your own program, which best practices does your program incorporate?

Identifying Anticipated Outputs

What outputs will show that the activities were implemented as intended? Outputs are the direct products of program activities and usually are measured in terms of work accomplished (e.g., number of sessions attended, number of participants served, etc...).

Program Component	Anticipated Program Output(s)	
	Services delivered	How many?
1 st Component:	Outreach contacts	
	Days of treatment	
	Hours	
	Sessions	
	Other	
	Persons served -total/per service	

Program Component	Anticipated Program Output(s)	
	Services delivered	How many?
2 nd Component:	Outreach contacts	
	Days of treatment	
	Hours	
	Sessions	
	Other	
	Persons served -total/per service	

Planning each program component

Now that you have chosen your program components, each one needs to be planned. Here you need to think about all the *activities* that need to be completed in order to make each component successful. Each component is made of several activities.

Components	Specify Key Activities and their details	Scheduled Dates	Who is responsible?	Resources Needed/ Materials to be provided	Location
Component 1:					
Component 2:					

Target Groups

For program components that require recruitment of participants, how will that be carried out?

Target Group(s)	Anticipated Number	Recruitment Plan

Collaboration Partners

Who are the collaboration partners for your program or strategy and what are their intended roles?

Collaboration Partner	Role of Partner

Program Integration

What steps are being or will be taken to integrate this program or strategy with other existing programs and organizations?

Existing Program/Organization	Integration Efforts

Implementation Barriers

Programs face many challenges. It is helpful to forecast what these challenges or barriers might be and generate possible solutions for them. Below is a table for you to consider what the barriers to your program might be and space to generate solutions to those barriers. You may not know the solutions now, but you will be able to come back to this page and update it at any time in the future.

Program Barriers	Proposed Solutions



Summary Checklist

What must be done to prepare for this program or strategy? Have these tasks/activities been sufficiently addressed?

Checklist Item		If no, plan for completion	By when?
Component 1:			
Y/N/NA	Resources Obtained		
	Person Responsible		
	Staff trained		
	Duties Assigned		
	Location Identified		
	Time Line Written		
	Collaborative Partners Identified		
	Cultural Issues Addressed		
	Program Materials developed		
	Barriers considered		
	If preexisting program, all components are included OR adapted with good justification		
	If building new program, components are in-line with principles of effective practice		
	Other:		

Checklist Item		If no, plan for completion	By when?
Component 2:			
Y/N/NA	Resources Obtained		
	Person Responsible		
	Staff trained		
	Duties Assigned		
	Location Identified		
	Time Line Written		
	Collaborative Partners Identified		
	Cultural Issues Addressed		
	Program Materials developed		
	Barriers considered		
	If preexisting program, all components are included OR adapted with good justification		
	If building new program, components are in-line with principles of effective practice		
	Other:		

Applying This Step When You Already Have a Program

Chances are that you have a plan if you are already running a program. Reviewing the ideas in this step can help you:

- Document new details in your plan you hadn't thought of before
- Re-think your existing plan more critically and perhaps strengthen it
- Develop additional clear markers for success
- Ensure all of all of your activities are linked to the objectives that you set in Step 2.

It's good program practice to have your plan in writing so that if staff turnover occurs, your program plan is already established.



Sustainability Tip: A good work plan makes it easier to sustain your efforts. It brings together all of the work developed over the course of completing the tasks in the book with the wisdom and experience of you and your staff into a clear roadmap. Knowing where you need to go and how you'll get there optimizes your use of time, energy, and resources. A clear plan increases your chances of success and confidence that others have in your effectively implemented program. A clear work plan helps you:

Communicate your work to important stakeholders, like VA facility administration, VISN leadership, and potential collaboration partners.

Orient new staff and volunteers to your program and reduce turmoil when there is staff turnover.

Keep dates and opportunities for presenting and marketing your program in your work plan, too, such as CHALLENG meetings where you could meet potential community partners.

Ultimately, a good work plan should help you achieve your goals and desired outcomes for the Veterans you serve – nothing is more essential to sustaining a program than that.



Checklist for Step 6

When you finish working this step, you should have:

- Finalized your program selection
- Considered and planned appropriate program adaptations
- Identified program activities
- Considered and selected participant recruitment strategies
- Completed a program budget
- Confirmed your program is culturally appropriate
- Developed a work plan for implementing your program

Before Moving on to Step 7

You've now brought all of the GTO tasks you've finished up to this point into a solid work plan. Before launching your program, we recommend you take some time to review the tasks in Step 7 (Process Evaluation) and Step 8 (Outcome Evaluation) before implementation. Doing so will help you identify the process and outcome measures you need to obtain or develop before you launch your program and which ones you need to monitor while the program is running.

Part 3: Program Evaluation

Step 7 – Evaluate The Process Of Implementing The Program

Step 8 – Evaluate The Outcomes From The Program

Step 7: Evaluate The Process Of Implementing The Program.

Overview of Process Evaluation

Congratulations! At this point, you have selected your program and planned how to roll it out. This is a huge accomplishment. Before you actually implement your program, it will be important to spend some time planning two key pieces of how you will also measure and evaluate the impact of your program.

The first part of your measurement planning—which we'll undertake in this step—is to develop what's called a process evaluation. This step helps you establish a method for monitoring and documenting your implementation throughout the life of the program as well as review your progress as you go.

In Step 8, you'll work on planning your outcome evaluation. We encourage you to read and work through the planning portions of this step and Step 8 before launching (implementing) both your program and your evaluation efforts. This evaluation planning gives you a clear idea of what you'll measure and how to do it.

The tasks in this step will help you:

- Develop a clear process evaluation prior to launching your program
- Examine whether the activities captured in your logic model are implemented as planned
- Monitor the work plan you started in Step 6
- Determine the quality of your activities
- Identify and make midcourse corrections if needed
- Track the number of participants and their attendance
- Monitor your program fidelity

Here's what you'll need to get started:

- Your program work plan
- The Process Evaluation Planning Tool (found in this step)

Why?

A process evaluation measures the quality of your implementation efforts. It gives you an idea about how well your plans were put into action and whether the people who participated were satisfied with their experience. Understanding how well the process of implementing your program worked or didn't work helps you form a fuller picture of whether you are achieving

your goals and outcomes. It can also show you immediate and important places to make midcourse corrections that will help improve your program's operation.

As we mentioned in Step 3, implementing your program with high quality and fidelity increases your chances of reproducing the successes of an evidence-based program. This step also shows you how to track and measure quality and fidelity.

How?

Before Implementation: Organize and Develop a Process Evaluation Plan

Familiarize yourself with basic process evaluation activities

Process evaluation has numerous elements, but a plan can help it move smoothly. The process evaluation plan helps you organize your thoughts about these overarching questions:

- What process evaluation questions should we ask?
- What tools should we use?
- What should our data-gathering schedule be?
- Who's responsible for gathering the information?

A major part of planning your process evaluation is identifying which program elements you need to monitor. Thinking through this will prime you to more easily develop the details of your process evaluation plan. For each of the activities in your program, you want to provide answers to these process evaluation questions:

- What are the characteristics of the people who attended the program?
- How many Veterans participated in each activity?
- Was the activity implemented with fidelity?
- How satisfied were the participants with the activities?
- What does staff think of the program delivery?

For example, if you planned a program which involves eight small group sessions to teach and practice interviewing skills, your process evaluation activities would probably include all of the following:

- Collecting demographic information about your participants
- Tracking individual attendance and participation (e.g. for each of the eight sessions) to monitor how much of the intervention each person received.

- Conducting satisfaction surveys with participants during and/or after the program to see what they thought of the program
- Check in with staff on their perception about whether the participants seemed engaged

The Tipsheet on page 63 titled Process Evaluation Questions and Activities lays out the typical answers to these process evaluation questions and links them to their respective evaluation activity options. Use this tipsheet to point you toward the evaluation activities best suited to your organization and available resources.

If you need more information on some of the available data-gathering options to help you choose your activities, the Tipsheet on page 105 titled Ways to Gather Process Evaluation Information provides additional information.

Take some time to review both these resources as you prepare to develop your program's process evaluation plan.

There are many approaches to conducting process evaluation. We highly recommended you should collect the following process evaluation data:

Track participation – Keep track of each participant over time by creating a roster with youth's first names and list sessions, date, and attendance record for each session held for each participant.

Fidelity Monitoring – Check to see that the program is being delivered as intended. If you are using an evidence-based program, fidelity measures have likely already been created (see Appendix D).

Monitor your work plan – You should be following your work plan as you implement your program. You can use the work plan you created in Step 6 to track the completion of your activities.

If you have the resources and time, we suggest you also collect the following data on your program's implementation:

Participant satisfaction – Participants' perceptions of your program can be collected using brief surveys.

TIPSHEET: PROCESS EVALUATION QUESTIONS AND ACTIVITIES

Process Evaluation Questions	Evaluation Methods & Tools	When Conducted	Resource Requirements
1. What are the program participants' characteristics?	Demographic information collection (surveys or observations)	Before and after program implementation	Expertise: moderate Time: moderate
2. What were the individual program participants' dosages?	Attendance monitoring by participant	During program; summarize after	Expertise: low Time: moderate
3. What level of quality did the program achieve?	Fidelity monitoring: staff Fidelity monitoring: observers	During/after program	Expertise: moderate Time: moderate Expertise: moderate Time: high
4. What is the participants' level of satisfaction?	Satisfaction surveys Focus groups	During/after program	Expertise: low Time: low Expertise: high Time: moderate
5. What is the staff's perception of the program?	Program debriefing Staff surveys Focus groups Interviews	During/after program	Expertise: low Time: low Expertise: low Time: low Expertise: high Time: moderate Expertise: moderate Time: moderate
6. Did the program follow the work plan?	Completion of work plan tasks	During/after program	Expertise: low Time: low

TIPSHEET: WAYS TO GATHER PROCESS EVALUATION INFORMATION

You are likely to use a variety of methods for collecting your process evaluation data. Here's some additional information about a few key ones we've mentioned in this chapter.

Demographic Data
What it is: Specific information about participants including variables like age, sex, race/ethnicity, education level, household income, family size etc.
How to gather it: You have probably already gathered much of this kind of information in the course of planning for, establishing or running your program. Often, these types of questions are asked as part of an outcome assessment survey. Information can be gathered during an interview with each participant as well.
Why it is important: So you'll know if your program is serving the participants you planned to engage.
Focus Groups
What they are: A focus groups is a facilitator led discussion on a specific topic with a group of no more than 8-10 participants brought together to share their opinions on that topic.
How to manage them: Generally focus groups are led by 1-2 facilitators who ask the group a limited number of questions. Think of the structure of a focus group like a funnel—each major topic should start with broad questions, then get more specific. Be sure to tape record the focus group or have a designated note taker. The data can be analyzed by looking for the number of instances certain themes appear in the transcripts or notes. If you want more information on focus groups, some good resources to reference are: <ul style="list-style-type: none"> • First 5 California, Focus Group Online Course http://www.cafc.ca.gov/ffn/FGcourse/focusGroupCourse.html • Morgan, DL & Krueger, RA. (1997). The Focus Group Kit. Thousand Oaks, CA: SAGE Publication. Description available at http://www.sagepub.com
Why they're important: Focus groups are an excellent method to learn what people thought about your program and get suggestions about your program. Data from focus groups often yield "qualitative" (i.e., text) data as opposed to surveys, which usually yield "quantitative" (i.e., numerical) data. Listening as people share and compare their different points of view provides a wealth of information—not just about what they think, but why they think the way they do. For more information about qualitative data collection, refer back to see Step 1.
Satisfaction Surveys
What they are: Information about how much the participants enjoyed the program, whether they got something out of it, whether the program met their needs or expectations.
How to do them: The easiest way is to administer brief surveys to participants as part of the program, at the end of each session or activity. This is better than waiting to the end of the entire program, because sometimes participants forget details from earlier sessions. Surveys can also be handed out at the end of a program with self-addressed, stamped envelopes so the participant can complete the survey and return it later. This method, however, adds expense (cost of postage) and often fewer surveys are returned.
Why they're important: So you'll know if the participants feel good about the program and it can help you identify areas to improve participant satisfaction.

Staff Perceptions
What they are: Staff perceptions about what worked and didn't work during the implementation of a program.
<p>How to gather them: There are three methods for gathering data on staff perspectives:</p> <ul style="list-style-type: none"> • Focus groups • Interviews • Program debriefing <p>In addition to what we've already mentioned about <i>focus groups</i>, an <i>interview</i> can be a good way to get detailed information about program implementation from staff. While interviews with staff involve a similar type of questioning as a focus group, you're doing talking with one person at a time.</p>
<p>A <i>program debriefing</i> is a straightforward way for staff to quickly meet immediately after a program session has been conducted and answer two questions:</p> <ol style="list-style-type: none"> 1. What went well in the session? 2. What didn't go so well, and how can we improve it next time?
Why they're important: Program staff are often in an excellent position to comment on how well a program is being implemented.
Fidelity Monitoring
What it is: systematically tracking how closely each intervention activity was implemented as laid out in your final work plan.
How to do it: If you are using a packaged program, check with those responsible for disseminating the program to see if they have a fidelity instrument. If a fidelity instrument does not come with the packaged program materials or you have developed your own program, look at fidelity tools from other programs and create your own.
Why it's important: The closer you can come to implementing a program as it was intended, the better chance you have of achieving your goals and outcomes.

Sources: Getting to Outcomes: Promoting Accountability Through Methods and Tools for Planning, Implementation and Evaluation, RAND Corporation (2004); Getting to Outcomes With Developmental Assets: Ten Steps to Measuring Success in Youth Programs and Communities, Search Institute (2006)

Focus groups – Focus groups are a good way to solicit feedback on program satisfaction and gather suggestions for improvement. See the tipsheet on page 105 for guidance on focus group methodology.

Staff perceptions – Use the Project Insight Form we've included in Appendix E to solicit ideas from your staff on perceived successes and challenges in implementing your program. This form can be used to help track the responses to questions about which factors facilitated the program's implementation or which factors may have emerged as barriers. The information can be tracked over time to see if the barriers identified were adequately addressed.

Develop a simple process evaluation plan

Now you're ready to develop a simple, but effective process evaluation plan using the Process Evaluation Planning Tool found on page 108.



Instructions for Using the Process Evaluation Planning Tool

Make as many copies of the tool as you need for your work group to complete this task. The process for completing the Process Evaluation Planning Tool is as follows:

1. Have your work plan and program materials (i.e., guide or manual if available) as well as tipsheets from this step to help you complete the planning tool.
2. Starting with the first question on the Process Evaluation Planning Tool, fill in:
 - Which evaluation tools/methods you plan to use (e.g., surveys, focus groups, etc.)
 - Your anticipated schedule for completion
 - The person or persons responsible for gathering the data for each question
3. Repeat this process for each question.



PROCESS EVALUATION PLANNING TOOL

Program Name: _____ Name of person completing form: _____

Date: _____

Process Evaluation Questions	Process Evaluation Tool/Method	Schedule of Completion	Person Responsible
Did the program follow the basic plan for service delivery?			
What are the program characteristics?			
What are the program participants' characteristics?			
What is the participants' satisfaction?			
What is the staff's perception of the program?			
What were the individual program participants' dosages?			
What were the program components' levels of quality?			

Ready to Implement: Conduct a Process Evaluation

Now that you have developed your plan, you'll be ready to conduct your process evaluation during your program implementation. Remember to document and monitor the program work plan you developed in Step 6 as you implement your process evaluation.

Again – We recommend that you take time to read through Step 8 before you implement your program. This will help you consider if you need to do a pre-test survey of your program participants' behaviors and determinants, or recruit a control or comparison group before starting your program.



Sustainability tip: A process evaluation can help you see what's not working and needs to be changed as well as what activities are successful and worth repeating! Identifying strengths, weaknesses and areas for improvement will increase your overall effectiveness and builds confidence in your program with all your participants, staff and stakeholders as well – all that helps build sustainability



Applying This Step When You Already Have a Program

If you are already implementing a program, it's still not too late to begin documenting your work using tracking tools and monitoring fidelity. It's always useful to check on things that are going well and try to change things that aren't working out well. It's also not too late to consider ways to evaluate your program. We recommend you read through this step and Step 8 on outcome evaluation to glean any new ideas or identify tools you could use to assess and improve your program's implementation.



Sustainability tip: Process evaluation not only provides data about how well your program is going, but it also gives you a chance to reflect and learn about what is going as planned and what might need to be changed. Share more of what you're doing and learning with your stakeholders.



Checklist for Step 7

When you finish this step, you should have:

- Developed a clear process evaluation prior to launching your program
- Examined whether the activities captured in your logic model were implemented as planned
- Monitored the work plan you started in Step 6
- Determined the quality of your activities
- Identified and made midcourse corrections if needed
- Tracked the number of participants and their attendance
- Monitored your program fidelity

Before Moving on to Step 8

Once you've finished your process evaluation plan, you're ready to move on to Step 8 in which you'll plan your outcome evaluation and actually measure the effectiveness of your program.

Remember – Take time to review Step 8 to plan before launching your program so you'll know when to time your outcome evaluation activities.

Step 8: Evaluate The Outcomes Of The Program.

Overview of Outcome Evaluation

You have established a plan for implementing your program and developed tools for monitoring the process and quality of your implementation. Now it's time to determine if your program has had the effects you desired. Combining the process evaluation developed in Step 7 with outcome evaluation gives you a complete picture of your program's impact.

This step is about finding out whether your program resulted in your desired outcomes. More specifically, the tasks in this step will help you document whether or not your program caused changes in the lives of homeless Veterans.

The tasks in this step will help you:

- Develop an outcome evaluation plan
- Implement the outcome evaluation plan
- Analyze, interpret and report your results

Here's what you'll need to get started:

- Your work plan
- Your process evaluation plan from Step 7
- Existing program measures that came with your program (if available)
- Blank copies of the Outcome Evaluation Tool in this chapter found on page 113.

Why?

Evaluating the implementation of your program (process evaluation) is important but ultimately you want to know if you are reaching outcomes with the Veterans you serve. Planning and completing an outcome evaluation will help determine whether the program reached its goals and desired outcomes. We all want to improve the lives of homeless Veterans and an outcome evaluation can let us know if our program did so.

How?

There is a series of tasks you need to undergo in order to plan and conduct an outcome evaluation:

1. Identify what will be measured.
2. Choose the design of the evaluation.

3. Develop the methods to be used.
4. Develop and finalize a plan to put those methods into place.
5. Conduct the outcome evaluation.
6. Analyze the data, interpret the findings and report your results.

The following sections will walk you through a brief description of each of these tasks. To help you see where you're going, take a look at the Outcome Evaluation Tool found on page 113. The tasks described in the next sections will help you fill in this tool. Once you have completed the tool, this will serve as the outcome evaluation plan for your program.



Instructions for Using the Outcome Evaluation Tool

Our instructions for completing the Outcome Evaluation Tool will be presented in a little different format than what we've done in previous chapters. The instructions are broken down by topic and correspond to each of the six upcoming sections of this chapter shown in the list above. As you read through the tasks in this step, we'll give you the information you need to fill in each of the nine columns in the tool.

Make as many copies of the tool as you need.

- Start by writing each of your desired outcome statements in the space provided in the far left-hand column of the tool. You will fill in the information called for in the tool (measures, design, sample size, data analysis methods, mean pre scores, mean post scores, mean difference and interpretation) for each one of your desired outcomes.
- At the end of each topic section, look for the instructions that begin with Using the Outcome Evaluation Tool.



OUTCOME EVALUATION TOOL

Needs/Resources:

Target group (include numbers):

Goal(s):

Objectives (e.g., Desired outcomes)	Measures	Design	Sample Size

Data Analysis Methods	Mean Pre Scores	Mean Post Scores	Mean Difference	Interpretation

Identify what needs to be measured

Let's start by revisiting your objectives defined in Step 2—this will guide what you actually should plan to measure. In evaluating the impact of your intervention activities, you seek to measure changes in the lives of homeless Veterans.

For example, let's say you determined the following in Step 2:

- Your overall program goal is to increase long-term employment among Veterans enrolled in your program.
- One of the key barriers to sustained employment identified in your needs and resources assessment is unprofessional and inappropriate behavior resulting in interpersonal conflict with co-workers and managers and eventual job loss.
- Some of the specific “pre-vocational” skills targeted in your program to address these inappropriate behaviors include:
 - Improve communication and conflict resolution skills
 - Increase adherence to schedules and work routines
 - Increase knowledge of workplace norms

Once you identified your desired outcomes (i.e. desired changes in behaviors, skills, attitudes, and knowledge), you created objective statements for each of them. These statements are a critical piece of outcome evaluation because they tell you what you need to measure.

Based on the example above, it would be important to identify and use a measure of length of employment, incidents of inappropriate behavior, communication and conflict resolution skills, schedule adherence, and knowledge of workplace norms in the evaluation plan. The important thing is that you measure all of your desired outcomes.

Identify how to measure your desired outcomes

Once you have identified what you need to measure, the next step is deciding how to measure it. In the sections that follow, we refer to measure as a survey instrument or individual questions on a survey. One example of a measure to assess schedule adherence is the survey question “how many times in the last 2 weeks have you been more than a few minutes late for work?”

Creating a measure can be a hard task even for experts in developing measures. It's most efficient to start with existing measures and craft one that meets your needs from a bank of measures or individual survey questions that have already been developed and tested for use. Your chosen program may already have evaluation measures available with it. Review them to make sure they are appropriate for your priority population and use them. In this guide we

have included a brief listing in Appendix D **Error! Reference source not found.** of measures that you might be able to draw from.

When finalizing your survey instrument, you should:

- *Have at least one measure for each outcome* – It's important to have at least one measure (e.g. survey question) for each outcome you seek, but it's better to have a set of questions for each outcome to measure complex outcomes like communication skills.
- *Be as short as possible* – Shorter measures reduce the time needed to complete the measure. Shorter measures also save time on entering the data into a computer and also reduce test fatigue among your Veterans.
- *Pilot test the survey* – Whenever possible, it's useful to test out potential measures with a few users for readability, clarity, etc. before using them.
- *Format the survey* – Combine all the questions into one survey and number them continuously, including the demographic questions, to make your measures easy to follow. It's often best to place demographic questions at the end of surveys. Don't forget to create easy-to-understand instructions for the survey and sections in the survey needing special instructions.

Using the Outcome Evaluation Tool: Once you've developed measures for your desired outcomes, enter both the outcomes and the measures into the first two columns of the Outcome Evaluation Tool.

Choose the design of the evaluation

Now you're ready to move into designing an evaluation which fits your program and available resources. You want to design an outcome evaluation that, as much as possible, clearly demonstrates your program caused any outcomes you see. In other words, you want to be able to conclude there's a strong cause-and-effect relationship between your intervention activities and your outcomes.

To help you decide what design might work best for you, here's a run-down of the most common evaluation designs:

Post Only. Using this design, staff only measures outcomes after they deliver their program. This design is the least useful because you are not able to compare your results after the program to a measure taken before the program (called a "baseline" measure). Therefore, it's difficult to measure change. This design only allows you to compare your results to previously collected data from another source (e.g., national trend data) and does not allow you to say that your program had any positive or negative effect on the behaviors and related determinants—there is no way to know this. Additionally, if using this design, your outcome data may not be a

perfect match with data from other sources (e.g., different measures, different groups of people), and therefore the comparison will be even more difficult.

For example, if you measure the income in the last month among Veterans after your program has been completed, comparing that to national data would be less useful than if you had collected the same data on your participants prior to the program. Post-only design can be used when it is more important to ensure that participants reach a certain threshold (e.g., 200% of poverty level) than it is to know how much they changed because of your program.

Pre-Post. This design enables you to measure change by comparing your baseline measurement (remember, a baseline is a measurement taken before the program begins) to the measurement taken after the program ends. The measurement is done twice (before and after the program) and must be the same exact measurement done in the same way in order to be comparable. Also, you need to make sure to allow enough time for your program to be completed by participants. Although this design is an improvement over the Post Only, you still cannot have complete confidence it was your program that was responsible for the changes in the outcomes. There may be many other reasons why participants change which has nothing to do with your program, such as changes in the regional economy, an increase in the minimum wage, or a new employer moving into the area.

Pre-Post with a Comparison Group. The way to have more confidence your program is responsible for the change in outcomes is to also assess a group similar to your target group that did NOT receive the program called a comparison group. In this design, you assess both groups before, deliver the program to one group (called the intervention or program group), and then measure both groups after. The challenge is to find a group similar to your program group in demographics (e.g. gender, race/ethnicity, socioeconomic status, education, etc.) and in the situation that makes them appropriate for the program (e.g., both groups are recently homeless Veterans with a substance use disorder). The more similar the two groups are, the more confidence you can have that the program was responsible for the changes in outcome. With this design, you need to recruit a comparison group that is similar in number to the number of participants in your program. Typical examples of a comparison group are a group of Veterans receiving a vocational program compared to another group of Veterans on the waiting list for the program, or who receive another existing vocational program.

Although having a comparison group answers the question about which group had a bigger change, it does not completely answer the questions about whether your program caused that change. There still could be other reasons, such as the two groups were different in some way (different ages, races, levels of risk) that affected the outcomes.

Pre-Post with a Control Group. In this design, you randomly assign people to either a control group or a program group from the same overall target population. Random assignment means each person had an equal chance of winding up in either group (e.g. flip a coin to assign each participant to a group). Sometimes you can randomly assign larger groups like VA facilities if you are working with a large enough number. A control group is a type of comparison group (a group of people who are like the program group but do NOT receive the program) that is the

result of random assignment. This is the best-known way to ensure that both groups are equal; therefore, this design gives you the most confidence to claim that your program caused the changes that were found.

When you're trying to determine the best design to fit your program and resources while also getting evaluation results in which you can be confident, keep in mind:

A pre-post with control group	Is stronger than →	A pre-post with comparison group	Is stronger than →	A pre-post	Is stronger than →	A post only
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Although the Pre-Post Test with Control Group gives you the most confidence that your program was responsible for the changes in outcomes, it's also the most difficult to implement, costs the most, and raises ethical questions about giving some people a program while withholding it from others at random. You'll have to balance how much confidence the design will give you against the costs, the level of expertise you have access to or need to hire, and ethical considerations.

Using the Outcome Evaluation Tool: Once you've selected your evaluation design, enter the information into the design column of the Outcome Evaluation Tool. Be sure to indicate which designs you'll use to achieve each specific desired outcome. It is alright to use the same design for all your desired outcomes.

Choose methods of measurement and data collection

There are multiple methods for collecting outcome evaluation data and we referred to several methods in Step 1. However, in this chapter, we're focusing on one method for data collection and that is surveys. For a more comprehensive list of other methods, see the tipsheet titled Data Collection Methods at a Glance on page 118.

Develop and finalize a plan to put methods into place

Before you implement your program and conduct your evaluations, you need to decide who you'll collect data from and how often to collect it.

Who to assess: It should be fairly simple to determine whom you will assess. If you are conducting intervention activities with 50 Veterans and only doing a pre-post test design, then you'll be assessing all the Veterans in your program. If you decide to add a comparison or control group to your design, then you'll assess everyone in each group (a total of about 100 Veterans).

If you're conducting a community-wide prevention program, it may not be possible to assess every targeted Veteran, so you'll need to survey what's called a sample of the overall homeless Veteran population. Keep in mind that the larger and more representative the sample is of the

overall population, the more confidence you can have about stating that the results of your sample apply to the overall population.

How often to measure: We recommend you do at least a pre and post test measurement. If you have the resources, it's very useful to conduct a follow up post-test after several months to see if the outcomes are sustained. For example, you can build plans into your evaluation to do a follow-up survey with your participants 3, 6 or even 12 months after they have finished the program to see if your desired outcomes have continued or dropped off over time.

Using the Outcome Evaluation Tool: Once you've determined your sample size, enter the information into the sample size column of the Outcome Evaluation Tool. Be sure to indicate your sample size for each of your desired outcomes. It is alright if you have the same sample size for all of your desired outcomes.

Conduct your outcome evaluation

Now it's time to implement your program and conduct the process and outcome evaluations methods you've chosen. Regardless of the methods you've chosen, you'll need to decide who's going to collect the data you need. Whom you choose may affect your results. You need to ensure that your participants feel comfortable with the person or people you choose. Can the person gathering the information be as objective as the task requires? Will your participants feel comfortable enough to provide honest information or will they try to look good to the person collecting the data? This could happen if the person who delivers the program is also the one collecting the data. If possible, it's better to have someone who is not involved in delivering the program, be responsible for data collection.

TIPSHEET: DATA COLLECTION METHODS AT A GLANCE

Methods	Pros	Cons	Cost	Time to complete	Response rate	Expertise needed
Self-administered surveys	Anonymous Inexpensive Easy to analyze Standardized Easy to compare with other data	Could be biased if youth don't understand the questions or answer honestly. May get incomplete data.	Low to moderate	Moderate	Moderate to high, depending on how it is administered	Little to give out surveys. Moderate to analyze and interpret the data.
Telephone surveys	Same as paper (above) But may allow for conducting more surveys and doing more follow-up	Same as paper (above) But those without phones may not respond Others may ignore calls	More than self-administered (moderate to high, depending on number of surveys to complete)	Moderate to high	Moderate to high depending on how it is administered	Need some to do phone surveys Moderate to analyze and interpret the data
Focus groups	Can quickly get info about attitudes, perceptions, and social norms. Info can be used to generate survey questions.	Cannot get individual-level data from focus group. Can be difficult to run. Hard to generalize themes to larger group. May be hard to gather 6-8 persons at the same time. Sensitive topics may be difficult to address in a focus group.	Inexpensive if done in-house. Can be expensive if hiring a professional. Usually incentives are offered to get participants	High Groups can last 1.5 hours on average	Moderate Typically focus groups involve only 6-8 people.	Requires good group facilitation skills Conversation skills Technical aspects can be learned relatively easily

Methods	Pros	Cons	Cost	Time to complete	Response rate	Expertise needed
Interviews – face-to-face and open ended	Gather in-depth, detailed info. Info can be used to generate survey questions.	Takes much time and expertise to conduct and analyze. Potential for interview bias.	Inexpensive if done in-house Can be expensive to hire outside interviewers and/or transcribers.	About 45 min. per interview. Analysis can be lengthy, depending on method	People usually agree if it fits into their schedule.	Requires good interview/conversation skills Formal analysis methods are difficult to learn.
Open-ended questions on a written survey	Can add more in-depth, detailed info to a structured survey	People often do not answer them. May be difficult to interpret meaning of written statements.	Inexpensive	Only adds a few more minutes to a written survey. Quick analysis time.	Moderate to low	Easy to analyze content
Participant observation	Can provide detailed information about a program	Observer can be biased. Can be a lengthy process.	Inexpensive if done by staff or volunteers	Time consuming	Participants may not want to be observed	Requires skills to analyze the data
Face-to-faced structured surveys	Same as paper and pencil, but you can clarify responses	Same as paper and pencil but requires more time and staff time	More than telephone and self-administered surveys	Moderate to high	More than self-administered survey (same as telephone survey)	Need some expertise to implement a survey and to analyze and interpret the data
Record interview	Objective Quick Does not require new participants	Can be difficult to interpret. Often is incomplete.	Inexpensive	Time consuming	Not an issue	Little expertise needed. Coding scheme may need to be developed

Important issues come up about protecting participants in data collection regardless of the method you've chosen. Here are several critical considerations:

Informed consent – Informed consent is the direct consent of participants in an evaluation process.

Potential respondents in your evaluation must be given the opportunity to give their consent to their participation. Many times this is accomplished through written consent. The participant signs a consent form agreeing to take part in the evaluation (called obtaining “active consent”).

In some instances, it's required to obtain active consent. However, in other instances, it is often sufficient to obtain “passive consent.” Passive consent involves giving the potential participant the opportunity to refuse to participate verbally, without using a consent form. In either case, the potential participants must be informed about the purpose of the program or evaluation study, told that their answers will be kept confidential (and possibly anonymous), and that they can decline to participate at any time with no negative consequences. It is important to know how consent is handled in your VA facility.

Confidentiality – You must make every effort to ensure that the responses of the Veterans will not be shared with anyone but the evaluation team unless the information reveals imminent intent of someone to harm themselves or others (a legal statute that varies by state).

Confidentiality is honored to ensure more accurate information and to protect the privacy of the participants. Common safeguards include locking the data in a secure place and limiting the access to a select group, using code numbers in computer files rather than names, and never connecting data from one person to his or her name in any written report (only report grouped data such as frequencies or averages).

Anonymity – Whenever possible, data should be collected so each Veteran can remain anonymous. Again, this will ensure more accurate information while protecting the privacy of the Veterans. If you plan to match subjects on a pre and post test measure, you'll have to come up with some sort of non-identifying way to match surveys such as creating unique ID numbers or codes for each Veteran, for example.

Analyze the data, interpret the findings and report your results

Once you've gathered your data, the next step involves analyzing it. Just as there are quantitative and qualitative data collection methods, there are also quantitative and qualitative data analysis methods. When using quantitative data collection methods like surveys, it's common to use quantitative data analysis methods like comparing averages and frequencies. It may be worthwhile to consult an expert in data analysis procedures in order to ensure you're using appropriate techniques. Consider getting assistance from your Mental Illness Research,

Education, and Clinical Center (MIRECC), Systems Redesign Committee, or other local technical assistance groups in analyzing your data (see Appendix B for contact information).

Using the Outcome Evaluation Tool: Once you've gathered and analyzed your data, enter the information into the appropriate columns of the Outcome Evaluation Tool. Be sure to include information for each outcome on the data analysis methods used to arrive at your scores and conclusions.

Interpret data

While some of what occurs during your process and outcome evaluation seems technical, such as calculating statistical results, the actual conclusions about your ultimate impact require your analysis of the results. At this stage, you are now reviewing the data and information you've gathered in both Steps 7 and 8 about process and desired outcomes to see if you are actually changing the behaviors you set out to change and by how much.

There's a lot to think about. You may have a well-implemented program but still not achieve the positive outcomes you'd hoped for. Interpreting your results in a thoughtful way helps you see what's working and what you need to change. Perhaps the original theory you developed isn't right or you haven't provided enough dosage or length of time for your program to have the desired impact. Your process evaluation data should help you interpret your findings.

Compare your data to what you stated you were hoping to achieve in your objective statements. Look for patterns that may reveal where changes need to be made. Charge an individual or small group with examining the data more deeply and conducting a review which can be presented to you and your staff for discussion. Again, this may be a place where you seek out evaluation expertise to help you analyze and interpret your results.

Using the Outcome Evaluation Tool: Once you've analyzed and interpreted your data, enter the information into the final column of the Outcome Evaluation Tool. You may need to take extra room on another sheet of paper to compile your observations and interpretations.

Report results

Obviously the most important reason we evaluate what we're doing is because we want to know whether we're having an impact in the lives of Veterans we're working with. However, sharing our results in simple, meaningful ways can have other useful impacts as well.

Keep in mind that different groups of stakeholders may be interested in different types of information. Veteran groups may be less interested in lots of data than VA administrators.



Applying This Step When You Already Have a Program

If you are already implementing a program and haven't planned for an outcome

evaluation, it's still important for you to evaluate your program. In this case, you may only be able to use a post only design. If you decide against an outcome evaluation, we still recommend you at least conduct a process evaluation as outlined in Step 7.



Sustainability tip: To further build sustainability into your efforts at this stage, think about the following...

- Learning to do outcome evaluation “in-house” will help you to save money in the long-run.
- Reporting results to stakeholders such as VA leaders and community members is an important way to maintain and even increase the strength and support for your programs.
- Continually reviewing and fine-tuning the methods you use to assess your program outcomes will ensure the integrity of your work.



Checklist for Step 8

When you finish this step, you should have:

- Identified measures
- Chosen the design of the evaluation
- Developed methods to use
- Developed and finalized a plan to put those methods into place
- Conducted the outcome evaluation (collected your data)
- Analyzed data, interpreted your findings and reported your results

Before Moving on to Step 9

Congratulations! You've implemented your program and conducted process and outcome evaluations. You should have some idea at this point whether you achieved your original intentions and have actually achieved your desired outcomes. The final two steps in this process will help you reflect on what you've done, fine-tune your work before you conduct your program again, and bring together a set of ideas about how to sustain your work.

Part 4: Improving and Sustaining

Step 9 – Use **Continuous Quality Improvement (CQI)** To Improve Your Program.

Step 10 – Consider What Will Be Needed To **Sustain** The Success Of The Program.

Step 9: Use Continuous Quality Improvement (CQI) to Improve Your Program.

Overview of Continuous Quality Improvement

Now that you've planned, implemented, and evaluated your program, you've probably learned a lot along the way. Hopefully, many things turned out the way you thought they would, demonstrating good process and outcome results, but you may have discovered that some things didn't work out well. It's important to take time to see what should be fine-tuned to improve the program over time.

To help you do this, the tasks in this step are based on a common business strategy called continuous quality improvement or CQI. Continuous quality improvement means regularly considering feedback from evaluation information about planning, implementation, and desired outcomes in order to improve program quality.

This step is about learning how to continuously improve your program using your planning and implementation process as well as your evaluation results. Step 9 involves a simple, but systematic review of all your previous work to see what changes you could make to improve your program in the future. CQI is a strategy for providing continuous feedback to guide future planning and implementation. The tasks in this step will help you assess program activities which did not work well overall or for specific groups, and identify areas for improvement.

Here's what you'll need to get started:

- Completed tools from the previous chapters
- The results of your process and outcome evaluations
- Copies of the CQI Tool from this chapter

Why?

This step is critical to the continued growth and improvement of your program. Now that you've implemented your program, it's unlikely everything worked exactly as you had planned. You may not have seen the changes in some or all of the outcomes you had hoped for or, you may have discovered program barriers and challenges along the way that you didn't anticipate in the beginning -- this is expected and normal.

You can use all that you've learned to adjust and improve your program. Program staff open to learning from evaluations and feedback will implement increasingly more effective programs. For example, there may have been challenges with implementation, participant retention, or

issues related to fit. The CQI tasks can help you decide how to adjust your plan and implementation so you continue to move closer to your goals and desired outcomes.

How?

The CQI review sounds more complex than it is. When you sit down to look over all that you've learned and accomplished in the previous eight steps, you're asking yourself a simple question – what can we do better?

To help you review your work and answer this question, we've provided a CQI Tool on page 130 for you to use. The tool walks you through reexamining the previous eight GTO questions to determine how your plans went and prompts you to think about what you might do differently next time.

Here are some suggestions for preparing for your CQI Review:

- *Engage your program staff in discussions about the CQI process* – Let staff know ahead of time you're planning such a review. Get their ideas for how to do it, what information to use, and how to gather and incorporate their feedback.
- *Gather together all the information you want to review* – With the results of your process and outcome evaluation in mind, gather information from your:
 - needs assessment reports
 - goals and desired outcomes
 - fit worksheet
 - capacity assessment tools
 - work plan
 - process evaluation showing successes and challenges of delivering your program
 - summary of satisfaction surveys from staff and participants (if completed)
 - data summary of outcome evaluation

- *Set up a work group* – It might be helpful to have a specific group tasked with using the information you’ve gathered to go through the CQI Tool and answer the questions and suggest improvements to carry out.
- *Complete your review* – Complete each section of the CQI Tool by answering the questions using the information and data you have gathered from your program’s plan, implementation, and evaluation.

If you find that there are new needs among homeless Veterans in your local area, you’ll have to come up with new goals and desired outcomes targeting those needs as well as different programming, fit and capacity assessments, plans and evaluations. You may also find that the only things you need to change the next time around are some of your implementation strategies.

When you’ve finished your review process, summarize the information learned by answering these questions. You can use the CQI Tool as your checklist for this step.

What should you do with this information when you’re done?

- If you feel confident you’ve had a positive impact in all of the previous steps, then go on to Step 10 to learn more about sustainability.
- If your CQI assessment suggests you should make significant changes to your program or change the program you’re delivering, it may be premature to go on to Step 10. We recommend you take some time to figure out what needs to be changed and how you’ll do it. You may need to go back and re-do some of the tasks in previous steps.

Keep in mind that adjustments to improve the functioning of your program need not be major. You may find, for example, that the delivery of case management could be improved by working with one case manager to help him or her engage with clients more effectively. Such adjustments can be made while keeping other successful elements of your program moving ahead.



Instructions for using the CQI Tool

Make as many copies of the tool as you need for your workgroup to complete this task. The process for completing the CQI Tool is as follows:

1. Insert the name of your program, the name of the person(s) completing the tool, and the data it was completed.
2. Reconsider each of the previous eight accountability questions from GTO listed on the CQI tool in Column 1 in light of all the information that you have gathered about your program. Summarize your conclusions in Column 2.
3. Think about the implications of your conclusions in Column 2 for the on-going implementation of your program. In Column 3, summarize how these conclusions will be used to improve the implementation of your program in the future.



CQI TOOL

Program Name: _____ Name of person completing form: _____

Date: _____

Accountability Questions ① -⑧	Response to Accountability Question	How Will These Conclusions Be Used To Improve Program Implementation?
① Have the needs of the target group/resources in your local area changed?		
② Have the goals/desired outcomes/target population changed?		
③ Are new and improved science-based/best practice technologies available?		
④ Does the program continue to fit with your facility (both philosophically and logistically) and your local area?		
⑤ Have the resources available to address the identified needs changed?		
⑥ How well did you plan? What suggestions do you have for improvement?		
⑦ How well was the program implemented? How well did you follow the plan you created? What were the main conclusions from the process evaluation?		

<p>③ How well did the program reach its outcomes? What were the main conclusions from the outcome evaluation?</p>		
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Applying This Step When You Already Have a Program

If you have been delivering a program for some time now, CQI is a VERY important step toward reviewing what you have done to date, noting the successes and challenges you've encountered, and examining how well your program is achieving its goals and desired outcomes. Gather all the information you have available and work with your staff to complete the CQI Tool. No matter how well things have gone in the past, there's usually room for improvement in every program.



Sustainability Tip: Systematic reflection on what you're doing helps build sustainability. Such a process shows you important ways to continuously improve what you are doing so your program gets better and better. It also allows you to update your program as circumstances or research changes. You can also get a clearer picture of what you're doing well that contributes to your successes. Being willing to question, examine and make changes also helps build confidence in those involved in your program from staff and volunteers to your VA administration, Veterans groups and community partners. And a continuously improving program leads to a positive impact where it counts the most – with the Veterans you serve!



Checklist for Step 9

As mentioned earlier, you can use the CQI Tool itself as your overall checklist for this step. When you finish this step, you should have:

- Completed the CQI Tool
- Documented successful program activities
- Assessed program activities which did not work well overall or for specific groups in order
- Identified areas for improvement
- Created strategies for improvement
- Increased buy-in within your organization by soliciting and acting on the suggestions of program staff

Before Moving on to Step 10

Pull together all your work products, findings, and conclusions and maybe take a little time to digest what you've learned before moving on. You could have a meeting with some key members of your staff, volunteers, Veterans and/or stakeholders to talk about your conclusions and possible program changes.

In each chapter, we've tried to suggest ways you could begin thinking creatively about how to implement and sustain your program at each stage of its development. In Step 10, we'll summarize these and other ideas for sustaining the successes of your program.

Step 10: Consider What Will be Needed to Sustain the Success of the Program.

Overview of Sustainability

Clearly if your program was successful in getting the desired outcomes you'd planned on, you want to sustain your work and continue doing it. The whole point of the work we do is to help Veterans; so if our program is getting positive results, it is worth sustaining in order to maintain the impact we are having. Unfortunately one of the realities we face is that even successful programs may not continue to be successful because of staff turnover, changes in organizational priorities, or funding cuts. Sustainability is concerned with maintaining successful outcomes by planning ahead to deal with potential threats to continued success. Sustainability is an important activity that should be built into the plan for your program from day one and it is an ongoing effort.

However, not all programs should be sustained. Part of what you learn in your evaluation process might be that the program you've picked doesn't work, doesn't fit, or a better one emerges. This step will help you determine whether a program is worth sustaining and provide ideas about how to sustain it.

Why?

After all your hard work to plan, implement, and evaluate a program that achieves your goals, you want to make sure that the program can continue achieving your goals and not decline in effectiveness over time. In this step, you will identify and implement ways to sustain practices that are effective in your VA facility. This step will help you address potential threats to the sustainability of your program and use your GTO work to promote your program to those who can help sustain it.

How?

There is limited information about how to effectively sustain programs. Below are some common-sense strategies to consider that may assist you with your own sustainability plans:

Save money: VA administrators always want to save money. If you can show that your new program does this consistently, there is a greater chance those administrators will continue to support it.

Meet a performance measure: VA administrators are responsible for meeting performance measures. If you can show that your new program contributes to

meeting one more of these measures, there is a greater chance those administrators will continue to support it.

Program financing: Diversify your funding streams as much as possible to protect your program from being vulnerable to budget cuts.

Program champions: Obtain an influential program advocate or champion to generate goodwill for the continuation of the program to help support sustainability.

Training: Train multiple staff in all roles, so that you are prepared in the event of staff turnover. Having a large group of trained staff also forms a constituency to support the program.

Program documentation: Make sure that all aspects of your program are documented, so that key knowledge does not leave the program in the event of staff turnover.

Institutional strength: Work to maintain the capacities from Step 5 (e.g., staff retention, fiscal, etc.).

Integration with existing programs/services: Educate staff throughout your VA facility and community about your program, so that referring Veterans to your program becomes standard operating procedure.

Fit within your VA facility and community: Your program should demonstrate value over preexisting programs. This will enhance your potential for sustainability of the program.

Develop a Sustainability Plan

As in the other GTO steps, you may want to sit down with a workgroup and think through a simple plan for sustaining your program. Even though sustainability is a continuous process, making a plan that specifies what activities will be carried out and when you'll do them makes it much more likely that you'll follow through in this important area.

One possible approach to take – answer the GTO questions through a sustainability lens. Use the tipsheet we've provided on page 137 to help you. For example, what sort of resources do you think you need to sustain your program? What are your goals and outcomes with regard to sustainability? For example, if you want to increase community awareness and support for your program by participating in community events, how will you find out what events are coming up, then develop a plan for scheduling and prepare for these events. Planning for grants may be

similar. It's important to know what funds are available and when the deadlines are to ensure enough time to prepare and submit your application.

TIPSHEET: GTO SUSTAINABILITY RECAP

Step 1	Build relationships. Whether you're starting something new or refining an existing program, relationships are always important to your success. Get buy-in all along the way from a diverse group of participants, including Veterans!
Step 2	Choose goals and objectives that are meaningful and important to Veterans and your other stakeholders. Working towards goals that your stakeholders care about, will help you gather support from your stakeholders to sustain the program.
Step 3	Ground your work in what works. Use as many characteristics of science-based programs as possible to enhance what you're doing. This will increase staff competence and confidence and help you deliver a strong program.
Step 4	Take time to assess fit. The more congruent your program is with existing needs, resources, and characteristics of your Veterans, the easier it will be to gain support for it.
Step 5	Develop important capacities. Training is important to ensure your staff and volunteers know how to deliver a program. Cultural competency is key to include. Ongoing training ensures new staff are always up-to-date on your program and operations.
Step 6	A good work plan tells your story. Developing and using a clear work plan optimizes your use of time, energy and resources. It brings together all your research, assessments, goals, outcomes and evaluation plans which help you track your work, communicate what you're doing and more easily attain the goals of an effectively-implemented program.
Step 7	Process is important. Identifying strengths, weaknesses and areas for improvement will increase your overall effectiveness which helps build confidence in your program.
Step 8	Positive outcomes are crucial. The centerpiece of sustainability is achieving the impact of reducing Veteran homelessness. Clearly demonstrate the effectiveness of what you've done and tie it to your vision, goals and Veteran needs.
Step 9	Revitalize your work. Looking for ways to continuously improve what you're doing keeps your work fresh, current and strengthens your overall program.
Step 10	Plan for sustainability. You won't know where you're going on this important topic if you don't describe your goals and figure out how you'll know when you get there.

Some other ideas for helping you develop a sustainability plan:

- Using the strategies and tips we've presented so far, decide which ones make sense for you and then brainstorm other creative ideas for building sustainability of your program.
- Decide which strategies you'll use to sustain your program.
- Decide who will be responsible for carrying out each of the strategies.
- Share the development of your plan with your staff and volunteers. They may come up with some great, new ideas and certainly, involving them in sustainability planning will also increase their feelings of investment.
- Consider a similar, parallel process of involvement and investment with VA administration, Veteran groups, and other stakeholders.

Anything you do to generate fresh ideas, enthusiasm for your program, and its sustainability is going to increase confidence and positive support for your work.



Checklist for Step 10

- Started discussions with VA facility administration about sustaining the program
- Identified clear plan for financial sustainability
- Identified at least one, if not more, respected program champions
- Developed a sustainability plan

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Appendices

Appendix A – GTO Example

Appendix B – Helpful Contacts

Appendix C – Library of Evidence-Based Programs,
Promising Programs, and Best Practices

Appendix D – Assessment Measures

Appendix E – Sample Project Insight Form

Appendix A – GTO Example

Introduction

The following describes the GTO process of the Greentree Veteran’s Homeless Center. Although this is a fictional example, it is informed by the authors’ experience with GTO processes in actual Homeless Programs for Veterans.

Prior to beginning work with GTO, it is important to obtain support for the process. Typically, it is difficult for an organization that is new to GTO to implement a GTO process without training and technical assistance. In this example, the Greentree Veteran’s Homeless Center was able to arrange for training and technical assistance in GTO through their local MIRECC. The technical assistants first spent some time becoming familiar with center’s staff and programming by sitting in staff meetings and interviewing key staff. Information gained through this initial contact was then used to design a GTO training customized to the needs of the Homeless Center. This one-day, hands-on GTO training was conducted by the technical assistants and provided to all managers and staff within the Homeless Center. The training provided staff with an overview of the GTO framework and also had staff begin applying the GTO Steps to their own programming.

GTO Step 1: Needs and Resources

During a breakout session in the initial GTO training, staff discussed how many of the Veterans served by the Homeless Center appeared to lack basic life skills necessary for living independently and maintaining stable housing. In follow-up meetings with the GTO technical assistants, the staff decided to look into the life skills of Veterans more systematically. They contacted housing programs where Veterans are often placed after contact with the Homeless Center (Grant and Per Diem and transitional housing) and conducted brief phone interviews with housing staff to learn from their observations about the strengths and weaknesses of life skills among Veterans served by their programs. They also conducted a survey of current residents in the Homeless Center to assess their interest in acquiring specific life skills. The phone interviews with housing program staff indicated that teaching budgeting, shopping, and cleaning skills were the greatest need. The Veteran survey additionally indicated a strong desire among Veterans to acquire basic computer skills (e.g. how to access the internet, word processing, email, etc.).

Staff also conducted a brief resource assessment to determine what classes and groups were already offered and what computing resources were available through their local VA centers. Through this assessment several potentially useful resources were identified, including:

- A parenting skills group offered through the local Vietnam Veterans Leadership Program
- A problem solving skills group offered through one of the VA mental health clinics
- A life skills training group offered through one of the larger local Grand and Per Diem housing programs
- A resume skills course offered through the local VA Vocational Rehabilitation program which includes some computer skills training
- A VA staff computer lab at the local VA center which is currently underutilized

GTO Step 2: Goals and Objectives

Based on the information gathered in the needs assessment, the Homeless Center added a new goal related to life skills to their existing program goals, related to housing and employment. The goal was stated as follows: “Veterans will develop the life skills and social supports needed to sustain living in the community with the highest level of independence”. In order to track progress towards this goal, several specific objectives were created:

Objective	What will change?	For whom?	By when?	By how much?	As measured by?
1.	Knowledge of budgeting	Veterans enrolled in life skills program	By completion of life skills course	?	?
2.	Knowledge of proper food preparation	Veterans enrolled in life skills program	By completion of life skills course	?	?
3.	Knowledge of home and self-care	Veterans enrolled in life skills program	By completion of life skills course	?	?
4.	Knowledge of computers	Veterans enrolled in life skills program	By completion of life skills course	?	?

Initially, the staff were unsure what measures they would use to assess changes in Veterans’ knowledge. The GTO technical assistants suggested that this decision be postponed until after

GTO Step 3: Best Practices was completed, since many evidence-based practices provide measures to assess outcomes.

GTO Step 3: Best Practices

The GTO technical assistants and Homeless Center staff looked for an evidence-based life skills training curriculum by reviewing the literature and contacting other programs. No evidence-based curriculum suitable for a homeless population was found; however, curricula from two promising programs were obtained. Both curricula had been thoughtfully and systematically developed and were informed by the research literature and the author's clinical experience. These curricula had not yet been rigorously tested through peer reviewed research; however, the authors of the two curricula had some preliminary data suggesting both were successful at increasing knowledge of life skills with a homeless population. After reviewing both curricula, the staff decided to adopt one of them rather than reinvent the wheel and create their own. This curriculum also came with quizzes that could be used as measures of knowledge acquired by Veterans. In a phone conversation, the curriculum developer indicated that scores of 80% were average on the quizzes after program completion. This information allowed the staff to set a specific, measureable goal for each of their objectives (i.e. average scores of 80% on the corresponding curriculum quiz).

GTO Step 4: Fit

The chosen life skills curriculum contained many references to the region of the country in which it was developed and had not been specifically developed with Veterans in mind. The staff adapted the curriculum to fit better with their local community and a Veteran population. For example, they added information about grocery stores, food pantries, farmers markets, clothing stores, thrift stores, and financial institutions in the Greentree area, as well as resources exclusively available to Veterans, to the curriculum handouts.

GTO Step 5: Capacities

After adapting the life skills curriculum to their specific setting and population, the Center staff considered what human, financial, technical, and linkage resources would be required to implement the training. The Center already had sufficient staff qualified to provide the training, although they were not familiar with specific, chosen curriculum. In order to familiarize the staff who would facilitate the training with the curriculum and prepare for the training, it was decided that the designated trainers would rotate through each training module, providing the training to their co-trainers once before beginning with Veterans. Classrooms and a kitchen were already available in the Homeless Center; however, problems arose in locating computer facilities for the computer training. The staff decided to move forward with the other three

modules (budgeting, shopping and food preparation, and cleaning and self-care) while continuing to work on locating a computer facility. It was hoped that the computer training would be added at a future date once computing resources were obtained.

GTO Step 6: Plan

Once it became clear that the Center had the required capacities to provide three of the four desired trainings, the staff created a detailed implementation plan. The implementation plan described the who, what, when, where, and how of all the activities needed to prepare for and actually deliver the trainings, including the staff practice trainings, creating procedures for referring Veterans into the workshops, scheduling and reserving the needed rooms, preparing and copying program materials and handouts, and arranging the delivery of food from food services for the food preparation portion of the training. The staff also included a plan for continuing to search for a computing facility which included meetings with VA administration and local community organizations.

GTO Step 7: Process Evaluation

Prior to beginning the life skills trainings, the staff spent some time thinking about how they would track the implementation of the trainings. They decided that they would track Veteran attendance at the trainings through sign-in sheets and would also conduct a Veteran satisfaction survey at the completion of each training. The satisfaction survey would collect satisfaction on a number of key dimensions, such as satisfaction with program material, trainer facilitation, and hands-on activities, using 7-point scales. The satisfaction survey also contained open-ended questions for collecting ideas from Veterans for program improvement. The life skills curriculum contained an agenda for each class which was further broken down into individual activities. In order to track implementation of the curriculum, it was decided that each trainer would provide a checklist of completed activities for each class. This would allow staff to look retrospectively at whether or not class agendas were paced well (e.g. too slow or too fast) for a homeless Veteran population.

GTO Step 8: Outcome Evaluation

The next task for the Center staff to tackle after deciding on a process evaluation was deciding on an outcome evaluation plan. The objectives described in Step 2 all involved increases in Veterans' knowledge regarding the identified life skills. The curriculum included short quizzes to measure knowledge, but staff debated whether to administer the quizzes before and after each training (i.e. pre and post tests) or just at the end of training (i.e. post test only). On the one hand, staff saw the advantage of administering the quizzes twice in order to be able to measure changes in individuals' knowledge over time. On the other hand, staff were concerned

that because the quizzes were so short that Veterans could easily remember the specific questions if they saw them in advance during the pre-test and then would only focus on this information during the training, making the quizzes less informative as a post-test. There was also concern that Veterans would find taking the same quiz twice to be tedious. In the end, it was decided that the quizzes would be given once to a group of Veterans prior to the implementation of the trainings to get a sense of the average level of knowledge of Veterans in the Homeless Center without life skills training. Once the trainings were underway, Veterans would then be administered the quizzes only as a post-test.

Staff also indicated a desire to go beyond measuring knowledge to additionally include measures of behavior change or increased skill as a result of the life skills training. Since these are longer term objectives that typically would not be seen while the Veteran was still receiving services at the Homeless Center, but rather become apparent after the Veteran was moved to a more permanent housing situation, such as a Grant and Per Diem, staff realized that measuring behavior or skills changes would require long-term follow-up from staff. In the end, it was decided not to conduct a formal follow-up to assess behavior or skill change, but rather to periodically conduct informal phone conversations with housing staff to determine if Veterans were successfully navigating tasks related to the life skills training. Since the ultimate purpose of the life skills training was to increase independent and stable housing, it was decided that the housing status of Veterans completing the life skills training would be tracked using administrative data that was already being collected. By comparing this data to the data of Veterans prior to the life skills training, staff would get some sense of whether the trainings were having an impact on housing stability.

GTO Step 9: Continuous Quality Improvement

The staff providing the trainings decided to meet monthly to discuss how the trainings were going and also to review the data from the process and outcome evaluations. In general, staff felt that the trainings were going well. Veteran satisfaction surveys indicated high overall satisfaction with the trainings. Staff felt some specific activities within the trainings that did not go over well with the Veterans. For example, an exercise involving keeping a food diary which recorded food items, food groups, serving sizes, calories, fat intake, cholesterol, salt intake, vitamin intake, and food costs was found to be too long and tedious for most Veterans. This exercise was subsequently simplified to record only food groups, calories, and cost. The process evaluation also revealed that many Veterans were missing multiple classes from each module. When staff investigated the reasons for this, they discovered that case managers were often scheduling meetings with Veterans during the life skills training. This issue was addressed during a staff meeting, and case managers were asked to schedule meetings at different times whenever possible. Scores on the quizzes were initially somewhat lower than those reported by the program author, although they were higher than the scores from

Veterans who were administered the quizzes prior to the start of the skills training. The second cohort of Veterans receiving the trainings had higher scores, perhaps indicating that staff became more proficient at administering the program over time. No changes were seen in housing stability. This finding has prompted questions about whether or not the skills training courses are actually leading to improvements in skills or whether the targeted skills are really an important factor in housing stability. The staff are currently revisiting whether it would be worthwhile to conduct follow-up assessment of Veterans behaviors and skills once they are placed into permanent housing.

GTO Step 10: Sustainability

The Homeless Center staff have met to discuss how to sustain the life skills training program. Fortunately, ongoing funding for the program is not a current concern. Since only three staff are involved in delivering the program, the greatest threat to program sustainability is staff turnover. If one of the three staff left for any reason, the program would become more difficult to sustain. If two of the three staff left, the program would be very difficult to sustain. Center Staff decided to address this issue using two strategies. It was decided that staff involved in the skills training program would create a program “how to” manual, detailing their wisdom and knowledge around the specifics of implementing the program. For example, what is the contact information for the person in food services who needs to be contacted to order food prior to the cooking class? How far in advance must this food order be placed? What needs to be communicated to the Homeless Center kitchen staff to ensure this order is kept separate from the usual food deliveries? Also, it was decided that other Homeless Center staff would be cross-trained to deliver the skills training curriculum with one new person being trained each time the curriculum is offered.

Conclusion

Implementing the new life skills training program meant a lot of work for Homeless Center staff, particularly at the outset of the program. Staff, however, have enjoyed creating a new program and seeing it develop from an idea into reality. They also learned a lot along the way regarding evidence-based practices, program planning, program evaluation, and quality improvement. Veterans report being highly satisfied with the training, although questions remain about its impact on housing stability. Since staff are now involved in program evaluation and continuous quality improvement, there now exists a mechanism within the Homeless Center to investigate this question. Staff have a venue through which to escape the day-to-day demands on their time and to systematically examine how they deliver programs. Staff feel that this is resulting in higher quality programs and will ultimately mean better outcomes for Veterans.

Appendix B – Helpful Contacts

MIRECC CENTERS

	Director	Administrative Officer
VISN 1 MIRECC Dual Diagnosis	Bruce Rounsaville, MD	Richard Carson
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	Fax: 203-937-3472	Fax: 203-937-3472
	bruce.rounsaville@va.gov	Richard.Carson@va.gov
VISN 3 MIRECC Serious Mental Illness	Larry Siever, MD	Mark Levinson
	New York/New Jersey	New York/New Jersey
	Veterans Healthcare System	Veterans Healthcare System
	130 West Kingsbridge Road	130 West Kingsbridge Road
	Bronx, NY 10468	Bronx, NY 10468
	Phone: 718-584-9000 x5229	Phone: 718-584-9000 x3698
	Fax: 718-364-3576	Fax: 718-364-3576
larry.siever@va.gov	mark.levinson@va.gov	
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	Director	Administrative Officer
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	Pittsburgh, PA 15206	Pittsburgh, PA 15206
	Voice: (412) 954-5662	Voice: (412) 954-5360
	Fax: (412) 954-5369	Fax: (412) 954-5370
	Gretchen.Haas@va.gov	Deborah.Coudriet@va.gov
VISN 5 MIRECC Severe and Persistent Mental Illness	Alan Bellack, PhD, ABPP	Mary Lupi
	VA Maryland Healthcare System	VA Maryland Healthcare System
	10 N. Greene Street, Suite 6A	10 N. Greene Street, Suite 6A
	Baltimore, MD 21201	Baltimore, MD 21201
	Phone: (410) 605-7383	Phone: (410) 605-7456
	Fax: (410) 605-7739	Fax: (410) 605-7739
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VISN 6 MIRECC Post-Deployment Mental Illness	John A. Fairbank, PhD	Perry Whitted
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	Phone: (919) 286-0411, ext. 6439 or 6154	Phone: (919) 286-0411, x5106
	Fax: (919) 416-5912	Fax: (919) 416-5912
	John.Fairbank2@va.gov	Perry.Whitted@va.gov
VISN 16 MIRECC Serving Rural and Other Underserved Populations	Greer Sullivan, MD, MSPH	Debbie Hadsel
	2200 Fort Roos Drive (16MIR-NLR)	2200 Fort Roots Drive (16MIR-NLR)
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	Phone: (501) 257-1713	Phone: (501) 257-1741
	Fax: (501) 257-1718	Fax: (501) 257-1718
	GSullivan@uams.edu	Hadsel.Debbie@va.gov

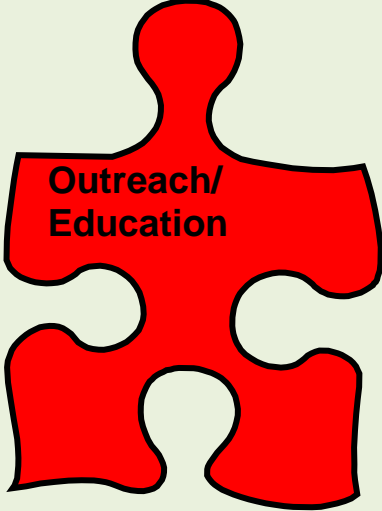
	Director	Administrative Officer
VISN 19 MIRECC Suicide Prevention	Lawrence E. Adler, MD	Douglas Blankenship
	VA Eastern Colorado Health Care System	VA Eastern Colorado Health Care System
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VISN 20 MIRECC Schizophrenia, PTSD, and Dementia	Murray Raskind, MD	Patrice Brower
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VISN 21 MIRECC PTSD and Dementia	Jerome Yesavage, MD	Edward Wkabayashi
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CENTERS OF EXCELLENCE

Center	Contact
Center for Clinical Management Research	Eve Kerr, MD, MPH (734) 845-3502 email: eve.kerr@va.gov website: http://www.annarbor.hsrdr.research.va.gov/
Center for Health Quality, Outcomes, and Economic Research	Dan Berlowitz, MD, MPH (781) 687-2650 email: dan.berlowitz@va.gov website: http://www.va.gov/chqoer/
Center for Organization, Leadership and Management Research	Martin Charns, DBA (857) 364-4945 email: martin.charns@va.gov website: http://www.colmr.research.va.gov/
Center for Health Services Research in Primary Care	Eugene Oddone, MD, MHSc (919) 286-6936 email: eugene.oddone@va.gov website: http://www.durham.hsrdr.research.va.gov/
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Center for Mental Healthcare and Outcomes Research	Richard Owen, MD (501) 257-1710 email: richard.owen2@va.gov website: http://www.hsrdr.research.va.gov/centers/cemhor.cfm

Center	Contact
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Center for Health Equity Research and Promotion	<p>(Pittsburgh) Michael J. Fine, MD, MSc (412) 954-5256 email: michael.fine@va.gov website: http://www.cherp.research.va.gov/</p> <p>(Philadelphia) David A. Asch, MD, MBA (215) 898-0102 email: david.asch@va.gov website: http://www.cherp.research.va.gov/</p>
Northwest Center for Outcomes Research in Older Adults	<p>Stephan D. Fihn, MD, MPH (206) 764-2651 email: stephan.fihn@va.gov website: http://www.hsrp.seattle.med.va.gov/</p>
Center for the Study of Healthcare Provider Behavior	<p>Lisa Rubenstein, MD, MSPH (818) 895-9449 email: lisa.rubenstein@va.gov website: http://www.providerbehavior.med.va.gov/</p>
Maximizing Rehabilitation Outcomes	<p>Audrey Nelson, PhD, RN, FAAN (813) 558-3910 email: audrey.nelson@va.gov</p>

Appendix C – Library of Evidence-Based Programs, Promising Programs, and Best Practices

	<h3>Outreach and Education</h3> <p>Overview: Outreach is a broad term to describe activities which increase the likelihood of the homeless engaging in services over time. Education, in this case, involves educating both homeless Veterans and the VA and non-VA providers who serve them about the services available to meet the needs of homeless and at-risk Veterans. With outreach, the outreach worker meets the homeless where they are, bringing services into their world rather than expecting the client to come to their agency. Quite aside from this practical element of outreach, there is a personal connection that develops over time, and results in a trusting relationship between worker and client. Over time, and based on this relationship, the client may choose to use the services available to move from homelessness into housing, recovery or employment. Skilled outreach teams in the Access to Community Care and</p>
<p>Effective Services and Supports (ACCESS) program have proven effective in reducing involuntary commitment and increasing enrollment in services (Lam & Rosenheck, 1999). When outreach workers develop a genuine relationship with homeless individuals who abuse substances, close to half will engage in treatment services voluntarily (Fisk, Rakfeldt, & McCormack, 2006). Outreach has been especially successful in reaching those homeless individuals with mental health issues, who may be most in need of services, but unlikely to seek them out (Rowe et al. 2002). Homeless Veterans experience a high level of frustration and stress while accessing traditional health care delivery systems (Applewhite, 1997), and are more likely to access care through outreach services (O’Toole et al., 2003). The ultimate goal of outreach services for the homeless is to integrate individuals back into the community and create the highest level of functional independence possible for the individual.</p> <p>Street outreach to homeless individuals is not without risk, and those considering implementing a program of outreach will need to develop a comprehensive training program for outreach workers (see Additional Resources below). New outreach workers are urged to seek experienced workers as guides as they begin street outreach. There may be community agencies that are doing outreach who can provide local guidance. It is especially important to carefully prepare treatment provider organizations to receive Veterans who are reached through outreach, so that the efforts of outreach workers are followed up by successful treatment or services.</p>	
<p>Established VA Services and Programs:</p> <p>Although <i>Healthcare for Homeless Veterans (HCHV) Programs</i> initially served as a mechanism to contract with providers for community-based residential treatment for homeless Veterans, many HCHV programs now serve as the hub for a myriad of housing and other services which provide VA a way to outreach and assist homeless Veterans by offering them entry to VA care.</p>	

Outreach is the core of the HCHV program. The central goal is to reduce homelessness among Veterans by conducting outreach to those who are the most vulnerable and are not currently receiving services and engaging them in treatment and rehabilitative programs.

Stand Downs are one part of the Department of Veterans Affairs' efforts to provide outreach to homeless Veterans. Stand Downs are typically one to three day events providing services to homeless Veterans such as food, shelter, clothing, health screenings, VA and Social Security benefits counseling, and referrals to a variety of other necessary services, such as housing, employment and substance abuse treatment. Stand Downs are collaborative events, coordinated between local VAs, other government agencies, and community agencies who serve the homeless.

The *National Call Center for Homeless Veterans hotline* (1-877-4AID or 877-424-3838) is another program that increases the accessibility of VA homeless services and provides information and assistance regarding these services to VA Medical Centers, federal, state and local partners, community agencies, service providers and others in the community. The hotline provides homeless Veterans or Veterans at-risk for homelessness with free, 24/7 access to trained counselors.

Best Practices: In 2007, the Homelessness Resource Center reviewed the evidence for outreach to determine what is known about the practice. What follows are the common themes that emerged:

1. Outreach is an interactive process between outreach workers and clients that involves repeated contact over a period of time, for as long as services are needed. Follow-up is essential to successful outreach and engagement. The process involves time and patience.
2. Outreach is many things: a location, a service, and a step along the way. Outreach can be understood as many different things. Essentially, it "seeks to establish a personal connection that provides the spark for the journey back to a vital and dignified life" (Bassuk, 1994, p. 103).
3. It is the job of the outreach workers to meet people where they are (literally, judgmentally, metaphorically). Outreach workers should try to see from the client's point of view. Literally, they should meet people in their neighborhoods and bring services to them, rather than expect them to visit a service agency for help.
4. Outreach and engagement is designed to treat the whole person. Assessment and supports for medical and mental health issues are just as important as teaching life skills to emphasize that people can do better for themselves.
5. Respect for the client is critical. Outreach services should be person-centered and should help clients to feel encouraged and hopeful about their futures.
6. Relationship-building is of utmost importance. Relationships should be therapeutic. It is important to give it time and get to know people. Outreach allows the time to build trusting communication in order to create these relationships.
7. Meeting basic needs is an important component of outreach. Helping people to secure food, clothing, shelter and housing builds a strong foundation for the relationship.
8. Teams and networks are critical to successful outreach. Teams with knowledge of mental health and substance use are needed during days and evenings. These teams should be connected with other programs, and help to bridge the gaps between

service systems.

9. Flexibility and creativity are essential for effective outreach. Clinicians that are members of outreach teams may use creative, non-traditional approaches to treatment. This might include getting to know clients' daily activities and using this information to engage them in ongoing, meaningful ways.
10. Coordination of services is a key function of outreach. Outreach and engagement services should be connected to other community services. Linking clients to a network of services helps clients to develop a sense of personal control.
11. Community education is one responsibility of outreach workers. The efforts of outreach workers can only go so far if the community does not have adequate resources or attitudes to support clients. Outreach teams can help by providing consultation, education, training, and referrals.
12. It is important to involve consumers in outreach. Outreach programs are successful when they use consumers as outreach workers. They bring knowledge and lived experience that are extremely valuable to people who may be unsure about accepting treatment and building relationships with service agencies.
13. Safety, boundaries, and ethics are primary concerns for outreach teams. Workers must constantly be concerned with safety and judge each situation. It is important to maintain boundaries with clients – do not socialize outside or work hours, and do not give or accept gifts.
14. Outreach programs should be designed to serve people who have difficulty accessing services. People who are homeless and experiencing mental illness easily fall through the cracks because they may be harder to engage in services. The goal of outreach is to reach people who would otherwise not be reached.
15. The end goal is to integrate people into the community. Outreach can invite people into an empowering community. Many outreach efforts teach life skills, job training, and help those they serve learn to function independently.

(Homelessness Resource Center, 2007 as cited in Olivet, Bassuk, Elstad, Kenney, & Shapiro, 2009)

Involvement of Consumers: Outreach workers who have themselves been homeless and are in recovery may be especially effective at engaging those who are currently homeless (Fisk, Rowe, Brooks, & Gildersleeve, 2000). They bring knowledge and lived experience that are extremely valuable to people who may be unsure about accepting treatment and building relationships with service agencies (Olivet et al., 2009). The ACCESS project, a large research demonstration project across nine states, looked at the outcomes of hiring formerly homeless persons with mental and/substance abuse disorders for their outreach teams. These individuals served as regular members of clinical teams. Although researchers identified challenges with working with consumer providers in this program, they conclude that “collaboration between consumer and non consumer staff members holds exciting promise for comprehensive client care” (Fisk et al. 2000, p. 252).

Additional Resources: The National Council on Health Care for the Homeless has developed a curriculum for training outreach workers. The curriculum can be accessed online (<http://www.nhchc.org/Curriculum/>) and contains six training modules. The training uses the Relational Outreach and Engagement Model to train workers to listen to and be compassionate with homeless individuals. Each module has three or four activities, and there

are videos and exercises included in the program. This is a study that could be facilitated by a mental health professional, and the curriculum provides tips for facilitating the process. The six modules of the curriculum are:

- Introduction, including the history and philosophy of the homeless outreach
- Preparation, including the values orientation of the program, issues of worker safety and worker self-care.
- Approach, including ways to observe individuals who may be homeless, and introduction and listening skills
- Companionship, including frameworks for engaging with the homeless
- Partnership, including skills for referrals and community linking
- Mutuality, including the meanings of home, and transition and closure skills

This curriculum includes many tips and suggestions for adapting it to the specific needs of your program.

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Prevention

Overview: Most VA homelessness services are designed to help Veterans who have already lost their housing to find and keep new housing. No matter how effective these services are these services will never end homelessness among Veterans, as long as new Veterans continue to lose their housing. Programs to prevent loss of housing in the first place are just as important if the goal of ending homelessness among Veterans is to

be realized.

The typical route to homelessness is well documented, and usually starts long before an individual or family arrives at shelter care. The National Alliance to End Homelessness suggests imagining a sequence of events from a crisis to shelter care, and thinking of them like a bus route to homelessness. People can get on at different points, and they can exit whenever they can find a solution to their crisis (NAEH, 2009). Early intervention and assistance is the key to preventing homelessness. Keeping existing housing is often the least expensive and least traumatic solution to homelessness, and may involve financial assistance or negotiations with the landlord or host family. If this does not occur, later intervention can still prevent homelessness if those seeking shelter can be diverted to safe temporary housing. A systematic and comprehensive system of prevention that can be accessed at any point in an individual's "bus route to homelessness" is recommended for optimal prevention of homelessness.

Preventing homelessness is an effort that involves community wide participation. Current homeless programs at the VA are well positioned to use their community contacts to approach homelessness from a prevention perspective. However, some experts suggest an overall redesign of the current model. A model of prevention recommended by Culhane and Metraux (2008) requires that programs move away from a continuum model based on shelter, and move towards a model based on stabilizing or sustaining housing, and then providing individualized services as needed. While the current model provides everyone with shelter and services, Culhane and Metraux (2008) argue that many could be better served with early interventions to maintain existing housing.

Established VA Programs and Services: The *Veteran Justice Outreach Initiative (VJO)* is a program that prevents homelessness by assisting incarcerated and justice involved Veterans with their reentry into the community. Incarcerated Veterans are at substantial risk of homelessness at the point of community re-entry (Mumola, 2000). VA Medical Centers have been strongly encouraged to develop working relationships with the court system and local law enforcement and must now provide outreach to justice-involved Veterans in the communities they serve. Each VA medical center has been asked to designate a facility-based Veterans' Justice Outreach Specialist, responsible for direct outreach, assessment, and case management for justice-involved Veterans in local courts and jails, and liaison with local justice system partners.

Best Practices: Two major studies of community-wide homelessness prevention have been done through the Department of Housing and Urban Development (Burt & Pearson, 2005). These studies focused on what communities have tried, and which strategies were most effective. They divided prevention strategies into primary prevention (stopping people from

ever becoming homeless) and secondary prevention (limiting the length of homelessness after it occurs). The HUD studies looked extensively at six communities that aimed to provide a conscious, comprehensive approach to the prevention of homelessness. Their research documents five effective prevention strategies:

- Subsidies for housing, a strategy that is also supported by other research (Shinn et al. 2001). When used for both primary prevention and secondary prevention, housing subsidies can help 80-85% of homeless families achieve housing stability.
- Permanent supportive housing with services is especially effective for those with serious mental illness and co-occurring substance abuse.
- Mediation in housing courts for those at risk for eviction is a strong prevention strategy. Even after the land lord has filed for eviction, mediation can preserve tenancy. In one county, 69% of cases were settled without eviction, and housing was retained. In one county in Massachusetts, homelessness was reduced by at least one third when mediation was used.
- Cash assistance is an effective strategy for households still in housing but threatened with loss. The HUD study found that only 2-5 percent of families who received cash assistance became homeless in the next year, compared to an estimated 20% in similar circumstances who did not receive assistance.
- Rapid exit from shelter care is a secondary prevention method that shows promising results, in Hennepin County, the rapid exit program reduced shelter stay lengths by half, and achieved an 88% success rate for keeping families out of the shelter for the following year.

Involvement of Consumers: Involving consumers in designing, implementing, and evaluating homelessness prevention efforts increases the chances of success with these programs. Veterans who have experienced a housing crisis have an important perspective on the problem that should help guide program design. They have experienced homelessness from the initial crisis that brought it about through the consequences that followed and the process that allowed them to recover. This intimate knowledge of the problem can inform prevention efforts in a way that may mean the difference between an effective or ineffective program.

Additional Resources:

- The National Alliance to End Homelessness has two helpful documents: Homeless Prevention: Creating Programs that Work, and Homeless Prevention: Creating programs that work- A Companion Guide. These are both available on their website: <http://www.endhomelessness.org>
- The Urban Institute Best Practices paper is available at: <http://www.urban.org/publications/1000874.html>
- Within the VA, information on the Five year plan to end Homelessness is available at http://vaww.sites.lrn.va.gov/vacatalog/cu_detail.asp?id=25653

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Critical Time Intervention

Level of Evidence: Evidence-based program

Description: Critical Time Intervention (CTI) is a case management model. It is designed specifically to prevent homelessness for individuals with mental illness as they are being discharged from institutional settings. The CTI model grew out of experiences in the 1990's with homeless individuals in New York City. Treatment staff there found that after a period of shelter-based treatment, individuals could be moved into permanent

housing, but many became homeless again soon after discharge. In spite of good discharge planning and available housing, these individuals lacked the supports to manage the transition to independent housing.

CTI works in two ways: by providing practical and emotional support during the transition time, and by intentionally strengthening the individual's ties to services, family and friends. Unlike other assertive or intensive case management strategies, CTI is time limited, and lasts for nine months following discharge or placement into housing. The goal is to help the client establish community supports, and then keep these supports in place, with a specific goal being to prevent homelessness.

CTI involves three distinct phases, carried out over nine months. In the first phase, during the first 3 months, the case manager makes home visits, and meets with the client and new community providers. The case manager provides support and guidance for both the client and the new care givers. In the next four months, a second "tryout" phase is devoted to testing and adjusting the system of support. The case manager works to increase the client's problem solving skills, and observes how the client's support network is operating. Finally, in the last two months, the final "transfer of care" phase occurs, where a gradual process allows a total transfer of care to the new community providers. This phase often includes a party or formal recognition of the transfer of care.

Goals:

1. To prevent homelessness among individuals being discharged from shelters, hospitals, and other institutions into the community.
2. To strengthen individual's long-term ties to services, family, and friends.

Target Population: Individuals being discharged from shelters, hospitals, and other institutions into the community.

Outcomes

General Populations: Compared with services as usual, CTI has been shown to cut the number of homeless nights over an 18-month follow-up period by one third (30 days versus 91 days)(Susser et al., 1997). In another study, individuals assigned CTI were five times less likely to be homeless at the end of the study than those given services as usual (Herman et al., 2009).

Veteran Populations: Homeless Veterans with mental illness being released from inpatient

treatment who received CTI had 19% more days housed, 14% fewer days in institutional settings, and lower scores on a standardized measure of drug use at one year follow-up than those who received services as usual (Kasprow & Rosenheck, 2007).

Best Practices: The Critical Time Intervention Manual created by New York Presbyterian Hospital and Columbia University identifies four clinical principles for CTI:

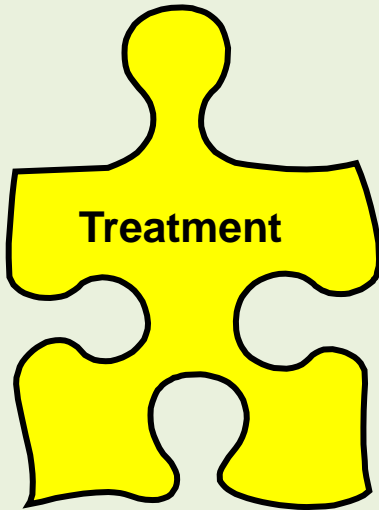
1. *Assessment of concrete needs and linking.* The short and long-term needs of the client are evaluated for each of the following areas: psychiatric treatment and medication management, money management, substance abuse management, housing crisis management, and family interventions. Since the needs of the homeless individual are often rapidly changing, it is recommended that a careful needs assessment be conducted during the initial contacts (outreach), at the point of entry into treatment, and when the client becomes ready to find housing. *Linking* involves finding appropriate resources in the community capable of meeting identified needs and working with homeless clients and these resources to make sure the resources are successfully accessed.
2. *Assessment of psychological needs.* Psychological needs which may impact the success of the intervention, such as needs for autonomy, nurturance, social support, and support coping with specific stressors are assessed from multiple perspectives. Sources of information include discussions with the client, observations of the client's behaviors, consideration of life and treatment history, and conversations with others involved in the client's life, such as family, friends, or treatment providers.
3. *Assessment of client's strengths.* The CTI model assumes that clients have the internal resources needed to make positive changes in their lives. These resources, however, may not be recognized by the client or those around them because they have fallen into disuse through circumstances related to homelessness. The CTI case manager's role is to identify and rehabilitate these strengths, which may include job skills, social skills, educational strengths, or creativity.
4. *CTI case manager's therapeutic stance.* CTI identifies a few therapeutic guidelines believed to lead to a better therapeutic alliance and better treatment outcomes. These guidelines include being active and focused, supportive and empathic, consistent but flexible, fostering autonomy while remaining available, and effectively dealing with treatment refusal.

Training and Implementation: Individualized training and implementation support are available from www.criticaltime.org. The Center for Social Innovation has issued a final evaluation report on its NIMH-funded effort to develop and pilot test a web-based CTI training and implementation support model for social workers and other staff working with homeless persons. This innovative project, which brought together experts in CTI, adult and team-based learning theories and multi-media technology, was the initial phase in what is hoped to be an ongoing initiative intended to make web-based training on CTI and related interventions broadly available to providers and to evaluate the effectiveness of such training. According to the report, initial results are quite promising; high levels of completion, knowledge development and satisfaction were reported by most trainees. Most encouraging, however, is that 80% of trainees reported that they had actively begun to implement CTI in their agencies within 30 days of completing the course. The complete report is available at www.criticaltime.org.

Special Considerations: CTI provides a strong tool for following homeless Veterans into the community and increasing their successful transition from institutional care to community life. It addresses the specific issues of homeless individuals who are also dealing with mental health issues. The CTI model has the potential to be adapted for working with Veterans who have received HUD/VASH vouchers, or Veterans who are being discharged from Domiciliary care. It could also be adapted for use with Veterans who have been in residential care while they begin new job placements, and need to transition to independent community housing. The CTI model relies on mobilizing and coordinating existing housing services and community supports. As the success of the model is heavily dependent on these resources, the local community of care for the homeless will influence results with the CTI program.

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Treatment

Overview: Homeless Veterans often have significant treatment needs:

- 66% Alcohol abuse
 - 51% Drug abuse
 - 54% Serious psychiatric diagnosis
 - 39% Dual diagnosis
 - 58% Health/physical
- (Dougherty & Smits, 2009)

Homeless Veterans with serious mental illnesses and/or co-occurring substance use disorders have complex problems that require comprehensive treatment. Although their need for treatment is often higher than Veterans with housing, they face more difficulties accessing the services they need. Some

of the barriers to engaging homeless Veterans in treatment include: social isolation, distrust of authorities and service providers, geographic instability, and multiplicity of treatment needs (Zerger, 2002).

Established VA Programs and Services: The *Domiciliary Care for Homeless Veterans* (DCHV) Program provides biopsychosocial treatment and rehabilitation to homeless Veterans. The program provides residential treatment to approximately 5,000 homeless Veterans with health problems each year and the average length of stay in the program is 4 months. The domiciliaries conduct outreach and referral; vocational counseling and rehabilitation; and post-discharge community support.

The *Homeless Veteran Dental Program* was established by the Veterans Administration in 1992. In surveys listing and ranking the 10 highest unmet needs for homeless Veterans, dental care was consistently ranked by homeless Veterans as one of their top 3 unmet needs, along with long-term permanent housing and childcare. Dental problems, such as pain and/or missing teeth can be tremendous barriers in seeking and obtaining employment. Studies have shown that after dental care, Veterans report significant improvement in perceived oral health, general health and overall self-esteem, thus, supporting the notion that dental care is an important aspect of the overall concept of homeless rehabilitation.

Best Practices: An integrated approach is superior to a parallel or sequential approach to treatment for people who have co-occurring disorders.

Practice Principles of Integrated Treatment for Co-Occurring Disorders include:

- Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders.
- Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses.
- Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages.
- Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage.
- Substance abuse counseling, using a cognitive-behavioral approach, is used to treat

consumers in the active treatment and relapse prevention stages.

- Multiple formats for services are available, including individual, group, self-help, and family.
- Medication services are integrated and coordinated with psychosocial services.

(SAMHSA, 2003)

Involvement of Consumers: Consumers and recovering persons can serve as positive role models and help decrease stigma around mental illness and treatment (Van Tosh, 1993). Staff in recovery from mental illness or substance use disorder, or those who are formerly homeless, bring a perspective to programs that helps make sure these programs are sensitive to the needs of those they serve. Two programs (described below) to involve consumers in treatment are already operating within the VA:

1. The Consumer Providers program hires consumers as clinical team members in the mental health care system. Consumer Providers (CPs) are often involved directly in patient care, especially care with a recovery focus. They may be involved in providing new patient orientation, leading patient support or 12 step groups, and can help to complete screenings, intakes and treatment plans. They receive formal training in their role and have access to patient records.
2. The Vet to Vet program is a peer-professional partnership model which allows mental health consumers to be embedded in the VA mental health system. Vet to Vet holds meetings which are open to all, although they are primarily attended by Veterans receiving services in psychosocial rehabilitation. The meetings are completely run by peer facilitators, and follow a series of topics including Disability Awareness, Disability Pride, Recovery Workshop, Writers Meeting, Wellness, and Mental Illness Anonymous (MIA). Peer facilitators are not VA staff and are not able to access Veteran records.

Additional Resources:

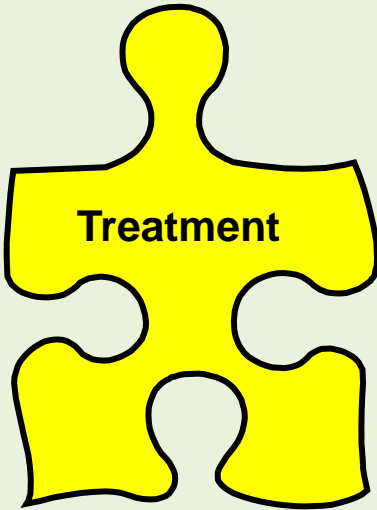
- An implementation resource kit for integrated dual disorders treatment is available from SAMHSA through the National Clearinghouse for Alcohol and Drug Information:
<http://ncadi.samhsa.gov/>
- If you are interested in starting a Consumer Provider program, contact Dan O'Brien-Mazza, the Director of Peer Support at the VA, at 315-425-4445, Daniel.O'Brien-Mazza@va.gov
- At a national level, the Vet to Vet organization offers a twelve week training program for peer facilitators (www.vet2vetusa.org)
- The Vet to Vet training manual can be accessed here:
<http://www.vet2vetusa.org/LinkClick.aspx?fileticket=LoP%2bHL2dulq%3d&tabid=58>

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Assertive Community Treatment

Level of Evidence: Evidence-based program

Description: Assertive community treatment (ACT) got its start over 30 years ago in Wisconsin. A group of mental health professionals designed the program to address the needs of seriously mentally ill clients who were being discharged from inpatient treatment, only to find themselves right back in care a short time later. These repeated hospitalizations were an initial focus of ACT, a program that aimed to keep people in the community and address their needs without extensive inpatient care. In the ACT model, service is delivered by a team of professionals, who provide care to the consumer for as long as needed. The goal is to provide services 24 hours a day, 7 days a week, and to provide these services in the community. The team members collaborate to provide services, and adapt and change their approach as the client's needs change. The team is not established to broker

services, but to deliver services directly to the client. An ACT team usually consists of 10-12 people, from psychology, psychiatry, nursing, and social work. Many teams have a substance abuse counselor. The goal is to make the team large enough to provide coverage 24/7, while keeping the team small enough that each professional is familiar with all the consumers served by the team. Generally, a 1-10 ratio is recommended, although this can change slightly if the consumers have especially intensive needs, or are located in rural areas where extensive driving is necessary to reach consumers.

Ten principles of assertive community treatment:

1. *Services are targeted to a specified group of individuals with severe mental illness.*
2. *Rather than brokering services, treatment, support, and rehabilitation services are provided directly by the assertive community treatment team.*
3. *Team members share responsibility for the individuals served by the team.*
4. *The staff-to-consumer ratio is small (approximately 1 to 10).*
5. *The range of treatment and services is comprehensive and flexible.*
6. *Interventions are carried out at the locations where problems occur and support is needed rather than in hospital or clinic settings.*
7. *There is no arbitrary time limit on receiving services.*
8. *Treatment and support services are individualized.*
9. *Services are available on a 24-hour basis.*
10. *The team is assertive in engaging individuals in treatment and monitoring their progress.*

(Phillips et al., 2001, p. 773)

Goals:

1. To allow individuals with severe mental illness to remain in the community and avoid

institutionalization.

2. To decrease symptoms from mental illness
3. To decrease substance use

Target Population: Individuals with co-occurring severe mental and substance use disorders who are at high risk of institutionalization and other adverse outcomes.

Outcomes

General Populations: More than 25 randomized controlled trials have been conducted on ACT. The program has been shown to reduce hospitalization, and be more satisfactory to consumers and their families than standard care (Burns & Santos, 1995, Burns et al. 2007, Bond, Bond, G.R., Drake R.E., Mueser K.T., & Latimer et al, 2001, Mueser, Bond, Drake, & Resnick, 1998). In a review of studies specifically evaluating care for homeless individuals, Coldwell and Bender (2007) concluded that ACT offers “significant advantages over standard case management models in reducing homelessness and symptom severity.” (p. 393)

Veteran Populations: Intensive Psychiatric Community Care programs (IPCC) within the VA are based on ACT principles and have demonstrated results comparable to those of ACT (Rosenheck, Neale, Leaf, & Milstein, 1995). Veterans involved in these programs generally had lower hospitalization rates, and costs for care were lower in some but not all programs. The programs that most fully implemented the ACT principles had the greatest likelihood of successful outcomes. More recently, the Mental Health Intensive Case Management (MHICM) program has been implemented at the VA, and this program also uses ACT principles. MHICM programs have been extensively evaluated and results show reduced hospital use, improved mental health symptoms, and improved quality of life and client satisfaction (Neale et al., 2007).

Best Practices: Because ACT has been so successfully implemented in a variety of settings, researchers have tried to determine which elements of the program are essential to positive outcomes. Overall, programs that have strong fidelity to the original ACT principles are more effective. The program’s fidelity can be measured using the Dartmouth ACT Fidelity Scale (Bond & Salyers, 2004). Review research has also tried to determine which elements of the program are most critical. In 2000, the Lewin Group, a research group under contract with SAMHSA, looked at programs with strong fidelity and found that among those programs the best results were found when:

- programs used the team approach,
- programs provided services “in vivo” (in the client’s setting)
- programs used assertive engagement
- programs had a small caseload
- programs had explicit admission criteria for client

Training and Implementation: There are extensive materials available for implementing an ACT program, and for evaluating the fidelity of the program to the ACT principles. Implementing ACT requires a system wide commitment to changes in how patient care is funded and careful attention to adhering the ACT model (Phillips et al., 2001). Because ACT requires a team approach, it requires coordination and leadership support from higher levels in the organization- no single individual can decide to use the ACT model. Fortunately, SAMHSA has developed a tool kit for considering and implementing the ACT program, available at

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/>. This comprehensive resource provides guidelines for establishing your program, including establishing a vision, creating advisory groups, establishing program standards, and developing rules for admission, discharge and staffing. They recommend that program fidelity be evaluated regularly, and provide tools for doing the evaluation. The tool kit also provides an extensive curriculum for training staff in the ACT delivery service model. They advise program leaders on how to prepare for training, including visiting existing ACT programs, and arranging for training and cross-training of ACT team members. The curriculum provides four modules:

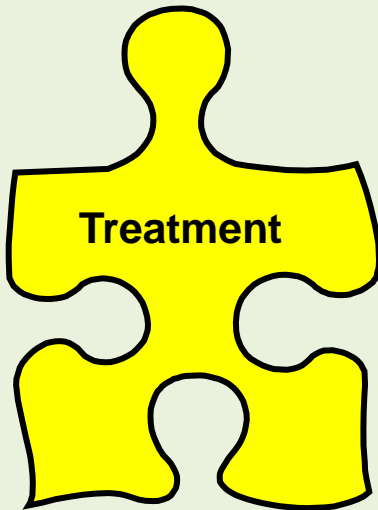
- an introduction to ACT, comparing it to other models, and discussing the critical elements of the program
- a module focused on recovery and stress, including treatment planning ideas and recovery process tools
- a module on the core processes of ACT, including scheduling and team processes,
- a service module that identifies and describes areas where ACT workers are most involved, including housing, community living skills, health promotion, medication support and employment assistance.

Special Considerations: Because the VA has a long history of providing ACT-like programs throughout the country, there are many well experienced people and programs within the VA that can serve as resources. Implementing an ACT program within homeless services is a major project, and requires a homeless, mentally ill population of sufficient size to warrant the development of an ACT program. Recent studies have also suggested that ACT can be successful for those who have substance use disorders only, another significant component of the homeless Veteran population. In addition, providing ACT services in a rural area involves challenges of travel and communication across distances, by both staff and clients. However, VA research has shown that rural ACT-like programs can be quite effective (Mohamed, Neale, & Rosenheck, 2009).

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Motivational Interviewing

Level of Evidence: Evidence-based program

Description: Motivational Interviewing (MI) is a counseling style, designed to create behavior change by exploring and resolving ambivalence in the client. Ambivalent feelings and attitudes towards a behavior lead to a lack of resolve that is a primary obstacle to behavior change. This approach was first described by Miller in 1983, and has been developed into a coherent theory by Miller and Rollnick (1991, 2002). Motivational interviewing has been used to bring about behavior change in many areas, including many that are closely associated with homelessness, such as substance abuse, mental health treatment compliance, and job seeking. Rollnick and Miller (1995) have stated that keeping true to the spirit of motivational interviewing is more essential than narrowly following any specific clinical technique. They

describe the spirit of motivational interviewing using the following key points:

1. *Motivation to change is elicited from the client, and not imposed from without.* Unlike other approaches which may be confrontational, coercive or punitive, MI works by harnessing the client's own internal motivation for change.
2. *It is the client's task, not the counselor's, to articulate and resolve his or her ambivalence.* Ambivalence is an expected part of behavior change where alternate courses of action are considered. Clients must weigh up the pros and cons of behavior change before committing to a course of action. Motivational interviewing helps clients explore both sides of this ambivalence so that it can be resolved and open the way to change.
3. *Direct persuasion is not an effective method for resolving ambivalence.* Although services providers often feel compelled to argue with clients about the need to change behavior they perceive to be dangerous or maladaptive, this approach has been shown to increase client resistance and decrease the chances of change occurring (Miller, Benefield, & Tonigan, 1993, Miller & Rollnick, 1991).
4. *The counseling style is generally a quiet and eliciting one.* MI counselors do a lot of listening in order to understand the client's perspective. MI counselors also spend a lot of time eliciting "change talk" from the client. "Change talk" is any talk that describes reasons for change, the possibility of change, or plans for change. The single most persuasive person to the client is the client himself or herself. The more clients hear themselves talk about change, the more likely change becomes.
5. *The counselor is directive in helping the client to examine and resolve ambivalence.* Resolving ambivalence is the key to behavior change. The techniques used in motivational interviewing are designed to help resolve this ambivalence. Counselors systematically and actively apply these techniques with the client to help the client understand and overcome their ambivalence.

6. *Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction.* The counselor attempts to relate to the client in a manner which promotes readiness to change. The counselor stays alert to signs of behavior change or signs of resistance, and uses these signs as cues as to how to interact with the client. Resistance is seen as a sign that the counselor needs to change tactics rather than as a static characteristic of the client.
7. *The therapeutic relationship is more like a partnership or companionship than expert/recipient roles.* Such a relationship encourages the client to become an active decision maker rather than a passive (and perhaps reluctant) recipient of treatment.

Goals:

1. To help people overcome ambivalence and commit to change.
2. To increase treatment engagement.

Target Population: Individuals who are ambivalent about making behavioral changes in areas such as substance abuse, mental illness treatment, and employment.

Outcomes

General Populations: MI interventions have been shown to be effective in reducing substance abuse, improving adherence to treatment, and mental and physical health outcome improvements. A major review of the research concluded that MI has better outcomes than “traditional advice giving” for a large range of behavioral problems and diseases (Rubak, Sandbaek, Lauritzen, & Christensen, 2005). They found consistent and significant improvement for changes in substance use, weight loss, blood pressure, and cholesterol level.

Studies have repeatedly shown that even one or two MI interventions of 30-45 minutes can result in significant changes in behavior. Rubak et al. (2005) found that 64% of brief intervention studies using MI showed an effect.

Veteran Populations: Motivational interviewing techniques have been used with Veterans to address substance use problems, PTSD symptoms (Murphy, 2007), and treatment adherence. Veterans randomly assigned to receive motivational interviewing were more likely to schedule appointments for treatment, and more likely to return for those appointments than Veterans receiving treatment as usual (Davis, Baer, Saxon, & Kivlahan, 2002).

Best Practices: Miller and Rollnick (2002) identify four principles essential to Motivational Interviewing:

1. *Express Empathy:* Create an environment in which clients can safely explore conflicts and face difficult realities. Counselors understand that that acceptance promotes change, and pressure hinders change. Reflective listening is used as a fundamental tool to explore ambivalence, which is a normal part of the change process.
2. *Develop Discrepancy:* The counselor works to help a client to see his or her behavior as conflicting with important personal goals. This discrepancy is used to explore the importance of change. The goal is to have the client - not the counselor - present reasons for change that are important to them. The counselor works to elicit and reinforce change statements, including recognition of a problem, expression of concern, intention to change, and optimism for this change
3. *Roll with Resistance:* The counselor avoids arguing for change, or arguing in general. MI trained counselors understand that resistance is a signal to respond differently to the client, and offer new perspectives without imposing them. As a client-centered

practice, counselors accept that the client is the primary resource in finding answers and solutions, and recognize that client resistance is significantly influenced by the counselor's behavior.

4. *Support Self-Efficacy*: Part of the counselor's role is to enhance a client's confidence in his or her ability to succeed, and to understand that the client is responsible for choosing and carrying out change – not the counselor. MI accepts that the counselor's own belief in a client's ability to change can have a powerful effect on the process of change.

Training and Implementation: The Motivational Interviewing Network of Trainers (MINT) is an international collective of trainers in motivational interviewing and related methods (<http://motivationalinterview.org>). Training for MI through the MINT is readily available through this website. Basic MI training is often a two day seminar, with many experiential and participative activities. More advanced training is also available for specific populations or areas of treatment. There are many tools, references and resources for using the MI approach and many have been translated into languages other than English.

Because MI is a treatment approach, it can be learned by an individual, or whole teams can be trained in the MI approach. The implementation of MI can be done informally, as people learn the skills and begin to practice them, or more formally as part of an intentional program to adopt this evidence based practice.

Special Considerations: Motivational interviewing involves a shift in perspective about counseling that is a paradigm shift for many in the therapeutic community. It involves looking at behavior change in a different way, and acknowledging that the change must fundamentally come from the client and not be created by the therapist. This shift can be challenging for therapists trained in other perspectives, and individual staff may struggle with accepting this different role in the client's recovery or journey through homelessness. Quality supervision is a key component of motivational interviewing and can address some of the issues that arise for those new to the motivational interviewing process.

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Housing and Supportive Services

Overview: The solution for ending homelessness is ultimately housing. However, a large portion of homeless Veterans face multiple barriers to independent living, such as mental illness, substance abuse, and physical disabilities. These Veterans are likely to need multiple supportive services over an extended period of time in order to maintain housing.

Housing programs vary widely in their philosophies, design, and provided support services. Careful consideration should be given when designing housing programs to

make sure that they meet the needs and preferences of the intended tenants. Segregated group homes have often been used to provide housing to people with serious mental illness, although people with serious mental illness prefer integrated, regular housing (Carling, Randolph, Ridgway, & Blanch, 1987; Brown, Ridgway, Anthony, & Rogers, 1991 as cited in SAMHSA, 2003). Veterans with substance use disorders may initially require low-demand housing (see Housing First program below) in order to encourage them to engage in services. Providing housing to homeless individuals has been shown to increase retention in substance abuse treatment, but these individuals these individuals will not do as well when housing requires participating in high intensity services (Orwin, Mogren, Jacobs, & Sonnefeld, 1999 as cited in SAMHSA, 2003). Programs that combine affordable, independent housing with flexible, supportive services have been shown to be most successful at establishing housing stability, and improving mental health and recovery from substance abuse (SAMHSA, 2003).

Established VA Programs and Services: The Department of Housing and Urban Development and the Department of Veterans Affairs Supported Housing (*HUD-VASH*) Program, through a cooperative partnership, provides long-term case management, supportive services and permanent housing support. Eligible homeless Veterans receive VA provided case management and supportive services to support stability and recovery from physical and mental health, substance use, and functional concerns contributing to or resulting from homelessness. The program goals include promoting maximal Veteran recovery and independence to sustain permanent housing in the community for the Veteran and the Veteran's family.

VA's Homeless Providers *Grant and Per Diem Program* is offered by the Department of Veterans Affairs Health Care for Homeless Veterans (HCHV) Programs to fund community agencies providing services to homeless Veterans. The purpose is to promote the development and provision of supportive housing and/or supportive services with the goal of helping homeless Veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. Only programs with supportive housing (up to 24 months) or service centers (offering services such as case management, education, crisis intervention, counseling, services targeted towards specialized populations including homeless women Veterans, etc.) are eligible for these funds.

Best Practices: Since housing programs vary widely, many best practices are associated with specific types of programs, however, there are some best practices that apply broadly across services:

- Consumers should have a choice from a range of housing options from low-demand housing to transitional and permanent supportive housing.
- Consumers should have control over their living environment
- Flexible supportive services should be customized to the needs of individual clients
- Receiving services should not be required to maintain housing
- Services, such as mental health treatment, substance abuse treatment, legal services, and income support, should be integrated.

(SAMHSA 2003; Technical Assistance Collaborative, 2002 as cited in Burt et al., 2004)

Involvement of Consumers: Veterans should be provided with meaningful input and leadership opportunities within housing programs, such as tenant councils, peer self-help groups, and other tenant-led organizations. Veterans should have input regarding all policies related to tenant and consumer rights, including leases, house rules, and grievance procedures. Veterans should also have input regarding the design, development, and delivery of supportive services provided in conjunction with housing programs.

Additional Resources:

- The National Alliance on Mental Illness (NAMI) has produced a housing toolkit. The toolkit provides guidance and information on expanding housing opportunities for people with mental illnesses. The fifteen fact sheets provide detailed information about resources available to finance the creation of new housing and new ways to think about housing options. In addition there are four background briefs to provide a framework for assessing housing needs and housing solutions. These materials are organized so that they can be reviewed as a whole for overall knowledge about housing or individually for information about specific funding programs or housing types. The toolkit is available from the NAMI website:

<http://www.nami.org/Content/ContentGroups/Policy/housingtoolkit.pdf>

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Supportive Housing

Level of Evidence: Evidence-based program

Description: Supportive housing is a broad term used to refer to independent housing where the tenant has access to a flexible array of services, including medical, mental health, substance use and vocational assistance programs. Other services may include case management, life skills, money management, and tenant advocacy. The use of these programs may or may not be a condition for continued occupancy. Supportive housing is appropriate for anyone who is facing or experiencing homelessness,

and also has chronic mental or physical health issues, substance abuse issues, or multiple barriers to housing access.

Historically, supportive housing emerged as a response to several emerging issues including a greater desire for independent housing by clients with mental illness, and a realization that affordable, permanent housing, with supports, was a path to decreasing homelessness.

In supportive housing, the tenant typically pays between 30%-50% of their income towards rent, ideally not more than 40%. The tenant in supportive housing has a lease or occupancy agreement, and the housing is considered permanent, as long as the conditions of the lease are met. Supportive housing often involves a working partnership between the service providers and the property managers.

Goals:

1. Increase housing stability
2. Decrease symptoms of mental illness
3. Decrease substance use

Target Population: Individuals with serious mental illness in need of housing

Outcomes

General Populations: In a review of 15 studies a strong, consistent finding is that those in supportive housing (regardless of type) are more likely to stay housed, for longer times, and are less likely to be hospitalized than those not provided any specific housing assistance (Rogg, 2004).

Veteran Populations: Research documenting the effectiveness of supportive housing for Veterans indicate:

- *Positive Impacts on Health.* Decreases of more than 50% in tenants' emergency room visits and hospital inpatient days; decreases of more than 80% in tenants' use of emergency detoxification services; and increases in the use of preventive health

care services.

- *Positive Impacts on Employment.* Increases of 50% in earned income and 40% in the rate of participant employment when employment services are provided in supportive housing, and a significant decrease in dependence on entitlements – a \$1,448 decrease per tenant each year.
- *Positive Impacts on Reducing or Ending Substance Use.* A one-year study found that 56.6% of those living independently remained sober, 56.5% of those living in a halfway house remained sober, and 57.1% of those living in an unsupported SRO remained sober – while 90% of those living in supportive housing remained sober.

(Summarized from A Leadership Dialogue: National Housing Conference, 2006, available at: <http://nchv.org/docs/vets%20leadership%20final.pdf>).

Best Practices: The Corporation for Supportive Housing (2009) developed seven dimensions of quality supportive housing through communication with supportive housing tenants, providers, funders, and other stakeholders, and through involvement in successful supportive housing projects around the country.

The seven dimensions are:

- *Dimension #1: Administration, Management, and Coordination*
All involved organizations follow standard and required administrative and management practices, and coordinate their activities in order to ensure the best outcomes for tenants.
- *Dimension #2: Physical Environment*
The design, construction, appearance, physical integrity, and maintenance of the housing units provide an environment that is attractive, sustainable, functional, appropriate for the surrounding community, and conducive to tenants' stability.
- *Dimension #3: Access to Housing and Services*
Initial and continued access to the housing opportunities and supportive services is not restricted by unnecessary criteria, rules, services requirements, or other barriers.
- *Dimension #4: Supportive Services Design and Delivery*
The design and delivery of supportive services facilitate access to a comprehensive array of services, are tenant-focused, effectively address tenants' needs, and foster tenants' housing stability and independence.
- *Dimension #5: Property Management and Asset Management*
Property management activities support the mission and goals of the housing and foster tenants' housing stability and independence, and appropriate asset management strategies sustain the physical and financial viability of the housing asset.
- *Dimension #6: Tenant Rights, Input, and Leadership*
Tenant rights are protected within consistently-enforced policies and procedures, tenants are provided with meaningful input and leadership opportunities, and staff-tenant relationships are characterized by respect and trust.
- *Dimension #7: Data, Documentation, and Evaluation*
All involved organizations reliably capture accurate and meaningful data regarding the effectiveness, efficiency, and outcomes of their activities, and use this data to

facilitate, and improve, the performance of those activities on an ongoing basis. (Corporation for Supportive Housing, 2009)

Training and Implementation: The Corporation for Supportive Housing provides information, training and support for groups interested in establishing or evaluating supportive housing programs. They point out that although Supportive Housing is supported by a great deal of positive research, it still requires a complex process of cooperation and collaboration to get a supported housing program going. Most programs have many different funding streams, including funding from federal housing authorities, social insurance program, private philanthropies, and medical areas. These sources of funding are often totally unrelated and need to be coordinated to make supported housing successful. (More information on this topic can be found at <http://documents.csh.org/documents/pubs/LayingANewFoundation.pdf>) The Corporation for Supportive Housing has developed training resources for groups interested in starting a supported housing program. These training resources are designed to help develop skills in supportive housing development and operations. For more information about upcoming supportive housing trainings, visit the CSH Calendar of Events or contact info@csh.org. They have also developed a curriculum called Successfully Housing People with Substance Use Issues (SHPSUI). This curriculum is designed to be taught in a one and a half day training series, with a trainer skilled in mental health and housing issues. The curriculum covers five main topics, including:

- Session I: Understanding the Issues Your Tenants Face, including topics of addiction, and typical issues of supported housing tenants.
- Session II: The Housing Context, including rights and rules around housing, and offering support services to tenants.
- Session III: The Effective Tool Kit, including building relationships with tenants, service planning with tenants, conflict resolution and issues of eviction.

In addition, the Supportive Housing Training Series is a collaboration between the Department of Housing and Urban Development, the Center for Urban Community Services, and the CSH. It includes curricula providing best practices and guidance on supportive housing development, operation and services. Each curriculum provides a one-day training for enriching the skills of supportive housing developers and providers.

Special Considerations: The research and evidence base on supportive housing reflects the great complexity of providing housing for individuals who have complicated, difficult situations. Many different communities have developed supportive housing programs of various types, and even within the VA there are a wide range of supportive housing programs. This great variety of programs has made comparative evaluation difficult. Within the treatment community there exist a variety of opinions about what kinds of housing supports are most effective, and how these supports should best be provided. Research generally shows that when consumers are interested in independent housing, and their clinicians support it, their likelihood of success is greater (Rog, 2004). Those with dual diagnosis of mental health and substance abuse issues are most likely to drop out of any housing program, including supportive housing programs.

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Housing First

Level of Evidence: Evidence-based program

Description: The Housing First approach was developed in 1999 by the National Alliance to End Homelessness (NAEH). The approach represents a shift away from providing shelter and transitional housing, and a move towards prevention and immediate re-housing. Housing First has few requirements for those who participate, and does not require treatment for mental health or substance use issues prior to or after housing is secured. The Housing First model has several important principles:

- Homelessness is first and foremost a housing problem and should be treated as such
- Housing is a right to which all are entitled
- People who are homeless or on the verge of homelessness should be returned to or stabilized in permanent housing as quickly as possible
- Issues that contribute to homelessness can best be addressed once housed

(Adapted from NAEH, 2009)

The Housing First model has several important delivery components. These include providing emergency services when needed and a complete assessment of housing needs, resources, and services necessary to sustain housing. Housing placement services are also provided, including financial assistance, and advocacy and assistance in facing barriers to housing. In many cases, time limited case management is also a part of Housing First programs. The Housing First approach has been used extensively with populations with severe mental illness and substance abuse histories.

Goals:

1. Decrease the time people are homeless
2. Increase housing stability

Target Population: Chronically homeless individuals with severe mental illness

Outcomes

General Populations: The most rigorous study of Housing First to date found that individuals randomly assigned to receive Housing First were housed sooner and spent more time housed in the two years following program entry than those receiving usual care programs (Tsemberis, Gulcur, & Nakae, 2004).

Veteran Populations:

Some current VA programs, such as the HUD/VASH program, have similarities to the Housing First Model, but research has not yet been done using a true Housing First model specifically with Veterans.

Best Practices: The key components and common design elements of the Housing First model are:

- Initial crisis intervention involving identifying the family's immediate needs and helping to meet them during the transition period.
- Housing search to help participants obtain permanent housing, including clarifying housing needs, helping develop rental resumes, assisting in obtaining housing subsidies, providing one-on-one and group tenant education workshops, and negotiating lease terms with and on behalf of clients.
- Home-based case management to stabilize participants once they are re-housed by linking participants with mainstream social services, ensuring children are enrolled and attending school, providing crisis management assistance, and helping participants work toward case management goals developed at the outset of program participation.
- Direct financial assistance to assist with move-in and other costs associated with becoming rehoused, such as current and previous utility bills, moving costs, rental deposits, furniture, and other goods.

(Lanzerotti, 2004)

Training and Implementation: The National Alliance to End Homelessness developed a handbook in 2009 to guide organizations interested in adopting a Housing First approach called *Organizational Change: Adopting a Housing First Approach*. They recommend following these steps towards adopting a Housing First approach:

- Establish a cross-functional team to spearhead the Housing First change process
- Develop a shared vision, and clarify the scope of change
- Do an organizational self-assessment to determine agency strengths and challenges for a change process
- Develop a time line for implementation, including staffing issues, policies and procedures, community collaboration and funding information.
- Determine who will manage the change process
- Initiate the Housing First project, and monitor and revise as needed
- Evaluate outcome and process indicators for the project.

Full details on how to work through these steps are available in the manual, which can be found at <http://www.endhomelessness.org/content/article/detail/2489>.

Special Considerations: The Housing First model is traditionally a community based model. It involves a commitment from the community government to establish and provide resources for apartments or other housing for homeless individuals. The initial financial investment is often quite large, and typically cost analysis does not include this investment.

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Income/Employment/Benefits

Overview: Employment and government benefit programs are the two primary potential sources of income to help homeless people secure permanent housing and basic needs. Forty-two percent of homeless individuals identify employment as a primary need and 24% identify lack of employment as a primary reason for their homelessness (Burt et al., 1999). However, serious mental and physical disabilities, and substance abuse are major barriers to employment for many homeless individuals in addition to a mobile lifestyle and limited work experience.

Although many homeless individuals qualify for Federal income and entitlement programs, such as SSI, many are not enrolled. Benefits counseling can help with enrollment by providing information about benefits and eligibility, helping gather required documentation, filing applications, and mounting appeals, if necessary.

For those who want to work, offering employment at the earliest stages of engagement may be effective to develop trust, motivation, and hope (Cook et al., 2001; Min, Wong, &

Rothbard, 2004). Fear of losing public entitlements, especially healthcare and Social Security Administration (SSA) cash benefits, can inhibit people from seeking work. Many Federal benefit programs have changed policies to remove barriers to work, but eligible recipients remain largely unaware of these changes. Benefits counseling can help homeless individuals navigate employment opportunities without sudden loss of needed benefits.

Integrating employment services with clinical treatment through multidisciplinary teams has been found to be superior to providing services separately, especially in regards to consumer engagement and retention (Bond, 2004). Integrating these services can be difficult, however, due to conflicting staff perspectives on treatment priorities, the importance of employment, and how services should be integrated. Cross-training in mental health and employment issues, creating protocols for communication among staff, and providing opportunities for program planning can help address these barriers (Quimby et al. 2001).

Established VA Programs and Services: In VA's *Compensated Work Therapy/Transitional Residence (CWT/TR)* Program, disadvantaged, at-risk, and homeless Veterans live in CWT/TR community-based supervised group homes while working for pay in VA's Compensated Work Therapy Program (also known as Veterans Industries). Veterans in the CWT/TR program work about 33 hours per week, with approximate earnings of \$732 per month, and pay an average of \$186 per month toward maintenance and up-keep of the residence. The average length of stay is about 174 days. VA contracts with private industry and the public sector for work done by these Veterans, who learn new job skills, relearn successful work habits, and regain a sense of self-esteem and self-worth.

VHA has provided specialized funding to support twelve Veterans Benefits Counselors as members of HCMI and Homeless Domiciliary Programs as authorized by Public Law 102-590. These specially funded staff provide dedicated outreach, benefits counseling, referral, and additional assistance to eligible Veterans applying for VA benefits. This specially funded initiative complements VBA's ongoing efforts to target homeless Veterans for special attention. To reach more homeless Veterans, designated homeless Veterans coordinators at VBA's 58

regional offices annually make over 4,700 visits to homeless facilities and over 9,000 contacts with non-VA agencies working with the homeless and provide over 24,000 homeless Veterans with benefits counseling and referrals to other VA programs. These special outreach efforts are assumed as part of ongoing duties and responsibilities. VBA has also instituted new procedures to reduce the processing times for homeless Veterans' benefits claims.

Best Practices: SAMHSA's Blueprint for Change (2003) identifies the following elements as common to successful job training programs for people who are homeless:

- Comprehensive assessment
- Ongoing case management
- Housing
- Supportive services
- Job training
- Job placement services
- Followup

Supported Employment (detailed later in this section) is the evidence-based program that has repeatedly demonstrated the best outcomes in placing homeless individuals with severe mental illness into competitive employment. Supported Employment is a clearly defined vocational model with empirically tested principles and fidelity scales. It is the "gold standard" against which other vocational best practices are measured.

Involvement of Consumers: Consumer representatives should be involved on program committees to ensure the consumer perspective is reflected in program procedures, policies and planning. Consumers make good advocates for system change and can be role models for others. Consumers also bring an important perspective on the fit of program components with the functional limitations of consumers the program serves. Understanding and addressing these fit issues leads to programs that more effectively meet the needs of consumers.

Additional Resources:

- *Work as a Priority: A Resource for Employing People who have Serious Mental Illnesses and are Homeless*
This guidebook is intended to provide a foundation, both conceptually and in practice, to increase employment among people who are homeless and have serious mental illness. Topics covered in the guidebook include: background information on what we know so far about employment for people who are homeless and have serious mental illnesses; an orientation to the principles of recovery; summaries of various employment models and approaches developed for people with psychiatric disabilities; personal, program, and system-level challenges to employment for people who are homeless with a serious mental illnesses; and examples from throughout the country of programs that have elevated work to a priority in their agencies as well as key factors to consider when developing employment services for people with serious mental illnesses who are homeless. An overview of employment-related services available through the state Vocational Rehabilitation system, and the implications of right to work legislation for employment of people with disabilities is also presented. The guidebook is available online from SAMHSA here:

<http://mentalhealth.samhsa.gov/publications/allpubs/SMA03-3834/default.asp>

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Supported Employment (SE)

Level of Evidence: Evidence-based program

Description: "Supported Employment (SE) is an approach to vocational rehabilitation for people with serious mental illnesses. SE emphasizes helping people obtain competitive work in the community and providing the supports necessary to ensure success in the workplace. SE programs help consumers find jobs that pay competitive wages in integrated settings (i.e., with others who don't necessarily have a disability) in the community.

In contrast to other approaches to vocational rehabilitation, SE de-emphasizes prevocational assessment and training and puts a premium on rapid job search and attainment. The job search is conducted at a pace that is comfortable for consumers and is not slowed down by any programming prerequisites.

People with serious mental illnesses differ from one another in terms of the types of work they prefer, the nature of the support they want, and the decision about whether to disclose their

disability to the employer or coworkers. SE programs respect these individual preferences and tailor their vocational services accordingly.

In addition to appreciating the importance of consumer preferences, SE programs recognize that most consumers benefit from long-term support after successfully attaining a job.

Therefore, SE programs avoid prescribing time limitations on services. Instead employment specialists help consumers become as independent and self-reliant as possible.

The overriding philosophy of SE is the belief that every person with a serious mental illness is capable of working competitively in the community if the right kind of job and work environment can be found. Rather than trying to sculpt consumers into becoming "perfect workers," through extensive prevocational assessment and training, consumers are offered help finding and keeping jobs that capitalize on their personal strengths and motivation. Thus, the primary goal of SE is not to change consumers but to find a natural "fit" between consumers' strengths and experiences and jobs in the community." (SAMHSA Evidence Based Practices Kit for Supported Employment, 2009, pp. 2-3)

Goals:

1. Increase consumers participation in competitive employment
2. Increase consumers self-esteem

Target Population: Individuals with severe mental illness and individuals with co-occurring substance use disorders

Outcomes

General Homeless Population: SE programs generally provide stronger outcomes for consumers than other programs such as sheltered work programs, transitional employment programs, and prevocational programs (Bond et al., 2001). Those in SE programs have been more successful in obtaining competitive work, worked more hours, and earned a more competitive salary than those in other kinds of vocational programs. (Summarized from the SAMHSA Evidence Based Practices Kit for Supported Employment, 2009).

Veteran Homeless Populations: Rosenheck and Mares (2007) did a two year outcomes study for Veterans in a supported employment program at nine VA sites. They found that Veterans in the SE program had both a greater number of days employed than those in traditional services, and a greater number of days housed during the two year follow-up period.

Best Practices:

Bond (2004) identifies six key principles which define Supported Employment:

- SE programs focus on finding competitive employment for consumers (rather than day treatment or sheltered work).
- Eligibility for SE is determined based only on a desire to find competitive employment. No exclusions are made based on symptoms, diagnoses, substance use, or "work readiness".
- A rapid job search approach is used without lengthy pre-employment assessment or training.
- There is close integration of vocational staff with mental health staff, both in and out of treatment team meetings.
- Services and job placements are based on consumer preferences rather than provider judgments.
- Individualized support is provided indefinitely, continuing after employment if needed.

Training and Implementation: SAMHSA provides a training "tool kit" for Supported Employment. This curriculum is available on line

(http://download.ncadi.samhsa.gov/ken/pdf/toolkits/employment/SE_Training_Frontline_Staff.pdf) and includes four modules for learning about how to implement supported employment.

- In the first module, staff is introduced to the model, its philosophy, and the extensive evidence supporting the model. There are exercises for exploring these issues in greater detail.
- The second module provides information on Referral, Engagement, and Benefits Counseling in supported employment. It includes exercises for working as a group to gain skills in these areas.
- The third module covers skills for Assessment and Job Finding, including how to complete a vocational profile, and how to develop an individual employment plan. There are exercises to assist in developing each of these skills.
- In the fourth module, developing job supports and working effectively with consumers is examined, as well as the need to establish good connections with other key stakeholders. Exercises and role plays allow the learners to practice providing job supports in a job over time, and also when a job crisis situation arises.

The SAMHSA tool kit is designed to be used by many different kinds of programs and populations. The tool kit contains training tips for those who teach the curriculum, and explains in detail how to assure a successful training experience. A mental health professional could adapt these tools for use in a VA Homeless training program, perhaps carried out over a period of several days.

Because Supported Employment involves activities not traditionally carried out in vocational programs, the implementation of a Supported Employment program will require support from the entire team, and its leadership. Vocational specialists working with SE consumers need to have access to vehicles to travel with Veterans to job settings, and need to have the resources

to commit to the long term nature of Supported employment.

The VA has made a serious commitment to SE for mentally ill Veterans, and Resnick and Rosenheck (2007) describe the extensive dissemination of training and mentoring for SE programs, with both on-site mentoring and telephone training and supervision provided as programs in SE are introduced.

Special Considerations: Supported employment has been developed for working with individuals with severe mental illness. Not all homeless Veterans have mental health issues, and a program should carefully examine the prevalence of mentally ill Veterans who use their services as they consider supported employment programs. Current research at the VA estimates that 54% of homeless Veterans have a serious psychiatric diagnosis. Because SE exists in some VA sites, there are individuals with experience within the VA system to assist in developing SE programs.

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Community Partnerships

Overview: The VA Uniform Mental Health Services Handbook requires each medical center to develop and maintain relationships with community agencies and providers to support them in working together to allow appropriate placement for veterans together with their families when they are homeless or at risk of homelessness. Community partnerships allow VA Centers to combine resources (human, fiscal, and technical) with other community agencies and stakeholders to accomplish tasks in overcoming homelessness that a VA Center alone would

be unable to accomplish. Community partnerships can help avoid unnecessary duplication of services, mobilize resources that otherwise would remain underutilized, and create a critical mass needed to raise community awareness and build political support for homelessness initiatives.

When building partnerships VA Centers should consider three questions (Lasker & Weiss, 2003):

1. *Who is involved in the partnership?* Partnerships with a broad and diverse array of participants have a greater variety of knowledge, skills, and resources with which to work than partnerships with a few homogeneous partners. This helps partnerships understand problems from multiple perspectives and develop unique solutions.
2. *How are partners involved in the partnership?* Partnerships only benefit from the knowledge, skills, and resources of partners, if partners are given the ability to influence plans and actions. If a "lead organization" assumes all the control over an initiative, little benefit may be gained by including other partners.
3. *How will management and leadership of the partnership support the interactions of the partners?* Leaders who have backgrounds and experience in multiple fields, understand and appreciate different perspectives, can bridge diverse cultures, and are comfortable sharing ideas, resources, and power tend to be more effective in leading partnerships. Leaders must be able to inspire and motivate partners, facilitate collaboration among partners, and create an environment where differences of opinion can be voiced.

Partnerships are not without their costs, and they do not guarantee success. Some studies have shown that efforts of partnerships to integrate systems lead to improvement in the system's organization and performance but little or no improvement in clinical outcomes and quality of life for clients (Randolph et al., 2002). Partnerships can be time consuming for staff and involve a loss of autonomy and control over programs and initiatives. The decision to enter into partnerships must, therefore, be made carefully weighing both the costs and potential benefits.

Established VA Programs and Services:

The Community Homelessness Assessment, Local Education, and Networking Groups (*CHALENG*) for Veterans is a nationwide initiative in which VA medical center and regional office directors work with other federal, state, and local agencies and nonprofit organizations

to assess the needs of homeless Veterans, develop action plans to meet identified needs, and develop directories that contain local community resources to be used by homeless Veterans.

Best Practices: A literature review by Zakocs & Edwards (2006) identified six factors associated with effective community coalitions:

1. Enacting formal governance procedures
2. Encouraging strong leadership
3. Fostering active participation of membership
4. Cultivating diverse membership
5. Promoting collaboration among membership agencies
6. Facilitating group cohesion

Involvement of Consumers: Consumers have unique knowledge, perspectives, and skills that can help a partnership understand a problem fully, develop effective plans, inspire and energize partners, and refine the partnership's actions over time. Consumers should be involved in all aspects of partnerships' functioning, including governance, planning, implementation, evaluation, and quality improvement.

Additional Resources: The Community Toolbox created by the Work Group for Community Health and Development at the University of Kansas contains tips and tools for creating and maintaining coalitions and partnerships:

http://ctb.ku.edu/en/dothework/tools_tk_1.htm

The Partnership Self-Assessment Tool (created by Center for the Advancement of Collaborative Strategies in Health) assesses how well collaborative processes are working, as well as to identify specific areas to focus on to make collaborative processes better

<http://www.partnershiptool.net/>

References

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Circles

Level of Evidence: Promising program

Description: Circles™ is an innovative model based on a body of research suggesting that in order for individuals with low income to improve their situation, they must have bonding social capital within the community, bridging social capital to access the resources contained by higher income networks, and linking social capital that connects the first two with community institutions. In Circles, low-income individuals receive support from community volunteers, increase their ability to access community resources and opportunities, and develop

hope for the future. First, bonding social capital is created through peer relationships with other participants. This occurs primarily through required weekly meetings and leadership tasks the participants share. Second, bridging social capital is created through the relationships across class lines that are contained within Circles, where each participant is mentored by at least three middle or upper income community volunteers called “allies”. Third, linkage social capital to institutions is created through the involvement of human service agencies, educational institutions, faith communities, and businesses in the Circles initiative. Circles is initiated by a lead organization, such as a VA facility, community action agency, or faith community. The lead organization facilitates the engagement of other human service organizations, faith communities, businesses, and community volunteers through the formation of a “Guiding Coalition” which is ultimately responsible for the ongoing operation of the initiative. One of the big advantages of Circles over other support programs for low income individuals is its systematic approach to leveraging other community resources which otherwise would not be directed towards alleviating poverty. Retention is a major problem with many programs for homeless and low income individuals. Circles directly addresses transportation, childcare, and other barriers to program participation and has very high retention rates compared to other programs.

Goals:

1. Move participants completely out of poverty.
2. Increase the social support of participants.
3. Raise awareness in the community of barriers faced by low-income people.

Target Population: Low income individuals who are motivated to leave poverty. Circles is not appropriate for individuals with active substance-abuse problems or with unmanaged mental health disorders. It is most appropriate for individuals capable of employment and in need of additional social support.

Outcomes

General Populations: Pilot data from 236 participants found a 251% average increase in earned income (from \$343/month to \$863/month) at 12 to 20 months from initial involvement in Circles (Move the Mountain Leadership Center, 2007). Initial results of 33 participants in an independent national evaluation found an 88% increase in income (from \$634/month to

\$1200/month) 6 months after completion of the initial Circles curriculum (Move the Mountain Leadership Center, 2010). Participants also reported an increase in social capital (from 4 friends "I can count on" to 9 friends "I can count on").

Veteran Populations: Circles has not been studied with Veteran populations.

Best Practices: Move the Mountain Leadership Center (MTM, 2007) has identified eleven core components required for successful Circles initiatives.

1. The Leader of the lead organization or community coalition is committed to Circles™- there is a community champion.
2. A community coalition representing all sectors of the community is responsible for the Circles™ initiative
3. Low-income people are on the community coalition
4. The provided curriculum for participants is used as part of the orientation for participants to support individual plan development and identification of systemic issues
5. The provided curriculum for volunteers is used as part of the orientation for coalition members and volunteers
6. Participants are partnered with 2-5 volunteers
7. Weekly meetings occur with meal, child care, and program
8. Meetings occur monthly to address systems change
9. Trained individuals provide case management support to participants and volunteers
10. Community organizing is a supported function of the initiative (through paid or volunteer positions)
11. Community demonstrates fidelity to the model and participates in evaluation of Circles™ initiative following national protocol

Training and Implementation: Move the Mountain Leadership Center provides training and support for organizations interested in implementing Circles including:

1. Two site visits to provide training, orientation, and to help bring together stakeholders
2. Hands-On Training (four day immersion at experienced Circles™ site) for 2 people
3. Program facilitator webinar
4. 25 copies of Until it's Gone...an introduction to the Circles Campaign
5. Monthly coaching for Circles staff and key coalition members
6. Circles™ Manual
7. Participation in national evaluation
8. Two registrations to the annual Circles conference
9. Membership to Circles™ Community of Practice and web access to Circles™ Forum and up-to-date Circles™ materials from around the country.
10. Inclusion in media campaigns and use of promotional videos which can be customized for your local community.

Special Considerations: The Circles model holds great promise in forming community partnerships to meet the substantial needs of low income Veterans, particularly social support needs which are often not addressed by traditional homeless programs. Circle programs have been primarily initiated by community action programs to meet the needs of a general low income population. Careful consideration would need to be given to adapting this program for a Veteran population and also for a population that is transitioning from homelessness.

Circles relies primarily on non-professional, community volunteers supported by a professional case manager. The program is, therefore, not appropriate for individuals with active substance-abuse problems or with unmanaged mental health disorders. It is most appropriate for individuals capable of employment and in need of additional social support.

References

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Appendix D – Assessment Measures

Evidence Based Practice	Assessment Measure	References
Housing with Appropriate Supports	The Seven Dimensions of Quality for Supportive Housing	Corporation for Supportive Housing. (2009). <i>The Seven Dimensions of Quality for Supportive Housing</i> . New York, NY: Corporation for Supportive Housing.
Intensive Case Management / Psychosocial Rehabilitation	Dartmouth Assertive Community Treatment Scale	Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment: Development and use of a measure. <u><i>American Journal of Orthopsychiatry</i></u> , 68, 216-232.
Motivational Interviewing	Motivational Interviewing Treatment Integrity Scale	Madson, M., & Campbell, T. (2006). Measures of fidelity in motivational enhancement: a systematic review. <i>Journal Of Substance Abuse Treatment</i> , 31(1), 67-73.
Modified Therapeutic Communities	Protocol to Improve Clinical Practice	Kressel, D., Morgen, K., De Leon, G., Bunt, G., & Muehlbach, B. (2009, Spr). A protocol to improve clinical practice (PICP) in therapeutic community treatment. <i>Therapeutic Communities</i> , 30(1), 6-22.
Self-Help Programs	Participant and observer rating forms Group Environment Scale	Roberts, L. J. (1985). Measures of Self-Help Group Quality: Observer and Participant Views. Paper presented at the Annual Convention of the American Psychological Association (93rd, Los Angeles, CA, August 23-27, 1985). Moos, R. (2008). How and why twelve-step self-help groups are effective. <i>Research on Alcoholics Anonymous and spirituality in addiction recovery</i> (pp. 393-412). New York, NY US: Springer Science + Business Media. Moos R. <i>Group Environment Scale Manual</i> , 3rd edn. Menlo Park, CA: Mind Garden; 2004.
Involvement of Consumers and Recovering Persons	Mental Health Consumer Meaningful Participation Rating Tool	http://www.gov.ns.ca/health/mhs/pubs/depression/ConsumerRatingToolSept2005.pdf

Mental Health and Substance Abuse Treatment	Integrated Dual Disorders Treatment Fidelity Scale	http://download.ncadi.samhsa.gov/ken/pdf/toolkits/cooccurring/EBPKIT_CoOccur_Evaluate.pdf
Employment, Education, and Training	Supported Employment Fidelity Scale	Bond, G. R., Becker, D. R., Drake, R. E., & Vogler, K. M. (1997). A fidelity scale for the Individual Placement and Support model of supported employment. <i>Rehabilitation Counseling Bulletin</i> , 40, 265-284.
Cultural Competence	Cultural Self-Efficacy Scale, Trans-cultural Self-Efficacy Tool	Gozu, A., Bass, E., Powe, N., Cooper, L., Beach, M., Price, E., et al. (2007). Self-Administered Instruments to Measure Cultural Competence of Health Professionals: A Systematic Review. <i>Teaching & Learning in Medicine</i> , 19(2), 180-190.

Appendix E – Sample Project Insight Form

Note: you might also generate discussion among staff using these questions at a program staff meeting or other group venue.

Name of Program or Intervention Activity:
(e.g., program session, group meeting, program activities)

Date:

Staff person(s) completing this form:

Please list the factors that were **BARRIERS** to implementation of this program or activity:

Please list the factors that **FACILITATED** implementation of this program or activity: