Case Study: Evaluating a Rural Homeless Program

Evaluation Context. The Rural Homeless Outreach Program (RHOP) was a three-year program funded by a federal agency to serve homeless adults with substance abuse and co-occurring mental health disorders in six rural counties. The federal agency request for proposals required an evidence-based practice model and a comprehensive evaluation. A grant of $500,000 per year was awarded to a large community mental health center (CMHC) to conduct the proposed program and an internal evaluation. The CMHC employed 600 staff and provided comprehensive treatment services throughout the state; it included a Research and Evaluation Department with 10 staff, of which the lead evaluator was a member.

The RHOP provided services to homeless adults using an evidence-based treatment model with a low staff-to-client ratio, flexible service delivery, and comprehensive services to meet the clients' needs and goals. Services included outreach in the rural communities; case management; psycho-educational group sessions; 24/7 crisis assistance; housing, employment, education and job training assistance; and psychiatric treatment and medication management. RHOP was staffed by a project director, a therapist, four outreach counselors, a part-time nurse practitioner and consulting psychiatrist. An Advisory Council was made up of professionals and community members who worked with and were advocates for the homeless in the rural counties served by the grant.

The internal evaluation was conducted by a doctoral-level evaluator with more than 25 years of experience in evaluating community-based programs, who worked half-time on the evaluation, and a full-time research assistant who was responsible for data collection and entry.

Entry, Contracting and Design. The design included an outcome and a process evaluation. The purpose of the outcome evaluation was to determine the effectiveness of the program in reducing alcohol/substance abuse, increasing housing stability, increasing engagement in education or employment, improving mental and physical health, and decreasing emergency room use. The outcome evaluation used a single-group longitudinal design with four data collection points—intake (baseline), program discharge, and follow-ups at 6 months and 12 months from baseline. Discharge occurred when clients completed their program goals or dropped out.

The instruments for the outcome study and the domains they measured were the following: 1) The federally-required instrument that measured demographics, alcohol and substance use, housing, education, employment, criminal justice involvement, and inpatient, emergency room and outpatient treatment; 2) A standardized 45-item questionnaire on mental health symptomatology; and 3) A standardized 12-item measure of physical and mental health. Clients received $20 for participating in each interview.

The process evaluation assessed fidelity to the program model using a standardized instrument that measured program organization and structure, staff composition, and types of services provided. Every 6 months, the evaluators involved the entire program team in an internal self-assessment using the fidelity scale to help refine the implementation of the program model. In addition, at program discharge, evaluators obtained clients' perceptions of the program and their recommendations for improvement through open-ended interviews.

The evaluation team met with the full program staff during program development to plan the evaluation design and instruments, and to coordinate the data collection procedures, especially at intake and discharge. The CMHC has its own internal Internal Review Board (IRB) that approved the evaluation plan and data collection procedures. The evaluation team shared the

IRB application so the program staff would be aware of the informed consent procedure, $20 incentive for evaluation participation, and so on.

Data Collection. The research assistant lived in one of the rural counties and had worked for the CMHC as a case manager for five years. He was a strong advocate for homeless populations and participated in numerous community groups serving the homeless. He shared office space with the outreach counselors, and frequently accompanied them to do outreach at the homeless shelter, bus station, jails, emergency rooms, parks, and other locales. This helped him establish rapport and maintain a relationship with clients so they would participate in the evaluation data collection. He was very successful in locating program clients from this transient population for follow-up interviews and maintained a follow-up rate above 90% (the federal government required 80%). He conducted follow-up interviews in person or, as necessary, by phone to clients in shelters, jails/prisons, and hospitals in distant states.

Data Analysis and Interpretation. The grant application proposed target percentages for each outcome performance measure, for example, to increase the percentage of clients in stable housing by 50% at 6 months and by 75% at 12 months. During the second and third grant years, the evaluation team prepared quarterly reports comparing the rate of change from baseline to 6-month and 12-month follow-ups to determine whether the project was meeting its targets. These reports were provided in quarterly meetings with program staff and the Advisory Council. Midway through the grant, areas below target were job training, employment and emergency room utilization, prompting staff and the Advisory Council to discuss additional program activities and to determine how to better use community resources to address those issues.

Every six months the evaluation team presented to program management and staff the aggregate client responses to the open-ended questions, and used them to discuss areas where the program was working well as well as where it needed improvements. At the first meeting, the staff got sidetracked by the negative comments and guessing who said what. After that meeting, the evaluators prepared major themes from the content analysis, with only a few illustrative verbatim comments. This helped the team focus on the substance of the feedback and was more useful for facilitating a discussion of possible program improvements.

Regression analyses and other analytic methods appropriate for a repeated measures design were used to prepare the final report on program outcomes. The themes from the client interviews were summarized and presented with frequencies.

Dissemination and Utilization of Results. Since the evaluation team had provided interim reports throughout the grant to program staff, management, and the Advisory Council, the final report had few surprises. The evaluators used graphs extensively to show rates of changes across the follow-up periods, and de-emphasized use of statistical terminology that was meaningless to staff and Advisory Council members. The CMHC used the positive program results to write a new grant proposal to expand the program model in another area of the state.

The evaluation and program staff jointly presented a poster at the annual federal grantee meeting and at a national homeless conference. The presentation included client demographics, outcome data on the targeted domains, client perceptions, and a case study on a typical client. Program staff felt sufficient ownership of the data that they were comfortable discussing results and answering questions along with the evaluation staff. Similar future presentations at state and national conferences are planned.