An Interventional Study of Guiding Homeless Persons to Self-Reliance Using the Outcomes Star™ for Homelessness

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The Outcomes Star™ (TOS) for homelessness, a tool developed to promote self-reliance among the homeless population, was implemented in a homeless shelter in a small city of a southeastern state. Ten homeless persons were selected to use TOS as part of 6 weekly, one-on-one sessions that focused on skill building, community resource access, and coordination of care. Each participant chose 2 of the 10 available TOS domains (e.g., self-care, managing money) for focusing their improvement efforts; a third TOS domain, physical health, was a common domain shared across all participants. At the beginning and end of the intervention, participant self-reported scores using TOS were recorded. The participants demonstrated statistically significant changes in their 2 chosen domains of TOS. The common domain, physical health, did not indicate a significant change alone. When all 3 domains were combined, however, the statistically significant change remained. This study supported using TOS as a structured format to guide homeless persons toward self-reliance.

Keywords: homeless; self-reliance; Outcomes Star™; transtheoretical model

Health care systems strive to meet the needs of all those within their care, but the specialized needs of those who are homeless may require more than the average effort. The Health Care for the Homeless programs that have been established through federal legislation attempt to meet the health care needs of this population, but oftentimes, there is no true focus on tangible goals for the homeless individual.

A recent national survey indicated 1.6 million persons in the United States are homeless on any given night (Health Resources and Services Administration, n.d.). According to 2008 statistics, within the geographical area that this study encompassed, there were 1,606 homeless persons (National Alliance to End Homelessness, 2010).

Health care providers have the opportunity to empower the homeless population to embrace necessary steps to achieve independence, which is also known as "self-reliance." The Outcomes Star™ (TOS) for homelessness (see Appendix A), a tool used to benchmark the movement of homeless persons toward self-reliance, was developed to track the progress of this population toward the goal of autonomy.[1]

TOS uses an interpretative approach to validation rather than a positivist approach (see Appendix B). The

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tool has been shown to reliably measure what it is supposed to measure and to contribute to effective practice.

Literature Review

Caring for the homeless population presents unique challenges. Three of the most prevalent problems within this population are mental illness, alcohol abuse, and illegal substance abuse (Baggett, O'Connell, Singer, & Rigotti, 2010). For the health care provider to deal with any one of these three issues is a challenge in itself, even without the added burden of homelessness. Homeless persons also frequently express feelings of loss of control over their lives (Nickasch & Marnocha, 2009), further complicating a provider's ability to encourage positive health care practices.

TOS tool is a 10-pointed star with 10 steps in each point. There are 10 areas in which the tool attempts to help the homeless person achieve more independence: motivation and taking responsibility, self-care and living skills, managing money and personal administration, social networks and relationships, drug and alcohol misuse, physical health, emotional and mental health, meaningful use of time, managing tenancy and accommodation, and offending. The tool provides a hands-on way to address the common problem areas that homeless persons face. It also allows the health care worker to establish a trusting relationship while nurturing a holistic, autonomous approach.

TOS has been implemented and data has been collected in at least 25 organizations throughout England and Ireland (Burns, MacKeith, & Graham, 2008). A pilot study using TOS was conducted in the United Kingdom with three facilities and 33 participants. AnyBodyCan Limited (2008) conducted the study using TOS to gather data for the study. The aim of this pilot study was to demonstrate how using a social performance indicator, such as TOS, can improve the service and outcomes when working with the homeless population. A social performance indicator is a tool used to measure a person's behaviors within the norms of society.

In May 2010, the Horizon House in Philadelphia began a pilot study using the Recovery Star, a specialized mental health version of TOS. Dr. John Axsom (personal communication, August 29, 2011) is currently using the tool with clients at the facility. He stated that clients using the tool discovered personal needs that they did not previously realize. Dr. Axsom also shared that the Recovery Star allowed clients to develop some goals for their lives. Barbara Cohen, MSW, director of Special Projects, Behavioral Health Services Division at Horizon House (personal communication, September 8, 2011), also confirmed participants using the Recovery Star found it very helpful to monitor progress. The staff found that using the Recovery Star was helpful because it provided a framework for working with the client.

Theoretical Model

James O. Prochaska, PhD and Wayne F. Velicer, PhD describe a stages of change model/transtheoretical model (TTM) that emphasizes intentional change through the individual's own decision making. The TTM was developed through the integration of several different accepted processes and principles of change (Prochaska & Velicer, 1997). According to the TTM, the pros of the change should be emphasized in some stage changes, whereas the cons of the change need to be emphasized in others.

The stages of TOS correlate closely with the stages of change in the TTM. The stages of change in the TTM, precontemplation, contemplation, preparation, action, and maintenance compare to stuck, accepting help, believing, learning, and self-reliance of the ladder of change for TOS (see Appendix C).

TOS was used in this study to direct each homeless person, at his own speed, to the best quality of life possible. Using an outcomes-based approach, this tool allowed the homeless persons to choose areas of their lives on which they wished to work and to see visible progress on paper. Using TOS promoted self-respect and a sense of accomplishment and helped the homeless person to achieve the goal of self-reliance.

Methodology

This capstone project was an interventional study conducted at the men's alcohol/drug rehabilitation facility of a mission for homeless persons. The ladder of change was carefully followed, because this has been shown to provide consistency in the plotting of the homeless person's perceived progress (Boswell & Skillicorn, 2009). The ladder allowed the homeless person to accurately and easily plot the improvement, or lack thereof, in each observed domain.

Participants and Setting

After institutional review board approval of the project, a convenience sample of 15 men was selected by one of the facility counselors to participate in the project. Inclusion criteria included homeless men ages 18–80 years old, ability to speak English, and score of 0–4 on the Short Blessed Test (SBT). The SBT (Morris et al. 1989; Appendix D) is a six-question test that includes questions

	RANGE	MEAN	MEDIAN
AGE	19–61 years	34.5 years	30 years
DAYS IN FACILITY	43–147 days	93.7 days	87 days

RACE	13 White participants 2 African American participants
EDUCATION	7 with high school (HS) or less 8 with more than HS education
PREVIOUSLY HOMELESS	3 "yes" 12 "no"

Figure 1. Participant demographics.

related to memory and orientation. Potential participants must have scored 0–4 points, which is considered "normal cognition," to have participated in this study. The first author met with the 15 men as a group at the outset of the project. The potential participants were informed that the project was part of the requirements toward the completion of the first author's doctor of nursing practice (DNP) degree and that participating in the project may or may not benefit them. The first author met with each potential participant individually to explain the written consent and Health Insurance Portability and Accountability Act (HIPAA) consent forms. After a potential participant signed both of these forms, the first author administered the SBT. All of the men were determined to be competent to participate in the project according to the test results (Figure 1).

TOS research report (Burns et al., 2008) indicated that facility workers have updated TOS with participants on a 3–6-month basis, depending on client and worker discretion. For this study, the first author and facility staff agreed to a 6-week data collection interval. To participate, the potential participants needed to plan on being a resident at the shelter for the duration of the 6 weeks necessary to gather data.

The decision was also made to include only the men who were already part of the Miracle Hill Overcomers program in order not to lose participants to attrition. This program is for men desiring to overcome alcohol and/or substance abuse addictions and is a shelter with dormitory rooms for living. Women were excluded because the study facility does not accept women at this particular site. Men comprise 67.5% of the single population of homeless persons (National Coalition for the Homeless, 2009), so beginning with this client group was also practical.

Ten participants completed the entire 6-week study. Five participants left the facility after Week 4 and were therefore eliminated from this study. The participants comprising the sample in this study were men from 19 to 61 years old. The participants' education levels ranged from the ninth grade to a bachelor of science degree. Four of the participants had previously been homeless; one of them had been homeless twice and another had been homeless multiple times. All participants were able to name a support person who would be able to assist them toward self-reliance. These support individuals included family members, a friend, and a fiancée, all of whom were not homeless.

Each participant of the study group plotted TOS at the onset of the project. The first author met face-to-face with each person to discuss his individual results for each domain of the tool. The homeless person decided which two areas of TOS to work on first. A third common domain, physical health, was chosen for the participants by the first author for consistency in measurement. Each participant created individual short-term goals to move toward achievement of the next step on the ladder for the chosen areas on TOS.

The first author met with each participant individually on a weekly basis to discuss progress toward the individual's goals. During these weekly meetings, the first author recorded some participants' comments related to TOS (see Appendix E) and encouraged them in their progress toward self-reliance. At the end of the 6-week study, participants replotted TOS and compared the first results with those plotted when the project was finished.

Statistical Analysis

The data collected from each participant's TOS was analyzed using a paired-samples *t* test for each chosen domain, the physical health domain, and for total score change (sum of all domains; Table 1). The participants'

TABLE 1. Paired-Samples *t*-Test Results for Two Chosen Domains, Physical Health Domain, and Combined Totals of All Three Domains

		N Significance	Mean	Standard Deviation	Standard Error Mean	*t*	*df*	(2-tailed)
First choice	Pre1 post1	10	−3.10000	1.37032	43333	−7.154	9	.000
Second choice	Pre2 post2	10	−2.90000	0.99443	31447	−9.222	9	.000
Physical health	Pre3 post3	10	−0.60000	2.11870	66999	−0.896	9	.394
Total of all choices	PreT postT	30	−6.60000	2.41293	6303	−8.650	9	.000

TABLE 2. Summary of Participant Change

$N = 10$	Positive Change	No Change	Negative Change	Average Score at Assessment	Average Score at 6-Week Review	Average Change (Level Progression)
Common domain (physical health)	3 (30%)	6 (60%)	1 (10%)	7.6	8.1	0.5
Motivation and taking responsibility	9 (90%)	1 (10%)	0 (0%)	5.6	8.4	2.8
Self-care and living skills	6 (60%)	3 (30%)	1 (10%)	6.5	8.7	2.2
Managing money	8 (80%)	2 (20%)	0 (0%)	5.8	7.6	1.8
Social networks and relationships	10 (100%)	0 (0%)	0 (0%)	5.4	8.1	2.7
Drug and alcohol misuse	7 (70%)	3 (30%)	0 (0%)	6.1	8.1	2.0
Emotional and mental health	10 (100%)	0 (0%)	0 (0%)	5.3	7.8	2.5
Meaningful use of time	9 (90%)	1 (10%)	0 (0%)	5.8	8.0	2.2
Managing tenancy and accommodation	9 (90%)	0 (0%)	1 (10%)	6.1	8.0	1.9
Offending	7 (70%)	2 (20%)	1 (10%)	6.9	8.5	1.6

average score in each domain was tabulated before and after the study. These scores indicate the progress, or lack thereof, in an average of the participants' scores in each domain (Table 2).

The *t*-test analysis indicated that the domains chosen by the participants to address (as indicated by Choice 1 and Choice 2) showed statistically significant improvement between their pre- and postscores. The physical health domain, common to each participant, did not show statistically significant improvement (Figure 2). This could be considered an expected result because the participants did not choose, and may not have been vested in, this domain.

When the paired-samples *t* test was used to analyze the combined data from all three domains of the participants' results, a statistical significance was found. So even though the physical health domain did not show any significant change when analyzed alone, there was a measured change when combined with the two chosen domains.

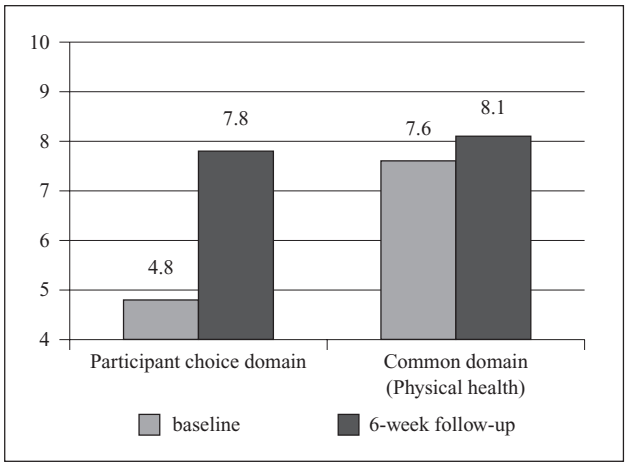

Figure 2. Change in Outcomes Star mean score: baseline to 6-week follow-up.

The results of the 6-week intervention showed positive results of the participants' progression toward self-reliance. All of the participants significantly improved in their two chosen domain areas. As expected, the common domain of physical health did not show statistical improvement. However, 3 of the 10 participants did show improvement even in the physical health domain (Table 2).

The average change level, or number of step movement upward on the ladder of change, is listed in the last column for each of the domains. In all 10 domains combined, there was an average progression of 2.02 steps. Translating that into actual progression for the participants indicated that each domain showed progression from one stage to another on the ladder of change. For instance, the participant moved from "stuck" to "accepting help" or from accepting help to "believing." According to the organization guide for TOS (MacKeith, Burns, & Graham, 2008a), this would be considered "a very significant step."

The added benefit of using TOS showed that participants did improve in many, if not all, of the other seven domains that were *not* addressed during the weekly meetings with the first author. Most of the domains showed at least a progression of two places on the ladder of change, which would indicate that a participant had progressed a full level toward self-reliance.

Discussion

Summary

Implementation of TOS resulted in positive results in each of the participants' journeys toward self-reliance. The

men experienced statistically significant growth in each of their chosen domains of change. Surprisingly enough, all of the men showed growth in most of the other seven unchosen domains of change. One difficulty encountered in the project included dealing with the attrition rate associated with the transient nature of the population. The facility counselor expressed that the population of this setting is in a constant flux, at times making progress toward self-reliance a difficult task.

Relation to Other Evidence

The results in this study have supported the positive results in the studies that have been conducted in the United Kingdom using TOS. The pilot study in three facilities in the United Kingdom showed a mean score on admission of 5.9 with a mean improvement score of 1.9, resulting in an overall mean score of 7.8. The scores from this project were slightly higher than the pilot study scores. The beginning mean score of the participants' first choice was 4.7 with an end mean score of 7.8, with an overall improvement score of 2.3. The participants' second choice beginning mean score was 4.9, the end mean score was also 7.8, with an overall improvement score of 2.9. The third common domain, physical health, had a beginning score of 7.5, an end score of 8.1, with an overall improvement of 0.6. The high beginning score in this domain resulted in the no statistical improvement result by the end of this study. The time frame of the pilot study and this study are comparable because the pilot study recorded second scores at a little more than 5 weeks as compared to the 6 weeks of this project.

Limitations

One limitation of this study includes the small sample size of the study group. The transient nature of the homeless population contributed to the difficulty in achieving an adequate number of participants for this study. The decision was made to begin with 15 participants in an attempt to offset attrition and achieve a sample size of 10 participants throughout this study.

The fact that the sample was not random and that a facility counselor chose participants to be involved in this study is also a limitation. The counselor chose men that he felt would be good candidates for this study and remain in the facility for the 6-week duration. If a random sample had been chosen, more participants could have been lost to attrition, or the results may have been different or negative.

Another limitation may have been the first author was from the outside and not part of the facility staff. Although this may have been more beneficial to the participants because several expressed appreciation sharing things with an outsider, this could also potentially limit the progress of those participants in future studies who may be interacting with only the facility staff. To the participants, it becomes a trust issue when choosing between the facility staff and the outsider. If participants perceive that sharing certain information with staff would result in a negative outcome, then this information may remain unshared.

Because another limitation to this study is that women were excluded, further intervention could produce different or negative results if women were to be included. The findings from this study may not be generalizable to homeless women.

Interpretation

Even though an expected outcome was that the participant would progress toward self-reliance more quickly in the two chosen domains, rather than the common physical domain, it was unexpected that the results in the physical domain would be so insignificant. TOS separates the alcohol and drug domain from the physical domain and rightly so. However, it was interesting to note that during data collection and weekly meetings, the participants rarely associated their substance abuse problems with their health. The two areas seemed compartmentalized in their minds.

Using TOS at this facility proved to be a very effective means of promoting a more independent lifestyle for the men in the program. The participants made considerable change in their progression toward self-reliance, moving from their initial stages within the ladder of change to the next level toward independence.

Conclusions

This project demonstrates that TOS may be a useful tool to assist the homeless to progress toward self-reliance. The intervention was simple to implement and produced statistically significant positive outcomes.

Given the positive results of the tool's usage in England, the Health Care for the Homeless works here in the United States could also reasonably be expected to benefit from its implementation within their individual programs. Society would benefit by the person's achievement of self-reliance as the homeless person moves toward a more productive lifestyle and moves

away from relying on government assistance. As these persons become more self-reliant, the cost to society should also decline. These costs include, but are not limited to, both physical and mental health care costs, drug and alcohol misuse costs, and the monies saved by the reduction of individuals in correctional facilities.

It is hoped that this study will serve as a catalyst for future usage of this very simple but impressive tool to assist homeless men toward self-reliance and an independent life. The medical director of the study's area community health care center has already expressed interest in implementing TOS in the local Health Care for the Homeless program. If proven worthwhile, TOS tool usage as a structured format could actually change the face of the way that shelters provide and share care with the homeless population.

Note

1. The Outcomes Star™ for homelessness is one of a suite of more than 20 tools adapted for particular client groups including the Recovery Star (for mental health), the Work Star, the Drug and Alcohol Star, the Family Star (for parents), and My Star (for children). Training and a license are essential to use the Stars. Full details and preview versions of all the Stars can be found on http://www.outcomesstar.org.uk.

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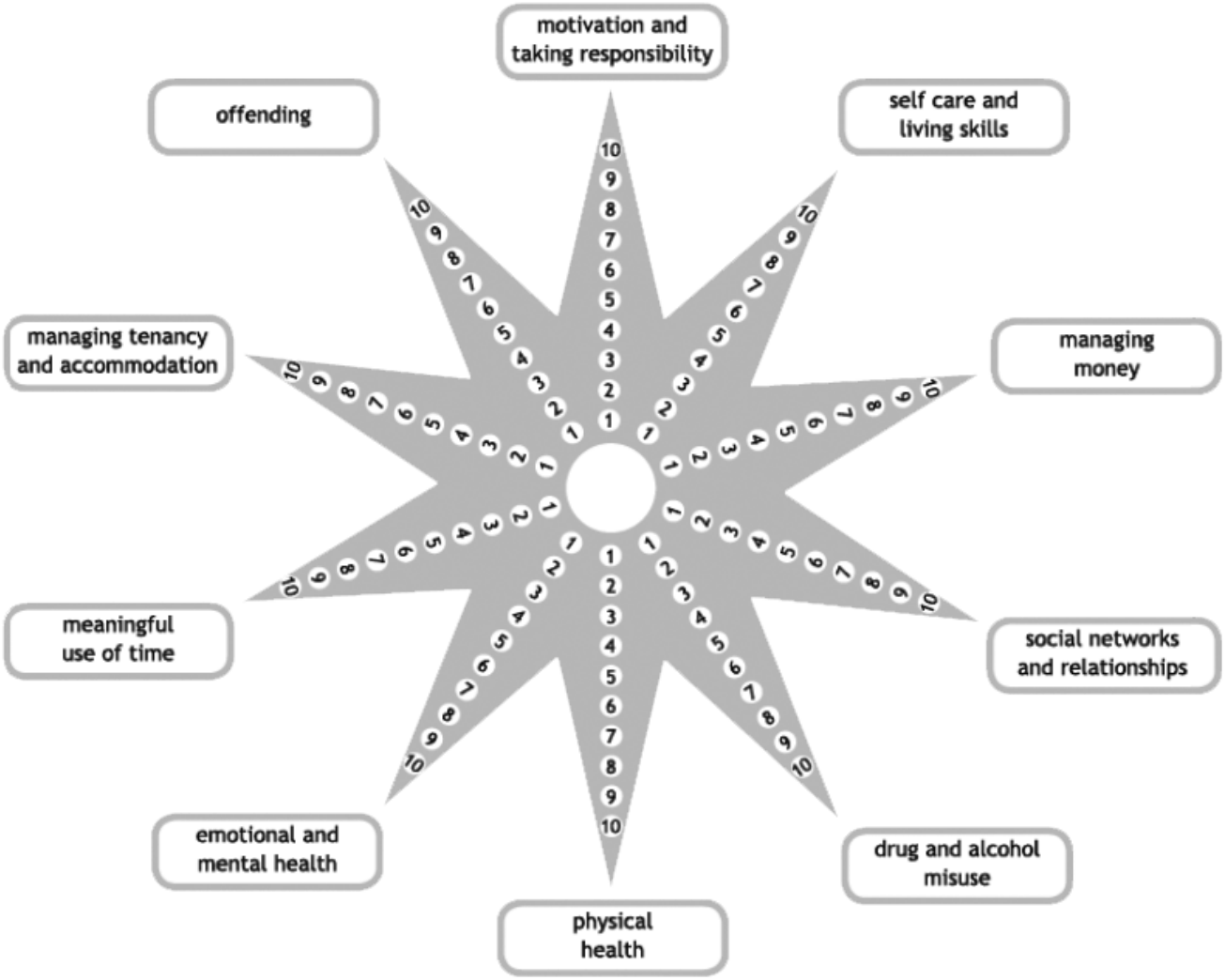
Appendix A
The Outcomes Star™ for Homelessness



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Appendix B
Positivist Versus Interpretative Approach

Positivist Approach to Validation	Interpretative Approach to Validation
Does the tool measure what it is supposed to measure?	
Do the tool's measurements correlate with those of existing tools (convergent validity)	Does the tool measure those things that are most important and relevant to the service and service users? Do the descriptions within the tool resonate with service user and worker experiences of change? Is the data plausible to workers and managers and does it fit with their experience of service user needs and change?
Does the tool measure reliably?	
Does it measure this reliably over time? (Test-retest reliability) Does it measure it consistently across different users? (inter-rater reliability)	*The intention is that use of the tool changes the perceptions and motivation of the service user, therefore reliability over time is not seen as achievable or desirable*
Does the tool contribute to effective practice?	
As the tool is intended to be used for research rather than as part of treatment the effectiveness of the tool in achieving change is not seen as relevant	Does the tool support the consistency and effectiveness of keywork/casework and help service users to make progress? Is the data helpful in assessing the effectiveness of the service, identifying service strengths and weaknesses as a basis for on-going improvement?

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Appendix C
The Ladder of Change

The Ladder of Change

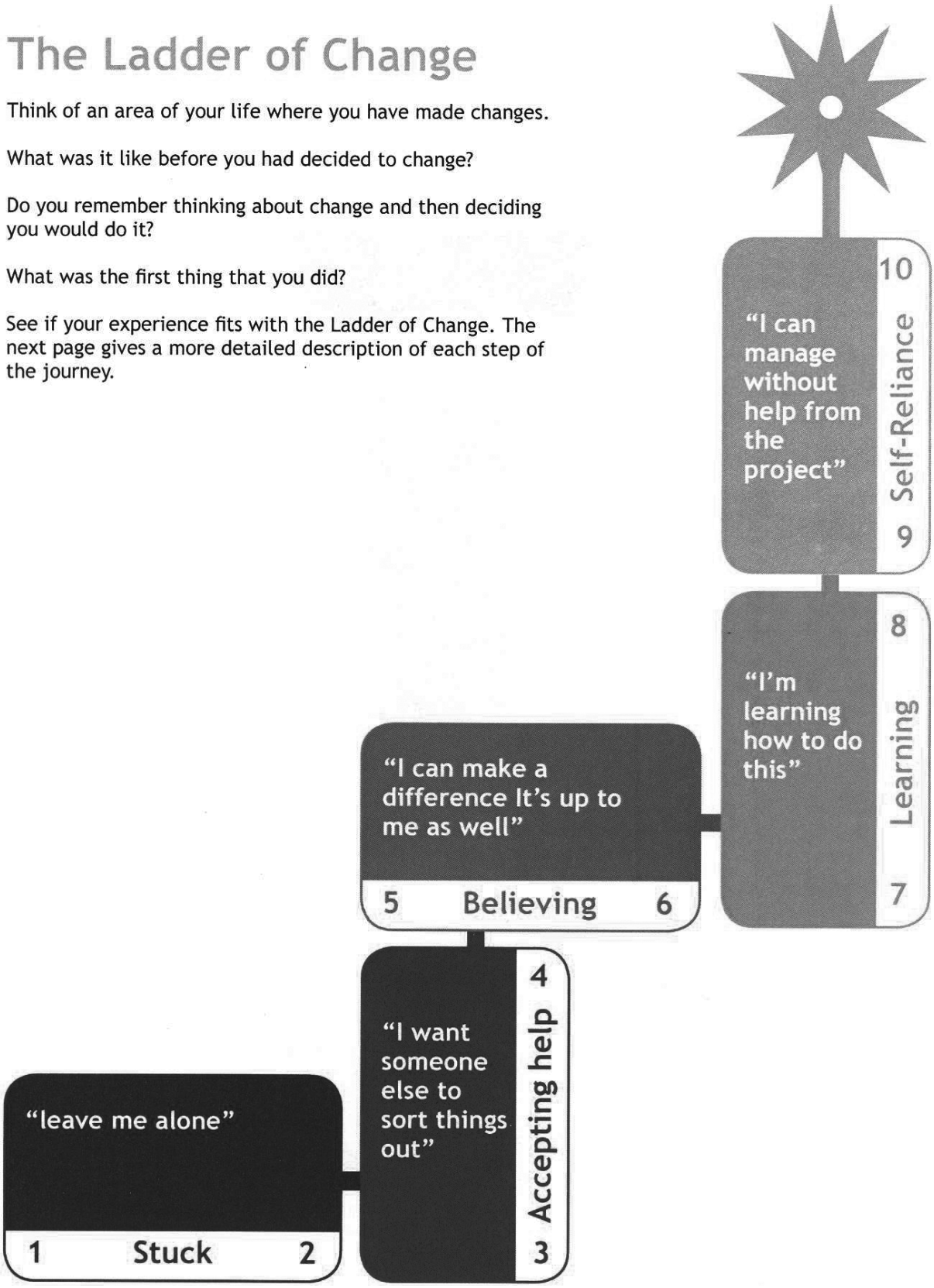
Think of an area of your life where you have made changes.

What was it like before you had decided to change?

Do you remember thinking about change and then deciding you would do it?

What was the first thing that you did?

See if your experience fits with the Ladder of Change. The next page gives a more detailed description of each step of the journey.



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Appendix D
Short Blessed Test

SHORT BLESSED TEST

"Now I would like to ask you some questions to check your memory and concentration. Some of them may be easy and some of them may be hard."

	Correct	Incorrect
1. What year is it now?	0	1
2. What month is it?	0	1

Please repeat this name and address after me:
John Brown, 42 Market Street, Chicago
John Brown, 42 Market Street, Chicago
John Brown, 42 Market Street, Chicago
(underline words repeated correctly in each trial)
Trials to learn ____ (if unable to do in 3 trials = C)

"Good, now remember that name and address for a few minutes."

3) Without looking at your watch or clock, tell me what time it is.
(If response is vague, prompt for specific response

Within one hour Correct (0) Incorrect (1)

4) Count aloud backwards from 20 to 1 0 1 2 Errors
Mark correctly sequenced numerals. If subject starts counting forward or forgets the task, repeat instructions and score one error
20 19 18 17 16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1

5) Say the months of the year in reverse order 0 1 2 Errors
If the tester needs to prompt with the last name of the month of the year, one error should be scored – mark correctly sequenced months.
D N O S A JL JN MY AP MR F J

6) Repeat the name and address you were asked to remember.
John Brown, 42 Market Street, Chicago 0 1 2 3 4 5 Errors
___ ____ __ _____ _____
Check Correct Items ("street" not required)

SCORING

Item # Final	Errors (0 - 5)	Weighting Factor	Item Score
1		X 4	
2		X 3	
3		X 3	
4		X 2	
5		X 2	
6		X 2	
		Sum Total = (Range 0 – 28)	

INTERPRETATION
0-4 = normal cognition
5-9 = questionable impairment
≥ 10 = Impairment consistent with dementia

From Morris, J. C., Heyman, A., Mohs, R. C., Hughes, J. P., van Belle, J. P., Fillenbuam, B. G., . . . Clark, C. (1989). The consortium to establish a registry for Alzheimer's disease (CERAD). Part I. Clinical and neuropsychological assessment of Alzheimer's disease. *Neurology*, *39*, 1159–1165.

Appendix E
Participants' Comments

WEEK 1

- Wants to start thinking about what can substitute for alcohol and drugs; "I was always there no matter where I went."
- Worked on living skills by organizing locker; "I actually thought about this (TOS) when I was doing it."
- Working on social networks and relationships; was discussing with friend that it is difficult dealing with 60 adult men and everybody has their own point of view; friend responded with "You're actually looking at things with a sober mind."
- Working on meaningful use of time; did an outline of time from Monday through Friday; did a timeline plan to see exactly where was wasting time
- Working on social networks and relationships; wrote a letter to his dad; had not had contact with him in 6 months; "The resentment I had towards my dad made me realize that I couldn't get close to anyone."
- Working on emotional and mental health; "When I get angry, I just start thinking about my grandchildren or start taking a walk."
- Working on emotional and mental health, social networks, and relationships; "I'm working on *reflecting* on my past, rather than *revisiting* it." "Drugs and alcohol are inanimate objects, and they don't have any power, unless I give them power."
- One participant mentioned that he was even working on an area of TOS that was not one of the two on which he had decided to start.
- One participant stated that during the week, another participant had asked him, "What two areas are you working on?"

WEEK 2

- Had held guilt for 5 years because his mother died in his arms with a heart attack; blamed himself for her death; was able to talk about this in group meeting this week; "I felt relief."
- "I know since starting this I have more motivation; putting it on paper makes a difference; when it comes time to relax, I can."
- "I feel like I will never have this amount of time to work on myself ever again."
- "I cannot allow people's views of me to determine the direction and the quality of my life."
- "I can never allow anyone else's actions to determine my behavior or feelings."
- "I visited with my fellow program-mate asking him to forgive me for being such a poor listener—when I only heard his words, I should've been listening to his heart."
- The first author suggested that one participant list the pros and cons, as described by Prochaska and DiClemente's (2011) stages of change/transtheoretical model, related to his continued usage of marijuana. He had a medical marijuana permit in his state but stated that he really did not need the marijuana for his pain. The first author explained that if cons outweighed the pros, then the participant was really not ready for the action (believing) stage.
- "I have a purpose in my conversations with people."
- "There's no blueprint to being a father; I can learn to forgive my father and want to grow in our relationship."

WEEK 3

- "Instead of taking away from the community, I want to give back to the community."
- "If I write down what I want to do with my life, it makes it more real to me."
- "Drugs don't discriminate."
- "Just started Level 2—you learn how to feel. Last night I cried for the first time in 4 years. I've prayed for the last 3 years that I could cry."

(Continued)

Appendix E
Participants' Comments (Continued)

WEEK 4

- "I really don't like being told what to do, but that's everywhere; if it isn't the police, it will be my boss."
- Related to marijuana usage (medical marijuana legal in participant's state; however, participant admitted that didn't really need); used Prochaska and DiClemente (2011) to list negatives and positives related to marijuana usage—found that actually had more positives and decided to quit using.
- "I have to be careful not to take on too much responsibility. I have learned that within those boundaries that I have freedom."
- "I'm an adult chronologically but emotionally I'm an adolescent . . ."
- "My most heartfelt prayer, at the moment, is that I do not continue to seek out self-imposed pain in the pursuit of happiness."

WEEK 5

- "There's triggers for addiction; when you hear a song or when you smell something, or if you see something; you don't want to act on it—just run, get away, otherwise you're putting yourself in a trap, and you can see it coming, too."
- "TOS puts it in your mind during the week to work on the goals."
- "I refuse to be tempted to focus on how far I have to go, so I'm choosing to realize how far I have come already."
- "The addiction becomes a god."
- "Wherever you go, there you are—I was trying to run away from my problems, but there I was."