COMPASS: A Comprehensive Approach to Supporting Veterans with Co-Occurring Disorders

Alicia R. Millard, DSW, MSW, LCSW

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Dr. Brittany Lytle-Rodriguez, DrPH, MSW
Faculty Advisor

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Dr. Jacqueline Gustafson, EdD
Dean of the College of Behavioral and Social Sciences

Dedication

I dedicate this project to all my family and friends on this educational journey, whom I love very much. To my husband, Jonathan, I love you very much because you have been so supportive and helped carry such a huge load during the past two years. You are such a great partner and supported my decision to resume my education without hesitation. To my kids, Noelle and Nathan, Mommy loves you so very much, and you helped me get through this, even though you may not realize it now. To my sisters (Monica and Renee) and friends, you have encouraged me to stay strong the whole way, and I appreciate you all. Thank you for those I haven't mentioned but have silently said a prayer for me. With the support I received, I am blessed beyond measure to end this academic chapter.

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Abstract

This comprehensive project identified homelessness's social problem—specifically, veterans experiencing homelessness with mental health and substance use challenges. Additionally, my professional and personal experiences as a Senior social worker in a homeless program at the VA Loma Linda Healthcare System are discussed and have shaped my awareness of the challenges faced by this marginalized population. The social problem is grounded in three theoretical principles: sociological - imagination, critical and conflict theory, and empowerment theory. Using community-based participatory research methods, I conducted interviews with stakeholders to help inform the innovation project while integrating faith-based practices when providing services to individuals will provide better service delivery to the community. A scoping review was done to review the literature on current interventions to assist veterans experiencing homelessness with co-occurring disorders. This writer piloted a screening tool to assess clients during the initial stages of engagement in a homelessness program. A mixed evaluation method was used to assess the project using surveys. Recommendations for future research and practice include more studies on practices for increasing social connectedness and more training components for students and professionals already in the field to discuss military culture and acclimation into society after homelessness.

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Section 1: Executive Summary

Problem Identification and Background

Homelessness in the veteran population is a multidimensional systemic social problem. In addition to homelessness, contributing factors of co-occurring mental health and substance use disorders (CODs) plague this marginalized population's ability to sustain permanent housing. Innovative treatment approaches in a client-centered manner are explored in this project, along with evidence-based treatment. Tsai et al. (2017) reported that the prevalence of veterans becoming homeless is far greater than nonveterans, as reported by the U.S. Department of Housing and Urban Development (HUD). Bent-Goodley (2016) discussed ending homelessness as one of the grand challenges for social work, thereby creating a more substantial social fabric. The main discussion throughout this paper will be to focus on veterans experiencing homelessness, in addition to having the challenge of being diagnosed with mental health and substance use. To tackle the social dilemmas listed in the grand challenges, social workers must incorporate "research, practice, and education" (Williams, 2016, p. 68).

Community Engagement

Community engagement was completed to begin to work on establishing relationships with the community and to start working on solutions. To gain more insight into the social problem from community stakeholders and discuss possible solutions two interviews were conducted. Additionally, another community member involved in activism with veteran homelessness was identified, and a critical dialogue was conducted.

Conceptual Model

The conceptual framework that informed this project is based on sociological imagination, critical and conflict theory, and empowerment theory. Sociological imagination

theory posits that the social problem results from the breakdown of systems (economic, educational, political, and family). From the critical and conflict theory perspective, power and inequality have a historical foundation. Therefore, when considering the stigma and barriers associated with homelessness within the veteran community, it is to take a closer look at how history has played a part. Regarding the application of empowerment theory to this project's social problem and population, the theory postulates that the social problem occurs at the micro level and needs to make people more inclusive in their treatment. In addition, the theological perspective and how faith-based involvement is essential on how society should address veteran homelessness.

Social Innovation

The innovation for this project is a training and tool that was piloted, called COMPASS. The tool is guided by the quality-of-life assessment, which stands for Comprehensive Assessment. This tool is to be used by service providers who engage with veteran clients experiencing homelessness and co-occurring disorders. The goal is with this information, the clinician will be able to provide support and resources to the individual within the scope of what they determine to be important to them.

Evaluation

Participants in the training received pretest and posttest surveys to determine their skill level and understanding of the information presented and provide feedback regarding the readiness screening tool. The surveys also evaluated their satisfaction with the materials presented and how applicable they are to their job.

Conclusion and Future Directions

An integrated treatment approach is the highest level of service possible when working collaboratively and in a coordinated manner with this population. It is essential to continue to provide training in evidence-based practices, including Seeking Safety, for substance use and mental health staff members to support veterans in programs that sustain their housing. Also, with further evaluation the screening tool piloted in this project can be administered on a larger scale to individuals experiencing homelessness. To begin local-level dissemination, an agency will be formed to address the 12th social work grand challenge to provide alternative supportive housing solutions for those with mental health and substance use disorders.

Section 2: Observation

Introduction

I focus on the marginalized community of interest throughout this paper, addressing the social problem of veterans who experience homelessness and have a co-occurring disorder in rural areas of San Bernardino and Riverside counties. To discuss this topic in more detail, I provide information about what I have observed professionally and personally regarding this social issue. I then define the social problem in more detail, identify critical stakeholders, and examine how the community is affected. Third, I integrate the biblical perspective on the social problem and how social work principles can apply to solutions. Last, I describe my plan to involve the community in engagement, build trust, and ensure cultural humility to address the grand challenge of ending homelessness.

Professional Experience

In my experience I have recently worked with a marginalized community at the Department of Veterans Affairs (VA) in a community housing program. My first encounter with working with the veteran homeless population came from my role as a Senior Social Worker at the Greater Los Angeles VA in the homeless program. My role in this program was to oversee a non-profit that was awarded a grant to provide transitional housing to veterans who were actively using substances and not fully engaged with mental health services. This program primarily serves people who are presently at risk of becoming homeless. In my current role at the VA, I work with Housing and Urban Development in a collaborative effort to provide housing and supportive services to veterans. The HUD-Veteran Affairs Supported Housing (HUD-VASH) program has made collaborative efforts to support this marginalized community affected by homelessness (Veterans Affairs Supportive Housing (VASH) - PIH, n.d.).

In my current role, I work with veterans experiencing homelessness at the VA Loma Linda Healthcare System. I am currently a senior social worker in the HUD-VASH program, where I work on-site as the case manager for 25 veterans who reside in a project-based permanent housing location. Project-based vouchers are vouchers allocated through public housing authorities and designated for use at a particular project. People must meet specific income limits to qualify, households contribute 30% of their income to rent, and the voucher pays the difference between the tenant contribution and the unit's total rent. The initial program was developed in 1998 and has since been updated through the Housing Opportunity Through Modernization Act (2016).

One benefit of the Housing First model is that services are housing oriented, which means they aim to help veterans remain housed; HUD-VASH and other project-based sites provide on-site supportive services, they have unique benefits. Second, the services are multidisciplinary. By having a multidisciplinary team, veterans are served from a social determinants of health standpoint. The World Health Organization (2019) defines social determinants of health as indicators of health that affect a person's overall health and wellness. Providers help veterans address physical health, mental health, and substance use; apply for Social Security benefits; access health care; attend school; gain employment; and become involved in their community.

Sam Tsemberis (2011) helped create the Housing First model. In his research, Tsemberis (2011) discussed nine principles that help create the foundation for ending homelessness (World Health Organization, 2019). The totality of these principles is the focal point for how we treat clients and our attitudes toward them. The HUD-VASH program follows the Housing First model, an exciting concept with weaknesses and strengths. I have observed throughout my

experience working with this population that this model instills hope. I also have seen how housing is a basic social determinant of health and should not be based on whether someone wants to receive treatment for substance use or mental health problems.

Section 3: Identification

Social Problem

Homelessness is a public health, mental health, and social problem. Homelessness is a way of life for some and an unfortunate circumstance for others. Homelessness is "having no home or place of residence" (Merriam-Webster, n.d.a). Regardless of choice, it is still a worldwide issue due to its societal implications. Moreover, it is imperative not to overlook people in different housing situations but to explore those issues that cause the most disturbance. The term "homeless" has many definitions, depending on which type of services are offered at agencies. The social problem is a widespread and international issue with many facets, but the focus here is on the social problem in the United States and more specifically, rural areas of Riverside and San Bernardino counties.

Homelessness in the veteran population is a multidimensional systemic social problem. However, despite proven methods to address veterans experiencing homelessness with substance use and mental illness, there continues to be a need for innovative methods to address the issue. In addition to homelessness, CODs plague this marginalized population. Innovative treatment approaches in a client-centered manner are explored alongside discussion of an evidence-based treatment. Tsai et al. (2016) reported that the prevalence of homelessness is far greater among veterans than nonveterans, as reported by HUD. Of course, these numbers may fluctuate due to annual point-in-time counts.

Scope of Social Problem

Understanding the history of homelessness in the United States is critical to addressing this challenge. In 1963, John F. Kennedy signed the Community Mental Health Construction Act into law, providing federal funding to community mental health centers to provide services to

people exiting mental health institutions and returning to the community (Community Mental Health Act, 1963). Trawver et al. (2019) discussed the deinstitutionalization for those in living in large facilities with mental illness and mental retardation of 1960 as one of the ways societies saw the vast increase in homelessness of those diagnosed with mental health issues released to the community setting. One of the implications of this act being in place was the widespread increase in homelessness in the United States which is stipulated communities did not adequately staff their service agencies to manage these individuals needing ongoing mental health services and housing.

Global Social policy and Program Analysis

Globally, homelessness is a social justice issue, and in order to develop an innovative solution, it was imperative to look at how solutions and social policies are being implemented around the world. The United Nations Universal Declaration of Human Rights (UNDHR) is pivotal in defining what human rights are fundamental to people. The UNDHR is a standard for all nations to follow and enforce to provide equity and equality. The human right that closely aligns with my social problem is Article 25, #1, which states that everyone has the right to adequate housing and social services (UNDHR, n.d.). Social services are essential for those experiencing homelessness to augment the immediate housing component.

Charters or Conventions Support the Problem

An organization that is helping to address global homelessness is the Ruff Institute of Global Homelessness (*Institute of Global Homelessness*, n.d.). IGH was founded in 2014, and the primary focus is to end street homelessness within the states and globally. (*Institute of Global Homelessness*, n.d.) Three strategic goals are aligned to maintain the course toward the mission: advocate, create partnerships with other countries and cities, and engage with others.

The NGO Working Group to End Homelessness (*UN NGO Working Group to End Homelessness (WGEH)*, n.d.) is also breaking barriers to end homelessness globally. The WEGH came after 2017 and is grounded in bringing together like-minded NGO organizations that want to advocate, change, promote policies, and increase awareness for global homelessness at the UN. In addition, one crucial key feature of the NGO is that individuals provide lived experiences, similar to the community engagement piece discussed in the book, The Principles of Community Engagement (Centers for Disease Control and Prevention, 2011).

Impact on Population

The marginalized communities with high risk factors of homelessness are those with mental health and substance use disorders, which is a huge stigma issue because it leads to a barrier to accessing care (Tsai & Kelton, 2022). The VA has collaborated with community providers and stakeholders, including for-profit and nonprofit groups, individual providers, and agencies, to mitigate issues with accessing and providing care.

Instead of looking at homelessness as stigmatized, it should be considered the result of an unfortunate set of events that culminated in the loss of housing, which does not say anything about an individual. Two other pivotal reasons for the increase in homelessness should be noted: systemic issues and other personal life factors. The National Coalition for Veteran Homelessness reports there are reasons as to why veterans are homeless including: systemic issues include poverty, economic recession and depression, wars, inadequate income, lack of jobs, high unemployment rates, lack of affordable housing, immigration of people without resources, natural disasters, and lack of access to health care, behavioral health, and other social services (Moduet, n.d.). Personal factors include individual or family health crises and illnesses, trauma, domestic violence, mental illness, and addiction (Trawver et al., 2019, p. 4).

The *2020 Annual Homeless Assessment Report to Congress* concluded, "On a single night in 2020, roughly 580,000 people were reported homeless in the United States" (HUD, 2021, p. 5). This report also noted that 37,572 veterans were homeless, which accounted for 8% of all homeless people (p. 52). According to Tsai et al. (2017), "understanding the behavioral health needs of the homeless population and developing interventions to address their needs are instrumental to preventing and ending homelessness" (p. 113).

According to a Substance Abuse and Mental Health Services Administration (2020) report, 3.9 million veterans had substance use and mental health disorders. Moduet (n.d.) reports veterans who are homeless are typically not engaged in services, and utilizing acute services frequently are most likely homeless or on the verge of losing their housing. Cusack et al. (2016) reported that permanent supportive housing provides for those who are marginalized, vulnerable, and have a history of being homeless. However, the added supportive services of case management, psychological services, peer support and nursing care can assist them with their mental health and substance use.

One collaborative effort currently in practice involves HUD and the VA, known as the HUD-VASH program. "HUD-VASH is a collaborative program between HUD and V.A. combines HUD housing vouchers with V.A. supportive services to help Veterans who are homeless, and their families find and sustain permanent housing" (VHA Office of Mental Health, n.d.). The goal is to provide housing and supportive services to address mental and medical health needs and help veterans maintain their housing. As a government agency, HUD is working with communities to provide resources to assist or prevent homelessness. HUD defines homeless status based on federal funding statutes and four specific categories. On December 5, 2011, HUD published its Final Rule Defining Homeless (76 FR 75994), which provides the four

categories of homelessness and sets guidelines for who can receive housing assistance through the HUD program. The four categories are people living in a state not meant for human habitation, emergency shelters, or transitional housing or exiting a facility where they temporarily resided.

Although providing permanent housing is essential, engaging with individuals who face mental health challenges and addressing long-term barriers to sustaining housing continues to be important. According to researchers, although the HUD-VASH program effective at increasing the availability of permanent housing, "it is less effective for Veterans with mental health and substance use" (Smelson et al., 2018, p. 7). In this paper a definition and analysis of an evidence-based treatment approach at the micro level to address homelessness in the veteran community with CODs will be further explored.

The National Alliance to End Homelessness (2021) provided statistics for January 2020, when point-of-contact reports were made before the worldwide COVID-19 pandemic. These statistics indicate that 161,548 people experienced homelessness in California, representing 40.9 per 10,000 people in the general population. In the San Bernardino County and City report from the exact statistics, 3,125 people were homeless on any given night. In the Riverside County and City report, on any given night in 2020, 2,884 people were homeless.

One key proponent of tackling the grand challenge of ending homelessness is the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, passed in May 2009. In 2022, the U.S. Interagency Council on Homelessness developed a strategic plan called All In, which discusses ways to reduce homelessness by 25% by 2025. This federal strategic plan discussed some of the characteristics of people at high risk of being and remaining

unsheltered; one marginalized population is those with CODs, mental health conditions, or substance use (FSP, n.d.).

The HEARTH Act (2009) was very much needed after decades of the original homeless assistance law was put into place. "The HEARTH Act also codifies in law the Continuum of Care planning process, a longstanding part of HUD's application process to assist homeless persons by providing greater coordination in responding to their needs" (HEARTH Act, 2009). HUD developed its definition of homelessness as a result of the HEARTH Act.

The complexities of homelessness are grand, but the impact of homelessness on our communities is even more significant. The risk factors associated with homelessness include social, economic, and cultural. HUD's *2022 Homeless Assessment Report* stated that "580,466 people experienced homelessness in the United States on a single night in 2020, an increase of 12,751 people, or 2.2 percent, from 2019" (HUD, 2022, p. 13). In this HUD (2022) report, the information gathered indicated that the rise in homelessness occurred before the COVID-19 pandemic. What is important to note is the different demographics of homeless people. Per the HUD (2022) report, veteran homelessness did not decrease from 2019 to 2020 and people of color had the highest and disproportionate risk of homelessness.

Negative Consequences of the Social Problem

Homelessness directly affects our children, families, and communities. It also indirectly affects our economy and education and public health systems. The label of homelessness is used to criminalize, discriminate, and stigmatize this particular group. Homelessness has implications, such as less access to medical and mental health services when needed, leading to more acute conditions not being correctly treated. Therefore, barriers to accessing mental health and medical services are related to socioeconomic status.

Social Work Grand Challenges

Bent-Goodley (2016) discussed ending homelessness as part of the Grand Challenges for Social Work initiative, which seeks to create a more substantial social fabric. Viewing homelessness as a systemic problem and not an individual problem can put it in perspective and make us more knowledgeable about the long-term implications of inadequate resources within the community. Williams (2016) called on social workers to keep in mind that to tackle the social dilemmas listed in the grand challenges, we will need to incorporate "research, practice, and education" (p. 68). Reviewing the grand challenges, I believe the path to ending homelessness involves addressing the grand challenges of "building financial capabilities for all, reducing extreme economic inequality, and achieving equal opportunity and justice" (Williams, 2016, p. 68).

Section 4: Integration

Christian Worldview and Theological Literature

Christianity and social work are more alike than we may know, so it is essential to become educated about how they are cohesive in their values. According to Stennis and Gillian (2019), "Both professional and religious values call us to carefully engage in a process that involves listening to their voices, speaking truth to power on their behalf, and addressing the needs of members of the groups mentioned above" (p. 3).

In the Bible, Proverbs 3:27 states, "Withhold not good from them to whom it is due when it is in the power of thine hand to do it" (King James Bible, 1769/2017). I want to continue making myself available to others when I have the availability and gift to provide to those in need. The research surrounding church-based health programs is one way to close the gap between mental health disparity and engagement within homeless communities by incorporating a faith-based approach as an intervention or resource.

The theological literature that discusses how Christians should address homelessness includes a passage in the Bible that summarizes how we should help the poor. Matthew 5:42 states, "Give to him who asks you, and from him who wants to borrow from you do not turn away" (New King James Version Bible, 2005). God has commanded us to help those in need when they come to us for help. This verse speaks to us being charitable without looking for something in return. However, when conceptualizing how the social problem of homelessness should be addressed, another passage in the Bible, Luke 6:40, speaks to those who are called and led by God's teachings (New King James Version Bible, 2005). As believers in God's work, we are given the awareness and gift to help those in need knowing it is what He has commanded us to do.

Dekraai et al. (2011) discussed how because faith-based organizations are essential stakeholders in community engagement and most people already trust their faith organizations, they represent a great resource. Hays (2018) discussed church-based health programs in the African American community and noted this framework could be adapted in different cultural communities. She summarized, "In general, [these] programs are efforts to address health issues through intentional partnerships, consultations, or collaboration with religious institutions" (Hays, 2018, p. 352).

It is essential that case managers and peer supporters utilize and practice cultural humility in the engagement and assessment phase. Therefore, if veterans' spirituality is discussed during these critical initial stages, their beliefs or practices can be incorporated into their treatment. Shaler (2016) stated, "It is important to all clinicians to assess the client's spirituality as a part of holistic assessment" (p. 53).

Therefore, integrating faith-based collaboratives more effectively in communities and providing a more holistic assessment during the initial assessment phase when engaging veterans in services is another aspect that needs further research. Research also has shown that individuals with a faith-based background tend to lean on their faith in a time of need (Shaler 2016). The hope is that integrating different innovative treatment approaches and faith when providing services to individuals with CODs will provide better service delivery to the community.

Conceptual Framework

The social-ecological model of health helps illustrate the engagement to address veterans experiencing homelessness (Appendix 1) . According to the CDC (2011), "The social-ecological model understands health to be affected by the interaction between the individual, the group/community, and the physical, social, and political environments" (p. 20). Using this

model, politicians, community members, clinics, and stakeholders can learn that all aspects of homelessness are interrelated. The collaboration between HUD and the VA, known as the HUD-VASH program, exemplifies a partnership between two large entities to fulfill a greater need. Community coalition action theory is defined by Butterfoss and Kegler (2009), as "bringing social capital" which outreaches and brings community resources from other organizations. An example of how this worked in this project is how the VA Loma Linda Healthcare system holds "stand-downs" to promote, provide, and refer services to homeless veterans throughout the year.

Theoretical Analysis

Sociological Imagination

In the book *Sociological Imagination Theory*, sociologist C. Wright Mills (2000) said this theory is a tool to help distinguish between "the personal troubles of milieu and the public issues of social structure" (p. 8). Mills described "troubles" relating to the personal character of the individual and "issues" relating to the social institutions that are out of the control of the individual (p. 8). Sociological Imagination depicts how individuals cognitively try to make sense of the world by thinking in micro (individual) and macro (large group) paradigms. Therefore, from this perspective, veteran homelessness indicates a breakdown in systems (economic, educational, political, and family).

To apply Sociological Imagination to veteran homelessness, Mills (2000) described the "human variety, which consists of all the social worlds in which men have lived, are living, and might live" (p. 132). Cronley (2010) suggested that "people become homeless in the United States not because of a dysfunctional system but because of a dysfunctional self" (p. 325). Also, the assumption is that political agendas and policies are based on those granted the power and privilege to be in those in power. Historically, there has been inequity in thought and behavior as

to why people are homeless. Mills (2000) explained that some people are more susceptible than others to being discriminated against than those privileged to be in political positions of power to form legislation (p. 181). Another scholar, Mooney (2018) addressed veteran homelessness using this theory by framing the issue to foster critical thinking in educational arenas and using it as a conceptual tool to make sense of our reality (p.5).

Therefore, Mills (2000) reinforced that as liberal educators, we should strive to use the discourse and historical context necessary to explain how personal troubles relate to public issues and how these public issues affect various individuals (p. 187). Through this analysis, there does not appear to be many strengths associated with this theory regarding addressing the problem of veteran homelessness. However, understanding that critical analysis and thinking should be taught and implemented in research would assist in the solution of addressing novel idea to end homelessness.

A limitation of this model is that it assumes that all people are created equal and does not take into the individual circumstances that would affect someone's unsheltered status. Sociological Imagination Theory does not consider that individuals have specific trauma histories that affect their unsheltered status. Cronley (2010) stipulated that most people in the United States tend to blame the individual, viewing homelessness as their responsibility (p. 324). Throughout the years, many programs and funding have been allocated for homeless veterans. However, these programs' success has been limited because of the need for more implementation of effective services and oversight (Cronley, 2010, p. 327).

Critical and Conflict Theory

Critical and conflict theory is one theoretical method that can explain the social problem of veteran homelessness from a systems perspective. Karl Marx provided his view of classism

and discussed the contention between those in power and those they tried to keep from having power (Barkan, 2011). Salas et al. (2010) discussed the philosophy of critical theory more about social structures and the locus of power; when we acknowledge power structures and how to change the system, we are then able to develop a strategy to formulate solutions to solving homelessness. As it applies to veteran homelessness, this theory looks at the issue from a lens of how systems were historically put in place to keep the status quo. Rountree et al. (2010) outlined in an editorial how "Critical Theory is an important operating framework that encourages social workers to critically analyze and reflect systematically and contextually about oppression" (p. 293). Applying this description to the social problem of homelessness, it is vital to examine how specific groups are targeted critically and diligently for oppression and how history has played a considerable role in its foundation.

Critical theory has been used in research to help explain the social issue of homelessness. Although it has strengths, it is equally essential to consider its limitations. Salas et al. (2010) pointed out the strength of this theory because it can use social systems and individual experiences to find explanations for inequality. Additionally, veterans experiencing homelessness are stigmatized based on their current circumstances and limitations to this theory apply to the social problem of interest is focusing on something other than the individual. One way to bridge this gap is to apply the following theory of empowering individuals to make specific changes in their life and encouraging them to seek assistance when necessary.

Empowerment Theory

Empowerment theory is the third theory to be critically summarized, analyzed, and applied to social problems and this theory most directly aligns with so how to conceptualize the social problem. Paulo Freire (1973) founded the empowerment approach, which he applied to his

work in education. A definition of empowerment is "the act of empowering someone or something, the state of being empowered to do something" ("Definition of Empowerment," 2023). Perkins and Zimmerman (1995) described how "empowerment theory, research, and intervention link individual well-being with the larger social and political environment" (p. 3). Empowerment theory focuses more on the micro level of strengthening individuals' consciousness to believe they can change their circumstances. The theory applies to homeless veterans due there being more inclusivity in making the client to be the focus of their treatment.

O'Shaughnessy and Greenwood (2020) indicated that empowerment theory should be at the forefront of homeless interventions. They discussed three components of psychological empowerment as being interactional, intrapersonal, and behavioral (O'Shaughnessy & Greenwood, 2020). The interactional component is essential when working with homeless veterans because it "may refer to an individual's perception about whether they can achieve the recovery and housing goals" (O'Shaughnessy & Greenwood, 2020, p. 146). A strength of this theory is that it takes a person-centered and strengths-based approach. Essentially, this theory states that the individual is powerful because a person is powerless in a state of homelessness. Wallerstein (1993) articulated that this theory posits people acquiring the skills and cognition to conceptualize having power over their lives (p. 219).

A limitation of this theory is that although it is essential to recognize the social structures causing oppression, an individual's self-determination may not change the more significant inequities that have led to their homeless status (Turner & Maschi, 2015). Due to the limitation there appears to be more of a need for more capacity building and education to empower people to start a social movement. Furthermore, more research on evidence-based trauma treatment practices that help empower homeless veterans.

Section 5: Engagement

Summary of Community Engagement

When engaging the homeless community in the Inland Empire (San Bernardino and Riverside counties) it is vital to get familiar with the community stakeholders. Knowing the community means being mindful of the "community's culture, economic conditions, social networks, political and power structures, norms and values, demographic trends, history and efforts by outside groups to engage in various programs" (CDC, 2011, p. 47). To engage with the community, one crucial stakeholder is faith-based organizations. Churches have been integral to community engagement, providing food, shelter, and additional services to those in need. Henceforth, enlisting them as a stakeholder in how to educate the community would be very beneficial due to their high access to people and their outreach efforts.

Another critical stakeholder that should be considered is working with hospitals and clinics in the area. Because they can reach a large target population, including them in this effort would be prudent. Tsai et al. (2017) explained that due to the high utilization of emergency departments, it is critical to work with community partners that also see an influx of homeless people to determine alternative ways to engage with individuals so they can seek medical treatment before their medical condition becomes acute. Including scholars, researchers, and those in clinical direct practice in the solutions needed to mitigate high emergency use of emergency services is beneficial, but it is imperative to remember those directly affected by this

issue. Therefore, including veterans experiencing homelessness, formerly homeless veterans, and their families from diverse backgrounds would make the process more inclusive.

Alternative vital stakeholders to consider in community engagement efforts are those already serving the marginalized populations in the area: local civic leaders and congressional representatives, the Housing Authority of the Counties of San Bernardino and Riverside, Community Development & Housing Department, San Bernardino County Vet Centers, San Bernardino County, Department of Veterans Affairs, county Department of Mental Health, and homeless shelters.

The CDC (2011) discussed nine elements of community engagement relative to what should happen before, during, and after intervention programs to promote success. In this project, the first point involved developing an agenda for addressing this issue so that all members involved have a clear understanding and to communicate the mission. Community engagement begins with knowing the community that is targeted. Also, social media is a viable way to survey members and stakeholders about the problem. In some cases, it would make sense to go to homeless encampment sites to get feedback about the culture, problems, barriers, solutions, and housing options they would like to see in their community. Creating coalitions is essential to share information and resources that may be limited by one partner (Butterfoss et al., 1993. In working with stakeholders in this project, having clinics work with law enforcement on outreach in specific areas may also be necessary since they may also have a high number of encounters with individuals who are homeless.

Building these networks is essential, but sustaining the efforts put in place is equally crucial through capacity building. According to the CDC (2011), “Building capacity to improve health involves the development of sustainable skills, resources, and organizational structures in

the affected community" (p. 52). One way to achieve capacity building is to provide ongoing training. Therefore, continuing meetings for all stakeholders to discuss the mission and goals will help them focus on the problem. Meeting in person or virtually would increase the likelihood of sharing resources and addressing issues quickly.

As discussed by the CDC (2011), with the increase in social networking sites, it would be feasible to reach more stakeholders and members with a vested interest to "establish and maintain communication channels, exchanging resources, and coordinating collaborative activities" (p. 154). Having social networks will also assist in building social connectedness. Attree et al. (2010), in their review, found that "social outcomes of community engagement may be significant for 'at-risk' population groups" (p. 6), which means for the marginalized population of homeless veterans, having more social events would be helpful.

Community-Based Participatory Research Methods

Interview 1

Before beginning the study, I conducted a qualitative interview with a community member who works with the marginalized group I focused on in this project. U.S.Vets is a large national nonprofit organization that serves the veteran population. It has 11 offices across the United States. Veterans initially started the organization to help other veterans. Its services include housing, mental health and wellness, workforce development, and individualized support. The community stakeholder I spoke with is Pedro Jauregui, and he is one of the lead outreach workers at the U.S.Vets Inland Empire location, which serves Riverside and San Bernardino counties with housing.

Jauregui's definition of homelessness goes deeper than having a roof overhead; it is a safe place to sleep at night and not worry that they will be physically attacked or have items

stolen. He disclosed his homelessness experience when he exited the military. He appeared to minimize his experience because he had a place to stay, which was sleeping in his car. He said he felt safe and warm even though he was in his car. Juaregui reported he knew there were services available through the V.A. when he first got out of the military, but he was not aware of the specific services available and how to access them.

As for his perspective on the contributing factors that lead our society to not pay attention to veteran homelessness he stated, "First, our community does not have love." He provided his biblical perspective on this issue as well, quoting Matthew 25:35, "For I was hungered, and ye gave me meat: I was thirsty, and ye gave me drink: I was a stranger, and ye took me in" (King James Bible, 1769/2017). In his opinion, society does not provide enough essential services. Juaregui mentioned that when veterans get out of the military, they are often unaware of available services. Second, he said the general population probably does not know how to help either. The Veterans Benefits Association provides a booklet about veteran benefits. However, it is useless to someone who may not have the education and ability to read and comprehend the information. Third, he said people end up on the streets after having hope taken from them, and they experience so much heartbreak that they often believe they belong on the street.

Jauregui mentioned that acknowledging someone's homelessness and speaking to someone on the street is important because they are people, too. He said working with this population and seeing changes take place provides "a sense of belonging and purpose, and hope is the key." When working with people experiencing homelessness, stakeholders should identify and make assets available to sustain their housing. Jauregui provided a case study of a veteran he worked with for more than a year, and that veteran is now an employee at U.S.Vets and in graduate school. He said he is grateful for those who provide food, but there is more to do

beyond food. Additional services needed include mental health, substance abuse, and basic living (showers, laundry)—some of the primary living skills we take for granted need to be relearned.

Interview 2

Additionally, another way to gain perspective from key stakeholders in the field was by interviewing Kathryn Monet, the chief executive officer of the National Coalition for Homeless Veterans (NCHV). Her role at the agency is to put forth the mission and vision outlined in addressing homelessness within the agency.

> NCHV is the only national organization solely focused on ending veteran homelessness. We work to achieve our mission by promoting collaboration, shaping policy, building service capacity, ensuring accountability, and managing a referral helpline for veterans experiencing and at risk of homelessness. (NCHV, n.d., Our Work section)

The NCHV, a nonprofit, provides a vast array of resources for national community partners that provide homeless services to veterans at the local, state, and federal levels.

After working in government agencies as a policy analyst, Monet worked with the National Alliance to End Homelessness, providing information to legislators regarding evidence-based interventions to address homelessness. Monet mentioned federal bill S.2172, which NCHV fully endorses, and said it could alleviate barriers to service access among people experiencing chronic homelessness and those at risk of homelessness. Monet discussed how this bill is vital due to homeless veterans' daily complexities, which include some that are aging and have disabilities that inhibit them from accessing care. This bill would expand public transportation, increase long-term safe housing, and provide medically necessary services for older veteran adults while waiting for permanent housing.

Additionally, other federal legislation, include the Homeless Veteran Reintegration Program (HVRP); COVID relief legislation in the Coronavirus Aid, Relief, and Economic Security Act (CARES); and the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020. These bills and programs are currently in effect, but there are requests to sustain and increase funding in these areas to further the goal of ending veteran homelessness. Of note, the COVID-19 pandemic affected service delivery by providers due to the housing and financial instabilities of the veteran population, which prompted the modification and addition of legislation to accommodate the pandemic crisis for homeless veterans.

Monet defined activism as "when you are willing to lose something to gain a greater reward." She further explained that she does not consider herself an activist as one would imagine an activist to be: "I think I'm more of an advocate for those that can't speak up for themselves." She added, "I've not a veteran, and I've never been homeless." However, Bent-Goodley (2016) stated, "It is not necessary to fully appreciate another's experience with oppression to empathize with those in such situations and remain committed to fighting injustice" (p. 101). Monet discussed how the NCHV is heavily involved with training and offering consultation to local communities at the state and federal agencies regarding innovative and evidence-based interventions.

Monet's challenges included providing medical services for an aging and rural population, COVID-19 pandemic, and other-than-honorable veterans. NCHV, alongside other organizations, supports enhancing services with veterans who live in rural areas. This could be accomplished by allowing HUD-VASH to provide additional enhanced aftercare case management services to the aging population due to their vulnerabilities while awaiting

permanent housing. Since the onset of COVID-19, housing veterans and providing services has been more of a challenge than before, so NCHV is supporting additional funding to help with rental assistance and emergency. Another social gap identified during the interview involves other-than-honorable veterans and how they cannot access specific medical services, including HUD-VASH, due to their status. Even though she does not see herself as an activist, Monet's description of herself and her work reflects Bent-Goodley's (2016) four elements of social activism.

First, Monet represents herself in the political realm as she engages in discussions necessary to frame the issue of veteran homelessness to those who do not understand the barriers and challenges. Second, "as a thought leader and change agent," she can work with community partners spearheading services for the veteran population. Third, she works with the community and legislators to bring innovative ways by advocating for new legislation to bridge the gap for people to access services. Fourth, with the COVID-19 pandemic, the veteran homelessness issue has caused her to stay vigilant and be aware of the growing need to solve this social problem.

Before obtaining assistance from the VA, veterans have to go through a long and sometimes tedious process. This process includes getting a medical screening, mental health screening, and compensation and pension examination. Monet discussed racial inequities during the initial engagement with the VA, which is a barrier for marginalized groups because of the screeners who have initial contact with veterans for services tend to make final determinations because they are Black and Latino minority groups are disproportionately represented and make up a large part of the enrollment group. Gollust et al. (2018) discussed key contributors related to how staff members perceive minority groups in the system and identified "cultural incompetence and unconscious bias" (p. 2).

Summary of Engagement Results to Inform Innovation

In summary, this engagement of two community stakeholders was enlightening. It provided information about policy, legislation, how current direct practices are in place, and how stakeholders view social problems. Therefore, the complexities of these issues create a continued need to find strategies to address the homeless problem. Three key takeaways from the interviews are that there needs to be more community awareness and training, and poverty in marginalized populations makes them more susceptible to being unsheltered. The innovation developed in this project involved three pieces: (a) providing additional training for those working with veterans experiencing homelessness; (b) educating community partners about mental health and substance use evidence-based practices; and (c) piloting a readiness tool for staff who work in a homeless program to use while asking cultural questions to engage veterans in treatment services.

Section 6: Assessment

Introduction

Understanding the existing literature is the first step to developing social innovations that address veteran homelessness. Before developing the innovation project, a scoping review was conducted to determine "What are the current interventions being used for veterans experiencing homelessness with co-occurring disorders?" The review revealed a lack of evidence-based programs specifically designed for veterans with co-occurring disorders. As a result, a tailored program was developed to address this gap. The program was designed to provide veterans with comprehensive support for their physical, mental, and spiritual well-being.

To address the research question, a scoping review was conducted. Arskey and O'Malley (2005) noted that scoping reviews aim to give a well-rounded overview of a vast amount of literature and provide information about gaps that must be addressed. The Joanna Briggs Institute's scoping review method was used as a guide (Peters et al., 2015). Additionally, when facing time constraints, "a rapid review (RR) is a form of knowledge synthesis that accelerates the process of conducting a traditional systematic review through streamlining or omitting a variety of methods to produce evidence in a timely and resource-efficient manner" (Hamel et al., 2020, p. 2).

A scoping review was performed to obtain all relevant research information on treatment services for veterans experiencing homelessness with a diagnosis of CODs. The goal was to investigate what programs or practices are currently used to intervene with this population. Therefore, to answer the question effectively, a scoping review was helpful to examine the research in this area to determine gaps and limitations and identify what type of research should be conducted in the future.

Inclusion Criteria

The research question addressed in this study was: What interventions exist for veterans experiencing homelessness and CODs? Tsai and Rosenheck (2015) completed a systematic review of risk factors of homeless veterans and found that mental health and substance use represented the most significant risk factors. O'Connell et al. (2008) reviewed studies that explored risk factors by following formerly homeless veterans receiving intensive case management intervention services to mitigate their use of drugs or alcohol. Due to the complexity of mental health and substance use, there is a continued need to find innovative strategies to address this social problem.

Definition of Key Terms

Veteran: This term refers to any U.S. military service member regardless of discharge status. This study focused on understanding effective interventions that help veterans. Additionally, the veteran population does not include active-duty military service members.

Co-occurring disorder: For this review, co-occurring disorder refers to mental health and substance use disorders. Severe mental illness diagnoses are documented in the International Classification of Diseases, 10th Revision, Clinical Modification (U.S. Centers for Medicare and Medicaid Services, n.d.). They can involve psychological, emotional, or mental health distress. A substance use disorder can involve drug or alcohol use, as documented in the International Classification of Diseases, 10th Revision, Clinical Modification (U.S. Centers for Medicare and Medicaid Services, n.d.).

Intervention: Interventions included: (a) psychoeducation about mental illness and substance use; (b) psychiatric treatment services to reduce mental health symptoms either through inpatient or outpatient locations; (c) substance abuse services in inpatient or outpatient

formats; (d) individual, group, or family therapy (if the veteran is present during the intervention); (e) services to reduce maladaptive behaviors; and (f) skill-building training programs related to sustaining housing (e.g., job, education, medical, financial).

Homelessness: HUD (2014) defined the following categories of homelessness: (a) trading sex for housing; (b) staying with friends no longer than 14 days; (c) being trafficked; and (d) left home because of physical, emotional, or financial abuse or threats of abuse and have no safe or alternative housing.

Integrated treatment: The key components of integrated treatment are that the participant is treated by the same professional provider or team, receiving both mental health and substance use treatment services collaboratively (Morse et al., 2006).

To be eligible for inclusion, studies had to describe interventions to address CODs among veterans experiencing homelessness. Studies needed to be empirical reviews examining the association between homelessness status and interventions used to treat CODs. Articles published in English, globally, in peer-reviewed journals, and in non-peer-reviewed outlets were eligible. Only articles published between 2002 and 2022 were included. Additionally, grey literature, such as relevant national and government documents, reports, and policy information, was included.

Exclusion Criteria

Any papers (including dissertations and theses) currently being written and reviewed were excluded. This study did not include studies with children or youth, and articles that primarily focused on training agencies or mental health providers were also excluded. Any reports that described an organization that provided services to veterans experiencing homelessness and CODs without discussing the intervention used were excluded. Also, articles

that did not include veterans as direct participants or reported on services only provided to family members of veterans were excluded. Any publication that discussed training for those who provided services to the target population was not used for this review. Finally, any articles that summarized policies to address issues among veterans experiencing homelessness and CODs were excluded.

Search Methodology

An extensive electronic database search was conducted using the following resources: Google Scholar, California Baptist University Anne Gabriel Library's OneSearch, APA PsycInfo, Sage Premier, Medline, Academic Search Premier, CINAHL, and Scopus. The Boolean operator "AND" was used in conjunction with the keywords listed in Table 1; for example: "homeless" AND "co-occurring disorder" AND "treatment" AND "veteran." Titles and abstracts were screened based on the selection criteria. Then, the full text was reviewed to determine inclusion in the study. Using guidance from Munn et al. (2018), the PRISMA approach was used to chart how studies were screened as a part of the review process (Figure 4). The literature search primarily focused on treatment services for veterans. However, if intervention strategies were applicable to the research question, studies that did not involve veterans were examined for relevance.

As illustrated in Figure 2, the database search yielded 2,891 results, and identification of studies via other methods yielded 10 results, for a total of 2,901 results. Once duplicates were removed, the number of titles screened was 1,135. Abstracts (n = 170) were further screened, and 143 articles were excluded based on the criteria outlined in the original protocol. This resulted in 27 studies being further assessed for eligibility by reading the full-text articles.

Some reasons for reports being excluded at this step were (a) more of an organizational focus, (b) no veteran participants, (c) a focus on professional training rather than a specific intervention, (d) no applicability to homelessness among veterans, (e), in-progress dissertations or theses, and (f) no specific intervention discussed. Following a hand search of organizations, websites, and citation lists, 11 sources were screened and were deemed eligible. Thus, 11 articles were included in this study.

Data Extraction

After articles that addressed the research question were identified, emergent themes were synthesized in an organized method. An empirical literature matrix was used to organize the information gathered from the articles included (Table 2). The information in the matrix includes the author, date, intervention characteristics, study type, findings, and limitations.

Study Characteristics

Table 2 illustrates the main points extracted from each publication for this study.

Study Type

Four studies used for this review were randomized clinical trials (Chinman et al., 2017; Skinner, 2005; Smelson et al., 2012, 2018). There were five outcome studies (Desai et al., 2008; Harpaz-Rotem et al., 2011; Kasprow & Rosenheck, 2007; McGuire et al., 2011; Rosenheck et al., 2007). Finally, Kaplan et al. (2019) completed a longitudinal study with veterans experiencing homelessness as the primary participants.

Intervention, Program, and Service Delivery

Of the 11 studies, three discussed the MISSION-VET program as an intervention (Chinman et al., 2017; Smelson et al., 2013, 2018). The MISSION-VET program (Smelson, Sawh, Kane, et al., 2011) is an evidence-based intervention that assists veterans experiencing

homelessness with substance use and mental illness. The MISSION-VET approach is very similar to other methods implemented in the field, but additional features of this intervention promote success. The intervention is designed for veterans, but its theoretical framework comes from the health belief model (Becker, 1974). This model was initially designed "in the 1950s by social psychologists to explain the failure of some individuals to use preventative health behaviors for early detection of diseases, patient response to symptoms, and medical compliance" (Henshaw & Freedman-Doan, 2009, p. 2).

MISSION-VET uses critical time intervention (Susser et al., 1997) and dual recovery treatment (Ziedonis & Trudeau, 1997) to fulfill its mission to end homelessness in the veteran community. The MISSION-VET program has five essential components: critical time intervention, dual recovery treatment, peer support, vocational support, and case management (Smelson, Sawh, Kane, et al., 2011). Susser et al. (1997) mentioned that "[critical time intervention] was originally designed to help homeless people with serious mental illnesses (SMI) successfully make the transition from institutional care to community living by providing services that decrease in intensity over the first nine months following discharge" (p. 257). The MISSION-VET treatment method utilizes critical time intervention with modifications to apply case management services to veterans exiting inpatient treatment while working in tandem with the HUD-VASH program. This way, each veteran receives individualized support based on their needs, considering that some may require more attention than others.

The second component involves dual recovery treatment (Ziedonis & Trudeau, 1997). MISSION-VET modifies this approach to include 13 psychoeducational sessions. "Dual recovery therapy is a psychoeducational approach that uses structured exercises developed around addiction treatment therapies (Relapse Prevention, Motivational Enhancement Therapy,

and 12-Step Facilitation) and mental health approaches (Cognitive Behavioral Therapy and Social Skills Training)" (Smelson. Sawh, Rodrigues, et al., 2011, p. 35).

The third component involves peer support specialists who may have lived experience with homelessness or substance use. This is helpful because it allows veterans to see themselves through the lens of someone who has experienced something similar to what they are going through. Weir et al. (2019) reported that a peer support worker role proved essential because it "helped to provide veteran patients with a more veteran-centered clinical process and treatment experience and create an environment of belonging, shared identity, and understanding" (p. 651).

The fourth component is vocational and educational support to aid veterans experiencing homelessness in maintaining housing. Through work programs and furthering their educational goals, veterans experience empowerment and confidence. Last, the fifth component is for case managers and peer support specialists to receive specialized training in trauma-informed care. The main goal is to recognize when a further trauma safety assessment is needed, implement safety procedures in acute cases, and provide appropriate referrals.

Two studies focused on female veterans as intervention participants (Desai et al., 2008; Harpaz-Rotem et al., 2011). These studies explored the Seeking Safety intervention delivered in a residential treatment setting with female veterans (Desai et al., 2008; Harpaz-Rotem et al., 2011). This intervention consists of 25 therapeutic sessions in which participants receive psychoeducation regarding relapse prevention, safe behaviors, and social support.

Harpaz-Rotem et al. (2011) found that residential treatment services for female veterans experiencing homelessness with psychiatric and substance use had positive outcomes. Intensive Seeking Safety services were offered during the program stay, but additional case management

and psychoeducation were available. Both clinical and nonclinical case managers provided the intervention services.

Two studies discussed residential treatment services (Harpaz-Rotem et al., 2011; McGuire et al., 2011). McGuire et al. (2011) focused on veterans receiving three programs in time-limited residential treatment in a VA setting. These programs were Healthcare for Homeless Veterans, Grant and Per Diem, and Domiciliary Care for Homeless Veterans. Harpaz-Rotem et al. (2011) evaluated residential treatment for participants in a community setting, considering the provision of clinical and social services.

Another study examined and individual placement and support model for 2 years (Rosenheck & Mares, 2007). While in a community housing setting, veterans were assigned an employment specialist. This model supports clinical case management and vocational services to sustain job placement. A sample of 629 veterans was selected for the study. Once the model was implemented, 321 participants remained in the program. This study showed that veterans had better overall outcomes when an employment specialist worked with them and facilitated engagement in mental health services when needed.

Kaplan et al. (2019) and Kasprow and Rosenheck (2007) discussed case management as a helpful intervention for veterans experiencing homelessness with CODs. Kasprow and Rosenheck (2007) mentioned using critical time intervention as a practical intervention for veterans leaving institutional settings and entering the community. Kaplan et al. (2019) explored how assigning case managers to dually diagnosed veterans in community settings also benefited the veterans' overall well-being and housing success.

Skinner (2005) completed a quasi-experimental study in which a modified therapeutic community model was applied to individuals experiencing homelessness with CODs in a shelter

setting. The model involves key characteristics to help this population: Staff members provide direct psychoeducation, groups are less intense in terms of duration, and seminars are administered in smaller sessions to increase veterans' engagement. The intervention also emphasizes a more individualized treatment approach.

Findings

For the Seeking Safety intervention, even though the primary participants were female veterans, the results of the study indicated better outcomes in numerous domains (employment, education, social support, housing, and psychiatric distress; Desai et al., 2008; Harpaz-Rotem et al., 2011). Improvement in these psychosocial domains helped sustain their housing status. Additionally, it should be noted that follow-up assessments with participants at 6- and 12-month intervals showed the intervention remained helpful. Harpaz-Rotem et al. (2011) found in their 1-year clinical study noticeably lower scores of psychiatric distress, higher scores indicating better mental health functioning, and lower substance use.

When participants engaged in services and received a case manager, evidence suggested that dually diagnosed veterans had better mental health functioning status and better overall quality of life (Kaplan et al., 2019). As Kasprow and Rosenheck (2007) indicated in their study, critical time intervention during the transition from an institution to the community is equally crucial in engaging veterans. The study found that veterans were housed 19% more in the prior 90 days at 1-year follow-up and spent 14% less time in institutional settings compared to those who did not have case management during critical time intervention, in addition to showing lower psychiatric and alcohol use scores based on the Addiction Severity index (McLellan et al., 1980). As Kaplan et al. (2019) indicated, assigning a case manager resulted in less need for mental health and substance use services.

Rosenheck and Mares (2007) found that the individual placement and support model led to a better long-term work history, and participants whom they followed up with were housed longer on average. They also found lower psychiatric symptoms and a less hostile attitude toward going to work. Regarding the outcomes of the three federally funded residential services, no general trends supported one over the others (McGuire et al., 2011). In fact, on average, across all three services, veterans were found to stay engaged in the program for 7 months. One program had a slightly higher length of stay (Grants & Per Diem), which may be because at admission, veterans were more likely to have no psychiatric diagnosis and less likely to have a severe mental illness (McGuire et al., 2011).

Two studies in this review took place in shelter settings (Kaplan et al., 2019; Skinner, 2005). Kaplan et al. (2019) focused on direct case management services provided to veterans in homeless shelters while emphasizing older adults (aged 50 or older). However, in the study by Skinner (2005), there was no age distinction in the sample, and veterans spent an average of 111 days to 121 days in the shelter. Both studies showed a higher quality of life and medication compliance (Kaplan et al., 2019; Skinner, 2005). Skinner (2005) also controlled for and measured housing outcomes, finding that participants in the modified therapeutic community model showed improvements in positive housing discharge rate.

Limitations

One limitation of this review of outcome studies conducted in sizeable integrated health care settings is that randomization was not evident, which led the results to be less generalizable to smaller health care settings that are not as collaborative or do not have the resources to deploy an intensive model (Harpaz-Rotem et al., 2011; Kasprow & Rosenheck,

2007; McGuire et al., 2011; Smelson et al., 2013). The Patient-Centered Outcomes Research Institute defined outcome studies as those helping "patients, clinicians, purchasers and policymakers in making informed health decisions by advancing quality and relevance of evidence" (Frank et al., 2014, p. 1513).

In the MISSION-VET model, one crucial component was having peer support available on the treatment team, and because it is an integrated treatment approach, there needs to be a specific number of staff members for the model to be effective (Smelson, Sawh, Kane, et al., 2011). Chinman et al. (2017) revealed in their study that peer support specialists experienced high turnover and staff members were sometimes unavailable for teams. Additionally, peer support staff members had to be contracted to maintain the model's integrity, but this was challenging due to difficulty coordinating and recording notes. Therefore, the validity of data received may have been underreported, and therefore, less valid.

Another limitation involves low follow-up rates by participants at different stages of the studies, which likely affected internal validity (Desai et al., 2008; Kasprow & Rosenheck, 2007; Rosenheck & Mares, 2007; Skinner, 2005). Specifically, Rosenheck and Mares (2007) reported that 71% of follow-ups occurred. Kaplan et al. (2019) did not perform a full psychiatric diagnostic interview with participants; therefore, the level of mental health symptomology could not be determined prior to the intervention being administered. Another limitation is potential implicit bias due to employment specialists or case managers providing follow-up questionnaires as opposed to having a neutral party administer the questionnaire to decrease any need for veterans to be influenced to answer questions in a more positive manner (Kasprow & Rosenheck, 2007; Rosenheck & Mares, 2007). Self-reported substance used psychiatric symptoms were also a limiting characteristic of the studies, because of the inability to generalize the outcomes to a

more community settings (Harpaz-Rotem et al., 2011; Kasprow & Rosenheck, 2007; Smelson et al., 2013). Another crucial finding was that due to the transient nature of the participants and the challenges caused by CODs, the ability to administer the intervention was difficult.

Interventions for veterans experiencing homelessness and CODs were identified in different agencies and environments. An integrated treatment approach was the highest level of service used when working collaboratively and in a coordinated manner with this population. Some gaps in the literature were also identified, particularly concerning the need for a trauma-focused program with staff members adequately trained to assess, treat, and make referrals if necessary. Additionally, results indicate the need for community programs that incorporate and build social connectedness.

The findings suggest that interventions are already being used, with results showing their efficacy in specific settings for veterans experiencing homelessness with CODs. Due to challenges in all treatment approaches discussed in this review, trained substance use and mental health staff members are essential.

Implications

Further research is needed to promote inclusive, generalizable, trauma-informed interventions for veterans diagnosed with CODs placed in the community. Also, considering the number of shelter settings where veterans access housing, there needs to be more research about using interventions at this critical point of contact to increase engagement in services. Specific to this review, the MISSION-VET program involved trauma assessment, but there is limited information about how a more integrated trauma-informed intervention could be utilized (Chinman et al., 2017; Smelson et al., 2013, 2018).

Therefore, considering the alarming rate of veterans exiting programs, this may lead to the importance of the association between long-term housing solutions and social connectedness. Gabrielian et al. (2018) mentioned how informal relationships (family and friends) and formal relationships (case managers and other staff members) have a significant influence on how individuals transition from homelessness and maintain stable housing.

International Practice

Additionally, to understand the prevalence, contributors, and consequences of the social problem, it is essential to understand both national and global policies and programs. The purpose of this section is to highlight the social policies and programs that have been implemented around the world that inform the problem of homelessness and mental illness among veterans.

UN-HABITAT is a United Nations agency tasked explicitly with finding solutions for displaced individuals and creating housing (UN-Habitat - a Better Urban Future | UN-Habitat, n.d.). The mission of this charter within the United Nations is to "promote transformative change in cities and human settlements through knowledge, policy advice, technical assistance and collaborative action (*UN-Habitat - a Better Urban Future | UN-Habitat*, n.d.). Another critical point is that the approach is more of an integrated approach to tackling housing insecurity and human settlements.

Mackie (2015) critically examines Welsh Homelessness Prevention Duty models in Wales. The article aimed to investigate services within the legal framework, The Housing Act (2014) (p. 41). The homeless prevention policy was enacted to task local governments to prevent homelessness and not turn anyone who needed housing services away. Mackie et al. (2017)

discussed how the act also burdens the government heavily because people can challenge the legal system for failing to take necessary steps to provide adequate and appropriate services. Four different areas must be in place by local agencies to prevent homelessness, including accommodation-based, specific population groups, advice, support, joint working, and financial assistance.

St. Arnault and Merali (2019) analyzed how refugees in urban Alberta, Canada, are supported and what interventions are most helpful. The study aimed to examine homelessness among adult refugees using a mixed method. A key observation indicated that refugees leaned more on their faith as a "mental shelter" and used prayer as a coping mechanism (St. Arnault & Merali, 2019, p. 240). The practice approach used and highlighted was using advocates, specifically counseling psychologists. There were also findings that social connections with service providers were essential for making the new home process in Canada manageable. It was recommended for further practice to have counseling psychologists on staff expand their services as advocates since it is identified as being crucial. Advocacy can be done in three ways, writing letters of support, connecting them to their cultural community, and helping them navigate the housing system.

Parsell et al. (2013) completed a study to examine policies and programs implemented in Australia to help homelessness. The specific program discussed was Street to Home, a partnership between the state and local agencies. This model was based on other programs that have shown effectiveness in other countries (i.e., UK and USA) (Parsell et al., 2013, p. 191). In Parsell et al. (2013), the model being used in Australia has three components: 1. Street outreach, 2. Permanent housing, and 3. Ongoing housing support. (p. 191). The emphasis of this model is to have ongoing services readily available to individuals' experiencing homelessness.

Geertsema and Fitzpatrick (2008) discussed homeless prevention services in England and Germany. While looking into the services offered, the article explains how preventative measures to decrease homelessness have been widely accepted. Preventing homelessness was more cost-effective than placing individuals in temporary housing. Therefore, some of the most common strategies used include the following: enhanced housing advice, rent deposit assistance, family mediation, domestic violence victim support, and tenancy sustainment (Geertsema & Fitzpatrick, 2008, p. 83). Another critical component Germany and England use is placing more of a legal duty on local governments, which puts more of the spotlight on government entities to be more responsible and active in ensuring preventative measures due to the political backlash.

Anderson (2007) discussed the policy initiative to address "rough sleeping" in Scotland in the article. The rough sleeping initiative (RSI) was founded in 1990 in Scotland after it had already been implemented in England. The provision and services offered through RSI were hostels, outreach, resettlement, and move-in assistance. The initiative helps reduce homelessness. Still, it was also indicated that partnering with other agencies is essential to continue helping in this area.

Cross and Singer (2010) discuss interventions used in South Africa to address homeliness. Some contributing factors mentioned were income, poverty, financial instability, and unemployment. A critical piece is bridging the wage disparity gap and ensuring those who need programs know them in the communities. To appropriately fund efforts to eliminate homelessness, being mindful that homeless people have human rights entitlements is necessary (p.15).

Conclusions

CODs and homelessness are highly prevalent among U.S. veterans (Ding et al., 2018). The Housing First approach has shown to be very effective in addressing these challenges (HUD, 2014). More integrated treatment programs should be explored to help this marginalized population. To that end, gaps in the literature should be addressed so participants can sustain housing and get the necessary mental health and substance abuse support.

While examining those experiencing homelessness from a global perspective, some issues developing countries face include service availability, funding, and instituting policies. Some strengths that continue to be identified are that partnering with service agencies will be crucial to support the homeless population adequately. In conclusion, advocates will continue to be instrumental in bridging the awareness gap for governments to enforce policy changes since homelessness is a human rights concern.

Section 7: Innovation

In this project, COMPASS was developed as a social innovation. In addition to the innovation tool created, a guide is included that explains how to use it. In the innovation tool, you will find questions that encourage personal reflection and ideas for action. It helps individuals understand their role in the world and how they can contribute positively to the world by identifying an individual's motivational quality of life. This project is driven by the belief that everyone has the potential to make a difference if they are given the right tools and resources. COMPASS is an accessible resource that can be used by anyone with a desire to learn more about themselves and how to make a difference.

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Veterans experiencing homelessness with CODs face many challenges in obtaining and sustaining stable housing. Additionally, as indicated in past research, antecedent and prevalent risk factors for veteran homelessness have been related to mental health and substance use. While looking at the need to provide safe and affordable housing and mental health services, there is also a need to consider the perceived life satisfaction of homeless veterans as this has not been thoroughly examined in the literature.

In multiple studies, Desai et al. (2008), Smelson et al. (2012), and Smelson et al. (2013) utilized specific diagnostic measures to gather information about illicit drug use and alcohol use (McLellan et al., 1980). It is the reliability and validity of these tools that make them useful. Desai et al. (2018) also addressed a measure of self-esteem when looking at outcomes for female homeless veterans who participated in the Seeking Safety program. As mentioned in Tsai and Kelton (2022), socioeconomic information was obtained, as well as measures to determine clinical status. A suicide attempt assessment was conducted in addition to the PTSD assessment through the use of a PTSD checklist.

However, there is a gap in the literature about tools being utilized to assess multiple life domains for veterans experiencing homelessness with co-occurring disorders. As mentioned previously, measures are used to assess substance use and mental health concerns. Still, an added intervention that should be addressed is how the person's view on life impacts their willingness to engage in services—by using multiple domains, the whole person is addressed in treatment. This approach helps identify and target multiple areas of a person's life that may contribute to the overall problem. It also helps to create an environment of support and understanding that can lead to lasting change.

The World Health Organization has developed an assessment that identifies four domains (physical health, psychological, social relationships, and environment) with 26 questions looking at quality of life, called the World Health Organization Quality of Life (WHOQOL) (WHOQOL Group, 1998). The WHO Group defined quality of life as, “individual's perceptions of their position in the life context of the culture and value systems in which they live” (Group, 1998, p.1) The World Health Organization Quality of Life – Brief version (WHOQOL BREF) was developed to be administered in a shorter amount of time and has been used for the homeless

population. The domains addressed in the COMPASS tool (Appendix 2)) were guided by the WHOQOL BREF.

Working with a direct supervisor and a program manager in which I currently work at the VA Loma Linda Healthcare System. I got some feedback from community stakeholders to gather feedback on the innovation tool. As part of my efforts to gather qualitative feedback from the community, I spoke with other professionals at US Vets and at the Loma Linda VA who assist veterans experiencing homelessness in the community. Their interviews were conducted as part of their current work in gathering information about innovation regarding barriers and strengths identified in their daily practices.

Goals for Innovation

The primary goal of the innovation is to provide awareness of the evidence-based safe coping skills treatment modality—Seeking Safety—to direct practice professionals who work with the veteran population. The two measurable goals are: (a) to increase knowledge of Seeking Safety for staff who work with veterans experiencing homelessness and CODs; and (b) to increase the utilization of comprehensive screening tools with veterans experiencing homelessness and CODs.

Implementation of Social Innovation

As a senior social worker in the homeless program at the Loma Linda VA Healthcare System, the proposed plan implementation took place through a virtual platform, training six to 10 professionals who work in the homeless program. During the initial stage with clients, I provided COMPASS for social workers to identify risk, strength, barriers to learning, diversity, cultural considerations, and willingness to participate in group therapy services. I provided to the participants an example of an evidence-based practice called Seeking Safety to help sustain

housing for those with substance use and PTSD or other mental health disorders. Although a curriculum was used that is shown to be reliable and effective in the mental health field, the plan is to provide an addendum to enhance the current guide, which may include vignettes, role plays, or multimedia tools.

The participants included social workers, nurses, peer supporters, and vocational development specialists. The training consisted of a presentation on the Seeking Safety model and why it should be used more often for homeless veterans experiencing CODs. Additionally, the participants in the training were involved in going through one of the modules in the manual while providing the innovative piece of vignettes and an open discussion of how completing a comprehensive readiness tool in collaboration with veterans will help them develop goals for their treatment.

COMPASS Guide

Introduction

COMPASS was designed to provide a guide to targeted, yet brief, questions, when working with individuals with mental health and substance use. The questions enhance assessments already being done by promoting the clinician working with the individual to gather more information about their cultural, socio-economic, and strengths. The goal is with this information, the clinician will be able to provide support and resources to the individual within the scope of what they determine to be important to them.

How to use the COMPASS Tool

A guide is included to provide further instructions on how the tool should be used (Appendix 2). The clinician and individual can begin using the tool at the onset of engagement. The tool itself is a guide and while the questions are written with goals in mind, please consider

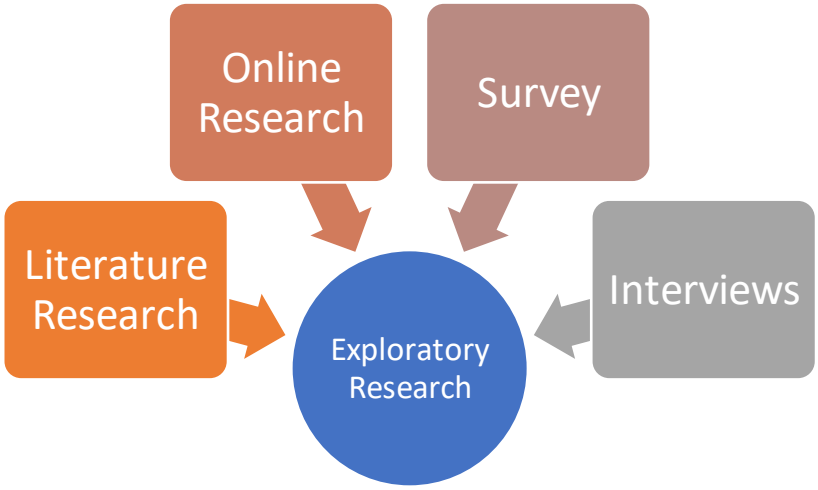
who the person you are working with to tailor it according to their needs. If there is sufficient ability on the part of the interviewee, the interviewer can administer the COMPASS (Appendix 2.1) on their behalf; otherwise, the interviewer must assist the interviewee. In the tool, nine questions can be asked in any order; each is a stand-alone question. The tool is designed not to be cumbersome and therefore should only take a short period of time to complete (approximately 20-30 minutes). The tool can also be used alongside other assessments that are being completed.

The tool will assist clinicians and non-clinicians can use this tool to assess a patient's whole health and to develop a well-rounded treatment plan (Appendix 3). In following up with the interviewee, the interviewer can discuss what goals will be most beneficial as they work on some of the areas/domains vital to them. The interviewee can further engage with the interviewee by discussing resources available in the community or other barriers to their success.

Section 8: Evaluation

The two measurable goals are: (a) to increase knowledge of Seeking Safety for staff who work with veterans experiencing homelessness and CODs; and (b) to increase the utilization of comprehensive screening tools with veterans experiencing homelessness and CODs. Quantitative data will be collected after the Seeking Safety training, and COMPASS tool are fully implemented to evaluate the innovation's effectiveness. Pilot tests were conducted for this project to assess the utility and feasibility of this innovation. This chapter will also provide a summary of preliminary feedback provided by service providers during the initial testing. The surveys provided were to gather information from different respondents as to their experience in the field and their use of a readiness tool.

Figure 1. Exploratory Research Model



Objectives

This social innovation was a continuous quality improvement project delivered to a small group of individuals to achieve the following objectives:

1. To increase knowledge of Seeking Safety with veterans experiencing homelessness and CODs.
2. To increase the utilization of comprehensive screening tools to assist veterans experiencing homelessness and CODs.

Methods of Recruitment for Pilot

I piloted the project at my current organization, the VA, in its homelessness program. In this program, project-based housing programs in the community work with nonprofit agencies, developers, and other stakeholders who provide permanent low-income housing. Nine individuals with different job titles participated in the training. The individuals were senior social workers (licensed clinical social workers), nurse case managers, social workers (unlicensed master's graduates), a chaplain, and vocational development specialist. Once it was determined who would be participating, an information flyer (Appendix 5) was sent to all participants on the type of training, location, date, and time.

The innovation involved training staff members who work directly with veterans experiencing homelessness in the HUD-VASH program. Najavits (2002) created Seeking Safety to work with individuals diagnosed with trauma and substance use primarily. To make the innovation relevant to homelessness among veterans, it was designed and administered in a way that met the needs of the population.

Methods of Measurement

At the beginning of the training, the participants were asked polling questions which asked about their tenure in the social work profession, use of comprehensive readiness tools in practice, and current knowledge of evidence-based practices.

Summary of Results

Research Question 1 Report satisfaction (Q1) with information and examine if satisfaction is related to "how interactive" (Q4) and to the knowledge of Treatment Modalities (Q9). Participants completed the pretest survey at the beginning of the training. In the presurvey, participants were asked how many years they had been in the social work field. The results indicated most participants had spent 11 years or more experience.

When asked about training expectations, eight individuals said they expected to learn new skills from this training to use on the job—eight participants had completed a Seeking Safety training before (Table 2). Additionally, six individuals had used a readiness tool before in their job (Table 2).

Research Question

Which types of knowledge of treatment modalities are most important to the respondents?

All five modalities of knowledge had a median score of 5. So, there was no difference between them. However, the mean score of knowledge of respect was 5, meaning everyone gave it the highest score.

The Freidman test was used to determine if there are any differences in the importance of five modalities (because the importance is measured using an ordinal scale since each measure is a single question). The Freidman test shows that there is no difference between any five measures of knowledge. Therefore, the Wilcoxon test was performed to determine which of the four modalities have statistically significant differences. This is similar to a post hoc test in an analysis of variance, but it was not applicable because Freidman's test was insignificant. Some key takeaways from the training are listed in Figure 4.

To gather more information about the COMPASS Tool feedback, some themes resulted from the open questions asked during the training: “I like the cultural wheel” and “It will be useful for our vets.” Most staff participants said they would use the readiness tool, as indicated in Figure 3.

Conclusion

The impact of the project on the social problem is that educating providers who work with the social problem is imperative to continue to learn what helps assess clients. To further evaluate the seeking safety and COMPASS tool, a formal survey will be conducted. Participants will be asked to comment on the tools' effectiveness. The survey will also include questions about participants' experience with the program. The survey results will be used to improve the program and evaluate its effectiveness. Additionally, implementing the training with other program and community providers will also help determine fidelity. The survey results will inform future training and COMPASS tool development. It is therefore essential to analyze the data to identify any trends or areas for improvement. This will help ensure that the program continues to meet participants' needs.

Continually building and expanding their skillset requires providers to monitor their clients' progress. In addition, providing adequate resources to those in need can help reduce the social problem. This will also help create a more comprehensive understanding of the social problem and its root causes and develop solutions tailored to the individual. Ultimately, this can lead to more sustainable, long-term solutions.

Section 9: Dissemination

Future Practice, Research, and Policy Development

Future research in this area is warranted to explore alternative ways to provide comprehensive integrative services to individuals. This paper provided a host of information about models that have proven to be effective, but there needs to be a gap in the sustainability of housing services. To achieve sustainable development to end homelessness, we should work as a society, including the world economy, global society, and Earth's physical environment (Sachs, 2015, p. 3). Additionally, good governance by governments and multinational corporations promotes economic growth that is socially inclusive and environmentally sustainable (Sachs, 2015).

Next Steps

As a result of the information I received through this project, I intend to provide further training and continue to be a subject-matter expert in delivering quality improvement strategies to marginalized populations. Further, steps have been taken to establish Nova Harmony, Inc., a nonprofit agency founded on the principle that everyone deserves home-especially low-income and marginalized populations. Its mission is to revolutionize housing services to build a stronger, brighter community. Its vision is to provide everyone with housing and create a harmonious community for all. Businesses need stakeholders to help them grow, including lenders, local government leaders, community members, customers (clients), employees, and faith-based organizations.

Challenges

As with any organization, my nonprofit will likely face challenges related to high turnover and staff retention. In addition, another challenge is staying focused on the agency's

mission to achieve the goals set forth and serve the community and having effective leadership in place to sustain the vision of the agency. Congress et al. (2016) identified the role of board members as "ambassadors" who are tasked with describing the needs of the agency's population, identifying social justice concerns, and making recommendations for innovative approaches to improve conditions.

Any agency or business model has constraints with the product or services being produced, and one question is how to sustain the outcomes. Eliyahi Goldratt, a philosopher who wrote the book *The Goal* in 1984 (Goldratt and Cox, 1984), introduced the theory of constraints, "based on the idea that three every system has at least one bottleneck, which is defined as any kind of situation that impedes the system from reaching a high-performance level in terms of its purpose" (Şimşit et al., 2014).

Concerning Nova Harmony, some constraints I have identified that may impede performance are funding, staying innovative in the field using technology, and marketing strategies to ensure sustainability. Nova Harmony is a new business, and the first 5 years are crucial to how well it will maintain operations. Therefore, it will be vital to seek professional consultation and have experts in the field contribute voluntarily or as board members to ensure the company flourishes. It is equally important to be aware of the current technological climate to succeed using social platforms. This is why creating a business plan with all aspects of the new business is essential, including financial trajectories.

Staffing

There are challenges associated with recruitment and retention in the nonprofit sector. To get a more accurate picture of the current staffing needs, it is essential to assess the community's needs. In addition, it is vital to determine the agency's goals and the ideal number of staff **needed**

to keep the agency focused on its vision. The third step is to examine a particular agency and determine the gaps (Scott & Schipper, 2006). It is possible to achieve this by incorporating an evaluation into the onboarding and exiting processes and during employment to gather employee feedback. Congress et al. 2016 state that continuing education should be a priority for all staff members, not just those hired. As a result of ongoing training, staff members will be able to develop in areas of interest to them and will be more likely to stay with the organization.

Recruitment of Volunteers

As a nonprofit, having volunteers on staff will benefit the agency from a financial standpoint and regarding one of the goals described earlier: increasing exposure. A few diverse ways to increase recruitment include job boards (i.e., indeed.com, Facebook, LinkedIn, and Google Jobs). Enlisting volunteers already in the agency to "put the word out" by posting on their social media pages. Individuals are more likely to volunteer if they know someone already participating; they can speak about the work environment and mission of the agency. It would be essential to ask active and past donors and board members to volunteer their time even though they are not giving money. Finding students wishing to contribute to their communities while also improving their resumes may be possible by reaching out to local colleges and universities.

Funding Sources

Different funding sources will be considered to support the startup. The first step is to apply for grants from government agencies that are seeking innovative programs aimed at marginalized groups. Second, lenders or investors may be an option to help with the startup cost of the business. Third, donations, fundraisers, and funding should be present to support the mission for a nonprofit to run successfully for an extended period. One strong consideration is

consistently reaching out to current donors with a genuine appreciation for their continued support and sending updates about where funds are being allocated.

Dissemination on Local, National, and Global Levels

In the next year, I would also like to continue piloting the COMPASS tool developed during this project to garner further feedback and improve its effectiveness provided to professionals locally and globally through networking channels. I will explore attending conferences and networking on social platforms to market COMPASS and the training offered. To be a principal leader in this field, I will benefit from continuing to submit my research findings to journals. Some social work journal articles include mental health, Healthcare in Social Work, Substance Use, or General Social Work Practice.

Conclusion

In spite of the vast amount of information about homelessness, more research is needed, and funding and healthcare policies need to be changed. The innovation discussed throughout this paper was inspired by community engagement, which helped drive its conception and implementation. This project provided continuing education because of the training undertaken. COMPASS with its incorporated client-centered approach and cultural competence provided cutting-edge care in a more inclusive, client-centered manner. Although the proposed project is distinct, there continues to be more data that supports its use on a larger scale. In conclusion, more research is needed, it must be put into practice, stakeholders should be involved, and implementation needs to be done.

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Table 1. Electronic Search Terms

Keyword	Synonyms and Boolean phrases
Homeless	"homeless" OR "homelessness" OR "unstably housed" OR "insecure housing"
Co-occurring disorder	"mental health" OR "mental illness" OR "substance use" OR "alcohol use" OR "drug use" OR "co-occurring disorder" OR "dual diagnosis"
Treatment	"treatment" OR "intervention" OR "program" OR "integrated treatment"
Veteran	"veteran" OR "vet*" OR "military service member" OR "service member"

Table 2. Studies Reporting Intervention Used for Homeless Veterans with Co-Occurring Disorders

Author(s)	Year	Study Type	Intervention and Delivery	Findings	Limitations
Chinman et al.	2017	Hybrid III, cluster-randomized trial	Evidence-based practice - MISSION intervention.	Getting to Outcomes (GTO) support can help launch new practices but multiple facilitators are needed for the successful execution of a complex evidence-based program like MISSION-VET	1.Peer specialists were not available for all teams.2. peer support high turnover and some teams had to share staff 3. contract peer specialists increased difficulty to coordinate and recording notes 4. only able to interview one peer support 5. data was limited. 6. not all veterans eligible.
Desai et al.	2008	Outcome Study	Seeking Safety, 25 sessions that cover topics to help build safety in client's lives and is present-focused, offering psychoeducation and coping skills	Participants reported better outcomes over one year in employment, social support, general symptoms of psychiatric distress, and PTSD, particularly in avoidance and arousal clusters	Groups were nonequivalent and low follow up rates limit internal validity
Kaplan et al.	2019	Longitudinal Study	Case Manager (CM) directly assigned	Dually diagnosed veterans had poorer mental health functioning status and better overall quality life	No full psychiatric diagnostic interview was completed. 2. participants were not asked where they received mental health services

Kasprow et al.	2007	Outcome Study	Critical Time Intervention (CTI) Case Management (CM)	Veterans had 19% more days housed in each 90-day period over 1 year follow-up and 14% fewer days in institutional settings. Lower psychiatric, drug and alcohol use scores.	No randomly assigned. Low follow-up rates and participants did not complete all interviews. Substance use and psychiatric symptoms were self-reported and administered by CM. Veterans had regular contact with CM.
Mcguire et al.	2011	Outcome Study	Time Limited Residential Treatment through 3 forms of VA funded services- HCHV, G&PD, DCHV	No general trends favoring one over the other. On avg vets stayed in programs for 7 months. Those in G&PD programs stayed longer than the other 2 programs.	1. veterans were not randomly assigned to either types of programs or targeted length of stay. 2. there was no control group that did not have access to residential treatment at all.
Rosenheck et al.	2007	Outcome Study	Individual Placement and Support (IPS) Model - Supported Employment	Better long-term work history . 15% higher follow up. Average days housed was higher. Lower levels of psychiatric symptoms and a less negative attitude toward work.	The bias of employment specialist to encourage those they thought would be more successful may have happened. Only 71% of follow-ups done. Study used. A shorten version of the IPS Fidelity Rating Sale which may have skewed the results.
Harpaz-Rotem et. al	2011	1-year clinical outcome study	Residential Treatment (RT)setting	RT for at least 30 days was associated with significantly clinical outcomes in a variety of	No randomization Unclear if results are generalizable to less integrated systems Substance use was only

				domains (psychosocial, psychiatric, substance use,	assessed by self-report. Unable to follow-up with study makes it difficult to make conclusions beyond the study.
Darren C. Skinner	2005	Randomized Clinical Trial	Modified Therapeutic Community (MTC) Model	Higher in compliance at the shelter in length of stay. Medication noncompliance was lower, improvement in positive discharge rate to housing	Study unable to control veteran status given the shelter population. 2. little to no literature on the MTC in a shelter, more studies needed. 3. more studies on homeless veterans with COD in different shelter settings
Smelson et al.	2012	Randomized Clinical Trial	8 week Time Limited Care coordination (TLC)	TLC participants attended more inpatient sessions and more likely to engage in outpatient services. Declines in alcohol and drug use was noted. Some modest declines noted in depression and anxiety symptoms.	Inability to test differences between groups on substance use and mental health outcomes. 2. limited documentation of group treatment beyond inpatient and outpatient settings 3. contact time was not identical between groups
Smelson et al.	2013	Quasi-Experiential Design	A low-intensity wraparound intervention-MISSION	Higher follow up rate at 6- and 12-month assessment. Hospitalization was reduced	No random assignment noted. Sample abused a variety of substances and variety of mental health diagnoses which did not allow to focus on one condition.

					Baseline and follow up interviews were self-reported which may be an underrepresentation in institutional setting.
Smelson et al.	2018	Hybrid Type III	Evidence based practice - MISSION intervention	MISSION-VET increased treatment engagement compared to those who did not receive MISSION-VET	1. small sample and comparison group not perfectly matched, 2. treatment group delivered modest amount of intervention as compared to the full protocol, 3. the outcome measures were made up of medical record extraction as opposed to primary data collection of client improvement

Table 3. Total Experience of Social Work

Years	*n*
0-5	4
6-10	1
11 or more	4

Table 4. Qualitative Data

	Yes	No
Have you taken a Seeking Safety training before?	11.11%	88.99%
Have you used a readiness assessment tool before?	33.33%	67.67%

Table 5. Vignettes

Vignette 1	A 54-year-old female has been a long-time client at the VA Mental Health Clinic, where a Seeking Safety group was recently started. The Veteran was diagnosed with PTSD, MST, and Alcohol Abuse Disorder about five years prior. Since then, she has lived in a Grant & Per Diem program. She participates in group activities, reports feeling stressed about where she will live and is tired of feeling "on edge and watching my back all the time."
Vignette 2	A 29-year-old homeless male was admitted to an acute inpatient facility two days ago. The veteran was diagnosed two years ago with Methamphetamine Abuse. The Veteran reports that his treatment team, especially his psychiatrist, is not listening to his needs. A short-term Seeking Safety group was recently started, focusing on relapse and trauma. When asked, the Veteran reports that he does have a goal he can think of now. What is a short-term related S.M.A.R.T. goal the facilitator and Veteran might collaboratively develop?

Figure 2. PRISMA Flow Diagram

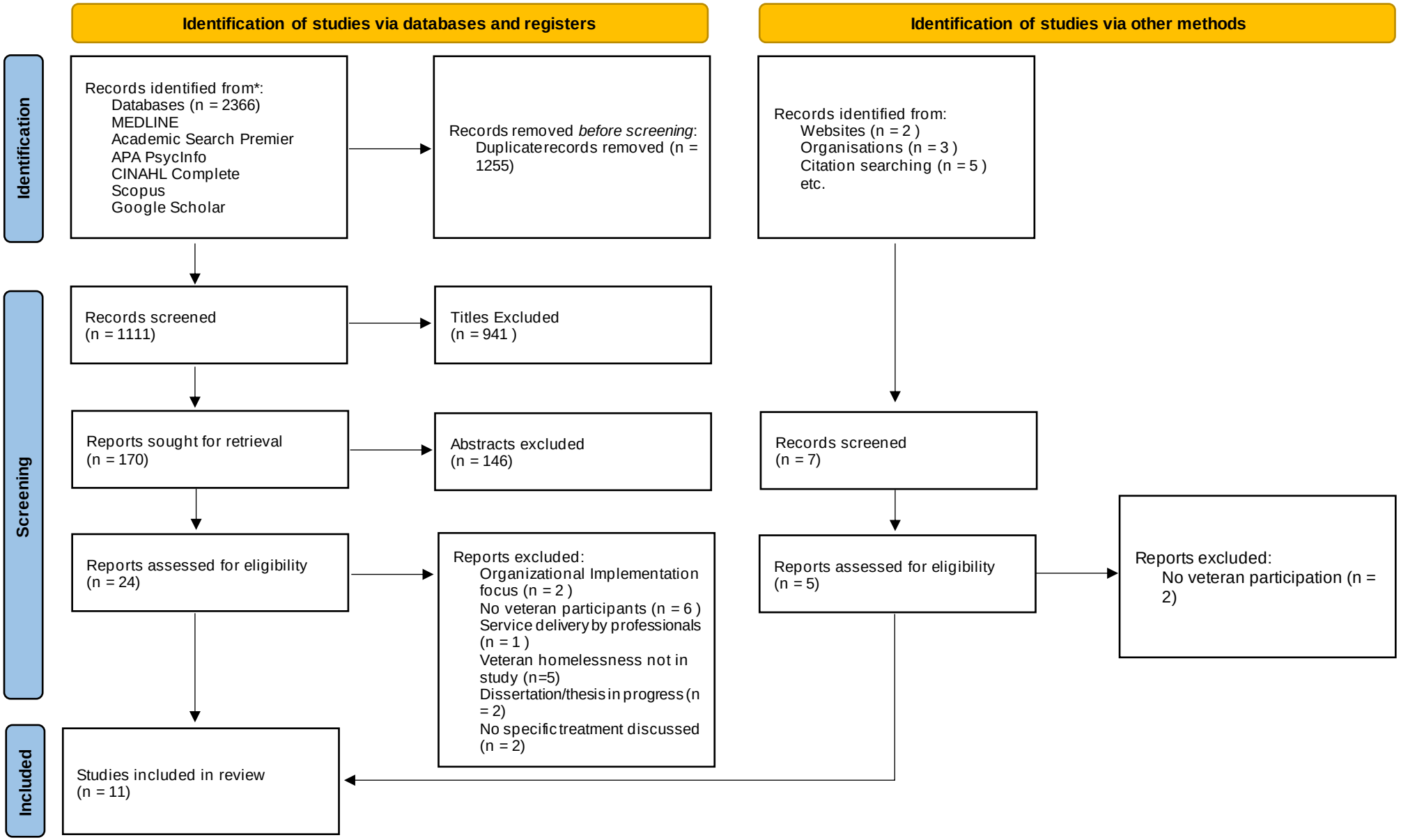


Figure 3. Staff Reponses

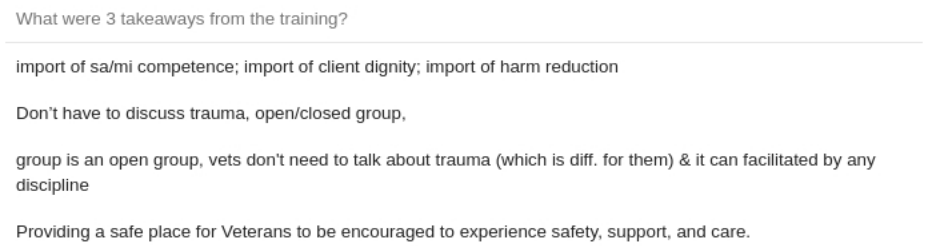
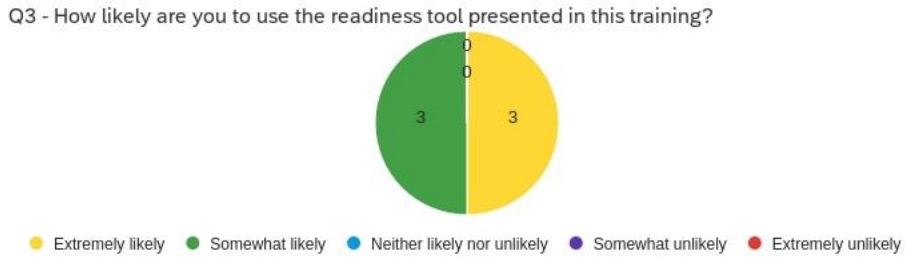
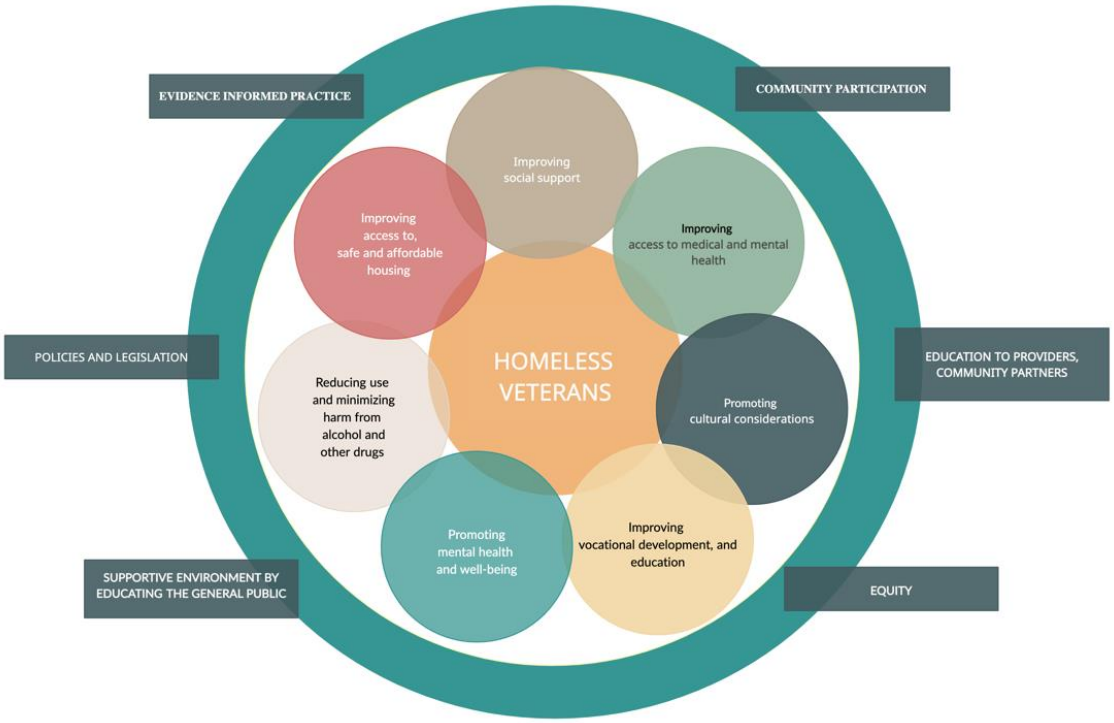


Figure 4. How likely to use COMPASS Tool



Appendix 1. Conceptual Model



Please contact the author, Alicia R. Millard, at alicia_millardlcsw@outlook.com for more information about the innovation.