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Client satisfaction with a new group-based model of case management for supported housing services

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ABSTRACT

Supportive housing typically offers rental subsidies and individual intensive community-based case management and has become a predominant service model for homeless adults. Alternative case management models have not been adequately explored. This study evaluates satisfaction with a novel group-intensive peer support (GIPS) model of case management for the Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) program. A total of 95 HUD-VASH clients rated their satisfaction with services and responded to open-ended questions about what they liked best and least about the program. Quantitative and qualitative analyses compared clients who attended groups as part of the GIPS model and those who did not. No significant difference in satisfaction between group and non-group attenders were found. Clients reported what they liked best about the program was the staff; those who attended groups reported what they liked best was the social interaction and peer support. These findings suggest clients who attend groups for their primary source of case management may be as satisfied as those who receive only individual case management. GIPS offers a feasible and acceptable service model and should be further explored along with other alternative models of care in supportive housing services.

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1. Introduction

The use of group treatment has not been adequately and empirically examined in supportive housing services. Supportive housing programs now exist throughout the country and typically provide individual intensive community-based case management along with rental subsidies. Anecdotal data suggest supportive housing programs are either offering groups on an informal basis and have not evaluated or described their role, or they are not offering groups at all. Regardless, there may be great potential in group treatment for homeless individuals who are in the process of obtaining and sustaining independent housing. Group treatment can be defined as formal services delivered in a group format facilitated by professionals, which should be differentiated from unstructured support groups.

There is a vast literature documenting the benefits of peer support from groups (Coates & Winston, 1983; Solomon, 2004) and the benefits of group membership and social connectedness in recovery (Corrigan & Phelan, 2004; Davidson et al., 2001). Groups for homeless clients can be economical and a more practical way of guiding the housing procurement process (e.g., paperwork to obtain rental subsidy, finding apartment) than seeing each client individually in community settings, as is the case with programs that rely on intensive case management models (Tsemberis, 2010). For example, groups can encourage information-sharing, mentoring, and peer support among its members.

Individual, intensive community-based case management was initially developed for the most severely mentally ill and most frequently hospitalized clients (Stein & Test, 1980), but it may not be the most clinically effective, efficient, or recovery-oriented mode of treatment for many supportive housing clients, such as those with primary addiction problems or non-severe (i.e., less disabling) mental illness. Granted there are clients who may benefit from individual intensive case management and a vast literature documenting its effectiveness (Bond, Drake, Mueser, & Latimer, 2001; Coldwell & Bender, 2007). There are also concerns that groups may not be appropriate for all clients or groups may lead to lack of individualized treatment and ultimately disengagement from services in some situations (Padgett, Henwood, Abrams, & Davis, 2008). However, incorporating groups as part of case management services in a flexible model of care may be an important evolution in supportive housing

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services. One demonstration project has shown that using groups led by case managers to help homeless veterans search for housing was feasible and successful in helping them find housing (Lucksted, Sturm, Lincoln, & Bellack, 2008), although it was not in the context of a supportive housing program (i.e., did not offer rental subsidies). The groups helped homeless veterans problem-solve and find housing in the open real estate market without providing formal individual case management services. Another study piloted a peer-assisted case management intervention that used formerly homeless veterans as peer advisors to help homeless veterans transition from an institutional setting to independent living (Weissman, Covell, Kushner, Irwin, & Essock, 2005). Veterans who received peer advisors were more engaged with services than those who did not.

The current study examined satisfaction with a novel group-based model of case management for supportive housing called the group-intensive peer support (GIPS) model for the Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) program developed at one site and is gradually being disseminated to other sites (Tsai & Rosenheck, 2013). The GIPS model was primarily developed to accommodate the increasing caseloads of HUD-VASH case managers and to tailor services to the needs of HUD-VASH clients. In the GIPS model, case manager-led groups are the default mode of case management services instead of individual, intensive community-based case management. Individual case management is provided on an as-needed basis, although some clients may still rely solely on individual case management and not attend groups. Thus, this study compared the service satisfaction of clients who attended groups as part of the GIPS model and those who did not attend any groups and only received individual case management. The results may be informative in development and dissemination of the GIPS model along with contributing to the scant literature on attitudes toward the provision of group treatment in supportive housing services.

2. Methods

2.1. Program description

The GIPS model was implemented in the HUD-VASH program at the VA Connecticut Healthcare System in April 2010 and has continued to operate as the service model at that site (Tsai, Rosenheck, Sullivan, & Harkness, 2011). An outcome study of GIPS in the HUD-VASH program has found some evidence of specific improvements in social integration with no loss of housing effectiveness or adverse clinical outcomes (Tsai & Rosenheck, 2012a). In contrast to the conventional case management model of HUD-VASH, case management under the GIPS model is mostly group-based and relies on peer support facilitated by case managers. All clients are still assigned individual case managers, but case managers run groups to help clients learn how to obtain a housing voucher, find an apartment to live in, and learn how to live independently. Individual case management is provided on an as-needed basis, which mostly involves case managers meeting clients in the community or in their homes to help them with obtaining and sustaining housing.

Attempts were made to enroll all clients in the HUD-VASH program at VA Connecticut into GIPS groups as it was understood that was the new service model. Participation in groups was strongly encouraged by all case managers and all new clients were explained this was an expected part of the program. HUD-VASH clients were expected to attend groups biweekly as their primary source of case management to meet program requirements of regular contact between case managers and their clients. The HUD-VASH program offers both project-based and scattered-site subsidized housing, and the GIPS model was implemented for clients living or planning to live in either of these arrangements.

Further details about the GIPS model have been described elsewhere (Tsai et al., 2011). Not all clients were able to or preferred to attend groups and instead relied exclusively on individual case management, so the GIPS model is flexible as individual case management is not phased out and the use of groups is based on client need and clinical judgment. Also most of the clients that attended groups also received individual case management, although to a lesser degree and often not in their homes, but briefly with their case managers at the end of groups.

In this study, satisfaction measures were distributed and compared between clients who attended groups and those who did not. To allow adequate time for GIPS implementation, data for this study were collected December 2010 to February 2011 during which there were approximately 167 clients in the HUD-VASH program at the study site.

2.2. Measures

HUD-VASH case managers distributed surveys that collected anonymous information on client background characteristics, service satisfaction, and open-ended responses about what clients liked best and least about the program. Case managers distributed surveys during groups and on individual community-based visits to clients (for those who did not attend groups). All surveys were distributed with enclosed envelopes and written assurance that their responses would be confidential and would not affect their services in any way. All the procedures were approved by the appropriate institutional review boards.

Background characteristics. Clients self-reported sociodemographic characteristics, years of lifetime homelessness, length of time in the HUD-VASH program, frequency of individual contact with HUD-VASH case manager, and frequency of group attendance.

Service satisfaction. A satisfaction survey was created for this study to specifically assess possible differences in satisfaction with the GIPS model. Thirteen items were created to assess client satisfaction about their most recent individual or group meeting. To group the items into domains, a factor analysis was conducted using maximum likelihood with a promax rotation per expert recommendations (Costello & Osborne, 2005) and the sample size was determined to be adequate for such an analysis ($N > 5$ times the # of variables) (Hatcher, 1994)

The factor analysis yielded 4 factors based on eigenvalues above 1.0 and visual examination of the scree plot. Factor 1 labeled General Support (6 items), including items like "How would you rate the knowledge you received during the meeting?" Factor 2 labeled Social Activities (3 items) included items like "Did the meeting help you participate in community activities?" Factor 3 labeled Attendance (2 items) included items like "To what extent are you looking forward to the next meeting?" Factor 4 labeled Freedom of Speech (2 items) included items like "How freely were you able to talk?" All items were rated on a 5-point scale from 1 (Extremely Poor/Not at All) to 5 (Excellent/Very Much) with higher scores reflecting greater satisfaction. Mean scores for each factor were calculated along with a total scale score.

An additional five items assessed satisfaction with the instrumental support provided in individual or group meetings (whichever the client's reference was previously). Items were rated on a 5-point scale from 1 (Strongly Disagree) to 5 (Strongly Agree), and included items like "These meetings helped/will help me get a voucher." The mean score was calculated for a total score.

Open-ended questions. Clients were asked two open-ended questions, which were "What do you like *best* about the HUD-VASH program?" and "What do you like *least* about the HUD-VASH program?" Clients had the option of listing three things they liked best and least about the program.