A Case Manager's Practical Guide to Implementing MISSION

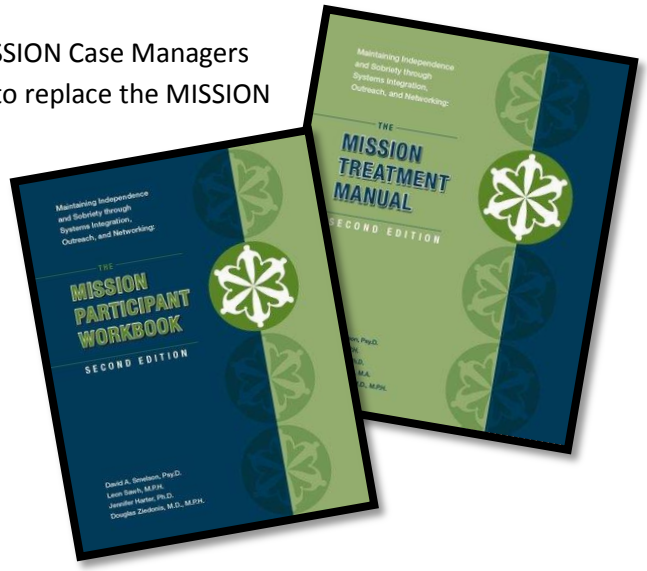
MISSION, *Second Edition*

Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking

Introduction to the Case Manager's Role

Introduction

Welcome to the MISSION Team! This is a practical guide for MISSION Case Managers (CM) on "how to" deliver MISSION services. This guide does *not* intend to replace the MISSION Treatment Manual, but highlights key CM roles and responsibilities; service delivery components; and references useful tools and materials for the CM to use as MISSION is implemented. Corresponding manual page numbers are provided within this guide which link to detailed information in the manual and workbook. For detailed information on the MISSION model of care please see pages 32-43 of the treatment manual. To access the manual, visit www.missionmodel.org.



Case Manager's (CM) Role

As part of a team, the Case Manager (CM) works alongside the Peer Support Specialist (PSS). The CM both delivers services as well as links clients to providers and other psychosocial supports in the community. The CM delivers five components of the MISSION model:

With regard to the provision of services, the CM uses Critical Time Intervention (CTI), which is a time-limited form of assertive outreach, to structure service delivery. The CM delivers 13 structured Dual Recovery Therapy (DRT) sessions that address both mental health and substance use problems. The CM offers rapid re-housing support by helping clients locate, secure, and maintain housing per the client's needs and preferences. In addition to these core components of MISSION, the CM also offers support and linkages around employment, either in the form of job coaching or a referral to a vocational rehabilitation specialist, as well as works in a trauma-informed way for those clients whom have previously suffered trauma. Table 1 outlines core and support services provided by CMs. For more information on the core components and the CM's role please see pages 45-62 in the MISSION Treatment Manual.

Table 1: Brief Overview of Core and Support Services in MISSION

Critical Time Intervention (pgs. 45-48; 53-56)
CTI is a time-limited, intensive case management model that focuses on critical transition periods, enhances continuity of care, and identifies/strengthens formal and informal community supports to prevent institutionalization and homelessness. It is similar to assertive community treatment, but offered for a time-limited period and includes

treatment stages and phases briefly described below.

Phase 1 - *Transition to Community*: The CM will help clients conduct a housing interview and identify critical community resources, facilitate the ongoing use of community resources, and ensure that each problem area identified in the treatment plan is targeted.
Phase 2 - *Try-Out*: Clients become more self-sufficient in the community while the CM offers guided support to help attain goals.
Phase 3 - *Transfer of Care*: The CM fine-tunes linkages to community supports and reflects with each client on the work accomplished.

Dual Recovery Therapy (pgs. 56-59; 167-183)

DRT is an evidence-based psychoeducational therapy that helps clients understand the interrelation of mental health problems and substance abuse. The CM will:

- Provide 13 weekly structured DRT sessions, usually in a group format, during CTI phases 1-2
- Facilitate booster DRT sessions, as needed, during CTI phases 2-3
- Complete a DRT status exam for each DRT session
- Review DRT related worksheets completed in the MISSION Participant Workbook with the client

Rapid Re-Housing (pgs. 59-60; 79-88)

The CM supports clients' housing needs and preferences by:

- Conducting a housing interview to understand each client's needs and housing preferences
- Helping clients secure housing entitlements
- Coordinating with public authorities and landlords
- Assisting clients in creating a budget or identifying a representative payee
- Maintaining ongoing communication with the landlord
- Assisting clients in resolving housing related conflicts
- Monitoring clients for symptom exacerbation or signs of relapse that may jeopardize their housing

Vocational and Educational Support (pgs. 60; 90-100; 223-231)

The CM monitors and supports clients' employment and educational goals by:

- Helping clients develop employment goals
- Assessing eligibility for vocational benefits and assistance
- Providing linkages to vocational specialists
- Helping clients understand benefits packages and retirement plans
- Assisting clients in managing conflicts with co-workers or supervisors
- Role-playing job interviews to provide direct feedback in a trusted environment
- Referring clients for academic assessments to determine additional educational supports (e.g., tutoring, disability services, etc.)

Trauma-Informed Care (pgs. 60-61; 102-115; 232-244)

Being "trauma-informed" means being aware of the possibility of trauma among homeless clients; knowing and being able to recognize symptoms of trauma; being aware of the impact trauma has on the lives of clients; being able to screen for trauma; and knowing how and when to refer out for specialized help. MISSION is *not* a PTSD intervention. The CM will:

- Screen for and identify trauma-related symptoms and disorders
- Refer clients to resources qualified to treat PTSD related disorders as necessary

- Create a welcoming and safe environment
- Focus on resilience, self-healing, mutual support, and empowerment
- Ensure voice, safety, autonomy, choice, trustworthiness, and the elimination of coercion

Getting Started with MISSION

The Case Manager has the primary responsibility of orienting the client to the program and its expectations. The following are steps that the CM can take to identify, orient, and initiate treatment planning with clients. Further detail on initiating the delivery of MISSION services can be found on pages 50-53 and in Appendix D, pages 162-166, of the manual.

Step 1: Screening and Enrollment of Participants

All referred clients should be screened to ensure that they meet program eligibility criteria. Eligibility criteria for MISSION include:

- Homeless, at risk for homelessness, or recently exited homelessness and are now living in the community
- Diagnosed with both a co-occurring substance use disorder and mental illness (COD)
- Willing to take part in the program and receive services, and able and willing to live in the community

During the screening, the CM describes the MISSION program to the client, and if he/she is eligible and interested, the CM proceeds with the enrollment process (i.e., reviewing and signing enrollment documentation such as the treatment contract and releases). Following the screening and enrollment process, the CM conducts a thorough mental health, substance use, and psychosocial needs assessment.

Step 2: Providing Clients with an Orientation to MISSION

The introductory meeting is an opportunity for the CM to learn about the client's goals, barriers, strengths, hopes, and interests, as well as, triggers, coping skills, and available supports. The CM describes his/her role as the client's designated CM and how the program works. The PSS can also be included in this introductory meeting but may do one on his/her own as well. The meeting is usually scheduled for 45 minutes. Table 2 includes areas to review with the client in his/her orientation to MISSION.

Table 2: Key Program Elements to Review with MISSION Clients

Key Program Elements	
MISSION Structure	• Program Length (2, 6, or 12 months) • Team Based Approach: CM and PSS work closely together as a team to help the client; CM and PSS have distinct yet complementary roles • Frequency, duration, location of intervention (e.g., weekly DRT sessions, home-based and in community sessions)
MISSION Goals	MISSION… ✓ Addresses co-occurring mental illness and substance use disorder (COD) ✓ Helps the client in reaching personal goals in his/her recovery

	✓ Helps the client transition into the community ✓ Helps the client secure and maintain housing ✓ Helps the client reach employment and/or educational goals ✓ Encourages the client to engage in healthy community activities that he/she enjoys ✓ Provides linkages and transportation to community resources to help the client meet his/her goals
Program Requirements and Policies	• Confidentiality (i.e., mandatory reporting, communication between PSS and CM) • Information sharing - Release of information for outside providers

Step 3: Initiating Treatment Planning

The treatment plan is informed by the mental health, substance use, and psychosocial needs assessment; discussion of the client's goals, supports, personal strengths, and potential obstacles to recovery; and information gathered from other sources (i.e., medical record, probation, and other providers). The CM, with feedback from the PSS, collaboratively develops a treatment plan with the client and then discusses it in detail to ensure an understanding of goals. An example of a MISSION treatment plan is on page 20 of this guide, as well as in Appendix G of the treatment manual on pages 193-194. The CM and the client review the treatment plan regularly to identify new goals and ways to solve challenges the client may come across on his/her road to recovery. The treatment plans are also reviewed regularly in team meetings and fine-tuned when necessary to reflect achievements, changed or new goals, and updated objectives. Although the CM is responsible for the treatment plan, the CM solicits and integrates the PSS's feedback into the plan throughout treatment.

Case Manager's Responsibilities: Critical Time Intervention (CTI)

The CM works in collaboration with the PSS to provide services and support to clients on their caseloads. As clients are introduced to MISSION, CMs are responsible for the orientation, assessment and linkage, treatment, and tracking of each client through the program. Table 3 outlines the key CM responsibilities per CTI phase. An outline of CTI phases and CM responsibilities can be found on pages 53-56 of the manual, as well as in Appendix D beginning on page 162.

Table 3: Case Manager Responsibilities per CTI Phase

CTI Phase 1: Transition to Community
During CTI Phase 1, CMs: ➢ Meet with each client to orient them to the MISSION model and program requirements ➢ Work together with clients to develop comprehensive treatment plans that include clients' treatment needs, individual goals, and identification of appropriate team responses to meet these needs ➢ Provide DRT sessions, usually in a group format, delivered at least once a week ➢ Meet with each client once a week for a case management session focused on assessing and providing linkages to community supports ➢ Facilitate a housing search process to rapidly re-house homeless clients into a permanent housing placement based on the client's housing needs ➢ Assess and track each client's progress and use of the community resources/supports that have been established ➢ Provide assertive outreach to ensure treatment engagement and retention (i.e., home visits, in-community sessions)
CTI Phase 2: Try-Out
During CTI Phase 2, CMs: ➢ Work together with each client to monitor and revise treatment goals in the treatment plan ➢ Provide remaining DRT sessions and begin to provide booster DRT sessions as needed ➢ Meet with each client, as needed, for case management sessions ➢ Continue to facilitate linkages that have been established ➢ Identify problem areas that need new linkages, and provide clients with additional community linkages; empower clients to identify resources independently ➢ Monitor for slips and relapse. If relapse occurs it should not be punished - it should be framed as something that can occur on the road to recovery ➢ Continue to identify any gaps in clients' support systems, barriers in accessing services, or areas where more support is needed ➢ Begin to taper frequency and intensity of the intervention as clients become more independent in the community ➢ Increase assertive outreach if clients become disengaged (i.e., no shows)
CTI Phase 3: Transfer of Care
During CTI Phase 3, CMs: ➢ Review and fine-tune community-based resources and supports with each client ➢ Meet with providers to review the transfer of clients' care and identify any gaps in services ➢ Reflect on accomplishments during the program ➢ Discuss a discharge and transition plan with each client ➢ Discuss the end of participation in MISSION in a framework that acknowledges the work accomplished as another

step in recovery

Assertive Outreach

The CTI phases described above rely heavily on the delivery of assertive outreach by CMs and PSSs. Assertive outreach is a way of organizing and delivering care via a CM/PSS team to provide intensive, highly coordinated, and flexible support and treatment for clients across CTI phases. It includes such activities as home visits, meeting with clients in their local communities, etc. It has been found to increase engagement and improve outcomes. CMs engage in assertive outreach activities throughout MISSION delivery. Outreach should be increased when concerns regarding engagement arise, for example if the client begins to miss appointments or disengage.

Case Manager's Responsibilities: Dual Recovery Therapy (DRT)

DRT is an evidence-based therapy that addresses both mental health and substance use recovery. DRT sessions help clients understand the relationship between their mental health problems and substance use, and how to address the challenges these connections bring. DRT is delivered in 13 weekly sessions in CTI phases 1-2 and booster sessions are delivered as needed in CTI phases 2-3. Sessions can be delivered in a group or individual session format, however group sessions are highly recommended. Additional information on DRT can be found in the MISSION Treatment Manual on pages 56-59 and in Appendix E beginning on page 167.

Dual Recovery Status Exam

The DRT Status Exam is used in every DRT session to structure the session to focus on both mental health and substance use. The exam is formatted as a checklist, and functions as a "to-do" list and helpful guide for the CM to use during sessions. The CM can have a copy of the exam with him/her in the session and check to ensure that he/she has covered each item on the exam. The exam is located on page 19 of this guide. For additional tools and techniques to structure DRT sessions, also reference Appendix F, beginning on page 184 of the MISSION Treatment Manual.

Ways to Structure Individual DRT Sessions

DRT sessions are fairly structured sessions; however the session content should be individually tailored to the client's needs and goals. The following techniques and activities are common to individual DRT sessions and can be used as a guide to structure the session.

- **Welcoming.** The CM begins by welcoming the client to the session. The CM can use the DRT Status Exam checklist to structure a welcoming check-in.
- **Introduction of the Topic**. The CM introduces the DRT topic and explains why it may be important and relevant to the client's goals. The CM should directly relate the topic to the client. To build on the topic, the CM provides a brief informative and interactive presentation of the DRT topic by integrating materials from the exercises and readings in the Participant Workbook; encouraging the client to record any notes or insights to the exercises; and using engaging questions to prompt discussion.
- **Engagement and Feedback**. The CM provides the client with a safe environment to engage in a discussion of his/her understanding of the topic and an opportunity to share personal connections with the topic. This allows the CM to engage and offer clarification and additional feedback to the client on his/her individual circumstance in an empathic and respectful manner.
- **Modeling**. The CM teaches the client the skills offered by the DRT session by modeling them. CMs may role-play skills with the client to illustrate how to use a skill. For example, during the "Anger Management" session the CM may choose a situation and role-play the situation in session to model adaptive ways to manage situations which trigger anger.
- **Reorientation**. The CM encourages the client to engage in effective actions that reinforce new skills or insights.
- **Closing**. It is important that some signal be given to indicate that the session is formally closed. Some sessions end with a summary of take home points, review of a collective goal, or homework - something to try during the coming week. For example, if the client learned positive ways to manage situations which trigger anger, he/she is encouraged to try them before the next session. The client should be reminded of the time and place of the next session.

Ways to Structure Group DRT Sessions

Similar to individual DRT sessions, group DRT sessions are fairly structured sessions but have a slightly different format. Group size ranges from 5-10 members and sessions last between 45-60 minutes. The following activities are common to DRT groups and can be used as a guide for structuring the group. It is not necessary to incorporate every activity mentioned here in each group meeting agenda.

- **Greeting of New Members**. Older members greet and welcome new members at the door when they arrive, introducing them to other members.
- **Opening of Meeting**. At the agreed upon time, the meeting should be called to order by the CM or a designated group member. Some groups open meetings with a quote, mantra, or even a mindfulness activity, such as relaxation breathing.
- **Introduction of Members**. Going around the room, each member can introduce himself/herself and state their reasons for coming to the group. This is especially appropriate for new groups forming to help members get to know one another and learn about common concerns. Offer members the option to "pass," if they would rather not introduce themselves.
- **DRT Status Exam Round Robin Check-in**. Going around the room in a "round robin" style, utilizing the Status Exam structure if preferred, each member can provide a Reader's Digest version of their week in the following areas: substance use since last meeting; tracking of mood symptoms since last week (i.e., on a scale from 1-10); medication compliance or changes; engagement in pro-social supports and activities (e.g., 12 steps, pro-social peers and family members). An outline for participation can help keep members on track when they speak. This outline can be posted in the room to remind members of the structure.
- **Discussion, Education, and Information Sharing Related to DRT Topic**. Here are some ways to structure the group discussion:
    - ***Introduction of the Topic.*** The CM provides an introduction to the topic, why it was chosen, and why it is something important for members to think about. To build on the topic the CM provides a brief didactic and interactive presentation of the DRT topic. The CM encourages participating members to use the exercises and readings in the Participant Workbook to follow along with the material covered during DRT sessions, and to record any notes or insights to the exercises.
    - ***Round Robin.*** The CM can ask a question to spark discussion. Otherwise, the CM may ask members how they responded to exercises in the Participant Workbook and go around the group as each member responds, giving everyone an opportunity to share their insights and responses.
    - ***Brainstorming***. Ideas are shared in a spontaneous way. Creative thinking is encouraged by not judging any particular idea. For example, during the "Scheduling Activities in Early Recovery" session, members can call out all of the positive activities they have engaged in and the CM can write them on a flip-chart to generate discussion of activities.
    - ***Role-playing*****.** Acting out a situation (e.g., how to communicate effectively with your spouse) can be helpful and fun. Some members enact the role-play while others observe and react or comment.
- **Closing**. It is important that some signal be given to indicate that the meeting is formally closed. Some groups end with a mantra, collective goal, or homework - something to try for the group during the coming week. For example, members may be encouraged to try one of their peers' positive activities that were called out during the discussion. Members are reminded of the time and place of next meeting.

Participant Workbook Utilization in DRT Sessions

Using the Participant Workbook for DRT sessions requires close coordination between the CM and the PSS regarding what is occurring in DRT sessions. Outside of the DRT session, the PSS works with clients on completing the DRT exercises in the workbook for the upcoming DRT session and/or clients may choose to do this work individually with just a quick check-in with the PSS about it. Completing the DRT worksheets is not a substitute for the DRT groups – clients are encouraged the week of the individual or group DRT session to review that session topic with the PSS. Clients are encouraged to bring the completed worksheets and workbook to each DRT session.

DRT Sessions with Corresponding Participant Workbook Pages

Below are descriptions and examples of the content in each of the 13 DRT sessions with the corresponding worksheet pages in the Participant Workbook, found in Section C beginning on page 60.

Session 1: Onset of Problems *Exercise Worksheets located on pgs. 62-64 of the Participant Workbook*	
Description of Topic	Clients learn about the dynamic relationship between mental health and substance use problems.
Notes for the Facilitator	*Explain* that there is usually a pattern to when symptoms begin and that symptoms for mental health and substance use are often interrelated. *Show* clients how to fill out the timelines and go over the sample. *Discuss* common patterns amongst members in the group.

Session 2: Life Problem Areas *Exercise Worksheets located on pgs. 65-67 of the Participant Workbook*	
Description of Topic	CMs and clients will review the problems they have experienced in major life domains and examine the degree to which these problems have affected their lives.
Notes for the Facilitator	*Explain* that this exercise will help clients and their MISSION teams understand how problems related to mental health and substance use are each affecting their quality of life. *Explain* that these problems will reoccur in discussions throughout DRT. Go around the group and have members *share* problems and *give examples* from each area, focusing on one area at a time. **Note**: Following sessions build upon and use the problem areas identified during this session.

Session 3: Motivation, Confidence, and Readiness to Change *Exercise Worksheets located on pgs. 68-69 of the Participant Workbook*	
Description of Topic	Clients complete a readiness ruler worksheet for each domain or life problem identified in Session 2. Rulers will help clients understand their stage of readiness to address each problem area.
Notes for the Facilitator	*Explain* to clients that a sense of importance, confidence, and readiness are all aspects of motivation. *Encourage* clients to answer honestly for each area they address. Go around the group and have members *share* problems they explored, the motivation

	they find to address them, and implications for recovery. **Note**: Having extra rulers during all sessions will make it easy for clients to explore different areas in which change is needed in their lives as they go.

Session 4: Developing a Personal Recovery Plan *Exercise Worksheets located on pgs. 70-72 of the Participant Workbook*	
Description of Topic	Treatment goals are reviewed and emphasis is placed on the importance of using and engaging in community substance use and mental health resources necessary to meet treatment goals.
Notes for the Facilitator	*Build* on the life problem areas identified in Session 2, *encourage* clients to refer back and *identify* positive steps they can take to address the problem. *Encourage* clients to *share* their thoughts with others who play a key role in their hopes for recovery. Give clients the opportunity to *share* around various strategies they have suggested for themselves in each area. **Note**: Encourage clients to use the PICBA tool on page 21 of the Participant Workbook to decide how they want to address each set of problems.

Session 5: Decisional Balance *Exercise Worksheets located on pgs. 73-75 of the Participant Workbook*	
Description of Topic	The worksheet is used to help clients identify the benefits and negative consequences of maintaining problematic behaviors and weighing the costs and benefits of continuing problematic behaviors.
Notes for the Facilitator	*Ask* clients to pick the biggest problem area in their life. *What behavior is the root of these problems?* *How could it be changed?* *What are the benefits and negative consequences of change?*

Session 6: Developing Strong Communication Skills *Exercise Worksheets located on pgs. 76-78 of the Participant Workbook*	
Description of Topic	Clients learn to recognize effective and problematic communication styles. The worksheets will assist clients in developing effective communication skills necessary for communication with those who play a key role in their recovery.
Notes for the Facilitator	Have clients *identify* elements of poor communication that applies to them. *Discuss* why they have used these forms of communication. Have clients *identify* elements of good communication they would like to use. *Role-play* good and poor communication skills and *provide feedback.*

Session 7: Orientation to 12-Step Programs *Exercise Worksheets located on pgs. 79-82 of the Participant Workbook*	
Description of Topic	Emphasis is placed on orienting clients who have never attended 12-step meetings to the structure, culture, rules, and language of the program. Emphasis is also on improving

	attendance at these programs.
Notes for the Facilitator	*Encourage* clients to *share* experiences they have had at programs. *Role-play* ways to overcome any barriers to attendance. *Share* information about types of groups and meeting times in the immediate area. *Talk* about each step and what it means to each client.

Session 8: Anger Management *Exercise Worksheets located on pgs. 83-85 of the Participant Workbook*	
Description of Topic	Focuses on prosocial skills training, moral reasoning, and anger control training. The goal is to teach clients cognitive strategies to combat unhealthy thinking styles. Discuss problematic behaviors in relation to values and goals.
Notes for the Facilitator	*Brainstorm: Why it is that one person gets really angry at something while another person just gets annoyed at the same thing?* *Identify: How do you know when you're really angry? What is the difference between anger and frustration?* *Discuss* negative consequences for becoming angry and out of control. *Share* techniques on cooling down.

Session 9: Relapse Prevention *Exercise Worksheets located on pgs. 86-92 of the Participant Workbook*	
Description of Topic	Clients learn to identify and review strategies that can be used to increase the likelihood of sobriety and decrease the chance for relapse. Emphasis is placed on how clients' mental health problems can lead to relapse and strategies that can be employed to prevent this from occurring.
Notes for the Facilitator	*Discuss* the chart on relapse prevention. *Review* safe coping strategies, and have clients *share* strategies they've found effective. *Fill out* the worksheet on the "Change Plan". *Encourage* clients to *practice* positive coping strategies.

Session 10: Relationship Related Triggers *Exercise Worksheets located on pgs. 93-97 of the Participant Workbook*	
Description of Topic	Clients will learn how unhealthy relationships can contribute to a high risk of mental health symptom exacerbation and/or substance use relapse.
Notes for the Facilitator	*Discuss* readings that come before the worksheet. *Fill out* the first two questions on the worksheet. Go around the group and *encourage* members to share their answers.

Session 11: Changing Unhealthy Thinking Patterns *Exercise Worksheets located on pgs. 98-108 of the Participant Workbook*	
Description of Topic	Clients learn how unhealthy thinking patterns can perpetuate emotional problems and result in substance use as a maladaptive coping mechanism.
Notes for the Facilitator	*Discuss* the descriptions of each of the various forms of unhealthy thinking.

	Discuss examples of stinking thinking. *Review* examples identified by clients on the worksheet and then *identify* healthier responses. *Explain* that we have a choice in how we think about something happening. Assign group members to think of healthy responses for some of their unhelpful ways of thinking.

Session 12: Changing Irrational Beliefs *Exercise Worksheets located on pgs. 109-112 of the Participant Workbook*	
Description of Topic	Clients identify dysfunctional beliefs and learn how to modify those beliefs to maintain flexibility in thinking.
Notes for the Facilitator	Have clients read through the examples of irrational thoughts and check those that apply to them. *Review* the examples. Have the group reframe each of the examples.

Session 13: Scheduling Activities *Exercise Worksheets located on pgs. 113-117 of the Participant Workbook*	
Description of Topic	Clients learn the importance of scheduling regular healthy activities in maintaining recovery.
Notes for the Facilitator	*Help* clients *identify* a guiding vision of what they want their lives to be like and how they want to use their time.

Case Manager's Responsibilities: Rapid Re-Housing

The MISSION team is responsible for helping homeless clients secure a permanent home via rapid re-housing support which is guided by the Housing First philosophy (see Table 4). The CM actively works with each client to determine housing needs and preferences, and then coordinates with housing authorities and landlords to help find a housing unit that suits the client. After the client is housed, the CM along with the PSS monitor the client to help him/her maintain his/her housing placement (e.g., tracking utility expenses, ensuring rent is paid, intervening in conflicts, etc.). Rapid re-housing is further explained in the MISSION Treatment Manual on pages 59-60 and 79-88.

Table 4: Housing First Principles Used in MISSION

Housing First Principle	Principle Description	CM's Role per Principle
Participant Choice Philosophy	MISSION clients actively participate in the housing selection process and are encouraged to openly share preferences.	CMs will… ✓ Conduct a pre-housing interview to understand each client's needs and preferences ✓ Engage clients in housing selection ✓ Coordinate with public housing authorities (PHA) and landlords
Separation of Housing and Services	Housing should not be conveyed as related to treatment adherence and sobriety. Housing should be posed as a client's right and critical need.	CMs will… ✓ Emphasize housing is not contingent upon services ✓ Work with clients, PHAs, and landlords during housing placement to monitor housing stability
Services are Voluntary and Flexible	MISSION teams deliver treatment services to clients to participate in voluntarily and also make the services individualized to match each client's needs thus having flexibility based on where the client is in his/her recovery.	CMs will… • Be accessible for clients to prevent/resolve crises • Match case management to each client's needs
Recovery-Oriented Services	Services are recovery-oriented, and are dependent upon each client's treatment goals.	CMs will… ✓ Discuss the importance of sobriety and symptom management to avoid negative consequences ✓ Encourage clients to avoid potential triggers
Community Integration	Clients should be encouraged to choose a housing location where they are able to integrate themselves into the community and participate in community living.	CMs will… ✓ Work with clients in identifying services in the community ✓ Encourage clients to engage in

	Clients should not be housed amongst other individuals with similar problems.	community living (i.e., substance free activities, work, 12-step meetings)
Harm Reduction	Clients are able to make choices and are not treated based on the choices they make. Instead clients are encouraged to discuss consequences of their actions to promote reducing negative behaviors.	CMs will… ✓ Not penalize or withhold services from clients for relapse ✓ Help clients identify a prevention plan to manage problematic behaviors associated with COD

Rapid Re-Housing Support

Rapid re-housing begins with the housing search. As the CM, you can start this process by conducting a pre-housing interview. Clients should be actively involved in this interview to ensure that their preferences are optimized. A housing preference tool can be found in Appendix K of the MISSION Treatment Manual on page 215; an example of a completed housing preference form is on page 21 of this guide. The CM can then open communication with local housing authorities and agencies to locate available units. During this process it is beneficial to keep clients actively involved as another way to reinforce independence in the community. One way to involve the client is to assist them in securing housing entitlements.

After housing is obtained it is critical to *maintain* it. The MISSION team can observe the client's living situation through home visits and determine how the transition is going. The team may take into consideration signs of being unpacked, has the client had family/friends over, and/or relapse signs. Although it is important to support clients in maintaining their home, it is also important to respect their privacy and boundaries. This can be done by making sure home visits are scheduled. The frequency of visits will vary depending on what stage the client is in in his/her recovery, however showing up unannounced should only happen if the CM is concerned about the client's safety.

Throughout MISSION the CM, along with the PSS, may address any housing related concerns or needs on the client's treatment plan. The client's housing goals are important to identify so that the team can help the client achieve them. The CM and the PSS may discuss ways of getting the client more involved in the community to help with the transition to his/her new home. For example, the CM may meet with the client at a local community center instead of at the client's home or in the office.

Case Manager's Responsibilities: Providing Vocational and Educational Support

Clients present with a variety of vocational and educational needs, such as needing help obtaining employment, maintaining employment, and applying for educational programs. The CM's general role includes monitoring and supporting clients' vocational and educational goals on the treatment plan; assessing clients' eligibility for vocational benefits and assistance; and providing clients with linkages to vocational specialists and vocational rehabilitation programs when needed. The CM's role varies slightly based on clients' vocational and/or educational needs as displayed in Table 5. More information on the vocational and educational support provided by the MISSION team can be found in the MISSION Treatment Manual on pages 60, 90-100, and Appendix M beginning on page 223.

Table 5: Case Manager's Role in Providing Vocational/Educational Support Based on Clients' Needs

Employed Clients	Unemployed Clients	Supported Education
Clients continue to need support as they move through different job stages, face challenges and stigma, and learn their role in the workplace, therefore CMs: • Help clients understand benefits packages and plan for retirement • Teach skills that will help clients maintain employment (e.g., time management, conflict resolution skills, and organizational skills) • Address symptom exacerbation on the job and related coping skills • Discuss the importance of medicine maintenance and impact of medication side effects on job functioning (i.e., timing of medication, fatigue, and scheduling job shifts)	Clients may experience difficulty maintaining a job, therefore CMs: • Identify the positives and negatives of the methods clients have been using in their job search and discuss them • Discuss employment in a focused and goal-oriented manner • Develop an employment goal with each client – based on past experience, preferences, and current life situation • Review employment related workbook exercises on pages 48-53 of the Participant Workbook and utilize employment related resources on pages 91-97 and 223-226 of the manual with clients • Identify potential employers and gather necessary employment documents (i.e., applications, resume) and personal documents (i.e., social security cards, proof of	Clients may want to pursue educational goals, therefore CMs: • Explore career and education goals and preferences, so that schools/training programs can be chosen to apply to • Refer clients for academic assessments to determine how much additional educational support is needed (e.g., tutoring, mentoring, disability services). • Track each client's progress towards his/her goals by tracking the number of identified potential schools, schools applied for, follow-up school applications, interviews and outcomes • Form working relationships with the schools clients are applying to. Most colleges and training programs have either campus-based support groups for clients or university-based client service departments and service coordinators

	citizenship, transcripts) • Help clients prepare for job interviews by getting the necessary attire, conducting mock interviews, and providing feedback • Track each client's progress towards his/her goals by tracking the number of identified potential jobs, jobs applied for, follow-up job applications, interviews and outcomes • Educate clients, as needed, on the difficulties of the job market and focus on practical barriers to obtaining and maintaining employment • Address possible criminal justice issues/barriers related to employment (i.e., myths vs realities of having a criminal record and seeking employment)	• Assist with enrollment and college readiness tasks (e.g., course selection, books, financial aid) • Provide regular or periodic check-ins to monitor and support each client's academic progress • Provide assistance with clients' applications for benefits

Case Manager's Responsibilities: Trauma-Informed Care Considerations

Many clients have experienced at least one traumatic event in their life. Therefore, MISSION CMs are trained to identify and monitor trauma symptoms and their impact on treatment and recovery. With that said, MISSION is a trauma-informed intervention and *not* a trauma treatment program. Being "trauma-informed" means:

- ✓ Being aware of the possibility of trauma among clients
- ✓ Recognizing the symptoms of trauma
- ✓ Being aware of the impact of trauma on the lives of clients
- ✓ Screening clients for trauma
- ✓ Knowing how and when to refer clients out for specialized help

During MISSION, the CM will screen all clients for trauma symptoms. If the client has clinically significant trauma symptoms, the CM will make a referral to have the client formally assessed by a qualified assessor (i.e., licensed clinical professional trained in diagnostic assessment and PTSD assessment/treatment). If the client is found to meet criteria for current PTSD and is in need of PTSD-focused treatment, the CM can work with the client and qualified assessor to identify and enroll the client in an evidence-based PTSD treatment program such as Seeking Safety, Cognitive Processing Therapy (CPT), etc. With close CM coordination and collaboration, PTSD specific treatment can occur simultaneously with MISSION services. Figure 1 provides an outline of the trauma-informed role of the MISSION-CJ CM. Trauma-informed care is further explained in the MISSION Treatment Manual on pages 60-61, 102-115; Trauma resources can be found in the manual in Appendix N, beginning on page 232.

Figure 1: A Trauma-Informed Case Manager

Trauma-Informed Role of the Case Manager	
	CMs screen for and identify trauma related symptoms and disorders. CMs will use validated screening tools, such as the PTSD Screen (pg. 240 of the manual).
	CMs ensure that clients who need specialized treatment are referred to resources qualified to treat PTSD and other trauma-related disorders.
	CMs serve clients with trauma histories who do not require specialized trauma-related treatment by utilizing present-focused treatment approaches, where the CM teaches the clients coping skills (e.g., altering present maladaptive thought patterns/behaviors, relaxation and breathing exercises), providing psycho-education regarding the impact of trauma on the client's life, and teaching problem solving strategies that focus on current issues.
	CMs recognize the links between past trauma and present difficulties when working with their clients.
	CMs provide ongoing support for those clients receiving treatment from a specialized provider.
	CMs coordinate care with specialized providers.

DRT Status Exam Checklist

- ✓ **Set agenda for session (Client and Case Manager)**
- ✓ **Check-in with regard to any substances used since last session**
- ✓ **Assess substance use motivational level**
- ✓ **Track symptoms of depression or anxiety**
- ✓ **Explore compliance with medications prescribed**
- ✓ **Discuss the primary agenda topic(s) for the session**
- ✓ **Ask about attendance at 12-Step groups and other elements of treatment**

Additional Notes

Example of a Completed MISSION Treatment Plan

Considerations for MISSION Treatment Planning

Primary Diagnosis

Major Depressive Disorder, severe, without psychotic symptoms

Secondary Diagnosis

Cocaine dependence, early full remission

Other Treatment Providers

Dr. Smith, Primary Care Provider
Dr. Jones, Psychiatrist

Service Needs

- **MISSION**
- **Residential substance abuse treatment (currently participating)**
- **Acute psychiatric care**
- ***Other Needed Services***
  - **Housing Needs: currently receiving residential care**
  - **Outpatient mental health/substance abuse treatment: referral needed once discharged from residential substance abuse treatment**
  - **Medical Care: diabetes management**
  - **Medication Management: psychiatric/diabetes medication management**
  - **Dental Services**
  - **Benefit entitlements**
  - **Vocational Supports: increase job-related experience; link to services**

MISSION Service Delivery

- **Frequency (Weekly, Bi-weekly, Monthly)**
- **Length (2 months, 6 months, 12 months)**

Treatment Goals & Objectives: **Client is currently receiving care in a residential substance abuse treatment program. In addition, client is being followed by MISSION staff. Client has identified the following treatment goals/objectives below:**

Treatment Goal #1: **Maintain abstinence from drugs**
Treatment Goal #2: **Improve management of depressive symptoms**
Treatment Goal #3: **Gain job-related experience**
Treatment Goal #4: **Transition to independent housing**

Next apt: **Mon Tue Wed Thu Fri Sat Sun** Time: **11:00 am/pm**
Provider:
Location:

Example of a Completed MISSION Housing Preference Tool

Client Pre-Housing Interview

Preferences

Type of Housing (1BR, Studio, Room, etc.): studio (easier to maintain), open to a room in sober living to help adapt to community living

Neighborhood preference? Suburbs, close to daughter's mother (need to discuss further)

Neighborhood preferred to avoid? Inner city, 12th street area (old dealing area)

Transportation needs (public transit, downtown area, etc.): need to use public transit! would help to be walking distance due to lots of meetings/appointments probation meetings, AA, and work

Potential Barriers to Housing

Criminal History: on probation for a DUI and possession with intent to sell

Family members potentially living in unit: none living with client, supervised visitation with daughter

Restrictions with subsidy-type: have section 8 voucher

Available budget (including utilities, security deposit, rent after subsidy, etc.) $ 800-1000

Special Accommodations

Grab bar in bathroom (YES) NO

Wheelchair accessible YES (NO)

Other Accommodations: first floor unit or building with elevator access