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

THE

MISSION
TREATMENT
MANUAL

SECOND EDITION

David A. Smelson, Psy.D.

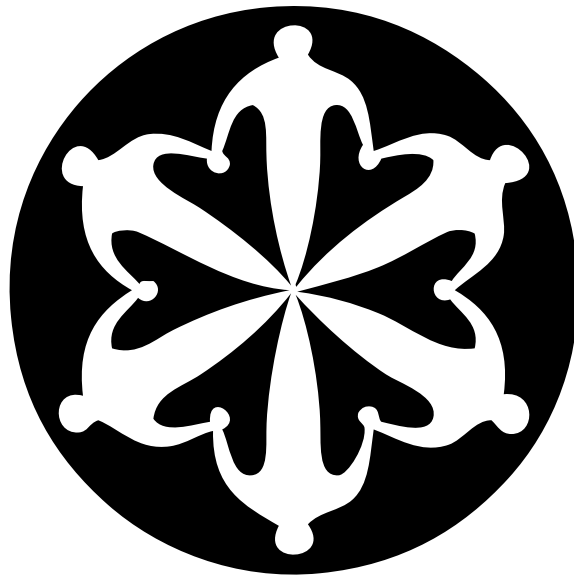Leon Sawh, M.P.H.

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About this Edition

Dear Reader,

Over the past fifteen years, we have been fortunate enough to implement the Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION) model in a number of community-based clinical settings with various populations of homeless individuals with co-occurring mental health and substance use disorders (CODs). We are indebted to those who work directly with this population and for all of the ongoing feedback that we have received from your experiences incorporating MISSION into your daily practices since the first edition of the MISSION manual was published in 2007. It is both our hope that the MISSION service-delivery model helps service providers better coordinate care to address the many complex barriers that exist for those individuals who are struggling with psychiatric problems, substance abuse and, of course, obtaining and maintaining housing. MISSION is designed to be a practical and useable manualized treatment approach that is user-friendly for clinical teams and clients alike. It is with this philosophy in mind that we continue to welcome suggestions and feedback as we continue to improve and update the manual to be as useful as possible to providers based on their field experiences using this manual. The inspiration for this updated manual came from such discussions with MISSION Case Managers and Peer Support Specialists about information that they would find most helpful to supplement the material already provided in the previous versions of the MISSION manual. Below is a description of the various additions made to the MISSION Treatment Manual, Second Edition.

- Addition of vocational and educational support chapter (first included in the 2011 MISSION-Veterans' Edition (MISSION-VET) manual and further adapted for this Second Edition)

- Addition of Trauma-Informed Care chapter (first included in MISSION-VET and further adapted for this second edition)

- Addition of a Rapid Re-Housing chapter to highlight how best practices, such as the Housing First approach, can be used alongside MISSION service delivery. Additional resources for Case Managers and Peer Support Specialists in the Appendices including updated Case Notes and DRT Status Exam (Appendix G), Sample Budget Worksheet (Appendix J), a Housing Preference Tool (Appendix K), and an overview of homelessness among Veterans (Appendix L).

- Lastly, throughout this second edition, additional guidance has been provided on topics such as difficulty initiating groups, challenges with transition hand-offs, and more updated case examples to reflect the experiences of our clinical teams.

The Veteran's 2nd Edition of the MISSION manual is available for download from our website www.missionmodel.org

Thank you for the work that you do! We continue to welcome the support and feedback that makes MISSION a useful tool for you and your clients.

David Smelson, Psy.D.

Table of Contents

ACKNOWLEDGEMENTS

We hope that you find this manual to be a useful resource as you provide day-to-day support to the clients you serve. For questions regarding the use of the MISSION manual or any questions related to the MISSION program itself, please contact:

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The following institutions are affiliated with and participated in the writing of the MISSION Treatment Manuals:

- University of Massachusetts Medical School
  - Department of Psychiatry

- United States Department of Veterans Affairs (VA)
  - National Center on Homelessness among Veterans
  - Office of Research and Development (ORD),
  - Health Services Research and Development Service (HSR&D)
  - Edith Nourse Rogers Memorial Veterans Hospital (Bedford VA)
  - Center for Healthcare Organization and Implementation Research (CHOIR)
  - VA New England Healthcare System (VISN 1)

- Commonwealth of Massachusetts
  - Department of Veterans Services
  - Department of Mental Health
  - Department of Public Health
  - MassHealth
  - Interagency Council on Housing and Homelessness
  - Interagency Council on Substance Abuse and Prevention

- Community Partners
  - Community Health Link
  - Behavioral Health Network
  - Soldier-On
  - Western Massachusetts Regional Network to End Homelessness

Dedication

We dedicate this treatment manual to currently homeless and formerly homeless individuals who deserve our support as they go through their own journey of recovery. We also dedicate this manual to those community service providers who serve homeless individuals with mental health issues, substance abuse problems, unemployment, and trauma-related problems. We hope that this treatment manual provides a roadmap that helps facilitate recovery, sobriety, and permanent housing solutions.

FOREWARD

The original Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION) treatment approach provided case management, peer support, and Integrated Dual Disorders Treatment (IDDT) using the Dual Recovery Therapy (DRT) treatment model, to homeless and formerly homeless individuals with co-occurring mental health and substance use disorders (COD) as they worked to achieve recovery from homelessness, mental illness, substance abuse, and unemployment while transitioning from institutional care to independent living in the community. This 2nd edition has been updated from its original form based on the many lessons we have learned since the publication of the original MISSION Treatment Manual and Consumer Workbook in 2007 and the Veterans Edition of the Manual and Workbook published in 2011. For example, this 2nd edition now formally incorporates a rapid re-housing framework that utilizes a housing first philosophy, additional guidance and tools for assisting clients in achieving vocational and educational goals, as well as the integration of a new trauma informed care service delivery approach.

MISSION services can be initiated in either inpatient/residential/shelter or outpatient settings and are provided by treatment teams consisting of a Case Manager (CM) and Peer Support Specialist (PSS) who support clients during this critical transition period. MISSION CM/PSS teams deliver services directly and also provide essential linkages to both clinical services and community-based programs to help homeless and formerly homeless individuals secure and maintain permanent housing; engage in mental health, substance abuse, and medical treatment services; obtain and retain employment; enroll in educational programs; and locate and participate in recovery support programs (e.g., AA/NA).

The original MISSION treatment approach was rooted in the theoretical framework of the Health Belief Model (HBM) and was structured upon the principles and phases of the Critical Time Intervention (CTI) case management model. To better meet the needs of homeless and formerly homeless individuals with COD, MISSION has systematically blended the following approaches into a flexible service delivery platform:

- Time-limited case management services using the Critical Time Intervention model

- Integrated Dual Disorders Treatment using Dual Recovery Therapy

- Peer support which offers role modeling and a 'been there' perspective

- Secure and maintain permanent housing via Rapid Re-Housing philosophies

- Vocational and Educational support by offering linkages to available programs

- Support for trauma-related symptoms by training MISSION treatment staff to identify and monitor symptoms that may be related to trauma. Referrals are provided to clinicians who specialize in stabilizing and treating trauma-related symptoms.

Overview of Manual Contents

This manual contains chapters targeted to the unique contributions of each member of the MISSION team, background information that will be of interest to all team members, and supplementary tools and resources that will assist in the implementation of the MISSION program. An overview of chapters and appendices follows.

I. *Replicating the MISSION Program: Guidance for Program Managers and Administrators.* This chapter provides information of particular interest to both clinical and community-based program managers

and administrators who are considering implementing the MISSION program for use in their treatment settings. This chapter discusses MISSION's target audience; applicable treatment settings; each of the service components; previous outcomes; staff training needs; and other logistical, staffing, and supervision requirements necessary for successful implementation. It is important to underscore that this chapter was intentionally developed to succinctly present key information from the manual as a whole that is essential for a sufficient, yet abridged understanding of MISSION.

II. *The MISSION Model of Care.* This chapter is important for all members of the MISSION team involved in the replication of the intervention, but it is of critical importance to the clinical supervisor. It explains how each of MISSION's components have been incorporated and adapted to meet the needs of homeless and formerly homeless individuals with co-occurring psychiatric and substance use disorders.

III. *Case Management.* This chapter highlights the role of the MISSION Case Manager (CM). MISSION CMs deliver Dual Recovery Therapy (DRT), offer necessary support and assistance, and provide service linkages to community-based treatment providers. The chapter also defines and explains how MISSION CMs carry out individual and shared responsibilities with the MISSION Peer Support Specialist (PSS). Given that MISSION CMs not only deliver services directly, but also serve as liaisons to community-based providers, this chapter also addresses the importance of strong communication, collaboration, and interaction with other providers who also deliver services to clients on their caseload.

IV. *Peer Support.* This chapter explains the unique position of Peer Support Specialists (PSSs). Following an overview of their role within the MISSION program, the chapter explains how PSSs work with MISSION CMs to carry out individual and shared responsibilities. This chapter also highlights how the MISSION PSS serves as a role model and as a source of ongoing encouragement and support to clients receiving MISSION services. Case examples are included to illustrate how PSSs facilitate discussions on topics of particular concern to clients, support clients in the community, and help them address problems and challenges that arise during community transition and adjustment.

V. *Rapid Re-Housing.* This chapter describes how the MISSION team assists clients to secure and maintain permanent housing utilizing a Rapid Re-Housing framework. The chapter also offers practical and concrete suggestions on how to incorporate Housing First principles alongside MISSION service delivery. We anticipate that it will be useful for case managers and Peer Support Specialists in assisting clients with housing.

VI. *Vocational and Educational Supports.* This chapter discusses the role and provision of vocational and educational supports offered within the MISSION treatment approach. MISSION CMs and PSSs are given a concise review of the critical components of existing vocational and educational supports, such as Individual Placement and Support (IPS), Supported Employment (SE), and Supported Education (SEd), developed to help clients meet their employment and educational goals. Suggestions for linking clients to these, as well as other, state- and community-based vocational and continuing education programs are provided.

VII. *Trauma-Informed Care.* A major enhancement from the First Edition of the MISSION treatment manual is the incorporation of Trauma-Informed Care (TIC) considerations. Because of the high rate of trauma among homeless and formerly homeless individuals, the principles of TIC were integrated into the MISSION treatment approach. As trauma reactions, including Post-Traumatic Stress Disorder (PTSD), are very complex and delicate issues that require special treatment considerations on a case-by-case basis, this chapter is meant to serve as a general resource for MISSION CMs and PSSs. The chapter also contains resources for evidence-based TIC approaches.

VIII. *Core Competencies for Clinical Supervisors.* This chapter provides guidance for clinical supervisors who oversee and support the work of MISSION CMs and PSSs. It includes an overview of the supervisor's role and provides guidance on how to successfully address key responsibilities. Specifically, it addresses how to forge an effective supervisory alliance with MISSION CMs and PSSs, respond appropriately to each team member's learning needs and styles, negotiate an agreement with team

members about the nature and tasks of supervision; ensure fidelity to the MISSION treatment approach; provide clinical direction to CM/PSS teams when emergency situations arise; monitor and help manage the team's stress and the potential for burnout; and attend to issues related to diversity.

Resource Materials. Resource materials that immediately follow the last chapter include biographical sketches of the authors, a glossary of acronyms and terms that have been used throughout the manual, a list of key resources for further exploration of related topics, and technical support materials.

Appendices. The authors have included a number of appendices that will assist with the implementation and service delivery of the MISSION treatment approach that include the following:

>   **Appendix A: Key Clinical Outcomes.** Evidence supporting MISSION's use and efficacy including results from previous studies are presented.

>   **Appendix B: Theoretical Framework Underlying the MISSION Model**. The MISSION model is built on the theoretical framework of the Health Belief Model (HBM). This appendix presents the structure and premise of HBM and how it guides MISSION service delivery.

>   **Appendix C: MISSION Sample Position Descriptions.** This appendix provides generic Case Manager and Peer Support Specialist job descriptions. These sample descriptions have been included to serve as a resource to programs.

>   **Appendix D: MISSION Sample Service Delivery Schedules.** Sample service delivery schedules have been included to serve as a guide for implementation of the MISSION model.

>   **Appendix E: Leading Exercises in Dual Recovery Therapy.** Facilitated by the MISSION Case Manager, these psychoeducational co-occurring disorder treatment sessions are essential to the MISSION approach. These structured sessions can be delivered in either an individual or group format. Guidance for delivering booster DRT sessions is also

provided to help CMs monitor their clients' recovery from both mental health and substance use disorders.

Appendix F: Helpful Therapeutic Techniques Underlying MISSION Components. MISSION Case Managers will need to employ several core therapeutic techniques to appropriately facilitate DRT sessions. Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention and behavioral role play techniques are discussed.

Appendix G: Supplemental Materials for Case Managers. As the Case Manager role is critical to successful implementation of the MISSION treatment approach, this section contains additional information which supplements the material presented in Chapter III.

Appendix H: Leading Peer-Led Sessions. Information on the topics addressed during the MISSION peer-led sessions is discussed. Peer Support Specialists are encouraged to use these ideas as inspiration rather than gospel; it is important that MISSION Peer Support Specialists are able to plan and lead sessions that speak to the most pressing issues of their clients.

Appendix I: Supplemental Materials for Initiating Peer Support. This appendix reviews some of the lessons learned during previous implementation of the peer support component of the original MISSION treatment program. Based on these important lessons, suggestions are offered to help troubleshoot any issues that may arise as MISSION is being implemented.

Appendix J: Sample Client Budget Worksheet. This budget worksheet has been developed to assist case managers and peers with developing a monthly budget with the client to aid in money management skills.

Appendix K: Housing Preference Tool. This tool was developed as a result of feedback from case managers and integration of the Housing First model. The purpose of this tool is to help clinicians obtain a general picture of the housing needs and preferences for clients in order to best incorporate participant choice.

Appendix L: Homelessness Among Veterans.
This appendix includes a chapter taken from the MISSION-VET (2011) manual to provide specific information about homelessness among the Veteran population. While you might also wish to look at the MISSION-VET manual for more information on Veteran homelessness, we also wanted to include an overview of basic information in this appendix.

Appendix M: Vocational and Educational Support Materials. This appendix includes several resources that will assist MISSION team members in exploring and accessing vocational and educational supports for their clients. Selected tools that will assist MISSION team members in assessing service needs are provided. References for more in-depth resources have also been included.

Appendix N: Trauma-Informed Care Resources. Selected screening instruments and assessment tools are provided to assist MISSION team members in determining whether referrals for more in-depth trauma-informed services are needed.

Appendix O: MISSION Fidelity Index. This fidelity index has been developed to assist clinical supervisors in monitoring fidelity to the MISSION treatment approach.

How to Use This Manual

This manual is being provided as a spiral-bound printed document or as a PDF document downloaded from the web. Most members of the MISSION team will want to receive the entire manual for reference. However, certain sections will be of greater relevance to particular team members than others. The printed document has been spiral bound in order to facilitate copying of individual sections where needed; of course, the online version is also useful for this purpose.

Program Managers and Administrators: If you are an administrator or program manager of a service agency or community program that provides services to homeless or formerly homeless individuals, you may want to review the entire manual; however, we have created a guide that serves as a compendium of the entire manual:

I. Replicating the MISSION Program: Guidance for Program Managers and Administrators

Clinical Supervisors: If you are serving as a Clinical Supervisor on the MISSION team, you will want to review the entire manual carefully. However, you will find a description of the core components of the MISSION treatment approach in:

II. The MISSION Model of Care

Your own role as a supervisor described in detail in:

VIII. Clinical Supervision

Descriptions of your supervisee's roles can be found in:

III. Case Management
IV. Peer Support.

Case Managers and Peer Support Specialists:
If you will be serving as a MISSION Case Manager or Peer Support Specialist, you will want to pay particular attention to the following sections:

II. The MISSION Model of Care
III. Case Management
IV. Peer Support
V. Rapid Re-Housing
VI. Vocational and Educational Supports
VII. Trauma-Informed Care

Clients: An updated MISSION Participant Workbook has been developed for clients who are receiving services through the MISSION program. The MISSION Participant Workbook 2nd Edition should be given to each client as he or she enrolls in the MISSION treatment program. The workbook is divided into two parts: Part 1, which includes exercises and checklists designed to help strengthen and solidify the recovery tools learned during DRT psychoeducational co-occurring disorders treatment sessions; and Part 2, which is intended to help clients prepare for the transition back to the community. Additionally, the reading material in the workbook is intended to help clients during their adjustment to the community and empower them to succeed in their recovery.

Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION) is a wraparound services model developed specifically to meet the needs of individuals who have experienced homelessness and whose ability to return to independent community living is further complicated by co-occurring mental health and substance use disorders (COD). The MISSION program is one of many designed to meet the objectives of Opening Doors: Federal Strategic Plan to Prevent and End Homelessness (U.S. Interagency Council on Homelessness, 2010). Given the high rate of mental illness and substance abuse among homeless and formerly homeless individuals, and as mental illness and substance abuse have been recognized as important contributing factors to chronic homelessness, the MISSION treatment approach serves the needs of a population that must be addressed in order to end homelessness. The primary goal of MISSION is to facilitate rapid community engagement and achievement of personal goals by helping individuals participate in a comprehensive array of outpatient mental health and substance abuse treatment services as well as vocational and educational rehabilitation programs. However, community engagement is also contingent upon stable housing. Thus, MISSION incorporates a rapid re-housing framework that acknowledges that housing is a basic human right and a necessary component of the recovery process.

MISSION was built on the theoretical framework of the Health Belief Model (Becker, 1974), and systematically integrates Critical Time Intervention (CTI) case management (Susser, et al., 1997), Integrated Dual Disorders Treatment (IDDT) via the Dual Recovery Therapy (DRT) treatment model (Ziedonis & Trudeau, 1997), Peer Support, Vocational/Educational Supports, and Trauma Informed Care (TIC) treatment considerations to support homeless and formerly homeless individuals seeking to maintain recovery from co-occurring mental health and substance use disorders and adjust to independent living in the community. Each client in the program is assigned to a team consisting of one Case Manager

and one Peer Support Specialist who both provide the client with support through psychoeducational exercises and the facilitation of service linkages in the community, including outpatient mental health and substance abuse treatment programs, primary and specialty medical care, housing supports, vocational and educational rehabilitation services, and trauma-informed treatment providers. With the support and guidance of an experienced Clinical Supervisor, the MISSION team helps the client resolve problems that arise, teaches and reinforces skills needed to meet treatment, recovery, and personal goals, and celebrates individual achievements along the way.

MISSION services can be delivered over two, six, or twelve months using our sample service delivery schedules and can be initiated in a wide variety of settings including within inpatient and residential treatment programs, during the housing placement process or once the client has received a safe and stable housing placement. Consistent with the CTI model, services provided by MISSION Case Managers and Peer Support Specialists taper off as the individual becomes more confident in his or her ability to access and use essential supports and to function independently in the community, free from drugs and/or alcohol.

MISSION primarily focuses on the delivery of case management to meet the unique needs of homeless and formerly homeless individuals with co-occurring disorders. It also includes treatment for mental health issues and substance abuse, rapid re-housing assistance, vocational and educational support, and incorporates trauma-informed care considerations across all of these interventions.

1. CTI case management is used within MISSION as the core treatment intervention. CTI is designed to give clients a "running start" and "safety net" by providing intensive services upon re-entry into the community, thus establishing firm linkages between clients and needed services.

2. Case managers provide Integrated Dual Disorders Treatment (IDDT) via the Dual Recovery Therapy

(DRT) approach. DRT sessions can be delivered in either a group or individual format. Discussion and exercises help raise awareness of the impact of mental illness, substance abuse and other harmful behavior on clients' lives and offers tools to aid in recovery.

3. Peer Support is provided alongside case management to help clients maintain their mental health and sobriety, follow healthy lifestyles, and participate in needed supports, thereby bolstering the effectiveness of the other interventions. Peer Support Specialists offer inspiration, the understanding of one who has "been there," and assistance in adjusting to new routines such as maintaining a home, working, attending various treatment appointments including participation in 12-Step programs if appropriate.

4. Rapid Re-Housing Supports are provided by the MISSION team to assist clients secure and maintain housing that meets their needs and preferences, helping clients to become integrated members of their communities.

5. Vocational/Educational Supports are offered by the MISSION team to help clients find and maintain employment and achieve educational goals, contributing to daily living stability and improved self-esteem.

6. MISSION incorporates Trauma-Informed Care Considerations. MISSION Case Managers and Peer Support Specialists are trained to screen clients for trauma-related symptoms and refer them as needed to treatment providers who are trained in delivering evidence-based treatments for the management of trauma symptoms.

Previous studies examining the efficacy of the MISSION approach have demonstrated improved outcomes related to psychological functioning, substance use, housing/employment maintenance, treatment retention, and use of outpatient services.

I. Replicating the MISSION Program:

Guidance for Program Managers and Administators

David Smelson, Psy.D. • Jennifer Harter, Ph.D. • Leon Sawh, M.P.H.

This chapter provides important information for administrators and program managers who are considering replicating the MISSION program in their own treatment settings. It summarizes the MISSION program and the key elements to be addressed when the program is adapted and implemented, including target population; treatment setting; program service components; staffing, education and training requirements; and other strategic considerations. At the outset of the chapter, we explain how the MISSION program has been adapted over time. More detailed information on the interventions that inform MISSION and on the roles of staff that are crucial to its success, are found in the later chapters and appendices of this manual.

A. Introducing MISSION: History and Background

Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION) is a flexible, time-limited treatment intervention rooted in the Health Belief Model (Becker, 1974). Originally known as Time-Limited Care (TLC) coordination, the program has been used successfully nationwide by U.S. Department of Veterans Affairs (VA) programs as well as other (non-VA) behavioral health agencies (Smelson et al., 2005; Smelson et al., 2007; Smelson et al., 2012; Smelson et al., 2013).

TLC now referred to as the MISSION 2-month curriculum, was originally developed in 1999 at the VA New Jersey Health Care System (VANJ) and subsequently studied in a randomized controlled trial through VA Merit # IIR-020-145. TLC integrated elements of Critical Time Intervention (CTI) case management, Dual Recovery Therapy (DRT), and Peer Support to meet the multi-faceted needs of individuals suffering from co-occurring serious mental illness (SMI) and substance use disorders transitioning from acute psychiatry to outpatient

care. Together, CTI and DRT formed the core treatment components of the TLC model, while Peer Support Specialists encouraged and reinforced use of available community-based treatment supports among clients. TLC Case Managers and Peer Support Specialists facilitated the transition from inpatient to outpatient care, providing more support than was traditionally provided during this critical time.

In 2004, TLC was extended from a 2-month to a 12-month intervention in order to provide clients with a longer support period given the comprehensive service needs of this population. This 12-month service delivery schedule, now called MISSION, offered longer community support and a wider array of service linkages for homeless individuals with non-psychotic mental health and substance abuse problems. The decision to lengthen the period during which the transitioning client received support was based on the concern that prospective MISSION clients would likely be ineligible for many of the community-based programs geared towards the treatment of only those individuals with a Serious Mental Illness (SMI) and would, therefore, likely need a longer period of service delivery to establish housing stability, maintain sobriety, and achieve community independence. Additionally, we often found that the target population of the MISSION program was often ineligible for entitlements such as VA disability and Social Security Disability.

A study of the 12-month curriculum was supported by grant #TI16576, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) - Center for Substance Abuse Treatment (CSAT). This 12-month curriculum study was also performed in the VANJ and targeted Veterans in the 14-week Domiciliary Care for Homeless Veterans (DCHV) substance abuse treatment program.

The following guide lists each of the federally funded studies involving MISSION as well as the adaptations of MISSION for vulnerable populations over the past 15 years:

Figure 1: MISSION Programs 1999 - 2013

MISSION Projects	
Model Development (1999-2005) PI David Smelson Supported by VA OPCS/VISN 3 MIRECC	**Components:** Model Development, Pilot Testing **Setting:** Acute psychiatry/inpatient treatment program
Brief 2-month Intervention (2005-2009) PI David Smelson Supported by VA HSR&D	**Components:** Critical Time Intervention (CTI), Dual Recovery Therapy (DRT), and Peer Support **Setting:** Acute psychiatry/inpatient treatment program
MISSION NJ (2004-2010) PI David Smelson Supported by SAMHSA	**Components:** CTI, DRT, Peer Support, and Vocational Support **Treatment Length:** 12 months **Setting:** Residential treatment program
MISSION Jail Diversion Project (2008-2013) PI Debra Pinals Supported by SAMHSA-CMHS.	**Treatment Length:** 12 months (treatment begins after adjudication) **Target Population:** returning OIF/OEF Dually Diagnosed Veterans with a trauma history who have been diverted from jail and selected by judge to receive treatment rather than serve jail time
MISSION Model Development (2010-2011) PI David Smelson Supported by VA ORD/HSR&D/National Center for Homeless Veterans	**Components:** CTI, DRT, Peer Support, Vocational/Educational Supports, and Trauma-Informed Care Considerations **Treatment Length:** 2 months, 6 months, or 12 months **Setting:** Inpatient treatment program, residential treatment program, or once placed in housing
MISSION CREW (2010-2011) PI Debra Pinals Supported by the Bureau of Justice Assistance (BJA)	**Components:** Dual Recovery Therapy, Critical Time Intervention and Vocational Support with trauma-sensitive contributions **Treatment Length:** 3 months pre-release and 6 months post-release **Target Population:** female offenders with co-occurring substance abuse and mental health disorders who committed a non-violent offense
MISSION RAPS (2011-2012) PI Debra Pinals Supported by the Bureau of Justice Assistance (BJA)	**Components:** Dual Recovery Therapy, Critical Time Intervention, and Vocational Support with trauma-sensitive contributions **Treatment Length:** 3 months pre-release and 6 months post-release **Target Population:** medium- and high-risk female offenders with co-occurring substance abuse and mental health disorders (may have committed a violent or non-violent offense)
HUD-VASH Randomized Controlled Trial (2011-2013) PI David Smelson Supported by VA National Center for Homeless Veterans	**Components:** In addition to standard HUD-VASH Case Management, for 6 months, participating Veterans received either MISSION, Telephone Counseling or symptom monitoring via telephone; Treatment Length: 6 months **Setting:** Formerly homeless, dually diagnosed Veterans who have received housing placements through HUD-VA Supportive Housing Program

MISSION Implementation Study (2011-2014) PI David Smelson Supported by VA ORD/HSR&D/National Center on Homelessness Among Veterans	**Components:** Compare Implementation as Usual to Getting To Outcomes (GTO) to determine the most effective implementation strategy for the MISSION Intervention within VA Homeless Services **Setting:** Formerly homeless, dually diagnosed Veterans who have received housing placements through HUD-VA Supportive Housing Program in Northampton, MA, Washington, D.C., and Denver, CO.
MASS-MISSION: Ending Chronic Homelessness in Central and Western MA (2011-2014) PI David Smelson Supported by SAMHSA-CABHI	**Components:** Housing Placement, CTI, DRT, Peer Support, Trauma-Informed Care, Vocational and Educational Support **Treatment Length:** 12 months **Setting:** Place chronically homeless individuals in permanent housing and receive case management and peer support services for co-occurring disorders
Improving Outcomes for Homeless Veterans with Peer Support (2012-2016) PI Marsha Ellison Supported by VA HSR&D	**Components:** Peer Support as proscribed by MISSION **Treatment Length:** 12 months **Setting:** HUD-VASH programs in Bedford, MA and Pittsburgh, PA
Maintaining Independence and Sobriety Through Systems Integration, Outreach, and Networking-For Offenders Recovering With Awareness, Resources, and Dignity, (MISSION-FORWARD) (2013-2016) PI Hilary Jacobs Supported by SAMHSA	**Components:** MISSION – Criminal Justice Edition components **Treatment Length:** 6 or 12 months **Setting:** Adult Drug Court and Veterans' Treatment Court
Housing Chronically Homeless Individuals through use of the MISSION Model (MISSION: Housed) (2013-2016) PI Hilary Jacobs Supported by SAMHSA	**Components:** MISSION – 2nd Edition components **Treatment Length:** 12 months **Setting:** MISSION delivered in the community alongside use of a Housing First model
MISSION – iRAPS PI Debra Pinals Supported by the Bureau of Justice Assistance (2013 – 2015)	**Components:** MISSION – Criminal Justice Edition components **Treatment Length:** 12 months **Setting:** MISSION delivered in the community post-release from prison

The MISSION approach has been shown to improve outcomes related to substance use, psychological functioning, and housing/employment retention (see Appendix A). Research further suggests that MISSION increases treatment retention and participation in outpatient services, while also improving behavioral health outcomes in other domains. Those interested in learning more about the findings from these treatment studies other than what is provided in Appendix A are encouraged to review the following publications: Smelson et al., 2005; Smelson et al., 2007; Smelson et al., 2012; Smelson et al, 2013.

The MISSION program presented in this manual is both an adaptation to and enhancement of previous editions of the MISSION model (1ST Edition (2007) and Veterans Edition (2011)). Chapters and resources in this manual that were not in the previous MISSION Treatment Manuals include a chapter on Rapid Re-Housing, a non-Veteran focused chapter on Trauma-Informed Care, expanded information on vocational and educational support, and additional resources included in the appendix which Case Managers and Peer Support Specialists will find useful when implementing the MISSION model.

B. Target Population and the MISSION Team

Individuals are targeted for MISSION services if they are homeless and transitioning from inpatient or residential treatment to community living and outpatient care or formerly homeless and living in the community and in need of additional support in their adjustment to independent community living. In order to be eligible for MISSION treatment services, individuals must meet the following criteria:

- Homeless or at-risk for homelessness

- Diagnosed with both a substance use disorder and mental illness

- Willing to take part in the program and receive services

- Able and willing to live in the community

The MISSION team consists of a Program Director, Clinical Supervisor, Case Managers (CMs), and Peer Support Specialists (PSSs). The heart of the intervention is the support provided by CM/PSS treatment teams, who work together to help clients make the critical transition from homelessness to community living.

PSS positions are filled by individuals who themselves have experienced housing, mental health, and/or substance abuse problems in the past, and who have achieved and maintained a successful recovery. With firsthand knowledge of just how difficult it can be to overcome these obstacles, MISSION PSSs serve as role models for their clients, providing not only guidance, but hope—that recovery from homelessness, addiction, mental illness, and unemployment are realistic and achievable goals.

C. The Population's Need for Services

Homelessness remains a persistent public health concern and a national tragedy. According to Point-In-Time (PIT) data from the 2012 Annual Homeless Assessment Report to Congress (AHAR), there were 633,782 people experiencing homelessness on any given night in the United States. Sixty-two percent of those counted were sleeping in emergency shelters or transitional housing. Thirty-eight percent were unsheltered, sleeping on the streets, in their cars, in abandoned buildings, or other places not meant for human habitation (AHAR, 2012).

MISSION was developed to link these homeless individuals, who have a wide variety of treatment and service needs, to providers who can directly deliver the services they require and support them while they transition to life in the community. Linkages provided by MISSION CMs and PSSs include integrated mental health and substance abuse treatment, housing assistance, employment and educational supports, Trauma-Informed Care considerations, and other community supports that individuals may need to remain sober, mentally stable, housed, and employed.

D. Settings for Service Delivery

Given that MISSION may begin during inpatient/ residential treatment or once clients have received a housing placement in the community, we have deliberately included descriptions of how to begin service delivery in each of these instances. Yet, regardless of the setting in which clients begin receiving MISSION services, the goals of the program are the same:

Major Goals of MISSION

1. Provide clients with direct support services to address substance abuse and mental health problems, secure and maintain housing, and in reaching their employment and education goals.

2. Help clients engage in treatment services, become integrated members of their communities, and maintain lives in recovery.

3. Coordinate care for clients across service providers, both within and outside the MISSION program.

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MISSION in Inpatient/Residential Settings

When MISSION is delivered in conjunction with inpatient/residential treatment services, the MISSION CM/PSS team begins to interact with clients while they are in the residential setting to build a foundation that will enable them to provide longer-term support as clients re-enter the community. The focus here is on providing transitional support, communicating with the inpatient/residential staff to obtain a better understanding of the client's needs, and assisting in the development of a discharge plan which will provide a roadmap for treatment and recovery once the client is residing in their own housing in the community. The table below, titled "Role of MISSION Staff while Client is in Inpatient /Residential Treatment," summarizes the responsibilities of MISSION providers at this juncture.

Role of MISSION Staff While Client is in Inpatient/Residential Treatment

- Participate in the development of the treatment plan

- Participate with residential staff in weekly team meetings

- Contribute to the development of the housing plan

- Participate in the development of the discharge plan

- Deliver group sessions on Dual Recovery Therapy (Case Managers) and issues related to the transition to community life (Peer Support Specialists)

- Play a key role in helping to facilitate the discharge plan

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It is very important to note that during the inpatient/ residential phase of treatment, staff from the inpatient/ residential program has the central role in treatment and discharge planning, thus it is essential that the MISSION team coordinates their work with those central team members. By respecting the role of the inpatient/residential staff as primary treatment providers, the MISSION team is able to augment the services of the facility, develop functional working relationships with both treatment facility staff and the client, and monitor the progress of the client throughout his or her inpatient/residential stay. Once the client leaves the inpatient/residential setting, the MISSION CM/PSS team works with the client to help him/her achieve recovery goals and resolve challenges that arise along the way, preventing a return to homelessness.

Given the flexibility of the MISSION service delivery platform, administrators and program managers should feel comfortable setting up MISSION in any inpatient or residential setting, regardless of desired treatment length. While the 12-month MISSION model was developed in conjunction with a 14-week residential program, the approach can be modified by adjusting the timeline of contact in the inpatient/ residential treatment phase. For example, sessions related to community transition can be delivered as the client's discharge from the inpatient/residential setting is approaching. Ideally, the client might complete the

13 DRT sessions while still in inpatient/residential care, since these psychoeducational sessions offer skills for adjusting to community living.

MISSION in Community Settings

A transition from inpatient/residential care to the community is not a necessary requirement for implementing the MISSION program. MISSION may begin when an individual who has been homeless receives a housing placement and begins to adjust to a new life in the community. The primary difference between implementation of MISSION in inpatient/residential and community settings is the loss of a stabilization phase in a controlled environment, which may require the MISSION CM/PSS team to offer more services and be even more proactive at the outset of MISSION service initiation. Nevertheless, the goals of MISSION remain consistent: engagement in mental health and substance abuse treatment, housing stability, and improved income/employment.

When implemented in community settings, care coordination may involve using MISSION's service delivery approach in conjunction with a specific outpatient program. When this is the case, the primary goals of MISSION staff are six-fold:

Role of MISSION Staff in Community Care Settings

1. Facilitates execution of the treatment plan

2. Participates with other case managers and care providers in weekly team meetings

3. Contributes to the development of the housing maintenance plan

4. Provides referrals and facilitates linkages to outpatient substance abuse, mental health, and medical treatment services

5. Plays a key role in coordinating both treatment program and non-treatment program services

6. Supports and inspires individuals by helping them pursue and achieve their goals as community members

E. Service Components

The MISSION model includes six essential components, each of which will be described below. These include **Critical Time Intervention (CTI),** the foundation of MISSION's services; **Dual Recovery Therapy (DRT)**, to address co-occurring mental health and substance use disorders (COD); **Peer Support,** which models and supports life in recovery; **Rapid Re-Housing** which helps clients secure and maintain housing; **Vocational and Educational Support,** which helps clients reclaim productive lives and achieve personal goals; and **Trauma-Informed Care Considerations,** which addresses the implications of trauma on effective service delivery (Fallot & Harris, 2001) and ensures that clients who need specialized treatment for trauma-related symptoms are referred to specialized treatment providers. If the onset of trauma-related symptoms occurs acutely, individuals return to the MISSION program once these symptoms have been stabilized.

Essential Components of the MISSION Model

1. **CTI** case management is used as the foundation of MISSION's service components. CTI is designed to give individuals a "running start" then provides a "safety net" of intensive services upon re-entry to the community, thus establishing firm linkages between clients and needed support services.

2. **DRT** helps educate clients on the impacts of substance use, mental illness, and harmful behavior, offering exercises and tools to aid in recovery.

3. **Peer Support** helps clients engage in sobriety and mental health stability services with a "mentoring" approach. The personal relationship and support provided by someone who "has been there" also bolsters the effectiveness of the other interventions.

4. **Rapid Re-Housing Support** helps clients locate, secure, and maintain safe and stable housing and is guided by client needs and preferences.

5. **Vocational and Educational Support** helps individuals find and maintain employment. This contributes to stability in daily living and improved self-esteem. MISSION also includes educational supports to help individuals understand and utilize benefits, navigate enrollment and registration processes, and further their educational goals.

6. **Trauma-Informed Care Considerations:** MISSION Case Managers and Peer Support Specialists are trained to screen for and identify trauma-related symptoms and in cases of acute symptoms, make referrals to treatment providers who are better trained to treat Post-Traumatic Stress Disorder (PTSD) and other trauma-related disorders. They are also trained to provide ongoing support for individuals while they are receiving treatment from a specialized PTSD program or to directly provide basic services to those who are not acutely symptomatic and do not require specialized PTSD treatment.

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Critical Time Intervention (CTI) Case Management as used in MISSION

Critical Time Intervention (CTI) case management, the core intervention component of the MISSION model, is a time-limited form of Assertive Community Treatment (ACT), specifically targeted for persons who have been homeless and are transitioning to community living (Susser et al., 1997). CTI is one of only a few homelessness prevention interventions to be featured in SAMHSA's National Registry of Evidence-Based Programs and Practices (Herman & Mandiberg, 2010) and has been examined in a number of studies (Baumgartner & Herman, 2012; Dixon, et al., 2009; Herman & Mandiberg, 2010; Kasprow & Rosenheck, 2007; Susser, et al., 1997; and Tomita & Herman, 2012). These studies support the intervention's effectiveness in improving outcomes among previously homeless adults with mental illness following discharge from an institutional facility. See *http://www.criticaltime. org/* for an overview of the model.

Within MISSION, CTI has been adapted to meet the needs of homeless or formerly homeless individuals

who have been diagnosed with COD. The classic approach to CTI begins with the individual's discharge into the community and is divided into three phases. However, since MISSION can be applied in a variety of settings, this classic approach is often modified somewhat. However, regardless of the setting in which MISSION is implemented and consistent with the CTI model, the three phases of CTI are characterized by a decrease in the frequency and intensity of services.

THREE PHASES OF CTI

1. **Transition to Community:** The client and MISSION Case Manager formulate an individualized treatment plan and identify community resources and service linkages most consistent with the client's needs. During this phase, the Case Manager may need to pay particular attention to monitoring medication compliance and facilitating appointments with mental health and other medical service providers.

2. **Try-Out:** Systems of community support are tested and adjusted and the MISSION Case Manager and Peer Support Specialist identify any service gaps or areas where the client requires more or less support.

3. **Transfer of Care:** Long-term, community-based linkages are established and fine-tuned to assure that transfer of care issues are resolved and long-term goals are finalized.

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The creators of CTI liken the process to passing a baton in a track relay race. The runner passing the baton runs alongside the runner receiving the baton until the first runner is sure that the second runner has a firm grasp on the baton. Similarly, the MISSION CMs and PSSs "run alongside" their clients until they can "carry the baton" on their own and perform life tasks independently without the treatment team's support.

Consistent with the DRT component of MISSION, CTI also uses the "Stages of Change" (Prochaska & DiClemente, 1983) model and Motivational Interviewing (Miller & Rollnick, 2002), to help individuals develop a

commitment to community-based recovery, remain engaged in treatment, maintain housing, sustain employment, and find other needed supports. The use of CTI within MISSION has been developed in collaboration with Dr. Alan Felix from the original CTI development team. Successful implementation requires the presence of trained MISSION CMs who have developed working relationships with key people able to link clients to community-based supports and services. Programs implementing the model need to establish mechanisms for tracking each contact between staff and clients, assessing clients' progress, and making appropriate referrals to meet clients' needs.

Outcomes Achieved with the CTI Approach

CTI is a time-limited form of ACT. In a meta-analysis of six randomized trials and four observational studies (N>5,775) that employed an ACT intervention for homeless populations with a mental illness, ACT was found to be significantly associated with a greater reduction in homelessness and greater improvement in mental health symptoms compared to individuals receiving standard case management services only (Coldwell & Bender, 2007). Similarly, in the first study of CTI, Susser et al. (1997) examined outcomes among 96 individuals who transitioned from a shelter institution to community living and received either a 9-month CTI intervention or usual services. They found that individuals who received CTI experienced fewer days of homelessness, greater continuity of care, and increased use of community supports when compared to individuals who received usual services only. Dixon et al. (2009) compared a brief CTI intervention to treatment as usual in a randomized trial of 135 participants, noting that those receiving CTI had significantly better treatment attendance and engagement. Also, in a recently completed randomized trial that compared homelessness outcomes among 150 participants who also received either CTI or usual services only, a substantial reduction of recurrent homelessness was observed among those who received CTI (Herman & Mandiberg, 2010). Similar outcomes have also been achieved in two recently published studies in the academic journal Psychiatric Services (Baumgartner & Herman, 2012; Tomita & Herman, 2012).

Consistent with the findings from these randomized trials, similar outcomes were observed in a non-randomized trial of 206 participants who received a 6-month version of CTI at eight locations. Compared to the 278 participants who received usual discharge planning services from the inpatient unit staff, those who also received CTI showed nearly 20% more days housed, fewer days in institutional settings, and lower alcohol, drug, and overall psychiatric symptom scores (Kasprow & Rosenheck, 2007).

Taken together, these studies suggest that delivering an intervention that employs a CTI component can be helpful in promoting continuity of care for homeless persons suffering from a mental illness after they are discharged.

Dual Recovery Therapy (DRT) as used in MISSION

Co-occurring substance use and mental health disorders (COD) may present serious challenges to the efficient delivery of needed treatment services. Until recently, the conventional approach has been to administer treatment for substance abuse separately from treatment for mental illness. Thus, individuals with COD have participated in either sequential treatments for each disorder or in parallel treatment for both simultaneously, but with different practitioners and different treatment plans at each program. Both approaches lead to fragmented and ineffective care for individuals with COD (Lurigio, 2003). Conversely, benefits of integrated care include sustained remission rates from substance use that are 2 to 4 times higher than traditional treatment approaches, with improved treatment retention and fewer hospitalizations (SAMHSA, 2002).

Dual Recovery Therapy (DRT) (Ziedonis & Trudeau, 1997) is an intervention that addresses COD in an integrated manner. DRT blends and modifies traditional addiction treatment therapies (relapse prevention, motivational enhancement therapy, and 12-step facilitation) with traditional mental health approaches (cognitive-behavioral therapy, supportive psychotherapy/social skills training). DRT is consistent with existing therapeutic models that manage

both substance abuse and psychiatric conditions simultaneously (Bennett, et al., 2001; Drake, et al., 1998; Minkoff, 1989; Shaner, 1997). Several studies have demonstrated improvements for populations with COD who received DRT (Ziedonis & Trudeau, 1997; Ziedonis & Simsarian, 1997; Ziedonis & Stern, 2001). Two important aspects of DRT have been adopted by the MISSION program:

1. Principles for successful treatment of persons who have COD, and

2. A structured series of sessions, led by the MISSION Case Manager, that introduce clients to tools, methods, and therapeutic techniques that can enhance the recovery process (see Appendix E).

DRT is delivered by the MISSION CM through 13-weeks of structured psychoeducational sessions. Topics addressed in these DRT Sessions are presented below.

Topics Addressed in DRT Sessions

1. Onset of Problems (History of lifetime substance use and psychological symptoms)

2. Life Problem Areas Affected by the Individual's Co-occurring Disorder

3. Motivation, Confidence, and Readiness for Change

4. Developing a Personal Recovery Plan

5. Decisional Balance

6. Communication Skills Development

7. 12-Step Orientation and Recollections

8. Anger Management

9. Relapse Prevention

10. Interpersonal Relationships

11. Changing Unhealthy Thinking Patterns

12. Changing Irrational Beliefs

13. Activity Scheduling

Additionally, booster DRT sessions and ongoing review of DRT worksheets and exercises should be used as needed after completion of the 13 DRT psychoeducational treatment sessions. When an individual enrolls in the MISSION program, he or she receives a MISSION Participant Workbook that contains all of the original DRT exercises, along with additional exercises and readings. All MISSION CMs and PSSs receive training in the principles of DRT to ensure consistency of the approach. See Chapter III on Case Management and Chapter IV on Peer Support for further details on implementing DRT sessions within the MISSION program.

Peer Support

MISSION adds the use of Peer Support Specialists (PSS) to the CTI case management model. PSSs, who work in partnership with MISSION CMs, offer the added benefit of being able to connect on a more personal level with clients, and share personal knowledge of challenges and opportunities during community transition. Trained PSSs can "run alongside" clients suggesting coping strategies, improving access to self-help/mutual support services, and linking individuals to community-based opportunities for constructive social engagement. While encouraging the development of other life skills and natural supports, these "teammates" provide an example of hope.

Peer support services, services provided by individuals who are role models for recovery, are emerging as an evidence-based practice for individuals with COD (Chinman, et al., 2010; Fisk, et al., 2000; Klein, et al., 1998; Roman & Johnson, 2002; Yanos, Primavera, & Knight, 2001) as well as for individuals who are homeless (Besio & Mahler, 1993; Van Tosh, 1993).

As part of this shift in the paradigm of care, peer providers help to move mental health services towards a sharper focus on recovery, as defined by the client, by identifying and eliminating subtle forms of stigma and bias within the health care system that can negatively impact treatment engagement if left unaddressed. Within the MISSION treatment program, PSSs can play an important role in helping the client to become a more fully integrated member in his or her community. PSSs can help clients work toward and achieve their goals

and, in collaboration with the MISSION CM, call on a range of other community-based providers to step up to the plate and help make recovery a reality.

The MISSION program employs a participant-provider model of peer support. In this model, PSSs "draw upon their lived experiences to share 'been there' empathy, insights, and skills… serve as role models, inculcate hope" (Chinman et al., 2008, pgs. 1315–1316). A review of research on this model of peer support (Chinman et al., 2006; Davidson, et al., 2006) shows that it can reduce inpatient utilization, substance use, social isolation, and symptoms.

Thus, each PSS is both a full staff member of the MISSION program and someone who has achieved significant recovery from challenges similar to those faced by clients receiving MISSION services (homelessness, unemployment, substance abuse, and mental illness). The combination of training and personal experience helps PSSs advocate for clients and empower them to determine their recovery goals, share wellness and relapse prevention strategies, and provide practical support to clients as they establish new lives in the community. The MISSION PSS may accompany clients to 12-step meetings and may, as needed, help them with essential tasks such as learning to use public transit, setting up a bank account, or getting a drivers license, among others.

At the onset of MISSION, clients attend weekly peer-led sessions (see Appendix H). The sessions reinforce DRT topics (discussed above) covered by the MISSION CM, but also encompass issues identified by the PSS as part of the recovery process, including humility, courage, and willingness to change. Interactions with MISSION PSSs, who have had similar problems with substance abuse, mental illness, homelessness, and unemployment and are now maintaining a successful recovery from these problems, reinforce the benefits of maintaining sobriety and give the client added confidence in his or her ability to achieve comparable goals.

Topics Addressed in Peer-led Sessions

1. Willingness

2. Self-acceptance and respect

3. Gratitude

4. Humility

5. Dealing with frustration

6. Handling painful situations

7. Significance of honesty

8. Courage

9. Patience

10. Medicine maintenance

11. Making a good thing last

Rapid Re-Housing as used in MISSION

MISSION promotes rapid rehousing and adopts a Housing First approach, based on the Pathways to Housing – Pathways Housing First model, developed by Dr. Sam Tsemberis, which considers housing to be a basic human right. According to this approach, when housing is offered as a matter of right instead of an enticement or coercion to become and remain sober, clinicians establish a unique rapport with the client. In this model, the housing must be permanent, separate from and unaffiliated with mental health services, and consistent with the client's housing preferences (Carling, 1990; Ridgeway & Zipple, 1990). Recovery-oriented services are made available to those clients who choose to access them once housed and can be delivered in a flexible manner most suitable to the client. The table below outlines the six essential ingredients of the Housing First Approach.

Six Essential Ingredients of Housing First

1. Consumer Choice

2. Separation of Housing and Services

3. Services are Voluntary and Flexible

4. Recovery-oriented Services

5. Community Integration

6. Harm Reduction

   (Tsemberis, 2010)

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MISSION involves intensive community outreach and meeting clients where "they're at" both physically in the community as well as in terms of their stage of recovery. The CM/PSS team facilitates the housing search by highlighting consumer choice and coupling rapid re-housing with wraparound MISSION services. Active community involvement and outreach by the MISSION CM and PSS demonstrates to clients that the clinical team is invested not only in their mental health and substance abuse recovery but also in their having comfortable and secure permanent housing. Rapid re-housing sets the stage for the initiation of linkages to supports in the clients' own community. The maintenance of these supportive connections in the client's community will be the foundation of the client's recovery both while in MISSION and after graduation. As others have suggested, when a person has a secure place to live, eat, and sleep they are better able to focus on other matters of recovery that will help keep them housed such as treatment for mental health and substance use disorders (Tsemberis, 2010; O'Hara, 2007).

Vocational and Educational Supports

Besides the stigma accompanying diagnoses of mental illness and substance abuse and any functional limitations that they may impose, many individuals with COD also face other barriers to achieving their employment and educational goals. For example, those with prior criminal justice involvement or significant gaps in their employment history may be less likely to be selected for a job. Furthermore, clients receiving MISSION services may have limited resources. Often times, these individuals are unprepared for job competition and even job application, and may need training in skills such as looking for a job, preparing and sending out resumes, and interviewing with potential employers. Even if a job is obtained, job tenure for persons with COD is especially low.

While MISSION CMs and PSSs are not trained as employment specialists, they can apply a range of employment principles and practices to promote the employment of their MISSION clients. Putting these principles into practice requires a special set of "Supported Employment" (SE) skills which is central to the Individual Placement and Support (IPS) model, which may be new to MISSION CMs and PSSs. The aim of IPS is to help people with psychiatric conditions achieve competitive employment based largely on their job preferences.

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Individual Placement and Support/ Supported Employment Principles

- Zero exclusion

- Focus on competitive employment

- Integration of mental health and employment services

- Attention to client preferences

- Work incentives planning

- Rapid job search

- Continuous job supports

- Systemic employer relationships

Swanson, Becker, Drake, & Merrens, 2008

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It is important for MISSION staff to familiarize themselves with SE principles and possibly receive specific SE training, either externally or internally using the following booklets: SAMHSA Toolkit *Supported Employment: Training Frontline Staff* and Supported Employment, A Practical Guide for Practitioners and Supervisors or the SE training manual available from Dartmouth University *http://sites.dartmouth.edu/ips/ fidelity/fidelity-review-manual.*

Rather than pursue employment, some individuals with COD who are homeless or recently removed from homelessness may wish to pursue their educational goals such as enrolling in a community college or attending a trade school on their way towards obtaining their desired position. Similar to SE, Supported Education (SEd) principles can be used with clients to help in achieving educational goals (Delman & Ellison, 2012). The table below lists some of the tasks MISSION CMs/PSSs may complete as it relates to providing vocational/educational support.

Supported Education Principles Used in MISSION

1. Accessing financial aid, scholarships, and other educational benefits

2. Interfacing with campus system including administration and faculty

3. Acquire support on campus through service offices

4. Determining educational goals

5. Ongoing monitoring and support

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MISSION CM and PSS responsibilities regarding the use of Vocational and Educational Supports are designed to help facilitate the client's full- or part-time employment, negotiate workplace accommodations and/or access to available special learning-needs accommodations. After the client is able to maintain employment or pursue his/her education independently, MISSION staff involvement in facilitating use of available employment/education programming is phased out. For example, MISSION CMs and PSSs may provide linkages and facilitate introductions to program staff at key vocational programs or from the admission department at a local university then reduce their involvement in these meetings as the client becomes more comfortable. A list of CM/PSS vocational/educational support responsibilities are listed in the table below.

Roles and Responsibilities for MISSION Team in Delivering Vocational/ Educational Supports

• Assess eligibility for vocational benefits and assistance (eg., local, state, federal)

• Facilitate linkages to specialized vocational training programs

• Establish career and educational goals

• Assist in the identification of potential employers

• Provide linkage to hiring departments/hiring managers

• Help prepare for job search (including resume development and online application forms)

• Help client in identifying applicable programs to continue education

• Assist client with setting up informational interviews/ attending career fairs

• Help clients make face- to- face contact with employers/admission departments

• Address potential criminal justice issues

• Address any potential transportation barriers (e.g., use of public transit)

• Assist in the filing and submission of applications

• Help in assessing financial aid, scholarships and other educational benefits

• Help clients prepare for standardized tests

• Conduct Mock interviews

• Provide guidance on how to follow-up on applications/interviews

• Provide strategies for coping with job/school related stress

• Address client feelings of isolation on campus/ associating with fellow students

• Connect client to the student with disabilities resource center

- Provide instruction on the use of time management skills

- Assist with course selection

- Facilitate interaction with professors/instructors

- Encourage use of healthy stress management techniques

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For more in-depth information on vocational and educational supports, please refer to Chapter VI. Vocational and Educational Supports.

Trauma-Informed Care Considerations

MISSION is not a specific trauma or PTSD intervention. However, as many homeless individuals have experienced trauma in their lives, Trauma-Informed Care (TIC) considerations have been incorporated into the overall MISSION treatment model. MISSION CMs and PSSs receive training on how to screen individuals for trauma and how to coordinate care with specialized trauma clinicians, when needed, until trauma-related symptoms stabilize. MISSION CMs and PSSs can provide support to individuals with elevated trauma symptoms; however, they are not expected to serve as primary providers of care for trauma-related disorders. The table below summarizes the goals of Trauma-Informed care as used in MISSION.

Goals of Trauma-Informed Care as Incorporated in MISSION

- Establish strong rapport with the client in an attempt to make him/her feel comfortable in raising any trauma-related concerns

- Document any trauma-related issues and review with Clinical Supervisor

- Develop a plan for increased safety when necessary (identifying triggers, reinforcing recovery thinking, supporting the use of techniques to address trauma symptoms, and creating meaning)

- Provide referrals and coordinate services to specialized clinicians as needed

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F. Replicating MISSION: Essential Services and Staffing

By blending the delivery of previously tested components of the MISSION model (CTI, DRT, Peer Support, and Vocational/Educational Supports) with Rapid Re-Housing and Trauma-Informed Care considerations, the authors strongly believe that the MISSION approach can more comprehensively address the complex and multi-dimensional service needs of homeless and formerly homeless individuals with COD. The effectiveness of the original MISSION-VANJ model was indicated in our original 12-month MISSION program study (Smelson et al., 2012; Smelson et al., 2013). Therefore, we recommend that any replication or adaptation of the model include all of these elements, even if accomplished through partnerships with outside providers.

The collaborative efforts of MISSION CMs and PSSs are seen as the essential conduit of service access and delivery. While caseloads often vary, depending on a variety of factors, the authors generally recommend a caseload of no more than 25 clients at any given time. The number of CM/PSS teams in your program should be dictated by the needs of the agency where the MISSION program is being implemented.

G. Orientation, Training, and Continuing Education

All MISSION CMs and PSSs receive a general orientation on confidentiality, documentation, reporting, and crisis management policies and procedures. They are also trained in the theory and application of all service components in the MISSION program (e.g., CTI, DRT, Peer Support, Rapid Re-Housing, Vocational/ Educational Supports, and Trauma-Informed Care considerations), the respective roles of all staff in the delivery of these key components, and how the MISSION team functions as a whole to support clients.

It is also important to consider additional training for the MISSION PSS role. The authors recommend using a training program that is designed specifically for PSSs working within traditional mental health systems. The table below describes areas to be addressed in PSS training.

Subjects to Address in Training for Peer Support Specialists

- The meaning and role of peer support;

- Skills needed to create and facilitate a variety of group activities that support and strengthen recovery;

- The recovery process and how Peer Support Specialists can use their own recovery story to help others;

- Self-care, including how to manage conflict and stress in the workplace; and

- The basics of mental health care systems and practices, such as treatment team processes, counseling skills, various mental illnesses, co-occurring disorders, cultural competency, resume writing, and interview skills.

If your organization is new to incorporating PSSs, it is recommended that you initially recruit at least one peer staff member who has training and experience (preferably certification) specific to peer support. Doing so will likely minimize role confusion among different MISSION team members, and readily demonstrate the unique and valuable contributions of the PSS. A fully trained and experienced PSS can also serve as a mentor to other peer support staff as they acquire their own formal training. Continuing education is strongly advised to help all staff hone their skills and increase their effectiveness.

Please also see the Peer Support, Case Management, and Supervision chapters for more detailed information regarding orientation, training, and continuing education for Peer Support Specialists and Case Managers.

H. Logistical Requirements

There are several logistical requirements to consider as you implement the MISSION program. It is essential to have clear policies and procedures governing transportation, reimbursement for travel expenses, and handling of emergencies involving clients in the community. The following overview serves as a resource to help you develop appropriate guidelines for your system.

Key Logistical Requirements for MISSION

Transportation

- MISSION CMs and PSSs spend a significant portion of their time meeting with clients in the community, which requires consistent access to reliable transportation. Community outreach is an essential element of MISSION service delivery, but each agency and setting has unique policies and liability issues that must be taken into consideration.

- It is generally necessary for all MISSION staff to have a valid driver's license. Ideally, team members should have access to a vehicle that can be used to meet clients in the community. If this is not possible, staff can also be asked to use their own transportation or public transportation, with proper reimbursement for these expenses.

Communication

- MISSION CMs and PSSs must have a reliable way to communicate with their clients as well as with each other. CMs and PSSs on the MISSION team utilize cell phones and e-mail communication regularly.

- All MISSION staff must have access to computers to maintain documentation and access program files and resources.

Safety

- Safety is the primary consideration associated with logistical aspects of the MISSION program. As with any program requiring staff to work alone in the community, they must have a means of calling for immediate assistance if needed. This includes traveling with a cell phone at all times with saved emergency contacts.

  - MISSION staff are encouraged to use their own judgment to determine whether they feel unsafe in certain areas or neighborhoods and are encouraged to conduct visits in teams when necessary.

  - In circumstances in which team members feel unsafe and are worried about the safety of their clients, staff are reminded that they can always call 911.

  - Regular discussion of safety issues in supervision is also recommended.

Emergencies

- After-hours, on-call schedule policies vary by institution. While the authors believe that on-call mechanisms can be helpful, as the individuals served often have after-hour crises, an equitable arrangement should be made across staff with regard to coverage.

- It is critical to have a mechanism for immediate consultation between MISSION Case Managers or Peer Support Specialists with their Clinical Supervisor when needed, as well as access to a physician for any medical emergencies. For systems that are unable to support an on-call mechanism, MISSION team members are encouraged to develop and review an emergency crisis management plan and review contact information for local Emergency Rooms with the client as part of the introduction to the program. Staff are further encouraged to leave information on how to contact these local agencies for emergency assistance on their telephone voice mail.

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NOTES

II. The MISSION Model of Care

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This chapter provides a basic overview of the MISSION model, including each of the components that have been systematically integrated into the treatment approach: Critical Time Intervention (CTI) case management, Dual Recovery Therapy (DRT), Peer Support, Rapid Re-housing, Vocational/ Educational supports, and Trauma-Informed Care considerations. It explains how the tenets of each element of MISSION have been incorporated into the model and how each has been adapted to meet the needs of homeless and formerly homeless individuals who have co-occurring mental health and substance use disorders.

A. Critical Elements of the MISSION Program

Built on the theoretical framework of the Health Belief Model (Becker, 1974), MISSION is an integrated treatment and service linkage model designed to meet the complex and multi-faceted needs of homeless and formerly homeless individuals with co-occurring psychiatric and substance use disorders. For a more detailed description of the Health Belief Model including how it was incorporated into the overall treatment approach, please refer to Appendix B. As noted earlier, the MISSION program combines Critical Time Intervention (CTI) case management, Dual Recovery Therapy (DRT), Peer Support, Rapid Re-Housing, Vocational/ Educational supports, and Trauma-Informed Care considerations. These treatment approaches and philosophies are blended systematically, creating an integrated treatment approach with a rich synergy that fosters and supports recovery and community independence among individuals with co-occurring mental health and substance use disorders (COD).

The primary goal of the MISSION treatment model is to facilitate rapid community transition and achievement of treatment and personal goals by helping MISSION clients engage in a comprehensive array of outpatient services. The MISSION model uses Case Managers (CMs) and Peer Support Specialists (PSSs) who link participants to community resources such as outpatient mental health and substance abuse treatment programs, primary and specialty medical care, housing specialists, vocational/ educational rehabilitation services, as well as providers trained to deliver trauma-informed treatment services when needed. Overall, the goal is to increase clients' participation in these services by increasing their motivation to do so and by empowering each person receiving MISSION services to increasingly manage their own affairs as they establish satisfying and meaningful lives in their communities.

Each of the following critical elements is essential in implementing the MISSION model:

1. CTI case management is used within MISSION as the core treatment intervention. CTI is designed to give clients a "running start" and "safety net" by providing intensive services upon re-entry into the community, thus establishing firm linkages between clients and needed services.

2. DRT involves MISSION Case Managers delivering 13 structured psychoeducational sessions to help raise clients' awareness of the impact of substance use, mental illness, and harmful behaviors on their lives. It offers tools to aid in recovery and encourages clients to reflect on their goals and choices.

3. MISSION Peer Support Specialists work alongside Case Managers and seek to help clients maintain their sobriety and mental health, follow healthy lifestyles, and participate in needed supports, thus bolstering the effectiveness of the other interventions. Peer Support Specialists also deliver 11 sessions that complement the 13 DRT sessions.

1. MISSION Case Managers and Peer Supports Specialists help clients find and maintain permanent housing and employment, and assist them in achieving educational goals. This, in turn, contributes to an improvement in general daily living skills, housing stability, and improved self-esteem.

2. MISSION Case Managers and Peer Support Specialists are trained to screen for trauma-related symptoms and, when appropriate, refer clients to clinicians better equipped and trained to treat PTSD and other trauma-related disorders.

B. Critical Time Intervention (CTI) Case Management

Critical Time Intervention (CTI) case management is an evidence-based, time-limited form of case management that provides the foundation of the MISSION treatment approach. CTI is used to link individuals with needed community services and to address common institutional barriers to service access. CTI 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 (Susser, et al., 1997). MISSION adapts the original design of CTI slightly to include individuals who have recently transitioned to the community in addition to individuals currently transitioning to the community from inpatient/residential treatment, shelter, and/or correctional settings. This adaptation allows MISSION services to be delivered within a rapid re-housing framework supporting the notion that homeless individuals should receive permanent housing followed by the delivery of needed wraparound supports. Because any lack of support during this "critical time" can lead to recurrent homelessness, MISSION emphasizes the need for a continuum of care and flexibility in meeting clients' needs, recognizing that different clients require different services and levels of attention.

The first randomized trial (Susser et al., 1997) of CTI case management examined outcomes among 96 individuals transitioning from a homeless shelter to community living who received either a 9-month CTI intervention or Usual Services and found that those individuals who received CTI experienced fewer days of homelessness, greater continuity of care, and increased use of community supports as compared to individuals who received Usual Services only. In addition to reducing homelessness, CTI has been shown to reduce the severity of psychiatric symptoms, alcohol and drug use, and to significantly reduce treatment costs because it decreases the use of more intensive services while producing comparable outcomes (Jones et al., 2003; Kasprow & Rosenheck, 2007).

CTI has been modified for MISSION with the consultation of Dr. Alan Felix, from the original CTI development team. The CTI approach is distinguished from traditional case management in several respects, as shown in the table, "Comparison of CTI to Traditional Case Management."

Comparison of CTI to Traditional Case Management

CTI	TRADITIONAL CASE MANAGEMENT
Focus on intervention at a "critical time" (for example, the transition from the institution to the community or ongoing support once the transition has occurred)	No specific focus
Time-limited	Open-ended
Focus on prevention of recurrent homelessness and continuity of care	Focus shifts based on most pressing service need
Phases of decreasing intensity	Unspecified phases/intensity

Note: For those interested in more information on CTI, please visit the CTI website at: http://www.criticaltime.org/

Areas of Intervention

As used in MISSION, CTI has five main areas of intervention:

1. *Psychiatric treatment and medication management.* The primary responsibility of the MISSION CM/PSS team is to link clients to services rather than to serve as the client's therapist. MISSION CMs and PSSs assist in areas such as accompanying clients to initial treatment visits and overseeing their participation in follow-up visits, monitoring medication compliance, or helping clients with service-connected psychiatric disabilities receive the additional health benefits to which they are entitled.

2. *Money management.* MISSION CMs and PSSs help clients set up a bank account and create a budget (for a sample budget, see Appendix J). The team also assists with collecting documentation needed to obtain entitlements. Neither the MISSION CM nor PSS, however, handles or receives clients' money. If necessary, an outside representative payee can be designated to manage clients' finances. This may be, particularly helpful early in the recovery process when there are often competing financial pressures.

3. *Substance abuse treatment.* The MISSION CM may work more closely with the client's outpatient treatment providers and 12-step program sponsor, however, both the MISSION CM and PSS should monitor clients for signs of relapse, its potential impact on mental health, and support clients in actively reducing or eliminating any substance use. As compared to original CTI, MISSION's use of Dual Recovery Therapy (DRT) offers a more integrated and intensively structured model of addictions and mental health treatment, including specific tools to increase the effectiveness of interventions (See Appendix E for more information on the DRT exercises).

4. *Housing support.* The MISSION CM/PSS team engages clients in the housing selection process and assists them in locating and securing housing based on their preferences and needs. The team helps clients to maintain their home by monitoring situations that threaten the clients' housing, such as potential eviction, psychiatric decompensation, unsafe living conditions, and geographic proximity to areas prone to frequent drug activity. MISSION team members may also intervene if necessary to help clients manage conflicts with landlords, identify alternate living arrangements if necessary, or provide links to community based supports. Either team member can also play a key role in resolving housing-related issues by teaching clients effective interpersonal skills and communication strategies and by modeling these healthy behaviors.

5. *Family interventions.* With clients' permission, the MISSION CM/PSS team may involve family members to provide support and respond to crises. Additionally, the team might provide emotional support to the family and/or supply psychoeducation on mental illness, substance abuse, and MISSION services. Family therapy, if needed, is accomplished via referral.

Phases

CTI includes three phases, with contact between the MISSION CM/PSS team and the client decreasing in each phase. These three phases, described in detail in the CTI manual (Felix et al., 2001), are:

1. *Transition to the community.* In phase 1, regardless of whether the client is in inpatient/residential care or the community at the outset of MISSION service delivery, the program stresses skills and strategies needed for successful community living. For individuals in inpatient/residential care, the authors suggest that MISSION CMs and PSSs attend discharge planning meetings with staff from the inpatient/residential treatment program in order to become familiar with the available services in the community that they will eventually need to facilitate and to provide input on the development of the treatment plan.

Within this phase, particular attention is paid to areas that the MISSION team and client feel are critical to community transition, with particular focus on the five core CTI domains previously described. Interactions might include the identification of a community-based psychiatrist, ongoing dialogue about the importance of medication compliance, the selection of a representative payee to manage client funds, the development of a realistic plan to pay rent, the identification of 12-step meetings in the community, the development of a crisis plan, and assistance in reconnecting with family and friends. The overall goal of this phase is to help the client adjust to community living and to develop a support system that can be used as a foundation for community living.

2. ***Try-Out.*** The services offered during the Try-Out phase focus on establishing the link between the client and community resources. During this phase, the MISSION CM meets with the client on a bi-weekly basis, testing and readjusting the community-based support system in order to fill any gaps in care, again with specific attention to the five CTI domains. The MISSION CM conducts a needs assessment, and if necessary the MISSION PSS accompanies the client to counseling, medical, and other appointments in the community, identifying first-hand, any holes in his/her support system and service plan. If holes are identified, the MISSION CM/PSS team works to address and resolve those issues. As the frequency of visits decreases, MISSION team members act increasingly as a liaison between the client and community-based services and less as a direct provider of supports.

It is essential that relationships are established between the client and staff from resources in the community that will be valuable to his/her ongoing recovery. Examples of resources include community mental health clinics, substance abuse treatment programs, housing supports, vocational/educational training programs, and other service organizations. The linkages provided during this time marks the true start of the transition from services primarily being offered through the MISSION team to being offered by treatment providers and other resources in the community.

3. ***Transfer of care.*** Visits in phase three, Transfer of Care, are used to fine-tune the connections established with community-based resources. The MISSION CM/PSS team and key community providers may meet to review the transfer of care and identify any existing gaps in services. The MISSION CM/PSS team and client reflect upon the work that they have done together. The termination of MISSION should be viewed as another step in the journey of recovery.

Clinical Principles

The CTI intervention requires a specific clinical approach, necessitated by the short-term and focused nature of the intervention. The MISSION CM/PSS team should take a flexible approach to assessing the client's strengths and needs, including evaluating the client's long-term needs (even though CTI is a time-limited intervention). Additionally, the MISSION CM/PSS team will need to be patient and work with clients "where they are" in recovery. Helping individuals to recognize and use their strengths is essential to help the client transition from reliance on MISSION services to supports within his or her own community beyond the life of the MISSION program.

MISSION CMs and PSSs may want to consider quickly reviewing the original CTI manual (Felix et al., 2001) as a source of in-depth information on clinical concepts and techniques that will help them assist clients in becoming self-sufficient and independent in their communities. The "Clinical Concepts of Critical Time Intervention" table describes some of the most important concepts and techniques that MISSION staff will need to employ when working with clients during their time in the MISSION program. Note these concepts and techniques dovetail nicely with the Dual Recovery Therapy approach.

Clinical Concepts and Techniques Used in CTI

- **Stages of Change** is a framework that recognizes people may be at different stages of thinking about any particular change and that,

depending on where they are, people working to help them change must adapt their approach.

- **Motivational Interviewing** is a technique that reinforces motivation for recovery across problem areas in which change is needed for healthy living. Instead of advising and directing the client, the person uses a "guiding" style that helps the client hear their own reasons and desire for change. SAMHSA's Treatment Improvement Protocol 35, Enhancing Motivation to Change, a free resource, addresses both motivational interviewing and the stages of change and is available for free download from SAMHSA: http://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Abuse-Treatment/SMA13-4212

- **Harm Reduction** is a therapeutic approach that recognizes people may be doing the best they can in recovery, even when their choices are unhealthy, and that punishment for engaging in problematic behaviors is not the best response. Rather, this approach encourages discussion of the negative consequences associated with problematic behaviors, focuses on reducing harmful behaviors and their impact, and promotes adaptive coping strategies.

- **Attachment and Engagement** strategies create an environment in which the person feels comfortable and safe to explore problem areas and develop insights that will help break the cycle of engaging in problematic behaviors.

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There are also several counseling techniques described in the CTI training manual. The following table lists some of these techniques. For more information, please refer to the CTI training manual (Felix, et al., 2001).

CTI Counseling Techniques

- Observing nonverbal behavior

- Identifying discrepancies between verbal and nonverbal behavior

- Reflecting the client's feelings

- Clarifying the client's statements

- Staying aware of the client's history and cultural background

- Maintaining an awareness of the care provider's own feelings and actions

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C. Dual Recovery Therapy (DRT)

MISSION addresses co-occurring mental health and substance use disorders (COD) through the use of Dual Recovery Therapy (DRT) (Ziedonis & Trudeau, 1997). DRT is consistent with existing therapeutic models that manage substance abuse and psychiatric conditions simultaneously (Bennet, et al., 2001; Drake, et al., 1998; Minkoff, 1989; Shaner, 1997) and has been demonstrated to significantly improve outcomes for populations diagnosed with COD (Ziedonis & Simsarian, 1997; Ziedonis & Stern, 2001). DRT 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). The guiding premise of the DRT approach is that equal attention must be paid to both psychological and substance abuse symptoms and that successful treatment will address the interrelationship of the two problems.

DRT structured weekly sessions generally begin immediately after the individual enrolls in the MISSION program. DRT sessions are designed to help clients recognize the nature and interrelationships of their COD and to choose supports and goals that will help them maintain healthy lives in recovery despite the presence of these disorders and the often complicated history

that goes along with them. Therapeutic techniques that facilitate the delivery of the 13 structured psychoeducational sessions are also included and described at length in Appendix E of this manual. Delivered by the MISSION CM, DRT sessions teach clients skills that will support them in their recovery from both mental health and substance use disorders and their adjustment to community living. Specifically, the topics covered in DRT sessions will help the client to:

- develop skills for recovery from drugs, alcohol, and mental health issues which in turn prevents housing loss;

- develop an understanding of the relationship between the client's mental health and substance abuse problems and how the two are interrelated; and

- understand that both mental health and substance abuse issues need to be monitored together and that level of motivation to change can be different for each problem area.

At the onset of enrollment into MISSION, DRT is delivered weekly by a MISSION CM. It is intentionally delivered at the onset of enrollment in order to provide clients with needed skills for recovery. It is important to note, that we have learned through more recent projects that some clients may not be ready to begin DRT sessions until they are securely housed which is the primary reason as to why we have incorporated a Rapid Re-housing framework into this Second Edition. Furthermore, in such cases, we have found a select number of individuals who typically express a preference to use their time with the MISSION CM and PSS to address housing search related activities. With such clients, it is recommended that a more flexible approach regarding the DRT sessions is taken until clients have secured a home and feel that they are in a better position to work on their mental health and substance abuse recovery.

DRT sessions can be delivered in an individual or group format, but should be delivered at least once weekly. Group formats are a little more complicated logistically as clients enter DRT groups at different points depending on their time of enrollment into the MISSION program. Consequently, each group may include clients

who have attended several DRT sessions or none at all. DRT sessions can also be delivered more frequently if the MISSION intervention is delivered over a shorter period of time. However, as illustrated in the "Content of DRT Sessions as used in MISSION" table, the content of the DRT sessions always remains the same.

An additional aspect to consider with regard to individual or group format is the client's level of acute symptomatology. This consideration is critical given that MISSION can be delivered to individuals with various mental health diagnoses and substances of abuse. Moreover, depending on the client's level of functioning and whether or not the client has a severe mental illness such as Bipolar Disorder or Schizophrenia, and is experiencing active symptoms, participation in the group format may be over-stimulating to the individual client and distracting to others in the group. Thus, until the client becomes less acutely symptomatic, it may be in every ones best interest for the clients to have individual DRT sessions until his or her symptoms stabilize. Other barriers to conducting groups include the location and time of the group. Transportation may be difficult for clients, especially for those in rural areas, and this may hinder the chances of delivering DRT in a group setting. Though conducting DRT or peer sessions in a group format is not a requirement of MISSION, the group dynamic has shown to provide a helpful environment and sense of camaraderie among clients. We encourage you to consider finding a convenient central location, such as a study-room in a library or other public space in the community where privacy can be maintained to hold group sessions and/or scheduling groups in the evening to increase attendance.

Content of DRT Sessions as used in the MISSION Program

1. Clients learn how mental health and substance abuse problems can affect one another.

2. Problems in specific life domains are identified to determine the impact each of these problems has had on the client's life.

3. Motivation, confidence, and readiness to address each problem area are assessed to help clients understand their willingness or reluctance to begin work on each identified issue.

4. Treatment goals are reviewed and emphasis is placed on the importance of participating and remaining engaged in substance abuse and mental health treatment.

5. Benefits and consequences of continuing undesirable behaviors are explored.

6. Clients learn about the importance of developing effective communication skills.

7. Orientation to or revisiting of the role that 12-step programs play throughout recovery.

8. Identification of situations that trigger anger and strategies to manage emotions during those situations.

9. Clients learn specific relapse prevention strategies to increase the likelihood of sobriety and decrease the chance for relapse. Special emphasis is placed on how the presence of mental health problems can lead to a relapse.

10. Clients learn how unhealthy relationships can lead to substance use relapse and/or mental health symptom exacerbation.

11. Clients learn how unhealthy thinking patterns can perpetuate emotional problems and result in substance use relapse. The interplay among thoughts, behaviors, and emotions is explored.

12. Clients learn how to modify dysfunctional beliefs to maintain flexibility in thinking.

13. Clients learn how participating in regularly scheduled healthy activities can promote recovery from substance abuse and mental illness.

D. Peer Support

MISSION's peer support complements and reinforces both CTI and DRT by inspiring clients to establish recovery goals, modeling a sober lifestyle, encouraging the development of a supportive social network, and helping clients establish linkages to community services. MISSION employs Peer Support Specialists (PSSs) who use their own recovery, housing, and employment successes to inspire hope for recovery in clients enrolled in the MISSION program. In MISSION, PSSs work closely with CMs and play an important role in socialization and recovery support. As role models, PSSs demonstrate to clients the concrete steps necessary to achieve recovery from mental illness, substance abuse, homelessness, and unemployment. For example, they may help clients monitor relapse triggers through discussion of daily activities, accompany them to 12-step meetings, help them avoid "people, places and things" that may trigger substance use, assist them in navigating community mental health systems, show them how to use public transportation in their new neighborhoods, and assist with other supports as needed.

PSSs are essential to MISSION service delivery as they can empathize and provide unique support to their clients because they know what it is like to suffer from mental illness, struggle with substance abuse, experience homelessness, and face unemployment. Many MISSION PSSs have experienced first-hand what it feels like to deal with cravings, be on psychiatric medication, be hospitalized, and to feel like they have lost out on life. However, PSSs also know what it is like win back their lives and it is this inculcation of hope that makes the role of PSSs in the MISSION model invaluable. Because of these shared experiences, MISSION PSSs tend to help clients set personally meaningful and realistic goals. As role models, PSSs share their recovery stories and may review their own experiences in developing and adjusting wellness strategies, as well as offer mutual support and practical guidance to their clients. Often, MISSION PSSs are able to develop a great sense of rapport and establish very trusting relationships that are special and intrinsically different from those of the MISSION CM.

As stated earlier, perhaps the most important contribution of MISSION's peer support component is the role PSSs play in offering inspiration to the client. That is, the hope that it is possible to overcome the barriers and obstacles confronting them. MISSION PSSs convey that recovery is a self-directed process wherein individuals are empowered to believe in and advocate for themselves, to support each other, and to develop personal wellness and relapse prevention strategies to achieve their recovery goals. As members of the treatment team, PSSs also help to strengthen the client's voice in the formal treatment process, helping to ensure that professional services are individualized to each client's needs. This liaison/coach role has been shown to enhance the likelihood that clients will stay engaged in treatment and successfully complete it.

Specific Services Offered to Clients by MISSION Peer Support Specialists

- Facilitate the use of the MISSION Participant Workbook

- Deliver 11 peer-led recovery sessions

- Help clients maintain sobriety and stability and avoid relapse and hospitalization

- Encourage attendance at 12-step and other support groups

- Further clients' acceptance of their problems

- Help clients rebuild relationships disrupted by substance abuse and mental illness

- Enhance clients' social and community living skills

- Enhance clients' activities of daily living (ADL) skills

- Help clients relieve stress or anxiety that could lead to relapse or loss of employment, housing, friends or supportive family relationships

- Monitor signs of relapse or decompensation

- Address stigma associated with substance use and mental illness

At the onset of their participation in the MISSION program, clients attend weekly peer-led support sessions (See Appendix H for a suggested list of peer-led discussion topics). MISSION PSSs also conduct a weekly "check-in" session with clients to facilitate the use of the MISSION Participant Workbook exercises and readings. As needed, MISSION PSSs offer transportation assistance which may include exploring alternate routes with clients to avoid drug zones or accompanying clients to appointments in the community when needed.

Additionally, MISSION PSSs arrange and participate in social activities suggested by their clients that provide an opportunity for social support and an alternative to substance use. Ideally, activities can be coordinated with the schedule of AA/NA meetings and work schedules to make them convenient for the maximum number of clients participating in the MISSION program. For example, activities might include bowling, going to movies, attending sporting events, visiting museums, or having dinner. As reinforced during DRT sessions, clients in MISSION are encouraged to participate in regularly scheduled healthy and safe activities as part of their recovery. PSSs who organize group activities should recognize the importance of scheduling activities that are local and diverse and that take into account the interests and abilities of each client. Additionally, activities can be simple at first and then become larger in scope. For example, a PSS may initially opt to shoot baskets at the local gym with a small number of clients. If this works well, the PSS may proceed to make arrangements for full-court basketball games with a greater number of clients. The PSS may even work to establish a MISSION basketball team if there is enough interest among participating clients.

E. Rapid Re-Housing

A critical need of MISSION clients is to secure safe and stable housing, thus an important goal of MISSION is to help clients become rapidly re-housed. MISSION housing practices are guided by key Housing First principles (see table below titled "Six Essential Ingredients of Housing First). Consistent with Housing First, the CM/PSS team actively engages the client

in the housing search paying special attention to the client's preferences. As prescribed by the Housing First model, housing is viewed as a human right rather than a privilege earned through compliance with mental health treatment or sustained sobriety, and housing is sought for the client regardless of his or her stage of recovery. The availability of flexible recovery-oriented services, for clients who choose to access them, is a core part of the Housing First approach. Housing placement is not terminated for lack of compliance with psychiatric or substance abuse treatment services. Employing these Housing First principles shows clients that the clinical team is invested not only in their mental health and substance abuse recovery but also in their having a safe and comfortable place to live. This can help the client to develop a trusting bond with the MISSION team, which may, consequently, empower the client to address his/her recovery issues.

Six Essential Ingredients of Housing First

1. Consumer Choice

2. Separation of Housing and Services

3. Services are Voluntary and Flexible

4. Recovery-oriented Services

5. Community Integration

6. Harm Reduction

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The MISSION team actively helps clients to secure housing by engaging in activities such as identifying the client's housing needs and preferences, coordinating with landlords and public housing authorities, assisting clients with utilizing available housing/rent subsidies, preparing clients for meetings with landlords and accompanying them to the meetings, and helping clients both physically and emotionally as they move into their new home. The team also assists clients in maintaining their housing by engaging in such tasks

as home visits, resolving conflicts with the landlord, and helping clients to develop a budget or identify a representative payee. Rapid re-housing sets the stage for the MISSION team to link the client to supports in his or her own community, and the maintenance of these supportive connections will be the very foundation of the client's recovery both while in MISSION and after graduation. For more information on MISSION rapid re-housing support services please see Chapter V. Rapid Re-Housing.

F. Vocational and Educational Supports

Another core need for clients enrolled in MISSION is vocational and educational supports. If MISSION services are initiated while the client is in residential treatment, vocational rehabilitation services are often provided through specialists associated with the residential treatment facility. However, if MISSION services are initiated in the community, MISSION CMs and PSSs will have to take extra care to ensure that linkages to vocational specialists are provided and that vocational rehabilitation plans are developed. Once developed, the MISSION CM/PSS team facilitates the vocational rehabilitation plan and executes based on changes in the client's employment status. For example, if the client loses his or her job, the MISSION CM/PSS team may assist in facilitating linkages with Department of Labor (DOL) - funded One-Stop Career Centers, whose employment specialists can assist MISSION clients with their job searches. If clients are struggling to maintain employment, the MISSION team provides support and helps the client to understand and follow operating procedures of the employer, maintain peer and supervisor relationships, and manage job-related stresses.

The MISSION team might also discuss educational options that would help the client broaden his or her qualifications or move to another career where there are further opportunities for advancement. MISSION CMs and PSSs can provide linkages to help clients understand possible educational benefits, learn how to apply for these benefits, and how to appropriately adjust work and treatment meeting schedules to attend classes. Additionally, MISSION CMs link clients to campus-based service departments that offer

additional information about enrolling in classes or obtaining tuition/fee assistance. This type of support is critical to those clients who wish to further their education.

The specific type of vocational/educational support offered by the MISSION CM/PSS team varies according to the individual's needs. For example, for those clients who are employed, the MISSION CM should discuss overall job satisfaction or dissatisfaction and review the nature of relationships with supervisors and co-workers. By doing so, potential problem areas are identified and potential solutions are explored. The MISSION CM may also facilitate role plays to practice healthy communication with supervisors and co-workers. Additionally, MISSION CMs/PSSs provide positive reinforcement for job successes and encouragement to deal with challenges.

If the client is not employed, the MISSION CM should determine the methods that the client has been using to search for and obtain employment. The positive and negative results of each approach should be discussed with the individual. With both employed and unemployed clients, the practical barriers to obtaining and maintaining employment (e.g., transportation difficulties and inappropriate attire) should be explored. Because the lack of a valid driver's license is a common barrier to employment among unemployed individuals, MISSION PSSs often help clients take whatever steps are needed in obtaining a driver's license.

As the client approaches the end of their time in the MISSION program, the CM and client discuss employment retention and growth. For example, they discuss how reliable the client has been regarding punctuality and absenteeism. If appropriate, the MISSION CM may also explore career advancement strategies with the client. As illustrated in the "Benefits of Vocational/Educational Support as Used in MISSION" table, clients gain skills essential to obtaining and maintaining meaningful employment and achieving educational goals.

Benefits of Vocational/Educational Support as Used in MISSION

- Understand that patience and hard work are more important than short cuts;

- Improve problem-solving skills;

- Learn to feel proud of work and educational accomplishments; and

- Learn to take constructive criticism and stay focused during conflicts.

Finally, it is essential for MISSION CMs/PSSs to link clients to community-based employment services, such as the DVR (Department of Vocational Rehabilitation) office and DOL One-Stop Career Centers. These linkages are used on an ongoing basis and as needed throughout the length of the MISSION program. The goal regarding these community-based vocational resources is for clients to become familiar with the services offered and comfortable enough to use them on their own upon completion of the MISSION program if needed. For more information on specific Vocational Supports please see Chapter VI. Vocational and Educational Supports.

G. Trauma-Informed Care Considerations

MISSION is not a PTSD intervention, nor is it designed to treat co-occurring PTSD and addiction. However, given the high rate of trauma present among this population, the MISSION CM/PSS team must be prepared either to assist clients with these issues directly or, for those clients who are acutely symptomatic, through a referral to specialized clinical care. Moreover, the MISSION team must assist in identifying and monitoring any symptoms of trauma that may impact treatment and recovery. For example, clients may relate information regarding exacerbation of these symptoms to their MISSION PSS, thus communication among MISSION team members

during these instances is crucial. Remaining sensitive to fluctuations in symptoms will allow MISSION CMs, in concert with the Clinical Supervisor, to make informed decisions on whether or not individuals need to be referred out to a specialized program to stabilize acute symptoms and/or to develop necessary coping skills

prior to admission or readmission into the MISSION program. The "Goal of Trauma-Informed Care as Used in MISSION" table illustrates how Trauma-Informed care considerations are incorporated into the MISSION program.

Goals of Trauma-Informed Care as Used in MISSION

- Establish strong rapport with the client to make him/her feel comfortable in raising any trauma-related concerns. MISSION staff are encouraged to communicate with each other to ensure that all team members are apprised of fluctuations regarding trauma symptoms. Clients should be informed about the importance of open communication between MISSION CMs and PSSs to avoid any setbacks toward the progress made in establishing rapport.

- Document any trauma-related issues and review with Clinical Supervisor. Documentation and review should be completed in a timely fashion in order to ensure that all providers involved in the client's care have access to important information that may influence treatment. MISSION Clinical Supervisors should be immediately notified of any emergency situations that arise during the client's enrollment in MISSION. In the event that a Clinical Supervisor is unavailable and a client is in need of immediate treatment, clients should be escorted by MISSION staff to the walk-in mental health clinic for assistance with exacerbated symptoms.

- Monitor these trauma-related issues on an ongoing basis. MISSION CMs are encouraged to use the assessment tools found in Appendix N to identify existing trauma-related symptoms during initial meetings with the client. Regular use of these assessment tools may be further encouraged during weekly follow-up meetings with clients to ascertain increases and decreases in symptoms that may impact treatment. For

optimal delivery of care, information acquired through these assessments should be shared with the MISSION PSS.

- Develop a plan for increased safety when necessary. MISSION CMs and PSSs are encouraged to have a plan in place for situations involving exacerbation of symptoms, suicidality, homicidality, and drug/alcohol relapse. Clients who are suicidal or homicidal with a clear plan or intent should not be left unattended and should be evaluated by the CM's Clinical Supervisor immediately. Once emergency situations have been stabilized and the client is safe, MISSION CMs are encouraged to develop a plan with their Clinical Supervisor that will continue to address the issue adequately and avoid any further exacerbation of symptoms. Documentation should immediately follow to ensure that all treatment staff are aware of any new developments in the client's care. Plans should be appropriately adjusted as the client continues to make progress.

- Provide referrals to specialized clinicians and coordinate services as needed. As MISSION is not a PTSD intervention or one designed to treat co-occurring PTSD and addiction, individuals with severe or chronic symptoms should be referred to a program that specializes in the treatment of trauma-related symptoms. Once symptoms have been stabilized and the client has developed some coping skills to manage these symptoms, the client is encouraged to reconnect to MISSION services.

Chapter Seven focuses on Trauma-Informed Care considerations and was designed to serve as a resource to help guide the MISSION treatment team regarding these issues. Additionally, Appendix N includes additional resources to help identify trauma-related symptoms. This Appendix also contains tools that will assist the MISSION CM/PSS team in monitoring symptoms, fact sheets and handouts for clients, and additional links to useful trauma-related resources.

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NOTES

III. Case Management

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This chapter describes the roles and responsibilities of the MISSION Case Manager and how it relates to MISSION service delivery. The chapter begins with an overview of the MISSION Case Manager's responsibilities. Settings in which MISSION can be delivered and implications for case management are then reviewed. The importance of teamwork with the Peer Support Specialist is stressed, and how the Case Manager's role is distinguished from that of the Peer Support Specialist is also discussed. We then review each of the Case Manager's primary responsibilities. Because case management is seen as the foundation of the MISSION model, this chapter refers to a number of appendices that will be useful tools for the Case Manager to use as MISSION is implemented.

A. Overview of the MISSION Case Manager's Responsibilities

The MISSION Case Manager (CM) and Peer Support Specialist (PSS) work as a team to help homeless and formerly homeless individuals who suffer from co-occurring mental health and substance use disorders (COD) make the successful transition and adjustment to independent community living. The MISSION CM ensures that supports are in place for the client to access treatment for substance abuse and mental health issues, including appropriate referrals for the treatment of trauma-related symptoms; sustain safe and stable housing; and secure employment and education. MISSION CM/PSS teams provide direct services and linkages to their clients over a stated period of time (2 months, 6 months, or 12 months depending on the service delivery schedule chosen), assess their needs, monitor their progress, and help resolve barriers that arise in achieving their personal goals.

This Chapter addresses the MISSION CM's specific responsibilities in the following order:

- Work effectively as a team with the Peer Support Specialist (PSS),

- Orient the client to MISSION services,

- Collaborate with other care providers and the client to develop a treatment plan,

- Deliver Dual Recovery Therapy (DRT) sessions to help clients understand and manage their substance abuse and mental health problems,

- Provide the client with rapid re-housing support, and

- Help the client secure and maintain employment or pursue continuing education.

The MISSION approach has incorporated the "Critical Time Intervention" (CTI) case management model to guide its delivery of direct treatment and service linkages. As described briefly here and in more detail below, CTI offers different types of support to the client in different phases of the transition and adjustment to community living. Briefly, the three distinct phases of care according to CTI are: (1) Transition to Community (the initial phase of intense support), (2) Try-out (in which the client accepts increasing responsibility for maintaining a healthy approach to life), and (3) Transfer of Care (in which the client relies increasingly on the community supports established during the first two phases rather than the MISSION team, and the program comes to an end). Consistent with the CTI approach, MISSION CMs/PSSs gradually reduce their frequency of contact with the client over the course of the intervention to reinforce the use of community supports throughout the MISSION service delivery period while simultaneously promoting independent living.

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The MISSION CM's responsibilities will unfold somewhat differently depending on the service setting in which the program is initiated. There are **two** kinds of service settings in which MISSION is implemented:

1. *The MISSION program begins while the client is in an inpatient or residential treatment setting.* This is seen as the start of CTI Phase 1: Transition to Community. The MISSION CM works in cooperation and coordination with the staff from the treatment facility, who serve as the primary treatment provider. The MISSION CM follows the client's progress through inpatient/residential treatment by attending meetings led by staff from the inpatient/residential treatment facility and by conducting DRT psychoeducational co-occurring disorders treatment sessions. Upon the client's discharge from the inpatient/residential facility, the MISSION CM assumes primary responsibility in executing the client's discharge plan by ensuring the necessary treatment, housing, and vocational/educational supports are in place. The discharge is the start of the second phase of CTI, Try-out. During this phase, linkages to supports are tested and any gaps in service or barriers to accessing services are identified and addressed. Next, during CTI Phase 3: Transfer of Care, linkages are fine-tuned, as the individual assumes the primary responsibility for managing his/her own care. MISSION services are terminated and the CM/PSS team says goodbye to the client.

2. *The MISSION program begins when the client is currently homeless (i.e., living in a shelter) or has been recently housed, such as housing secured through receipt of a housing subsidy.* The MISSION CM immediately assumes responsibility for facilitating the client's treatment plan and serves as either the client's primary or secondary provider of care, depending on whether or not the client is enrolled in another treatment, rehabilitation, or case management program. If the client is not enrolled in such a program, the MISSION CM immediately assumes responsibility as the client's primary treatment provider and focuses on stabilizing symptoms and achieving (or maintaining) sobriety. The MISSION team works to connect the client to programs that can meet his or her service needs, while the MISSION CM also provides DRT psychoeducational co-occurring disorders treatment sessions, which are described in detail below. In this setting, CTI Phase *1: Transition to Community,* begins as direct services are provided, community supports are identified, and linkages are facilitated by the MISSION team.

Once DRT sessions are complete, the MISSION CM provides DRT booster sessions as needed, but now encourages the client to use the supports that have been established during Phase 1. Linkages to supports are tested and any gaps in service or barriers to accessing service are identified and addressed. This is seen as Phase 2*: Try-out. Next,* during CTI Phase *3: Transfer of Care*, linkages are fine-tuned, MISSION services are terminated, and the CM/PSS team says goodbye to the client.

The "Overview of the MISSION Case Manager's Responsibilities," table outlines some of the ways the MISSION CM's role may vary depending on the situation in which the program is initiated. Note-this table offers an overview of the case managers responsibilities and tasks, with greater detail of the service delivery components to follow in this chapter.

Overview of MISSION Case Manager's Resoponsibilities

CTI PHASE 1: TRANSITION TO COMMUNITY	
Program is Initiated in Inpatient/ Residential Treatment	**MISSION CM:** • Meets with the individual and inpatient/residential treatment staff to discuss program expectations and boundaries, including the responsibilities of the inpatient/residential treatment team and the MISSION treatment team. ***Note: MISSION staff always serve as the secondary provider of services while the client is in inpatient/residential care.*** • Meets with inpatient/residential staff to review the individual's treatment plan. • Conducts 13 psychoeducational DRT co-occurring disorders treatment sessions. • Attends discharge planning meetings prior to the client's discharge to assist inpatient/residential staff in identifying community resources essential for successful community integration. • Assists with executing the discharge plan and provides linkages to key community supports. • Conducts a housing interview to capture the client's housing needs and preferences.
Program is Initiated in the Community	**MISSION CM:** • Meets with client alone or with other assigned care providers to discuss program expectations and boundaries. • Completes treatment plan or works with other care providers to review/modify treatment plan. • Serves as either the client's primary or secondary provider of care, depending on whether or not the client is enrolled in another treatment, rehabilitation, or case management program. • Conducts individual DRT sessions (unless individual is residing in congregate living, in which case, consider group format). • Provides linkages to community resources such as mental health, substance abuse, housing, vocational/educational, and trauma-related treatment supports. • Tracks client's progress in use of community resources and supports. • Conducts a housing interview to capture the client's housing needs and preferences.

CTI PHASE 2: TRY-OUT

MISSION CM:

- Continues to facilitate linkages that have already been established either by assertively bringing the client into treatment or other related programs or by working with the client to attend sessions on their own (discuss barriers with the client and consider use of telephone reminder calls).

- Facilitates new service linkages for identified problem areas.

- Identifies any gaps in support system, barriers in accessing services, or areas where the client needs more support.

CTI PHASE 3: TRANSFER OF CARE

MISSION CM:

- Fine-tunes connections with community-based resources and supports.

- Meets with community providers to review transfer of care and identify any gaps in service.

- Reflects (with the client) on work that has been accomplished thus far and acknowledges end of participation in MISSION program.

- Reminds client of supports that have been established, says goodbye, and wishes the client the best of luck in their recovery.

B. Working Effectively as a MISSION Treatment Team

The MISSION approach requires CMs and PSSs to work together on teams, with one CM and one PSS assigned to the same client. CMs and PSSs are seen as equal members of the team, each of whom brings to the table their unique backgrounds and experiences as they assist clients enrolled in the MISSION program. As shown in the table, "Responsibilities of the MISSION Case Manager and Peer Support Specialist," some roles and responsibilities are specific to the CM or the PSS, while others are shared. For more information on the role of the MISSION PSS please see Chapter IV. Peer Support.

For the CM/PSS team relationship to work effectively, it is critical that both team members share information with one another about the contact they have with each MISSION client. Such communication helps MISSION team members support each other's work and track evolving issues that may require special intervention. For example, the PSS may tell the CM that the client has been seeing drug-using friends at their old haunts, or the CM may tell the PSS that a client has been shy and nervous about going to AA meetings and request that the PSS offer to accompany the client to a meeting. At their regularly scheduled supervision meetings with the Clinical Supervisor, or earlier if necessary, the CM/PSS team should share any problems on which they would like guidance or assistance, preferably at the earliest stage possible to allow for prompt intervention.

Responsibilities of the MISSION Case Manager and Peer Support Specilist

Primary Responsibility of CM, with input from the PSS	Primary Responsibility of PSS, with input from the CM	Responsibilities Shared by the CM and PSS
• Orientation/introduction, mid-program progress check, transition to community, and discharge plans • Management of clinical crises • Delivery of DRT psycho-educational and booster sessions at each visit • Identify, monitor, and provide referrals for trauma-related symptoms • Provide rapid re-housing support as needed: pre-housing interview, coordination with landlords/ housing authorities, secure housing entitlements • Provide vocational/educational supports as needed: interview skills training, resume building, linkages to education and training programs • Facilitate linkage to other clinical services • Communicate with clinical service providers • Review and work through benefits and entitlements issues (Social Security Income and Social Security Disability)	• Help clients advocate for themselves with providers and ensure effective two-way communications • Deliver structured peer-led psychoeducational sessions designed to promote recovery • Recreational planning and modeling healthy living using free or low-cost community resources • Linkage to community mental health and substance abuse recovery programs (NA/AA, church groups, etc.) • Prepare client for interviews with landlords, assist client with housing applications, help client move in, arrange for needed household items • Accompany clients to clinical appointments, job interviews, recreational activities, and self-help group meetings • Increase motivation toward recovery goals • Assist clients with interpreting MISSION Participant Workbook exercises and readings, discuss material, and reinforce insights	• Weekly team meetings with staff providing care at inpatient/ residential treatment facility • Discharge session from the treatment facility • Linkage to needed community services, including vocational/ educational supports and trauma-related treatment resources • Assistance with housing maintenance • Ongoing monitoring of symptoms, psycho-education and training in symptom management, coping skills, medication compliance, problem solving, and relapse prevention • Transportation assistance • Provide support during job (or school) stresses • Provide support during clinical crises • Refer out as appropriate during exacerbation of symptoms

Depending on the issues to be addressed and the preferences of each client, MISSION CMs and PSSs may meet with the client together or separately. When the CM and PSS meet with the client separately, the authors suggest that the CM and PSS meet afterwards and discuss their observations and concerns regarding the client regularly. By working together smoothly, MISSION team members can enhance their effectiveness and ensure each client enrolled in the MISSION program is receiving consistent messages and support. Clients are informed at the outset of their participation that information is shared among MISSION team members to better facilitate the delivery of care.

MISSION CMs should have the judgment to make well-grounded decisions independently, but at the same time

be open to receiving assistance and guidance from others, primarily the MISSION Clinical Supervisor. CMs must be willing to enhance their clinical skills, follow applicable agency policies and procedures, and work within laws and regulations. Weekly clinical coordination meetings, led by the Clinical Supervisor, provide another opportunity for the CM and PSS to share their perspectives and benefit from additional insights and suggestions offered by the other team member. In the event of a disagreement between assigned team members, the Clinical Supervisor listens to both the CM and PSS, providing guidance to resolve the disagreement. The MISSION Clinical Supervisor also coordinates vacation schedules and manages service interruptions due to illness or personal emergencies, providing coverage to ensure that clients are not left unexpectedly without support.

MISSION CMs must be thoroughly familiar with both the policies and requirements of the MISSION program and those of any associated institutions and/or treatment programs that are also providing care to the client. In cases where clients are receiving primary care from another treatment provider, those providers govern record keeping, case notes, security procedures for computer access, and use of medical records. Record keeping is essential for effective long-term follow-up care and for allowing other providers to take over cases in progress when necessary. Therefore, MISSION CMs should be clear writers and possess strong organizational skills.

C. Initiating the Delivery of MISSION Services

The MISSION CM has the primary responsibility of orienting the individual to the MISSION program and explaining the expectations that come with being a participant. The client learns about the different services provided, what is expected of clients who participate in the program, the roles of each MISSION treatment team member and accompanying responsibilities, and how to communicate with each member of the larger treatment team. The client also receives the MISSION Participant Workbook at this time. The CM begins

the process of developing a treatment plan, involving the MISSION PSS as well as community treatment providers as applicable.

Identifying and Orienting MISSION Participants

Identifying Program Participants

When the MISSION treatment team is physically located within a larger healthcare system and MISSION CMs have access to that agency's patient record system, CMs (with authorized access to the system) can screen medical records to get a cursory sense of which clients currently receiving treatment services may be eligible for and/or benefit from MISSION.

MISSION CMs may also receive referrals from staff members who work in other programs. For example, during implementation of the 6-month MISSION service curriculum used to augment services for those individuals who have received housing placements through the use of existing housing vouchers, case managers from this agency frequently contacted MISSION CMs and referred clients who they felt may benefit from MISSION services.

Screening Prospective Participants

Regardless of whether MISSION services are commenced in an institutional setting or in the community, the MISSION CM screens prospective individuals for program eligibility. In general, persons are eligible for MISSION services if they have a co-occurring mental health and substance use disorder (COD), are currently homeless, are in imminent danger of becoming homeless, or have recently exited homelessness and are now living on their own in the community.

After confirming eligibility, the MISSION CM explains how the MISSION program works, describes potential benefits, answers any questions the client may have, and also reviews expectations with those who enroll in the program.

It is important to note that the CM who conducts this screening may not be the individual's assigned CM

once MISSION services are initiated, and the individual should be made aware of this at the outset of the program. Once he/she is screened and eligibility is confirmed by the MISSION Clinical Supervisor, a CM from the MISSION team is permanently assigned to the individual.

Clinical Assessment

If the individual expresses interest in participating, the next step is to conduct a thorough mental health, substance abuse, and psychosocial needs assessment. The authors recommend that the assessment be completed by the MISSION Clinical Supervisor, whenever possible. For sites that have CMs perform the diagnostic assessment, the authors suggest that the CM discuss the case with the Clinical Supervisor to clarify diagnostic issues, treatment needs, and verify program eligibility.

Orientation to the MISSION Program

Following completion of the assessment, the client is introduced to his/her permanent MISSION CM, who schedules an introductory meeting to begin the process of getting to know the client. Both the MISSION CM and PSS should participate in the meeting if possible, but if necessary the client can meet with CM and PSS separately. This initial 45-minute orientation meeting is an opportunity for the CM to learn about the client's strengths, interests, and goals as well the client's needs, triggers, and barriers. The CM also explains how the program can support and assist the client and distinguishes the roles of MISSION from that of the client's primary treatment provider, if they have one.

The orientation session lays the foundation for a healthy working relationship between the client and MISSION treatment staff, builds the client's understanding and expectations of the program, marks the beginning of MISSION treatment planning, encourages hope, and lets the client know that he or she will have support in facing any obstacles that may arise along the way – as well as people who will cheer and celebrate as the client meets his/her recovery goals.

Introducing the MISSION Participant Workbook.

During the orientation session, the MISSION CM and/or PSS give the client the MISSION Participant Workbook and explain that the workbook contains three important components:

1. Tools that will be used as part of Dual Recovery Therapy sessions led by the CM,

2. Exercises that are keyed to the DRT sessions which are reviewed during the Peer-led sessions,

3. Advice from others who have made similar transitions which will help program participants settle and adjust into their communities.

The workbook is seen as an important component of program orientation and symbolically offers clients a set of support materials that will assist them in their journey toward recovery and independent community living. While PSSs have a more critical role in the client's use of exercises and readings contained in the MISSION Participant Workbook (other than those used in DRT), the CM will want to review any significant issues raised by these materials with the client. A more extended discussion of the Participant Workbook and its use can be found in Chapter IV. Peer Support. The Participant Workbook can be delivered in a very structured format, going through all exercises in order from front to back. Alternatively, the order of the exercises can be individually tailored based on the client's needs and stage of recovery.

A MISSION team member explains her experiences in using the Treatment Manual and Participant Workbook flexibly in order to meet clients where they are:

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We have found that each client responds to the Participant Workbook in a unique way, and for that reason we have developed individual plans for providing DRT to each. For those who seem overwhelmed, we have tended to do exercises verbally or copy individual worksheets as a way of reducing anxiety around approaching written exercises. As one client noted, *"I can go for months without writing anything except my name so writing in the book is pretty stressful for me."*

Also, as the majority of our clients are actively using, and are pre-contemplative in their readiness to change, we most often pick topics that are relevant to the individual's experience at the present time – "meeting the client where they're at "– as a strategy to best address individual needs and promote therapeutic engagement. For example, when a client is demonstrating all-or-nothing thinking on a particular topic, we would refer to the "Practicing New Ways of Thinking" component of the Participant Workbook as a way to help them address that particular behavior as they are living in that moment.

Other clients enjoy working through the Participant Workbook on their own, at their own pace – sometimes covering a few sections in a short time and then taking a break. Many ask for notebooks to use along with the exercises to expand upon their reflections and to copy down specific sections that are personally meaningful. As a clinician, I have found the Participant Workbook to be a great starting point for further discussion – for example, one client identified "past trauma" and "fear" as reasons for her relapse. When we explored her responses more in-depth, she was able to identify the more specific and real "fears" that were triggers for her (e.g. adjusting to new responsibilities, fear of health issues, and loneliness) – an exercise that proved to be so effective that she made the decision to admit herself to Detox for her alcohol dependence for the first time in four years.

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Initiating Treatment Planning

Treatment planning is a critical component of MISSION and serves as the foundation for future program goals. While it is likely that the treatment plan will not be completed in the first session, it is suggested that the MISSION CM introduce the idea of treatment planning and prioritization of goals during the 45-minute orientation session. The direction of the treatment plan will follow logically from discussion of the client's goals, available supports and personal strengths, and potential obstacles to recovery. When the program is initiated in a treatment setting with an existing treatment plan, the MISSION team reviews the existing plan and

coordinates their treatment plan accordingly so the client sees his/her treatment goals as consistent and aligned.

In MISSION, treatment plans are reviewed regularly in team meetings and fine-tuned when necessary to reflect both goals achieved and new goals and objectives needed for independent community living. When developing a MISSION treatment plan, it is important to identify all problem areas, consider the work that has already been accomplished and the next steps that are needed, and work with the client to prioritize their treatment goals. MISSION treatment plans should have clear goals and objectives and clearly describe MISSION's responsibility in coordinating care across providers.

As treatment planning is an essential component of MISSION services, a blank copy of a treatment plan is included. Please refer to Appendix G for an example of a completed MISSION treatment plan.

MISSION Treatment Plan

Date:

Primary Diagnosis:

Secondary Diagnosis:

Other Treatment Providers:

Service Needs:

- ❑ MISSION
- ❑ Residential substance abuse treatment
- ❑ Acute psychiatric care
- ❑ Other Needed Services
  - Housing Needs
  - Outpatient mental health/substance abuse treatment
  - Medical Care
  - Medication Management
  - Dental Services
  - Benefit entitlements
  - Vocational/Educational Support

MISSION Service Delivery:

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

Treatment Goals & Objectives:

Treatment Goal #1:_____

Treatment Goal #2:_____

Treatment Goal #3:_____

Next appt: Mon Tue Wed Thu Fri Sat Sun

Time: ___:___ **am/pm**

Provider: _____

Location: _____

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D. Using Critical Time Intervention (CTI) Case Management

CTI case management, the cornerstone of the MISSION model, is an empirically supported, time-limited case management model (Susser, et al., 1997) that is designed to prevent homelessness and other adverse outcomes among those with mental illness following discharge from hospitals, shelters, prisons, and other institutional facilities. This transition is often difficult, as there are many challenges associated with re-establishing oneself in satisfactory community

living with access to needed mental health, substance abuse, permanent housing, and vocational/educational supports (www.criticaltime.org). Focused, time-limited assistance during this critical transition and adjustment period has been shown to have positive impacts (Baumgartner & Herman, 2012; Dixon, et al., 2009; Herman & Mandiberg, 2010; Kasprow & Rosenheck, 2007; Susser, et al., 1997; and Tomita & Herman, 2012).

The length of CTI within MISSION can be modified depending on the client's situation and the resources of the treatment program. Appendix D provides sample adjustments made to the MISSION program based on 2, 6, and 12 month service delivery schedules. Regardless of the period of time available to deliver MISSION services, the basic tasks and considerations described here still apply in each of the three CTI phases.

CTI Phase 1: Transition to Community

MISSION services may be implemented when an individual is receiving care in an inpatient or residential treatment facility, when the individual has already transitioned into the community (e.g. a shelter) and is trying to acquire stable housing, or when a person is living in newly acquired subsidized housing through the receipt of a housing voucher. The responsibilities of the MISSION CM in CTI Phase 1 will be somewhat different depending on which setting the client is in at the time of MISSION enrollment.

In circumstances when the individual is in institutional care, CMs are responsible for tracking the client's progress through inpatient or residential treatment by attending meetings led by the inpatient/residential treatment staff. MISSION CMs also meet with the client at intervals appropriate for the length of the intervention (but no less then bi-monthly) throughout his or her stay to discuss treatment progress and to establish a trusting alliance. In this service setting, the MISSION CM always serves as a secondary provider of care and works in cooperation with treatment staff from the institutional facility. The MISSION CM supports the inpatient/residential treatment team and the

client by: providing specialized COD treatment, including the delivery of 13 DRT psychoeducational co-occurring disorders treatment sessions (to be fully described in the next section), providing input on discharge planning, and helping to identify the resources and supports needed to facilitate a successful community transition.

As clients prepare for their transition to community living, MISSION CMs take primary responsibility for facilitating the client's discharge plan. Planning often includes arranging for the use of community resources, including mental health and substance abuse treatment programs, housing specialists, educational/vocational supports, and linkages to trauma-related treatment services as needed. This is a critical time in the recovery process, and one that requires a high-level of support from the MISSION CM. Following discharge, the MISSION CM is responsible for facilitating the implementation of the treatment plan in the community.

If MISSION services commence when the client is residing in the community the MISSION CM may be either the primary or secondary provider of care. This depends on whether the individual is enrolled in a structured outpatient treatment program, such as an Intensive Outpatient Program (IOP), or has another care provider. If the individual is not enrolled in an outpatient treatment program or does not have another treatment provider, then the MISSION CM serves as the primary provider of care and assumes responsibility for executing the treatment plan, making modifications as needed along the way. Regardless of the treatment setting that the individual originates from, the common goal of the first phase of CTI is to identify critical community resources that will help promote the successful recovery of each individual. This phase also includes facilitating the ongoing use of community resources and ensuring that each problem area identified in the MISSION treatment plan is addressed.

Rapidly re-housing homeless clients (whether they are coming from an inpatient/residential setting or a shelter) into a permanent housing placement is an important goal for the MISSION team. In order to facilitate the housing search process, the CM begins to address the client's housing needs in this initial phase of CTI. The CM will conduct a pre-housing interview to establish the client's housing needs and preferences and begin to coordinate with public housing authorities and landlords. The CM expresses interest and motivation to assist the client in finding specific housing that matches his or her preferences. This helps the client to experience the CM as genuinely concerned about his or her well-being and to establish a trusting rapport early on in the CM/client relationship.

CTI Phase 2: Try-Out

In the second phase of CTI, MISSION CMs continue to fine-tune linkages to community resources that may aid in recovery as the client makes progress reaching his or her goals. CMs adjust the treatment plan to include goals that the client was not ready to tackle prior to the progress made during Phase 1. For example, once a client has made sufficient progress towards securing housing and stabilizing mental health symptoms, he or she can begin to focus on other factors that may aid in recovery, such as rebuilding relationships with loved ones.

The primary goal of the Try-Out phase is for clients to become increasingly self-sufficient in the community. Thus, the MISSION CM offers guided support in the attainment of the client's goals, as documented in the MISSION Treatment Plan, while gradually encouraging the client to take small steps towards greater independence. In this Phase, the MISSION CM helps the client to build strong relationships with community providers to address his or her needs, which gradually lessens the client's dependence on the CM as a direct service provider. At this point, the frequency of visits between the MISSION CM and the client decreases, and the CM functions as a liaison between the client and other treatment providers rather than as a direct provider of supports whenever possible. For example, in Phase 1, the MISSION CM may make calls to community providers on the client's behalf, even scheduling appointments if necessary. However, in Phase 2, the CM may assist the client in identifying a suitable provider, but will encourage the client to call and schedule the appointment on his or her own. This reduces the amount of services provided by the

MISSION CM while reinforcing skills learned during CTI Phase 1.

It is important to note, however, that crises and other setbacks can be common in this phase of MISSION. MISSION CMs must be prepared to offer support and guidance to help clients re-establish their emotional stability and sobriety as needed. Additionally, clients' goals often change, and new and unanticipated obstacles may present themselves. Clients may find they have taken on more than they can handle in their financial obligations, encounter difficulty managing relationships, or find themselves overwhelmed by other responsibilities. As these situations arise, the MISSION CM works with the PSS to help clients regain their equilibrium and move forward.

The continuity of the relationship between the MISSION CM and client during this phase provides a safety net for the client and increases the likelihood that he/she will stay on course long enough to stabilize and remain clean and sober. The MISSION CM continues to monitor the client for signs of psychiatric symptom instability and substance abuse relapse, making referrals to appropriate services and community treatment programs and other supports as necessary.

MISSION CMs should never punish a client for a relapse; rather, the relapse should be framed as something that can occur on the road to recovery. The client should be helped to view every relapse as an opportunity for learning and personal growth. Supporting clients in this way can facilitate a deeper client/CM/PSS connection.

Another key role of the MISSION CM during the Try-Out phase is to provide increased linkages to community-based vocational/educational rehabilitation programs and track the client's participation and progress in these programs. Because a great deal of vocational/educational rehabilitation is delivered by others, the MISSION CM's responsibility is to help facilitate the vocational/educational rehabilitation treatment plan, ensure that it is effectively addressing the client's goals, and be prepared to fill in gaps as needed.

MISSION CMs also identify and address any barriers that prevent the client from fully participating in outpatient and community-based treatment and rehabilitation programs. It is the responsibility of the

MISSION CM to continuously maintain appropriate documentation of services needed and services rendered, as this is essential in identifying the client's most troubling problems that need to be targeted immediately. Prioritizing problems is always a team effort between the client, CM, PSS, and the primary treatment provider (when appropriate).

Throughout this Phase, the client's treatment plan and progress toward meeting stated goals is discussed in regular meetings with the MISSION Clinical Supervisor. The CM and PSS may discuss challenges to the client's recovery, including treatment engagement, symptom exacerbation, and substance use relapse. The MISSION Clinical Supervisor provides the CM with guidance and discusses various approaches to work around any barriers to the client's participation in appropriate community treatment programs and supports.

CTI Phase 3: Transfer of Care

During Phase 3, the MISSION CM fine-tunes linkages to community supports that were established during Phases 1 and 2. For example, the CM and client may meet with community providers to identify any existing gaps in service and to ensure that a continuing care plan for the client has been established. As the date for program termination approaches, the CM, PSS, and client reflect on the work that has been accomplished and acknowledge the client's upcoming termination from the program.

It is important for the MISSION CM/PSS team to recognize that for many clients, MISSION termination may be difficult. The loss of the team's support may be associated with drinking, using drugs, and engaging in other forms of destructive behavior. This possibility, and the need for a strong and deliberate plan to avoid this, should always be discussed with the client in a direct and forthright way. It may be helpful to review the skills that the client has developed through the DRT psychoeducational co-occurring disorders treatment sessions or the keyed exercises and readings contained in the Participant Workbook, as well as other skills and strategies the client has found helpful (for example, meditation exercises, physical exercise, or the pursuit of other (healthy) personal interests).

During the latter meetings, the MISSION CM should review the key community supports that have been established and explain to the client that he/she will soon no longer be a part of the client's treatment team and that ongoing care must be provided by community providers.

Clients can appear to be confident and on-course, but in fact may be putting on a façade as things begin to fall apart. Shame and guilt might make it hard for clients to reveal their insecurities, leading to a false impression of well-being. Previous MISSION CMs have the following advice to share about how to handle the transition of care:

- *Remember special events in the client's life when you can.* Wish him or her luck on a new job; offer congratulations on a daughter's graduation. Find ways to let these clients know you are thinking of them, you remember them, and you wish them well.

- *Don't let either the client or yourself become too complacent about his or her recovery.* It's important to make sure the client stays connected with support groups and peers in his/her recovery. Sometimes, when things seem to be going smoothly, the client may really be on the verge of relapse.

- *Foster independence.* Where you once might have made a phone call on the client's behalf, as Phase 2 and 3 progresses, you now give the client the number and let him or her make the call themselves.

- *Recognize the possibility of late-stage relapse.* Some clients will need to re-enter inpatient/residential care and start the process over again.

E. Delivering Dual Recovery Therapy (DRT)

Shortly after the Program Orientation session, during the first phase of the program (Transition to Community), the MISSION CM begins a series of sessions designed to help clients make crucial life changes to enable them to meet their recovery goals. These sessions are part of the Dual Recovery Therapy (DRT) approach and can be delivered in a group format (such as when the client is in inpatient/residential care or congregate living), but can also be delivered individually (such as when the client is living independently in the community).

DRT addresses the problems clients face in recovering from both mental health and substance use disorders, each of which may be a "trigger" for the other. DRT is particularly applicable to homeless individuals because of the many system and service-related barriers they routinely encounter. The DRT sessions use a collection of worksheets and tools to help CMs initiate and carry out therapy. Thus, it is essential that all MISSION CMs be trained to deliver the 13 psychoeducational DRT co-occurring disorder treatment sessions. For information on DRT training please contact the first author of this Treatment Manual, Dr. David Smelson.

The MISSION CM begins each DRT session by administering the Dual Recovery Status Exam. This status exam helps the CM ensure that both mental health and substance use problems are monitored equally. The CM then reviews treatment goals and the client's work on the MISSION Participant Workbook exercises before introducing the topic for the present session (also available in Appendix E).

Dual Recovery Status Exam

- 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 prescribed medications
- Discuss the primary agenda topic(s) for the session
- Ask about attendance at Twelve Step meetings and other elements of the treatment plan

As shown in the table, "DRT Session Topics," each session focuses on a particular task. For more detailed information on the DRT sessions and worksheets keyed to each session, please see Appendix E. Participating clients use the exercises and readings in the MISSION Participant Workbook to follow along with the material covered during DRT sessions and to record their answers to the exercises. Any questions related to the additional exercises and readings contained in the Participant Workbook (especially those not part of DRT) should be discussed with the MISSION PSS, but if questions are relevant to a discussion that arises during a particular DRT session, the client should be encouraged to share his or her thoughts with the CM as well.

Most sessions involve personalized, hands-on application of the concept to the client's life. As used in MISSION, the first four DRT sessions focus on assessment and treatment engagement, while the last nine sessions are devoted to skills training in the following areas: Relapse Prevention; Regulating Mood; Regulating Thoughts; and Managing Interpersonal Relationships.

Regardless of whether MISSION services commence in an institutional or outpatient setting, the authors suggest that the 13 psychoeducational DRT co-occurring disorder treatment sessions (outlined here and explained in more detail in Appendix E) are always delivered in conjunction with CTI case management and care coordination services, as this is critical to the successful implementation of MISSION.

DRT Sesssion Topics in MISSION

1. **Onset of Problems.** Clients learn about the dynamic relationship between mental health and substance abuse problems – that is, how one set of problems can affect the other.

2. **Life Problem Areas Affected by the Individual's Co-occurring Disorder.** MISSION Case Managers and clients review problems the individual has experienced in a number of major life domains and examine the degree to which these problems have affected their lives. The Case Manager will learn more about the client's level of motivation for recovery from each problem.

3. **Motivation, Confidence, and Readiness for Change.** The client completes a "readiness ruler" worksheet for each domain or life problem that was identified during Session 2. Completed rulers will help the client understand their stage of readiness to address each problem area.

4. **Developing a Personal Recovery Plan.** This session marks the end of the assessment and engagement stage. Treatment goals are reviewed and emphasis is placed on the importance of using community substance abuse and mental health resources necessary to meet treatment goals.

5. **Decisional Balance.** A "decisional balance" worksheet is used to help clients identify the benefits and negative consequences of maintaining problematic behaviors and weighing the costs and benefits of continuing a behavior (e.g., substance use, missing appointments, not showing up to work).

6. **Communication Skills Development.** Clients learn to recognize effective and problematic communication styles by using the "elements of good communication" and "elements of poor communication" worksheets. These worksheets will assist the client in developing effective communication skills necessary for communication with mental health, substance abuse, and medical treatment providers.

7. **Twelve-Step Orientation and Recollections.** 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 placed on improving attendance for those clients who have attended in the past, but who dropped out or attended inconsistently.

8. **Anger Management.** This session focuses on identifying situations that trigger anger and strategies to manage those emotions.

9. *Relapse Prevention.* Using a "relapse prevention" worksheet, clients learn to identify and review strategies that can be used to increase the likelihood of sobriety and decrease the chance for relapse with special emphasis placed on how the client's mental health problems can lead to a relapse and strategies that can be employed to prevent this from occurring.

10. *Interpersonal Relationships.* Using a worksheet on "relationship-related triggers," clients learn how unhealthy relationships can contribute to a high risk of mental health symptom exacerbation and/or substance use relapse.

11. *Changing Unhealthy Thinking Patterns.* Clients learn how unhealthy thinking patterns

can perpetuate emotional problems and result in substance abuse as a maladaptive coping mechanism. Basic cognitive behavioral principles are taught during this session, including the interplay among thoughts, behaviors, and emotions.

12. *Changing Irrational Beliefs.* Using a worksheet and a list of irrational beliefs, clients learn how imposing rigid rules on oneself and others can have negative consequences. Clients identify dysfunctional beliefs and learn how to modify those beliefs to maintain flexibility in thinking.

13. *Activity Scheduling.* Clients learn the importance of scheduling regular healthy activities in maintaining recovery.

The extent to which MISSION CMs are knowledgeable about and successfully utilize various evidence-based therapeutic practices during these sessions will influence the success of the service delivery of each session. The following "Therapeutic Techniques" table lists and describes briefly, several suggested evidence-based therapeutic practices that are grounded in motivational interviewing and cognitive behavioral therapy. Detailed descriptions of each therapeutic practice and technique can be found in Appendix F.

Therapeutic Techniques	
Motivational Enhancement Therapy	Blends Feedback Tools and Motivational Interviewing (MI), an empathic style that uses reflective listening to help clients resolve ambivalence and move toward change.
Cognitive Behavioral Therapy	Cognitive templates through which information is processed and determined; identification of schemas to help the client shift toward more adaptive ways of thinking.
Relapse Prevention	Identification of cues and triggers for substance use, early warning signs for mental illness recurrence; and skills training.
Behavioral Role Plays	Strengthen social skills, assertiveness, and communication skills through practice of real life situations in a safe environment to promote a higher degree of functionality.

Although DRT is delivered in 13 sessions, DRT principles are reinforced outside of these sessions as well. For example, MISSION CMs will find the Dual Recovery Status Exam, which was described earlier in this section, useful in monitoring recovery from each mental health and substance use disorder. The status exam may be used in meetings with the client that occur after the completion of the 13 psychoeducational DRT co-occurring disorder treatment sessions. Additionally, MISSION CMs can conduct DRT "booster" sessions as needed to revisit concepts and to reinforce skills and self-knowledge learned during the DRT sessions.

In addition to DRT sessions, CMs meet with the client frequently to promote compliance with other substance abuse treatment regimens, encourage clients to utilize identified community-based resources, and to become involved in community-based activities such as church groups and 12-step meetings to reinforce the use of recovery activities in the community.

When working with a chronically homeless population, or another population that is not coming from residential care, adjustments may need to be made to the model in relation to the frequency and quantity of specific DRT sessions conducted. As this population may struggle with more severe issues of substance use, it is suggested that additional DRT sessions be provided to focus on the following topic areas: Relapse Prevention, Decisional Balance, and Developing a Personal Recovery Plan. These topics should be reviewed on an ongoing basis to address any continued substance abuse. A harm reduction approach should be the center of all interactions with the client where relapse or continued use is not punished, but rather viewed as an opportunity to encourage discussion around the negative consequences associated with substance use.

F. Providing Rapid Re-Housing

A critical need of MISSION clients is securing permanent, safe, and stable housing, and an important responsibility of the MISSION team is to assist clients in becoming rapidly re-housed. MISSION housing practices are guided by the Housing First philosophy.

In line with rapid rehousing and Housing First, the CM/PSS team actively engages the client in the housing search and highlights consumer choice. The first CM housing related responsibility will be to conduct a housing interview with the client to determine the client's housing needs and preferences. Many clients have past histories in which it was explicitly or implicitly communicated to them that they should accept any housing situation offered to them, no matter how ill-suited to their needs, and that they are lucky to get it. Thus, clients may initially be taken aback when asked about their housing preferences and they may need further encouragement to talk about what housing features (e.g. accessibility requirements, location restrictions) are important to them and also to further validate that their opinions are valued. This offers an opportunity for the client to establish a trusting alliance with the CM, who the client now hopefully sees as being genuinely concerned with his or her overall well-being, including his/her housing situation. The CM will coordinate with the housing authorities and landlords to a help the client find a housing unit that matches his or her needs and will help the client to secure any potential housing entitlements.

Once the client is housed, the CM and/or PSS will remain actively involved to help the client maintain his or her housing placement. Responsibilities of the MISSION team will include: helping the client to develop a budget for ensuring rent can be paid monthly, tracking utility expenses, and other household costs, and/or to identify a representative payee if needed; maintaining an open line of communication with landlords and intervening quickly if conflicts arise; monitoring the client for increased psychiatric or substance abuse symptoms that could potentially disrupt the client's housing placement; and linking the clients to supports in his or her new community. The "Rapid Re-Housing Support Provided by MISSION Case Managers" table summarizes the CM's responsibilities in providing housing related support. For more information on MISSION Rapid Re-Housing support services please see Chapter V. Rapid Re-Housing.

Rapid Re-Housing Support Provided by MISSION Case Managers

- Conduct a housing interview to capture the clients housing preferences and needs.

- Help secure housing entitlements.

- Coordinate with public authorities and landlords.

- Assist client to develop a budget or to identify a representative payee.

- Maintain ongoing communication with the landlord and assist in resolving housing related conflicts.

- Monitor client for increased psychiatric or substance abuse symptoms that may jeopardize the housing placement.

- Provide linkages to supports in client's new community

* Please note that the last four responsibilities may also be fulfilled by Peer Support Specialists

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G. Providing Vocational and Educational Support

Clients may need assistance with vocational and/or educational issues at any phase in the MISSION program, and the MISSION CM should be prepared to respond appropriately. For example, employment concerns may arise early in the delivery of DRT sessions as a major area of concern, especially for clients whose work histories, disabilities, or criminal backgrounds make it difficult for them to obtain employment. Similarly, clients who are able to obtain employment may have difficulty keeping jobs. Other clients may request assistance with furthering their education. As a result, throughout the intervention period, MISSION CMs should carefully monitor and support their client's vocational/educational goals on the treatment plan.

The MISSION CM helps the client to overcome barriers to obtaining employment or enrolling in

educational programs by connecting clients to employment and educational resources throughout the community, including local Supported Employment programs, State Department of Labor resources, and local colleges and universities. The MISSION CM also provides practical assistance to the client to help him or her maintain employment satisfaction and cope with "on the job" stresses. Throughout the MISSION program, the CM and client frequently discuss barriers to obtaining and maintaining employment and/or achieving education goals.

The "Vocational/Educational Support Provided by MISSION Case Managers" table illustrates some of the CM's responsibilities in providing vocational and educational support. More information, including resources that will help MISSION CMs meet clients' needs in these areas, can be found in Chapter VII: Vocational and Educational Supports.

Vocational/Educational Support Provided by MISSION Case Managers

- Help clients learn to manage their time and develop a strong work ethic.

- Help clients establish a positive, viable work history by demonstrating longevity and dependability

- Manage conflicts

- Help clients understand benefits packages, including medical and dental coverage, as well as vacation, sick, and personal leave

- Help clients plan for retirement

- Connect clients to university-based service departments

- Connect clients to campus-based support groups (e.g., Students with Disabilities Resource Center)

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H. Trauma-Informed Care Considerations

While MISSION is not a PTSD intervention or one designed to treat co-occurring PTSD and addiction,

MISSION CMs must be prepared to appropriately address the high rate of trauma experienced by clients. As such, MISSION CMs must identify and monitor any symptoms of trauma that may impact treatment and recovery. Remaining sensitive to fluctuations in symptoms will allow MISSION CMs to make informed decisions on whether or not clients need to be referred out to a specialized program to stabilize PTSD symptoms and develop necessary coping skills prior to admission or readmission into the MISSION program.

Communication with MISSION PSSs is vital, as clients may relate information regarding exacerbation of these symptoms to their assigned PSS. Chapter VII: Trauma-Informed Care will help guide MISSION CMs, as well as the rest of the MISSION treatment team, regarding these issues. Additionally, Appendix N includes assessment tools and other resources that MISSION CMs can use to help identify and monitor fluctuations in trauma-related symptoms. Fact sheets and other useful handouts including websites and referral sources have also been included.

Considerations in Trauma-Informed Care: What Case Managers Need to Know

- Be aware of the possibility of trauma among clients

- Know and be able to recognize symptoms of trauma

- Be aware of the impact trauma has on the lives of clients

- Be able to screen clients for trauma

- Know how and when to refer clients out for specialized help

I. Ending the MISSION Program

As MISSION services delivered to the client taper off, the CM gradually helps the client prepare for the day when he or she will rely on community resources to help maintain their recovery. The final CTI stage of MISSION, Transfer of Care, helps clients to prepare for the termination of services and the "hand-off" to more

permanent community linkages at the end of his or her time in MISSION. At the final meeting with the MISSION CM (or with the CM/PSS team), the client's goals and accomplishments will be reviewed. The CM will also review next steps with the client, supporting his or her plans to maintain recovery. MISSION CMs may want to encourage individuals to share good news and stay in touch, but they also want to be sure that the client understands that once the program ends, the CM is no longer available as a care provider. It is important that the CM highlights the progress that the client has made and frames the successful completion of the MISSION program as a great accomplishment in the recovery process.

If a positive relationship has been established between the clinical team and the client, which often happens, this termination phase may prove to be difficult for the client (and possibly for the MISSION CM and/or PSS as well) and may bring up separation issues. In some MISSION studies, there were cases where clients who were faring well at the end of MISSION, relapsed immediately upon graduation from the program. When investigated further, it was found that clients simply did not want to end their treatment because working with the MISSION CM and PSS had been such a positive experience. In order to continue working with their clinical team, they relapsed to be reentered into the program.

It is for this reason that communication with the client and setting clear expectations regarding the termination of services is of the utmost importance, and we suggest that this process be initiated early in the treatment. In fact, when delivering MISSION, it is important to remind clients that treatment is time limited, while reinforcing that they will be able to live independently in the community without the MISSION team upon program completion as long as adequate supports are put in place and utilized. One troubling consequence of not successfully transferring service, in addition to potential relapse, is an overburdened caseload for the MISSION team, resulting in services which may be compromised for some or all of the clients enrolled. An alternate negative consequence is that fewer future individuals, who are eligible for MISSION and in need of services, will be enrolled

due to caseload size limitations, and will not have the opportunity to benefit from the MISSION program. For cases where it would be beneficial for both graduating clients and newer clients, the clinical team may want to discuss the option of creating a "graduates group" where graduates of the program meet to address issues of continued sobriety and participation in long-term treatment, and may even serve as mentors to new clients entering the program. Such decisions vary depending on individual agencies and should be discussed during clinical supervision.

Topics for Discussion During Final MISSION Session

- Review the client's progress throughout the program.

- How has it gone for you? What have been the highlights and difficulties?

- What are your goals now as you move forward beyond MISSION?

- What challenges/barriers do you see to achieving those goals? How do you plan to overcome them?

- What are you going to do to achieve those goals for yourself?

- Do you have a list of emergency numbers and available community resources?

- Do you have a list of your upcoming appointments?

- Say goodbye.

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Lastly, given the unique and comprehensive role of the MISSION CM, Appendix G has been developed to serve as a supplement to this chapter. It contains additional information on: special considerations in delivering care; training needs; the role of case managers and clinicians in existing programs; case examples; and sample notes.

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NOTES

IV. Peer Support

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This chapter is intended for those serving on MISSION teams as Peer Support Specialists (PSS). It explains the unique role of the position. Following an overview of their role within the MISSION treatment program, the chapter explains how the PSS works with the MISSION Case Manager. It also highlights how the PSS serves as a role model and as a source of encouragement and support to individuals receiving MISSION services. Case examples are included to illustrate how PSSs facilitate discussions on topics of particular concern to clients receiving treatment services and how the PSS continues to meet with clients regularly once they have transitioned to the community to provide ongoing support and service linkages to community programs and treatment resources. It also includes special considerations that are unique to the role of the PSS that should be taken into account.

"…this is something you'd have to be willing to do for free in order to do it for pay."
- MISSION Peer Support Specialist

A. Overview of the MISSION Peer Support Specialist's Responsibilities

During the often lengthy and difficult process of rebuilding a life in the community, clients receiving MISSION services can benefit greatly from the support of someone with similar experiences — someone who can offer advice and empathy when the client faces challenges along the way. Each Peer Support Specialist (PSS) on the MISSION treatment team has recovered from challenges (homelessness, unemployment, substance abuse, and mental illness) similar to those faced by the clients with whom they are working and has received training specific to serving as a PSS.

As MISSION PSSs advocate for the clients on their caseload, share wellness and relapse prevention strategies, and provide practical supports to improve socialization and community life skills, the unique mix of camaraderie and leadership empowers clients to self-determine their own recovery goals.

MISSION PSSs are full staff members on the MISSION treatment team; as such, their role is central no matter where MISSION services are initiated. However, if MISSION service delivery is initiated while the individual is receiving treatment in an institutional setting, MISSION PSSs facilitate weekly peer support group sessions. These sessions present opportunities for rapport-building, discussions of the upcoming transition, and assessments of anticipated practical supports, while introducing and emphasizing self-care and socialization skills. MISSION PSSs who have not facilitated groups before should look to the MISSION Case Manager (CM) or Clinical Supervisor as models, or they may request training to help them develop confidence and skills as a group leader.

If service delivery is initiated after the individual has transitioned to the community, the MISSION PSS will address the same topics as they become relevant to the client in one-to-one conversations. Peers meet with the client, often in the client's place of residence, ensuring that the client is utilizing the appropriate supports including community mental health and substance abuse treatment programs, 12-step meetings, and vocational/educational rehabilitation services. If the client is not using these supports, MISSION PSSs facilitate the process by accompanying clients to 12-step meetings or by assertively bringing them to their appointments.

In their "check in" sessions with clients, MISSION PSSs can reinforce both the work clients have done in Dual Recovery Therapy (DRT) sessions led by a MISSION

CM, as well as the work clients have done on the Self-Guided Exercises contained in the MISSION Participant Workbook.

A primary goal of the MISSION team is to encourage the client's involvement in adjunctive self-help and mutual support services, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), where clients will be exposed to others who are further along in recovery. These services and relationships are essential to the recovery process; and become increasingly important as the client transitions from the MISSION program to complete reliance on community-based services for ongoing care.

Implications of the "Critical Time Intervention" Model

The MISSION approach uses the tested model of "Critical Time Intervention" (CTI) case management. This approach offers different types of support to the client in different phases of the transition to community life. The three distinct phases of care are: (1) Transition to community (the initial phase of intense support), (2) Try-Out (in which the client accepts increasing responsibility for maintaining a healthy approach to life), and (3) Transfer of care (in which the client relies increasingly on community supports rather than the MISSION team, and the program comes to an end).

Consistent with the CTI approach, the team gradually reduces its frequency of contact with the client over the course of the intervention to reinforce the use of community supports and independent living. Therefore, peer support must be provided in a way that fosters independence and focuses on helping the client learn self-advocacy skills and establish connections in the community that he/she can maintain independently upon completion of the MISSION program. In order to accomplish this, the MISSION PSS works in close collaboration with the MISSION CM. Both the PSS and CM have the mutual goal of ensuring that clients assigned to their team have the resources and skills they need to achieve the goals they have set for themselves as well as for continued growth in their recovery.

Overview of the MISSION Peer Support Specialist's Responsibilities

CTI Phase 1: Transition to the Community

THE MISSION PSS:

- Meets with the client periodically to establish rapport and encourage the client in the changes he or she is making.

- Provides input on the MISSION treatment plan.

- Conducts group or individual peer support sessions on the 11 topics related to recovery and the transition to healthy living in a community setting.

- Discusses exercises and readings in the MISSION Participant Workbook with the client.

- Works with the MISSION CM to identify community resources essential for successful community integration.

- Assists with executing the discharge plan and helps the client overcome barriers that arise in using key community supports, including accompanying the client to appointments/meetings as needed and helping the client move into his or her new home.

CTI Phase 2: Try-Out

THE MISSION PSS:

- Continues to facilitate linkages that have already been established, helping the client think through and resolve obstacles and challenges that arise.

- Redirects the client's attention to exercises in the MISSION Participant Workbook as needed, helping the client recommit to goals and strategies or, when needed, express new ones.

- Identifies any gaps in support system, barriers in accessing services, or areas where the client needs more support and works with the CM and other providers to address these gaps.

CTI Phase 3: Transfer of Care

THE MISSION PSS:

- Celebrates the client's ability to maintain goals in healthy living and puts relapses or slips in perspective.

- Reflects (with the client) on work that has been accomplished thus far and acknowledges end of participation in MISSION program.

- Reminds client of supports that have been established, says goodbye, and wishes the client the best of luck in continued recovery.

B. Working Effectively as a MISSION Treatment Team

MISSION PSSs and CMs are paired into permanent teams and share primary responsibility for the clients assigned to their team. Other members of the MISSION program might provide back-up services; however, respecting the assignment of clients to particular teams is important to well-coordinated care. PSSs sometimes have contact with clients assigned to another MISSION PSS/CM team; this may occur through a chance meeting in the residential or inpatient treatment center, in the community, or if a client seeks out a particular PSS. Such contact is acceptable, but when a PSS discusses issues of clinical significance (i.e., issues that relate to the client's mental health or substance abuse recovery) with clients who are assigned to another team, the PSS must encourage the client to relay any relevant information to his or her assigned PSS/CM team, as this is often information critical to recovery.

For the team relationship to work effectively, it is critical that both team members share information with one another about the contact they have with the client. These communications help team members support each other's work and track evolving issues that may require special intervention. The PSS may tell the CM that the client has been seeing drug-using friends at their old haunts, or a CM may tell the PSS that a client has been shy and nervous about going to AA meetings and ask the PSS to offer to attend a meeting with that client. At their regularly scheduled supervision meetings with the Clinical Supervisor, or earlier if necessary, the PSS/CM team should share any serious problems on which they would like guidance or assistance, preferably at the earliest stage possible to allow for prompt intervention.

Depending on the issues to be addressed and the preferences of each client, PSSs and CMs may meet with the client together or separately. When the PSS and CM meet with the client separately, the authors suggest that the PSS and CM meet and discuss their observations and concerns regarding

the client regularly. By working together smoothly, team members can enhance their effectiveness and ensure each client enrolled in the MISSION program is receiving consistent messages and support. Clients are informed at the outset of their participation that information is shared among MISSION team members to better facilitate their care.

Within individual teams, the PSS and the CM coordinate care in order to promote consistency in service delivery. Many roles and responsibilities are shared, with each member offering his or her skills and perspectives to assist the client in achieving important goals. Each team member, however, also has areas of primary responsibility (see the table, "Responsibilities/

Roles of the MISSION Peer Support Specialist and Case Manager"). The MISSION CM takes the lead in developing treatment plans, but the plans should reflect the PSS's input. When one team member assumes a primary role in a certain area, the other team member provides assistance and serves in the primary or lead capacity when the primary team member is temporarily unable to fulfill that duty (for example, due to absence or sickness). While both PSSs and CMs share responsibility for assisting clients with use of the MISSION Participant Workbook, it is really the PSS who checks in with the client regularly; while CMs ensure that the appropriate 12-step supports are in place, it is the PSS who actually accompanies clients to meetings if necessary.

Responsibilities/Roles of MISSION Peer Support Specilist and Case Manager

Primary Responsibility of PSS, with input from the CM	Primary Responsibility of CM, with input from the PSS	Responsibilities Shared by the CM and PSS
• Linkage to community mental health and substance abuse recovery programs (NA/AA) • Help clients advocate for themselves with providers and ensure effective two-way communications • Assist clients with Consumer Workbook exercises and readings, discuss material, and reinforce insights • Prepare client for interviews with landlords, assist client with housing applications, help client move in, arrange for needed household items • Accompany clients to clinical appointments, job interviews, recreational activities, and self-help group meetings • Recreational planning and modeling healthy living using free or low-cost community resources • Increase motivation toward recovery goals	• Orientation/introduction, mid-program progress check, transition to community, and discharge plans • Management of clinical crises • Delivery of DRT psycho-educational and booster sessions at each visit • Provide rapid re-housing support as needed: pre-housing interview, coordination with landlords/housing authorities, secure housing entitlements • Provide vocational/educational supports as needed: interview skills training, resume building, linkages to education and training programs • Identify, monitor, and provide referrals for trauma-related symptoms • Facilitate linkage to other clinical services • Communicate with clinical service providers • Review and work through benefits and entitlements issues (Social Security Income and Social Security Disability)	• Weekly team meetings with staff providing care at inpatient/residential treatment facility • Discharge session from the treatment facility • Linkage to needed community services, including vocational/educational supports and trauma-related treatment resources • Ongoing monitoring of symptoms, psychoeducation and training in symptom management, coping skills, medication compliance, problem solving, and relapse prevention • Assistance with housing maintenance • Transportation assistance • Provide support during job stresses • Provide support during clinical crises • Refer out as appropriate during exacerbation of symptoms

C. Initiating Relationships with Clients

Orientation to the MISSION Program

The initial MISSION session occurs after the intake conducted by staff of the inpatient/residential treatment facility or upon referral from clinicians/case managers in other community programs. Before the MISSION CM and PSS meet the individual, the MISSION Clinical Supervisor (or if necessary the CM) performs a diagnostic assessment and screens the individual to determine his or her eligibility for the program. Once an individual has been determined eligible and has agreed to participate in the MISSION program, he/she is introduced to his/her permanent MISSION CM, who schedules an introductory meeting to begin the process of getting to know the new client. Both the MISSION CM and PSS should participate in the meeting if possible, but if necessary the client can meet with CM and PSS separately. This initial 45-minute orientation meeting is an opportunity for the MISSION treatment team to learn about the client's strengths, interests, and goals as well the client's needs, triggers, and barriers.

The orientation session lays the foundation for a healthy working relationship between the client and MISSION treatment staff, builds the client's understanding and expectations of the program, marks the beginning of MISSION treatment planning, encourages hope, and lets the client know that he or she will have support in meeting obstacles that may arise – as well as people who will cheer and celebrate as the client achieves his or her treatment and recovery goals.

During this initial meeting, the MISSION PSS takes a relaxed and supportive stance. She or he explains that the PSS's role is different than the CM's and offers to help clarify any aspects of MISSION that the client might not understand after meeting with the MISSION Clinical Supervisor or CM. In general, clients appear to be relatively comfortable with the informal nature of the relationship with the PSS. Sometimes, however, establishing rapport with an individual enrolled in the MISSION program will take some extra work.

During the orientation session, the CM and/or PSS give the client the MISSION Participant Workbook and explain that the workbook contains three important components:

1. Tools that will be used as part of DRT sessions led by the CM,

2. Exercises that are keyed to the DRT sessions which are reviewed in peer-led sessions, and

3. Advice from people who have made similar transitions designed to help clients settle into their communities.

While the workbook is essential to MISSION program orientation and symbolically offers the client a "gift" of support materials, it is our experience that some clients initially become somewhat overwhelmed with the content of the workbook. Therefore, it is essential for the PSS to provide an effective introduction to the workbook, discuss any concerns the client may have about reading and/or working on it, and allay his or her anxiety. It is important that the PSS helps the client to view the workbook as a critical resource to be used while he or she is enrolled in MISSION and as a set of recovery tools following his or her graduation from the program.

While MISSION PSSs have the lead role in facilitating the client's use of exercises and readings contained in the MISSION Participant Workbook (other than those used in DRT), the CM should be made aware of and review with the client any significant issues raised by these materials.

Working with Clients in a Treatment Setting

For individuals who reside in an institutional setting, MISSION PSSs get to know their assigned clients both directly, through peer-led group discussions, and indirectly, through treatment team meetings. Along with the MISSION CM, the PSS attends weekly treatment team meetings held by the staff of the treatment facility. By participating in these meetings, the MISSION team learns more about a client's clinical course and has opportunities to build relationships with residential care staff. Additionally, by building trust and camaraderie with clients during their inpatient/residential stay, the MISSION team can deliver targeted and informed treatment upon discharge.

Maintaining proper boundaries between the services and staff of the treatment facility and the MISSION team

is important; however, the role of the MISSION PSS is less likely than that of the MISSION CM to be seen as conflicting with that of the clinician or case manager who is in charge of providing services to the client in the inpatient or residential facility. Thus, the MISSION PSS typically has more extensive contacts with the client in the treatment facility prior to community transition than the CM.

D. Using the MISSION Participant Workbook

As described earlier, the MISSION Participant Workbook is given to the client during the orientation session. The workbook is divided into two parts. The first part contains Self-Guided Exercises; Dual Recovery Therapy: Tools and Readings; and Checklists. The second part contains readings on Sustaining Recovery and Community Living. While the authors encourage clients to complete the self-guided exercises contained in Part 1 independently, the MISSION PSS plays a critical role in the completion of these exercises and in helping the client put new skills and discoveries into action.

Part 1 of the workbook also contains DRT exercises, which are discussed during the DRT individual or group sessions led by the MISSION CM (the PSS works with the client to complete the worksheet in advance). The client's written responses to DRT exercises can be a helpful resource and a reminder of the client's commitment to achieving personal goals, the skills that help maintain recovery, and the essential concepts that will help the client stay focused on their recovery. It is helpful for both MISSION PSSs and CMs to refer back to the client's "triggers" for substance use, his or her personal goals, and plans for recreational activities—either as a reminder, or as an opportunity to re-envision the path to recovery.

PSSs have a brief weekly check-in session to review each exercise that the client has completed in the MISSION Participant Workbook. Although individuals receiving MISSION services while they are in inpatient/residential care participate in DRT sessions and other structured sessions, MISSION peer-led sessions are unique because they offer the PSS's "been there, done that" perspective. The amount of time spent is variable, depending in part on whether a client needs to work

through an issue raised by the DRT worksheets, the MISSION Participant Workbook Self-Guided Exercises, or the readings. Approximately 10 minutes a week is set aside for this purpose. This could also be done in a longer individual session with the MISSION PSS or, if appropriate, it could be brought into the PSS group session as an issue for everyone to discuss.

For those individuals leaving an institutional treatment facility, the readings in the latter part of the MISSION Workbook become particularly relevant, raising issues that currently concern the client and promoting useful discussion. Case managers facilitate the use of readings related to the transition to the community, which should correspond with the transitional care sessions. However, as is the case with the exercises described above, the PSS provides in-depth assistance with digesting these readings and helping the client work through fears and concerns. Because the CM and PSS work as a team, it is critical to have an ongoing dialogue about the client's progress regarding the readings in the workbook and the issues that may be of concern to the client. The readings also provide an opportunity for PSSs to share their own stories about re-entry in the community and the issues they faced.

Part 2 of the MISSION Participant Workbook includes a brief description of the most common mental health conditions experienced by individuals in the MISSION program. In addition to information on select mental health conditions, the workbook also contains a table with the most common medications used to treat these conditions as well as their possible side effects. We point this information out for two reasons:

- Clients enrolled in MISSION may want to talk about the materials in one of their sessions with the PSS.
- Authors have received feedback from MISSION staff that these materials, particularly the table of medications and side effects, are a useful resource.

E. Peer Support Sessions

For those in residential treatment or a congregate living facility, the PSS leads a weekly session of approximately 60-90 minutes (see Appendix H). The can be done

in an individual or group format but we prefer a group format for clients in settings that have congregate living arrangements. These sessions are scheduled at different times and conducted by different PSSs in order to accommodate the varying schedules of clients; however, each MISSION PSS covers the same selected topic for the week. The 11 topics (see Peer-led Sessions table) have been identified by PSSs from past MISSION-based projects as having particular relevance to those clients currently residing in treatment facilities or congregate living arrangements as they prepare themselves for independent community living. These group discussions serve several purposes. From the standpoint of the MISSION program, the primary purpose is to establish a sense of camaraderie among clients and the PSS, so that after the individual is discharged from the institutional setting, he/she is already comfortable seeking and accepting support and advice from the MISSION PSS. The weekly peer-led sessions offer clients a forum to air their concerns, fears, questions, and hopes in a safe environment, knowing that they will not be judged and that their peers (both the MISSION PSS and other clients) will support them. These sessions also offer the client a chance to start developing some of the skills and addressing some of the goals that will continue post discharge.

For clients who are already living independently, for example, if housing has been obtained through a state or federally-funded program, peer-led sessions often occur at the client's residence. While these sessions are delivered individually rather than in a group setting, the same 11 topic areas are covered and the purpose of each session is the same. The peer-led sessions allow the client to air any concerns about their living arrangement or adjustment to the community; the MISSION PSS can then identify problems and relay information back to the treatment team. Additionally, these sessions allow the client to raise other pertinent issues, ask additional questions, and express their future hopes in a comfortable, relaxed environment free of judgment and full of support.

Topics Exercises for Peer-led Sessions

1. Willingness
2. Self-acceptance and respect
3. Gratitude
4. Humility
5. Dealing with frustration
6. Handling painful situations
7. Significance of honesty
8. Courage
9. Patience
10. Medicine maintenance
11. Making a good thing last

Format

The design of the weekly peer-led sessions deliberately avoids excessive structure as clients receiving MISSION services participate in a number of structured activities either in the residential treatment program, structured outpatient programs, or in other programs relevant to their recovery. As a result, MISSION PSSs strive to present a more relaxed atmosphere.

Structure of Weekly Peer-led MISSION Meeting in the Treatment Facility

- A brief introduction to the day's topic, why it was chosen, and why it is something important for clients to think about

- Personal insight or a story offered by the Peer Support Specialist in order to further set up the topic

- Questions to spark discussion, if needed

- A facilitated discussion on the topic

When matters arise in peer-led sessions that involve safety or other critically important issues, the MISSION PSS's first step is to encourage the client to further discuss the issue with the rest of the treatment team, particularly the CM. The PSS shall also indicate to the client that he/she must share this information with the treatment team.

F. Providing Support in the Community

Providing Input into the Discharge Plan from a Treatment Facility

If the individual is re-entering the community from a treatment facility, the MISSION team will not only have its own plan for helping the client, but will also play a key role in fulfilling the goals of the facility's discharge plan. While staff from the treatment facility create the discharge plan for each person re-entering the community, the MISSION team, including the PSS, has input into the plan. The MISSION PSS's input is coordinated through the CM assigned to the same client. This input reflects insights gained from informal contacts, observation of the individual's behavior in group sessions, and information obtained in from weekly treatment team meetings.

The MISSION PSS often offers their personal insights and observations about the client and his or her needs. For example, the PSS may feel that a particular transitional housing program might or might not be a good fit for a particular individual and share this recommendation and the reasoning behind it. The client and his/her treatment team at the institutional treatment facility may take these insights into account as they finalize the discharge plan. When conflicts arise between the MISSION PSS and CM or between the PSS and/or CM and the inpatient/residential treatment staff regarding the care of a client enrolled in the MISSION program, the MISSION team should raise the issue with the Clinical Supervisor, who works with each party to provide guidance and helps to resolve the conflict.

After the discharge plan from the facility is completed, the assigned MISSION PSS and/or CM meets with the client to discuss the plan and the role that the team will play in supporting the plan. This meeting, which occurs prior to the client's discharge from the institutional facility, is called the "Transitional Session." As MISSION

PSSs may have already formed strong bonds with their clients while they were in the institutional treatment facility, PSSs play a crucial role in helping clients execute the plan and achieve the goals that they have set for themselves as they fully integrate into the community.

Providing Input into the Treatment Plan when the Program is Initiated in a Community Setting

If the MISSION PSS did not work with the client while he or she was in an institutional facility, the PSS actively works with the MISSION CM and Clinical Supervisor to develop a MISSION treatment plan that provides a clear path to achieving the client's goals.

It is important to note that when working with a chronically homeless population, or another population that is not coming from residential care, adjustments may need to be made to the model in relation to the frequency and quantity of specific Peer Support sessions conducted. As this population may struggle with more severe issues of substance use, it is suggested that additional Peer sessions that focus on topic areas that relate to the individual's substance use (such as Dealing with Frustration, Patience, Self Acceptance and Respect) be reviewed on an ongoing basis to address continued substance abuse. The review sessions should be based on the specific client triggers/needs and may change on a case-by-case basis. Furthermore, peers may also want clients to do 90 meetings in 90 days in order to establish a firm recovery foundation again. A non-judgmental harm reduction approach should be the center of all interactions with the client where relapse or continued use is not punished but instead viewed as an opportunity to encourage discussion around the negative consequences associated with substance use.

Types of Support Provided by the MISSION Peer Support Specialist

MISSION PSSs offer individual support to the client in areas that overlap with the support provided by the MISSION CM. This includes supporting clients in managing mental health symptoms, sustaining recovery from substance abuse, securing and maintaining permanent housing, obtaining gainful employment, and

achieving educational goals. The type of support that MISSION PSSs offer can be practical and/or emotional; for example, they might offer to accompany clients to initial mental health appointments, bring them to AA or NA meetings, tell them what to expect in a particular housing program, or offer advice and support as clients try to reconnect with their families. They also use specific tools and techniques, such as the "PICBA" tool for personal problem-solving (see the MISSION Participant Workbook), to empower their clients to become more involved in treatment decisions. Like MISSION CMs, PSSs make ready use of the tools and narratives contained in the workbook on an as-needed basis.

Below are descriptions of specific experience-based competencies that PSSs have and real case examples of how PSSs applied those competencies.

Reducing Fear

Achieving life goals requires overcoming fear of failure and fear of the unknown. Having been homeless and through institutional treatment, clients might doubt their ability to succeed on their own, to remain sober, and to adjust to work and other aspects of community life with which they have become unfamiliar. Clients might also fear taking medications or being stigmatized in the community as a result of their conditions or treatment. Having been through similar experiences, MISSION PSSs are able to provide emotional support and practical advice for facing these challenges. A client might call because he or she had a "drug dream," had a fight with a spouse or partner, or is simply feeling the urge to use.

Peer Support in Action: Example 1

"Isaac" was so debilitated by his co-occurring mental illness, drug addiction, and alcoholism that he could not by himself take the necessary steps to secure housing, even though he had enough money for a place to live. Isaac had already been asked to leave a residential treatment facility due to his continued use, and his MISSION PSS had helped him find transitional housing. Now, Isaac faced eviction from transitional housing after he relapsed, and in a panic he called his PSS for help.

By facilitating access to resources, the MISSION PSS was able to find Isaac a secure house located close to the rehabilitation hospital, where the MISSION team could monitor and support him during this critical time. With this new housing placement arranged by his PSS, he was able to easily acquire his medications and get mental health counseling and treatment. Throughout this process his PSS provided encouragement, support, reassurance, and positive feedback to help Isaac overcome his paralyzing fear and take the necessary steps back to a positive lifestyle.

Accompanying Clients

Another way in which MISSION PSSs can provide practical support to clients is to accompany them to their first few mental health appointments, as they learn unfamiliar public transportation systems, or when they need to buy groceries or shop for clothes. The PSS continues to accompany the client on these activities until they are comfortable doing such tasks on their own. For example, a PSS who has shopped for a child before might accompany a client who is trying to reunite with his family to help him buy clothes for his children.

This support can be especially critical in times when the client stumbles on his or her recovery path. The MISSION PSS can provide moral support if the client becomes homeless or has a substance abuse or psychiatric relapse by accompanying him/her to a shelter, detoxification facility, or the hospital if necessary.

Promoting a healthy lifestyle

A healthy lifestyle includes eating well, getting enough sleep, and exercising regularly. Sleep, exercise, and nutrition can all play a positive role in relieving stress and improving mood, while smoking and caffeine might have negative impacts. While recognizing that "old habits die hard," the MISSION PSS can help to promote healthy lifestyles with new habits of self-care.

Peer Support in Action: Example 2

"Ricardo" had recently received housing in the community after completing a residential treatment program. However, one month after he had gotten his own housing, he relapsed and subsequently became homeless due his inability to pay rent. Ricardo started living on the street, stopped eating and bathing, and

could not hold down a job. His MISSION PSS arranged a face-to-face meeting with him and talked to him about his weight loss, disheveled appearance, and lack of personal hygiene. His PSS asked him directly, "What do you need to get back on the road to recovery?" Ricardo knew that he needed the very things he had given up—a roof over his head, a place to shower, and food. This meeting with his PSS helped Ricardo realize that before he could value and retain these things in the future, he needed to understand the reasons that he gave them up in the first place. Ricardo acknowledged that he had gotten comfortable with his present condition and stopped putting in the necessary work to maintain his recovery.

Once Ricardo determined to pursue a healthy way of life, his PSS helped link him to a detoxification program and then a bed at the Salvation Army. Because there were no available apartments in his previous community, his PSS helped Ricardo find another long-term residential program in the community. His PSS also helped him retrieve and use the healthy living tools he learned while enrolled in MISSION during an earlier residential program stay, including information on the importance of hydration, selecting healthy foods, avoiding unhealthy foods, monitoring caloric intake, and exercising. With ongoing peer support, Ricardo began reclaiming his recovery by attending programs, taking classes, and seeing his family. He began feeling better about himself and regained his confidence in his ability to achieve his recovery goals and has just received permanent housing through a housing placement program.

Socializing

For clients who are transitioning back into the community, engaging in drug-free social events and socializing with drug-free friends can have a positive impact upon recovery. Because the MISSION intervention is time limited (2 months, 6 months, or 12 months), the development of positive and drug-free social relationships can be essential as these relationships can provide important ongoing support for the client after the MISSION program ends.

The MISSION PSS primarily relies on AA and NA social events because these events tend to be larger and better established, offering clients in the MISSION

program certainty that the event will be well-attended and thus worth their time. Such 12-step events might include dances or other enjoyable activities.

At times, MISSION PSSs may also set up small, informal social events for clients on their caseload. For example, a PSS might get together with three or four clients to eat pizza and play pool, each chipping in if another client who attends does not have enough money to participate.

Especially as clients return to work, social events are more likely to be successful on evening or weekend hours. Ideally, the work schedules of MISSION PSSs will include some evenings and weekends, since one of the hallmarks of peer support is that it is generally available when more traditional services are limited, and when clients are most in need of natural support and opportunities for social connectedness. Although MISSION PSSs have a working schedule that mostly follows "normal business hours," employing a mechanism that allows them to use "comp time" to shift their working hours, when necessary is useful. However, PSSs also tend to have natural contact with clients during nights and weekends since they often participate in the same type of activities as a part of their personal life (for example, going to AA or NA meetings/activities, place of worship, and grocery shopping).

Achieving goals

As someone who has had experiences similar to those of the clients enrolled in the MISSION program, the PSS often has excellent insight into what can be considered realistic goals for clients to set and achieve. Those clients who are really struggling might have goals that seem trivial to an outsider, but are understood by those who have experienced similar struggles. For example, a person who is feeling extremely depressed might have as a goal to smile three times per day or to go out in public twice a week and talk to someone. Of course, MISSION PSSs should help set goals as high as the client wishes, with shorter-term objectives being developed in the interim. After goals are set, it is important for the MISSION PSS to regularly check in on the status of those goals in order to ensure progress.

Peer Support in Action: Example 3

"Earl" faced a financial barrier to getting his driver's license back. He had accumulated many fines over the years and could not pay them on the salary he earned at his current job. His assigned MISSION PSS had also experienced a struggle with outstanding fines and explained to Earl how he had set paying off his fines as a goal and decided to quit smoking as a way of saving money to pay off those fines so he could get his license back. Using the eight dollars a day he had spent on cigarettes, the PSS was able to slowly pay off his fines and get his driver's license back. Even now that he has paid off his fines and has gotten his license back, he has decided to no longer smoke cigarettes. The PSS's sharing of his personal experiences showed Earl that the barrier he faced was not an insurmountable problem, and the PSS also helped to motivate Earl to seek a better paying job while also modeling healthy behavior (smoking cessation). Through perseverance, Earl got that job and was finally able to pay off his fines.

Working

As someone who has gone into a full-time job with responsibilities after experiences similar to those of the clients currently enrolled in the MISSION program, the MISSION PSS is a natural role model for providing support to a client who is considering returning to work, trying to find the right job, or adjusting to working life.

Many clients in the MISSION program have extensive criminal records and limited work experience; therefore, they often have difficulty finding a job or have to start out working in less desirable positions. The role of the MISSION PSS is to reinforce the work that the staff from the institutional treatment facility does in preparing clients for work—teaching them how to address questions that interviewers might have about their pasts, stressing to them the need for punctuality and showing up for work every day, or helping them cope with unpleasant work experiences.

Peer Support in Action: Example 4

"Marcus" lost a well paying job when he relapsed to cocaine use. He asked for support from his MISSION PSS, who understood first-hand the impact of losing a good job. Other opportunities for Marcus were very limited, and his PSS offered to help Marcus find a temporary job at a nursing home where he had previously worked. The pay for this job was much lower than Marcus's previous position, and Marcus was not sure he could get by on the reduced income. In fact, he did lose his apartment, but his MISSION PSS helped him to return to a residential facility. Throughout the process, his PSS helped him to keep his head up, pointing out that the job in the nursing home was "a step down in wages, but a step up in humility." His PSS also encouraged him to learn from his experience, suggesting that "he was being tested on the little things before he could go back to the bigger things."

This particular MISSION PSS drew from his own experience working at the nursing home for nine dollars an hour, explaining to Marcus the new perspective he had gained. He told Marcus, "you must have gratitude for your accomplishments now," rather than dwelling on the past. "You depleted your 401K to get high, and you're not going to get that back," he said. He helped Marcus realize that he would have to take things slowly in rebuilding his finances and helped him use his limited income to his advantage.

Addressing Stigma

While reports indicate that mental illness and substance abuse problems are widespread, stigma continues to be a prominent problem individuals face during recovery (Corrigan, 2004; NAMI, 2010) and has been linked to an increased risk for negative outcomes, which include reduced employability, imprisonment, and homelessness (Browne, 2007; Corrigan, et al., 2007; McNiel, et al., 2005). As such, if stigma is left unnoticed, it that can impede the MSSION client's progress towards his or her goals.

Traditionally, stigmatization has been defined as the process by which individuals who lack certain characteristics or traits belittle other individuals who have them (Piner & Kahle, 1984); however, stigma has further been broken down into two critical components public stigma and self-stigma. Public stigma occurs when there is a reaction toward a specific group of individuals who share a negatively viewed trait (Corrigan, 2004), while self-stigma results from one's own reactions toward oneself due to membership

in a stigmatized group (Corrigan & Watson, 2002). Moreover, self-stigma has been associated with decreases in self-esteem and self-efficacy, which may hinder motivation toward participation in activities that would promote recovery (Corrigan, et al., 2006), such as applying for a job or approaching a landlord for a housing application after one or more failed attempts.

Although public and self-stigma can be viewed as separate, it is important that MISSION PSSs consider both as these components are often present simultaneously and build upon one another. For example, if clients with COD encounter a landlord who is hesitant to rent to them due to their diagnoses (public stigma), they may internalize this stigma (self-stigma), which in turn may negatively impact perceptions of their own capabilities and decrease their motivation to approach another landlord with a new housing application.

MISSION PSSs are in a unique position to help safeguard their clients against the negative effects of both types of stigma by using two key strategies which have been shown to combat it: contact and education (Corrigan, 2004). Contact usually involves face-to-face interactions with individuals from the stigmatized group (Corrigan, 2004). The relationship between the PSS and the client affords the client regular contact with a person who faced stigma for having the same problems as the client (psychiatric illness, substance abuse, and homelessness) and, nonetheless, managed to move forward in his or her recovery and create a full, productive, and satisfying life. Witnessing the PSS's success dispels the myth for the client that individuals, including him- or herself, who struggle with psychiatric and substance abuse disorders and homelessness cannot succeed. In terms of education, MISSION PSSs teach their clients effective strategies for dealing with stigma, which they have learned through their own similar stigmatizing experiences. Through providing regular contact and education, MISSION PSSs can help prevent the debilitating outcomes associated with stigma.

MISSION PSSs are encouraged to check in with clients to assess and address any issues surrounding stigma that may ultimately impede recovery, as they may not always be directly reported by the client. In addition, as clients make their way through the MISSION program,

they will experience varying degrees of progress in comparison to other clients. MISSION PSSs are encouraged to monitor and address any situations involving stigma among clients in order to promote a safe environment where each client can continue to share, grow, and progress comfortably at his/her own pace. Due to their unique role, MISSION PSSs are also encouraged to monitor and address any issues regarding stigma that may interfere with their own recovery with a source of support outside the program.

G. Helpful Training for the MISSION PSS

MISSION PSSs receive training from a number of sources. Some of the day-to-day informal training of PSSs is discussed in the Clinical Supervision chapter of this treatment manual (please see Chapter VIII: Core Competencies for Clinical Supervisors for more information). The formal training in which the MISSION PSS participates includes internal training on program issues and operating procedures; certifications required by the agency and/or the affiliated homeless program that employs the PSS; as well as training for consumer-providers on mental health and COD provided by an outside agency. Additionally, MISSION PSSs have identified other areas in which training would be helpful and for which further training venues are being identified and/or developed.

Internal Training

In addition to basic orientation (such as timekeeping) offered to both MISSION CMs and PSSs, the MISSION program provides training to PSSs on a number of topics relevant to their job, including:

- Confidentiality policies
- Research and documentation policies
- Crisis management
- Expectations of the position

Third-Party Training Nationwide

Currently, training for PSSs varies widely across the country in breadth, scope, and length, ranging from 30 hours to 28 weeks. One of the most highly regarded

training programs is the curriculum developed through the Georgia Peer Support Certification Project. The Georgia program is a comprehensive, classroom-based, 40-hour, 30-module curriculum covering peer support, psychosocial rehabilitation and recovery, the impact of diagnosis on self-image, effective communication skills, and the basics of documentation. In addition, the Depression and Bipolar Support Alliance (DBSA), which works in collaboration with staff from the Georgia Peer Support Certification Program, provides an on-site, classroom-based, 40-hour training program. Both training programs include an exam that requires a minimum score of 80 percent in order to pass the course.

Most existing programs offer at least 40 hours (a useful minimum standard for peer training) and include an exam. Other nationally recognized programs that have trained peers are Consumer Connections of the Mental Health Association in New Jersey, Recovery Innovations in Pennsylvania and Arizona, and the Transformation Center in Massachusetts. Katz and Salzer (2006) of the University of Pennsylvania Collaborative on Community Integration summarized the details of 13 PEER training programs. All of these programs "certify" peers. Peer certification means that their services are reimbursable by state Medicaid programs. Many states including Georgia, Arizona, Iowa, Michigan, North Carolina, Washington, Pennsylvania, District of Columbia, Wisconsin, Hawai'i, and Florida hire certified peers. Previous PSSs have also participated in the extensive training program offered through consumer-run programs affiliated with the University of Massachusetts Medical School and other agencies.

Training Topics for MISSION Peer Support Specialists

- Basic Counseling Skills: Effective Communication and Helping Techniques
- Psychoeducation
- Treatment Planning
- Medication
- The Importance of Family Involvement
- Overview of Co-Occurring Disorders
- The State System of Care: Health, Mental Health, and Human Services
- Advocacy
- Crisis Intervention and Trauma
- Basic Principles of Case Management
- Cultural Competency
- Entitlement Programs
- Ethical and Legal Issues
- Professional Development
- Group Facilitation Skills
- Wellness Recovery Action Planning (WRAP)

MISSION PSSs who attend training such as the ones mentioned above may be eligible for certification after accumulating 2,000 work or volunteer hours in the mental health field.

Training on the Critical Time Intervention (CTI) Model

Previous MISSION PSSs have also participated in training offered by the CTI Project and can be found through criticaltime.org. This training is particularly helpful in ensuring that MISSION PSSs are able to work smoothly with CMs, with a common understanding of the foundations of this type of intervention for clients with COD.

Training Topics for CTI

- Assessment and Prevention of Suicidal Behavior
- Counseling and Interviewing Skills
- Motivational Interviewing
- Harm Reduction
- Drug Craving
- Axis I and II Disorders
- Trauma and PTSD
- Mental Health Research
- Employment Challenges for Ex-Offenders
- Drugs of Abuse and Their Impact on Psychiatric Disorders
- Public Benefits Packages and Systems
- Culture, Mental Health and Counseling
- Psychiatric Medications

Training on Dual Recovery Therapy (DRT)

Some MISSION PSSs have also completed training on Dual Recovery Therapy (DRT) focusing on COD. The topics covered in this training are listed below.

Training Topics for DRT

- Biopsychosocial Assessment
- Differential Diagnosis
- Drugs of Abuse
- Addiction-Focused Counseling
- HIV/AIDS Resources/Information
- Family Counseling
- Addiction Recovery

Training for MISSION PSSs and Clinical Supervisors

MISSION PSSs and their supervisors should pursue continuing education. The National Association of Peer Specialists, Inc. (NAPS), a private, non-profit organization dedicated to peer support in mental health systems, offers an annual conference (see http://www.naops.org/). The U.S. Psychiatric Rehabilitation Association also sponsors a national conference and other training opportunities for peers (see http://www.iapsrs.org/).

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NOTES

V. Rapid Re-Housing

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This chapter provides information on the role of MISSION in assisting clients to become rapidly re-housed and to maintain that housing once it has been secured. It summarizes the core principles of the Housing First Approach, an important housing model designed to meet the needs of homeless individuals who have co-occurring psychiatric and substance abuse disorders, and briefly highlights research supporting this approach. Next, the chapter provides practical guidance for MISSION CMs and PSSs on how to incorporate Housing First principles into their practices. Finally, the chapter ends with a case example of an innovative approach used to facilitate rapid re-housing.

A. The Housing First Model

The Housing First model was developed by Pathways to Housing to address the problems of traditional housing models designed to meets the needs of chronically homeless individuals with co-occurring psychiatric and addiction disorders (Tsemberis, 2010). Traditional models tended to move clients along a continuum in a step-by-step fashion from outreach to temporary housing, then to transitional housing, and finally to permanent housing. In these models, housing usually consisted of segregated group living, and housing and treatment services were bundled under the same roof. The client's ability to progress through the system was a function of the client's compliance with the program's rules. Almost universally, the rules required clients to participate in psychiatric treatment and to remain sober, which often proved too difficult for many participants. In addition, because housing and treatment domains were bundled, clients risked losing housing during a clinical crisis, and conversely risked losing their clinical team during a housing crisis. These factors made traditional models ineffective interventions for ending chronic homeless in this population.

In contrast, the Housing First approach is based on the belief that housing is a basic human right rather than something people have to earn or prove they deserve by being in treatment and by being sober. In Housing First, clients are offered immediate access to permanent housing and access to both a treatment team and community support. These services and supports are both flexible and consumer-driven (O'Hare, 2007), and housing and clinical domains remain separate. The primary focus is on attaining housing and encouraging individuals to participate in treatment and other supportive services that are made available to them (Tsemberis, 2010).

Research studies examining this model have shown that Housing First dramatically reduces homelessness and is significantly more effective than traditional treatment and housing models. For example, housing retention rates among the high-need population served by a Housing First approach have been recorded at 85% at 1 year post-housing (Montgomery, Hill, Kane, & Culhane, in press; Pearson, Montgomery, & Locke, 2009; Tsemberis, Gulcur, & Nakae, 2004) and up to 80% at 2 or more years post-housing (Tsemberis, Gulcur, & Nakae, 2004; Stefanic & Tsemberis, 2007; Tsemberis & Eisenberg, 2005). In addition, improved outcomes for individuals participating in a Housing First approach includes less frequent use of acute emergency and inpatient services compared to individuals in traditional permanent supportive housing (i.e., programs that place additional requirements for individuals to access and maintain housing) (Gulcur & Stefancic, 2003; Hirsch & Glasser, 2008). The below table summarizes the positive outcomes associated with of the Housing First Approach.

- It ends homelessness.
- It reduces the need for costly shelter care and transitional and short-term treatment services aimed at preparing clients to be "housing ready."
- It reduces ER visits as well as unscheduled mental health and medical hospitalizations.
- It decreases the frequency and duration of homelessness.

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(Montgomery, Hill, Kane, & Culhane, 2013; Padgett, Gulcur, & Tsemberis, 2006; Tsemberis, Gulcur, & Nakae, 2004).

B. Six Key Housing First Principles Used in MISSION

We have included the six key principles of Housing First because they can nicely guide the MISSION team as they assist their clients in becoming permanently housed. Utilizing these principals leads to more successful housing outcomes and has the additional benefit of helping the MISSION team to establish and maintain a trusting alliance with clients during the housing search and beyond. These six key principles in the Housing First approach which are utilized in MISSION are:

Six Key Housing First Principles Used in MISSION

- Participant Choice Philosophy
- Separation of Housing and Services
- Services are Voluntary and Flexible
- Recovery-oriented Services
- Community Integration
- Harm Reduction

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Participant Choice Philosophy

A central tenet of the Housing First model is the importance of participant choice. When a client is an active participant in the housing selection process – touring different apartments, selecting the neighborhood they'd like to settle down in, and ultimately choosing their new home – they become invested in the process and in turn exercise higher levels of control and autonomy in the program (Tsemberis, 2010; Tsemberis, Gulcur, & Nakae, 2004; O'Hara, 2007).

In MISSION, the case manager and peer support specialist encourage clients to openly communicate their housing preferences and to take an active role in the housing search and selection process. It is critical to convey to the client that he or she is an essential member of the housing placement team. For some clients, this will be the first housing search related experience in which their input is solicited ---as is illustrated in the case of Phil.

Case Example: Phil

When Phil started seeing his MISSION case manager, he was excited over the prospect of getting his own apartment but apprehensive about the process. Phil had spent time in many different residential settings. He was in residential treatment, was in an SRO for a bit, and had bounced around to multiple shelters. Typically when he had a place to stay, it was made clear to him that he was lucky to get an opening and should be thankful, no matter what setting he was in, to have a place to sleep. When he sat down with his case manager, he expected the same: to be told about a place that had a waiting list, a list of rules, and the possibility of a single opening eventually. When his case manager instead started asking him about neighborhoods he'd like to avoid, if he preferred to be near a bus stop, and whether or not a third-floor unit would be an issue, he realized this wasn't just another temporary situation, it was a real chance to start again. He also recognized that he wasn't on his own this time, his case manager had offered to help him fill out applications and his peer support specialist was working with him to figure out the down payment and even get some donated furniture to make this new place a real home. His home.

To determine the client's housing preferences, a pre-housing interview should be conducted by the MISSION case manager to determine the client's interests and to identify any necessary accommodations, such as location preferences/restrictions or accessibility requirements (Tsemberis, 2010). See the checklist in Appendix K for some suggested sample questions for the pre-housing assessment interview.

Separation of Housing and Services

Unlike traditional housing approaches that focus on the client's commitment to psychiatric treatment and sobriety as a prerequisite for housing, the Housing First approach highlights the importance of housing as an immediate and critical need. In this approach, housing is offered as a matter of right rather than being used as an incentive for the client to achieve and maintain sobriety. In addition, by separating the criteria for maintaining housing from a client's treatment status the client is not automatically placed in jeopardy of losing his or her housing because of a relapse. Likewise, the client is not at risk of losing his or her clinical team if the housing placement is disrupted or terminated. Additionally, because treatment adherence and sobriety are not tied to remaining housed, clients are free to discuss any symptoms or substance use in a candid and forthcoming manner, without fear that they will lose their housing placement.

Consistent with the Housing First Approach, the MISSION team works to meet the client's housing needs regardless of his or her stage of recovery. This demonstrates to the client that the MISSION team is committed to his or her overall well-being as opposed to only his or her mental health or substance use status.

Services are Voluntary and Flexible

Within a Housing First model the client's participation in treatment services and supports is voluntary, and treatment services and supports are flexible. Some clients may initially decide not to engage in recovery services, but later choose to participate after they have settled into their new homes and feel that they are in a better position to address additional treatment goals. Treatment services are delivered in a flexible, individualized manner that match the client's preferences and needs at any given point in their recovery.

MISSION teams offer direct treatment and support services to their clients, and allow clients to self-determine their own level of participation in the various components of the MISSION program. The team provides services and supports in a flexible manner best suited for the client's individual needs. For example, it is the experience of some MISSION CMs and PSSs that clients are not always ready to begin the MISSION Dual Recovery Therapy sessions before they are housed. These clients prefer to use their time with their CM and PSS for housing search related activities. This decision should be respected and accommodations should be made accordingly. In the above situation, for example, the CM or PSS may recommended to the client that he or she attend 12 step supports during this period as meetings are frequently held off-hours and are unlikely to conflict with housing search appointments. Another component of the MISION program where flexibility is frequently observed is the MISSION Participant Workbook as clients can opt to work on it at their own pace.

Community Integration

The integration of clients into their community is key feature of the Housing First model. In order to accomplish community integration, the model maintains that housing must be "scattered". This means that clients should be residing in many different locations throughout the community as opposed to clients residing in locations which are heavily concentrated with similar clients. This is accomplished through limiting the number of units available to clients in a given building and by housing clients in apartments that are available on the open market. Having "scattered" housing helps to ensure that people with psychiatric and substance use disorders are not all housed together in one building but are, instead, integrated into their building and their communities. An additional related benefit of "scattered housing" is social inclusion. The other tenants in the building can model neighborly behavior which helps the client to develop new ways of participating in community living.

The MISSION team helps the client to locate housing in his or her preferred community through interfacing with public housing authorities and private landlords. Clients in the MISSION program are provided with intensive

wrap around services to assist them as they assimilate into their new community, and these services are gradually decreased as the client becomes increasingly integrated. The MISSION team provides the client with community linkages which will serve as the bedrock of the client's recovery from homeless, mental illness, and substance abuse while he or she is enrolled in MISSION until graduation and beyond.

Recovery Oriented Services

According to the author of Housing First (Tsemberis, 2010), the success of the Housing First approach is dependent upon the treatment team's ability to develop a recovery-oriented working relationship with the client. It is essential that the treatment team carries the message that recovery is possible, conveys hope, avoids hierarchical power relationships, and communicates true caring and concern. The client's treatment plan is not based on the treatment team's assessment of the client needs, but rather on the clients' own treatment goals. This approach helps clients to stay motivated and engaged with the team.

In MISSION, the PSS is uniquely equipped to serve as role model and source of inspiration for the client. The PSS demonstrates to the client that it truly is possible for him or her to turn their life around--that just like the PSS, the client can recover from homelessness, psychiatric problems, and drug or alcohol abuse— and lead a healthy, satisfying, and productive life. Furthermore, the PSS helps the client to feel that he or she is not alone, but rather is in a partnership with another human being who has been there, understands, and cares.

Harm Reduction

Consistent with the overall MISSION model, the Housing First model uses the harm reduction approach. Harm reduction is a practical approach aimed at reducing the adverse consequences of psychiatric symptoms, drug abuse, and alcohol abuse. Harm reduction recognizes that people are at different stages in their recovery and provides treatment based on "where they are at". Clients are allowed to make choices - to take medication or not, to use drugs or

alcohol or not - and regardless of their choices are not treated adversely (e.g. housing status, treatment services, and supports are not threatened). Clients are encouraged to discuss the negative consequences associated with problematic behaviors (such as the possibility of eviction), to focuses on reducing harmful behaviors and their impact, and to develop and utilize more adaptive coping strategies. Helping clients to identify and take small steps gives them the opportunity to experience incremental control over the negative real life consequence of problematic behaviors.

MISSION CMs and PSSs use the harm reduction approach in treatment interventions with clients. For example, if a client is opposed to taking psychotropic medication due to a past history of troubling side effects, the CM or PSS may help the client to self-advocate with his or her physician for a low medication starting dose with only very gradual increases or provide him or her with additional training in stress management. Similarly, if MISSION team members have concerns that a client's drug or alcohol use is escalating they may suggest to the client a short-term goal for reducing their use, such as remaining sober for a scheduled meeting with a potential landlord.

C. Overview of Housing First Principles in MISSION

The MISSION Case Manager and Peer Support Specialist work as members of a larger team, comprised of staff from the clinical agency and the community at large, to support clients during their transition to permanent housing. Central to MISSION is the direct provision of services as well as the coordination of community-based supports. The table below summarizes the specific responsibilities of MISSION team members as they assist clients to secure rapid permanent housing using Housing First principles.

Housing First Core Principles

MISSION Team		Participant Choice/Client-Driven	Separation of Services and Housing	Services are Voluntary and Flexible	Community Integration	Recovery Oriented	Harm Reduction
	Case Managers	Conduct a Pre-Housing interview with client to capture specific housing preferences and needs Carry out client-preferences wherever possible and engage client in housing selection Coordinate with PHAs and landlords	Assessment and treatment planning with client Provide links to substance abuse and mental health treatment Work with PHA, landlords, and client during housing placement and ongoing housing stability Emphasize housing is not contingent upon services	Dose and duration of case management is matched with needs of client DRT and Peer Support Sessions align with areas the client needs at the time Accessibility: especially to prevent and resolve crisis 24/7 crisis plan in place	From the beginning of engagement, Case Managers should be referring clients to community supports Primary setting for services is in the community Community integration is key goal, not abstinence	Discuss the importance of staying sober and addressing stress and anxiety during this process Encourage the client to go to NA/AA meetings Be aware of and encourage the client to avoid potential triggers Do not require abstinence; focus on recovery with a harm-reduction approach	Do not withhold services or penalize clients for psychiatric or substance abuse relapse Discuss the negative consequences associated with psychiatric and substance abuse Help clients to identify manageable steps to minimize harm from the problematic behaviors associated with psychiatric and substance abuse relapse
	Peer Support Specialists	Assists client in application process and addresses barriers such as move-in kits and funding for security deposits/utilities Accompany client during the housing selection process Help client move in Offer any tips from a been there/done that model	Provide a been there/done that model for MH and SA treatment Assist with PHA applications, housing search, and move-in Promote housing stability and recovery action plans	Co-lead groups that are skills-building Engage client in Participant Workbook at his/her own pace Accessibility: especially to prevent and resolve crisis	Go with client to appointments and encourage to try new activities that are recovery-oriented Help client navigate transportation options if he/she struggles with public transport	Share personal experience of the difficulty of sobriety and the housing selection process Go to AA/NA meetings with the client during the housing selection process	Share personal examples of using harm reduction strategies to minimize the negative consequences of psychiatric and substance abuse relapse Assist the client in taking the manageable steps needed to reduce harm
	Other	Housing specialists help to identify units and navigate inspections/ assist with maintenance issues and other problem solving	SUD Specialists stress that addiction is a significant barrier to housing stability	Team Leaders and Clinical Supervisors help troubleshoot case-specific barriers to treatment and serve as mentors to other staff	Job Developers can assist in obtaining and maintaining employment for the client	AA/NA sponsors provide ongoing recovery focused guidance and support	Serve as a liaison for primary care referrals and prioritize on high-risk clients

D. A Closer View of the Case Manager and Peer Support Specialist Roles in MISSION Rapid Re-Housing

This section provides further information on the responsibilities of MISSION Case Manages and Peer Support Specialists as they work to rapidly house clients. Special considerations related to working with landlords and money management will also be described in greater detail.

Many individuals experience difficulty during the critical time of transitioning into a new home. Challenges inherent in the transition from streets and/or shelters to permanent housing in the community—such as the loss of existing supportive relationships, the presence of co-morbid disabilities, the need to establish connections with new health care providers, and a lack of resources such as furniture —increase the risk of recurrent homelessness (Herman, Conover, Felix, Nakagawa, & Mills, 2007). MISSION treatment teams remain sensitive to these potential difficulties, and address them through the provision of direct services as well as linkages to an array of supports in the client's new community. They recognize that the housing search is both arduous and stressful, and remain alert to increased symptoms of psychiatric or substance use at this time.

As housing may be among the first of the client's needs addressed by the MISSION team, the housing search presents an important opportunity for the CM and PSS to strengthen their bond with the client, and it can be a critical time period for gaining the clients trust. As one MISSION CM stated:

> *"Building trust is the goal of my engagement with clients from the first moment we meet. We're asking someone to consider making big changes in their life and that process tends to be less traumatic and more approachable for clients who sense that you're in this process together. I think your work is all about building that kind of empowering relationship."*

The table on the next page summarizes the housing related duties performed by CMs and PSSs. It is important to note that while the CM and PSS have some distinct housing-related responsibilities, they share many to others. In addition, when staffing issues prevent agencies from having staff maintain these distinct boundaries, duties can be assumed by either the CM or the PSS. It is essential that the CM and PSS work together as a cohesive unit, which will further the client's trust and reinforce that the team is invested in his or her well-being. A weekly or even daily meeting of the CM and PPS to discuss any updates of their clients helps to facilitate communication and promotes unified services for their clients.

Responsibilities of the MISSION CM and PSS in Rapid Re-Housing

HOUSING SEARCH

THE MISSION CM:

- Conduct a pre-housing interview with the client to optimize client-choice in the housing selection process
- Work with local housing authorities and other agencies about available units
- Assist the client with securing housing entitlements

THE MISSION PSS:

- Help client locate apartments, role play to prepare client for interviews with potential landlords, accompany client to meetings with potential landlords, help to fill out housing applications
- Help the client move in – this is positive event but can be stressful as well. Try to make this transition as smooth and as positive for the client as possible
- Assist the client with obtaining needed household items, such as furniture

HOME VISITS

- The CM and PSS observe the client's living situation and take a temperature of how the transition is going. Consideration of to the following questions may be helpful:
  - Are there signs that the client has "moved in"? Pictures on the walls, clothes in drawers instead of bags, etc.
  - Is someone else staying here? How many pairs of shoes are lined up by the door?
  - Any signs of relapse?
  - Always remember that boundaries must be honored as this is a private space for the client; it is home.

SCHEDULING

- In addition to making appointments for DRT and Peer sessions, any home visits should also be scheduled. Spontaneous visits should be conducted only when there is concern for the safety of the client.
- Appointments should be scheduled frequently with clients in the initial stages of treatment. These appointment may involve meeting with landlords, home visits, and meeting with the client in the community. These contacts will help to build a trusting relationship with the client.

PROVIDING SERVICES

THE CM AND PSS:

- Continue to address any housing related needs on the client's treatment plan. The client is an active member of this process. The housing goals are identified and a road map for achieving them is developed.
- Provide clients with links to support services within their new community.
- Develop and maintain ongoing lines of communication with the landlord. If necessary, intervene with any potential conflict between client and landlord.
- If needed help client develop financial budgeting skills, provide linkage to outside budgeting assistance programs, and/or assist the client in identifying a payee representative for money management.

As most CM and PSS responsibilities were described earlier in the present chapter and are discussed fully in Chapter III: Case Management and Chapter IV: Peer Support, what follows below is a discussion of two select issues which impact the rapid re-housing of clients.

Working with Landlords

MISSION case managers and peer support specialist should establish a relationship with the landlord from the onset of the housing search and maintain open lines of communication with him or her in order to increase the likelihood that the client will both secure and maintain housing. If a landlord is aware that a formally homeless applicant is receiving MISSION wraparound support services he or she may be more willing to accept the client's housing application as opposed to simply dismissing it. Frequent and consistent communication between the landlord, client, and MISSION clinical team will help to show an investment by all parties and contribute to better outcomes for both the client and landlord (Tsemberis, 2010). We suggest monthly visits in the beginning, perhaps corresponding with paying rent, that gradually become less frequent over time. In addition to regularly scheduled home visits to the client's apartment, the clinical team can help monitor and aid recovery if the landlord is willing to reach out to the clinical team when concerns arise. Landlord concerns may relate to substance use, high traffic in and out of the apartment, or other problematic behavior. When such behaviors violate the terms of the lease, ongoing communication between the MISSION team members and the landlord may also allow for prompt intervention preventing an eviction notice from automatically being served. The anticipated nature and frequency of communication between the landlord and the MISSION clinical team should be discussed with the client as early as possible in the housing selection process.

Money Management

One area where clients may require additional assistance when moving into a new home, is the successful management of their budget. The transition to housing, although a positive step, requires clients

to make changes to their previous daily routines. This includes changes in spending habits that can prove very stressful. Shifting routines may be particularly difficult for individuals with co-occurring mental health and substance use disorders, who face additional barriers when attempting to manage their typically modest income. Challenging financial habits include spending money before it is earned (borrowing from friends, charging, etc), poor budgeting techniques, or buying on impulse. Such habits can interfere with a client's ability to pay rent and other housing related bills. Clients can be supported and guided by the MISSION team as they make finance- related behavioral changes.

Upon enrollment into MISSION, clients work with their CM to determine what benefits they are entitled to, such as Medicaid, SSI, SSDI, TANF, and other government assistance. Some clients may have access to a housing subsidy which covers some or even all of their rent. However, there are additional costs associated with moving into a new apartment, this can include utilities, groceries, transportation costs, medication, and furniture. It is essential that the CM and PSS work with the client early on and assist him or her in planning ahead to budget for these expenses (See Appendix J for Sample Budget).

The MISSION team also refers clients to outside budgeting assistance programs. For example, AARP provides money management services for low-income older or disabled adults and is a good resource (AARP, 1995-2009).

For some clients securing a representative payee may be beneficial. Representative payees are individuals who receive benefits checks on behalf of another person and are responsible for allocating the funds to pay for that person's basic needs such as housing, food, medication, and clothing. Client use of the payee system has shown to reduce the risk of homelessness (Tsemberis, Gulcur, & Nakae, 2004). The role of representative payee should not be taken on directly by the CM or PSS, however they may help the client to identify an appropriate individual to serve in this capacity. Research and experience have shown that when a clinician serves as his or her client's payee, the relationship between client and clinician risks undue strain and potentially interfere with treatment (Elbogen, Wilder, Swartz, & Swanson, 2008).

E. An Innovative Approach to Facilitate Rapid Re-Housing: A Case Example of the Massachusetts Regional Network

We have included a case example of an innovative statewide approach to rapid re-housing below, which was developed with the goal of ending homelessness. This case example has been included here because we believe that many states/systems may be interested in moving beyond current site specific efforts and in developing regional or statewide mechanisms for facilitating rapid re-housing.

In 2009, under the leadership of Lt. Governor Timothy Murray, the Interagency Council on Housing and Homelessness launched a statewide effort to promote a Regional Network strategy. The goal of the effort was to seed integrated, streamlined, regionally-based networks that would demonstrate how greater coordination and local innovations can improve the Commonwealth's ability to eradicate homelessness.

As a result of this initiative, ten Regional Networks to End Homelessness were launched covering every community in the Commonwealth, and they continue today with overwhelmingly positive client- and system-level outcomes. Since inception, these Networks have tested best practices through flexible housing resources and innovative services. Networks piloted comprehensive, coordinated, regional partnership approaches to ending homelessness by diverting households towards housing and services and away from shelters. Lessons from these demonstrations have, and will continue to, inform statewide systems re-design.

The Regional Network initiative is premised on the idea that in all instances coordinated resources will be more effective and efficient. This concept should be considered broadly and interpreted in many different contexts beyond just these ten groups. The network concept itself challenges communities to re-envision how systems can work better together to solve homelessness, and it provides the framework for engaging multiple stakeholders to conduct business differently in order to more effectively address the needs of homeless individuals and families. Effective networks foster a culture of inclusion that values and promotes diversity and opportunity for all individuals. Network relationships should be developed in an environment built upon mutual respect, trust, inclusiveness, and reciprocity. Healthy and vibrant networks with diverse membership have the opportunity to bring resources together to implement effective systems of early warning, uniform assessment and decision making, as well as targeting appropriate resources to the right people at the right time and in the right locations. Networks should not be centralized physical structures. Rather, networks should be coordinated systems of assessment, decision making and referral services that should, through the use of strong inter-organizational collaborations and technology:

- eliminate access barriers to housing and services, including duplicative assessments and services; and
- streamline families' and individuals' immediate access to resources needed for their economic and housing stability.

Networks could be organized at the state, regional, municipal, or neighborhood levels. Many local networks that serve and coordinate resources for homeless and at-risk households have been in existence for some time. Given the strengths of existing networks, those working with homeless and at-risk households should use them as a foundation on which to build. Effective networks also must leverage multi-sector resources - both public and private - to accomplish true coordination of resources and the creation of a "no-wrong-door" approach.

This regional approach has been used in collaboration with MISSION services. In one such instance, a local regional network facilitates a monthly meeting of clinical service, community support, and housing providers to discuss local and available units and services for homeless individuals. Representatives of Veteran's services, local shelters, elder services, clubhouses, behavioral health agencies, Departments of Mental Health and Public Health, housing providers, and others gather around a table and discuss not only services or spaces that may be available but homeless individuals in the community that are in need of such services or placement. By creating a space for these various groups to convene, barriers that are usually experienced by homeless individuals are broken down as community members collaborate to discuss options in real time so that individuals are linked to needed care.

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NOTES

VI. Vocational and Educational Supports

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A. The Importance of Work

Work, or a goal-directed productive activity, is seen as central to anyone's well-being, including persons with COD who are homeless. Employment can thus provide psychological, social and financial benefits for MISSION clients, including improved mental functioning and increased financial resources for housing. Contrary to conventional thinking, many people who are homeless want to work and are capable of doing so. Thus, one of the primary goals of MISSION is to assist clients in obtaining and sustaining employment by providing direct vocational supports and linkages to specialized community-based vocational services.

People with COD who are homeless face formidable barriers to finding and maintaining employment. Therefore, MISSION provides vocational assistance to clients as needed throughout their entire enrollment in the MISSION program. MISSION case managers and peer support specialists assist clients in developing a work objective, preparing to apply for a job, searching for a job, and retaining the job. While competitive employment is the goal, people in the process of leaving homelessness may elect to seek a supported and/or temporary job placement.

MISSION CMs and PSSs use several strategies to help clients achieve employment success. CMs and PSSs should be trained to provide Supported Employment services. They should also be prepared to make appropriate referrals, such as to state vocational rehabilitation programs and to evidence-based Individual Placement and Support (IPS) programs. These programs will be discussed further in later sessions of this chapter.

Similar to other areas targeted by the MISSION program, case managers and peer support specialists work together as a team while at the same time having some specific tasks unique to their position. The following table provides a general outline of the unique and shared roles and responsibilities of the MISSION CM and PSS.

Roles and Responsibilities of Case Managers and Peer Support Specialists

Case Manager:
- Assess eligibility for vocational benefits and assistance (eg. state, federal, VA)
- Address possible criminal justice issues
- Linkage to potential employers
- Linkage to specialized vocational training programs

Peer Support Specialist:
- Transportation training
- Assist client in securing appropriate interview/work attire
- Share personal experiences and lessons learned from his/her own past job searches

Both Case Manager and Peer Support Specialist:
- Job and career goal setting
- Help prepare for job search
- Assist in the identification of potential employers
- Help secure necessary documentation (e.g. resume, transcripts, references)
- Assist in the filing of applications
- Help clients make face- to-face contact with employers
- Role play employment interviews
- Provide guidance on how to follow-up on applications/interviews
- Help client succeed on the job

B. Barriers/Challenges to Employment Success

MISSION clients face many barriers and challenges as they attempt to secure and maintain employment. They may lack the education, training and competitive work skills to find and retain a job. Job search barriers include weak social networks (for learning about job openings), poor social skills (for making a positive presentation during an interview), and spotty or remote work histories. Many lack skills that are marketable to large-scale work industries because they are not familiar with new workplace technologies and/or do not use computers.

Even when a job is obtained, the job tenure for clients with COD who are homeless is low. The loss of disability income or health care benefits because of increased job income has been shown to be a deterrent to maximizing one's potential to work. Female clients in particular may struggle with family care issues that interfere with their ability to be consistent at work. MISSION clients also face job challenges more directly related to mental health and substance abuse difficulties, homelessness, possible criminal history, and workplace stigma, as discussed herein.

MISSION clients frequently experience employment related challenges due to their mental health and substance abuse symptoms, and resultant relapses. It is vital that the MISSION team with the client develop an understanding of the stressors that trigger psychiatric difficulties and/or substance abuse. This information can he used to help clients choose jobs that support their recovery, and avoid jobs that by their very nature will contain these stressors (e.g., jobs in drug stores or restaurants may provide greater temptation to use drugs or alcohol, respectively). Communication among various treatment team members about relapse concerns will also be essential in arranging ongoing job related support and implementing interventions to prevent relapses.

Homelessness alone presents various challenges to employment. Staff and employers may find it very difficult to reach and leave messages for MISSION clients who have no fixed address, no email or limited computer access, and/or limited (cell) phone access. MISSION clients frequently have restricted access to showers, laundry, and clothing. They may be disinclined to look for employment because of shame, resentment, or a belief that they are "a lost cause." MISSION clients who are managing housing stability, COD, and work will generally need significant ongoing assistance.

Some MISSION clients may have a criminal record, which can serve as another major barrier to employment. Many professions are inaccessible to people with criminal records because of licensure requirements and/or legal mandates. In addition, certain employers routinely use criminal history checks to screen out applicants, particularly those with sex offender charges. Clients with felony convictions are likely to be restricted from obtaining jobs that require bonding, licensing, or working in the criminal justice system.

In addition, a significant external barrier faced by people with COD who are homeless is workplace stigma. Some potential employers may discriminate against individuals with COD who are homeless by not offering them a position for which they are well qualified. Discrimination can also take more subtle forms, such as not inviting certain categories of employees to company social events, thus limiting their networking opportunities. In addition, employers may be ignorant about or neglect to provide reasonable accommodations on the job, as mandated by the American with Disabilities Act, as discussed in greater detail below.

C. Training and Skill for Providing Supports

A key precept in the MISSION program philosophy is that with proper support, guidance, preparation, and dedication, clients can successfully obtain and sustain employment. To accomplish this, the MISSION team actively engages clients in discussions about their employment needs and preferences and supports them in taking the steps needed to attain their employment goals. The CM/PSS team should have knowledge and training in the use of a number of employment strategies in order to assist their clients in overcoming the very real challenges they face in becoming gainfully employed.

While MISSION CMs and PSSs are not trained as employment specialists, they can develop many of the necessary skills through specific Supported Employment trainings and by reading both the SAMHSA Toolkit *Supported Employment: Training Frontline Staff* and Supported Employment, A Practical Guide for Practitioners and Supervisors (Swanson, Becker, Drake, & Merrens, 2008).

When CMs and PSSs first discuss employment with MISSION clients, a primary initial goal should always be to develop a trusting relationship with the client. Employment related discussions should be focused and goal oriented. Techniques that CMs and PSSs can use that will foster open and direct communication include asking open-ended questions, active listening, and paraphrasing. It is essential to convey respect, hope and a positive attitude to the client; and it is equally important to refrain from making judgmental, paternalistic, or argumentative statements. For example, one way to show respect to clients is to offer to meet them where they are currently located, which might involve meeting on a park bench or under a bridge.

Although early job placements are typically preferred, some people with COD who are homeless may choose to stabilize their housing before proceeding directly to full- or part-time employment. If the client chooses to delay employment, the CM and PSS should still help him or her prepare for the job search, identify job preferences, and build self-confidence. Motivational Interviewing (MI) techniques are particularly helpful in enhancing the client's level of involvement in employment related activities. The client should also be encouraged to complete the Recovery Assessment Scale (RAS) in order to provide a shared perspective on his or her stage of recovery in relation to work readiness (Please see Appendix M). Additional information on Motivational Interviewing can be found at: *http://www. motivationalinterview.org.*

After a client is hired, the CM should help him or her complete the Job Start form (see completed sample in Appendix M). Employed MISSION clients will likely need assistance to address symptom exacerbations on the job, to organize work assignments, and to manage disagreements with co-workers or supervisors. Thus, MISSION CMs and PSSs should be prepared

to provide employed clients with highly individualized and flexible job supports. PSSs serve as positive role models, and should be skilled in how to best share "been there, done that" insights gained through their own job experiences with their clients. In addition, PSSs need to be well acquainted with the local public transportation system in order to help their clients develop successful transportation plans. When requiring more information or guidance, MISSION CMs and PSSs should turn to their Clinical Supervisor.

In addition, CMs should be trained to understand the employment supports and protections of the Americans with Disabilities Act (ADA). Through the ADA, an employee with a disability can request a "reasonable accommodation", such as a change in work environment, policy, or practice that enables the individual to perform essential job functions. Employers, however, do not have to provide an accommodation if it would cause an "undue hardship", meaning a significant difficulty or expense. Thus, the ADA presents an excellent (and mandated) framework for negotiating job decisions satisfactory to both MISSION clients and employers. Several federally funded agencies provide free technical ADA assistance and training for both employers and employees. The Job Accommodation Network (JAN) is an excellent resource, and CMs and PSSs are encouraged to read the publication Accommodation and Compliance Series: Employees with Mental Health Impairments, which can be accessed on the JAN website *(http://www.askjan.org/ media/psyc.htm).* The following websites also provide helpful job support information:

Helpful Job Support Websites

- Job Accommodation Network: http://askjan.org
- Boston University Center for Psychiatric Rehabilitation: *http://www.bu.edu/cpr*
- Supported Employment at the Dartmouth Psychiatric Rehabilitation Center: *http://www. dartmouth.edu/~ips/*
- Benefits counseling: *http://www.ssa.gov/work/ WIPA.html*
- Substance and Mental Health Services Administration on Work: *http://www. promoteacceptance.samhsa.gov/topic/ employment/*

- Overview of employment supports and vocational rehabilitation for people with disabilities: http://www.disability.gov/employment/jobs_&_career_planning/vocational_rehabilitation

- General employment supports and state Departments of Labor: *http://www.careeronestop.org/*

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D. Assisting with the Job Search

Even MISSION clients with prior job experience or solid work-related qualifications are likely to need considerable support and assistance with searching for and finding a job. CMs and PSSs will often need to address factors associated with clients' low motivation to obtain and maintain employment and cultivate the patience and determination to find employment. The table below lists the steps taken by the MISSION team to assist clients in finding a job, and then each of the steps is described. Assistance with each step may not be necessary for every client. However, it is important to routinely discuss progress made toward employment goals with all clients. Additionally, the steps do not necessarily take place in the order they are listed and often occur in an overlapping fashion.

Steps to Assisting in Job Search

- Develop an employment goal

- Review criminal record if applicable, consider expungement

- Identify potential employers

- Obtain and assemble necessary employment documents and related personal items

- Prepare for job interviews and related interactions

- Obtain references from trusted sources

- Help clients make face-to-face contact with employers

- Help clients apply for the job

- Follow-up to applications or interviews

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1) Develop an employment goal

The CM/PSS team help the client develop a formalized employment goal that is in line with his or her life situation. A sample completed "Individual Employment Plan" is included in Appendix M. It is important to educate the client on the realities of the job market, including the availability of jobs and related educational and licensure requirements. MISSION CMs/PSSs can help clients to identify their job aptitudes and job preferences, including job setting and hours worked per week. For example, a client who is unprepared to work in a formal business setting may do best in an outdoor job, while a client with a natural ability to fix things may be well suited for employment in a repair shop.

2) Review criminal record if applicable, consider expungement

A significant number of people with COD who are homeless have criminal records, most often for "minor" (non-felony) offenses. Many employers routinely conduct a criminal background check for job applicants. MISSION staff should be prepared to help clients request their criminal record and review their record with them. Clients often have limited knowledge of what is in their record and may be upset or surprised to learn the types and number of charges. When reviewing the criminal record, MISSION clinical teams need to evaluate several factors related to job eligibility. These factors include:

- The types of conviction(s): misdemeanor, felony, drug-related and/or violent offenses

- Effect of probation or parole requirements, such as curfews and restrictions from leaving a county or state

- Prior involvement in diversion programs (e.g. mental health or drug court)

- Pending court dates or outstanding charges

- Whether charges place restrictions on driver's license, living arrangement, contact with other persons, or child custody

Upon reviewing the record, the team may want to consider petitioning the court for "expungement" of one or more convictions. When an offense is expunged, all records of the case are sealed and removed from the person's official court record, as if it never occurred.

In addition, the client is not required to disclose expunged convictions to potential employers. While the requirements for expungement vary by state, in general only misdemeanor offenses can be expunged. In most jurisdictions, persons must also have been conviction-free for a specified amount of time after the case that is to be expunged.

3) Identify potential employers

CMs/PSSs should develop relationships with employers to learn more about their businesses and to assess their potential for hiring people with COD who have been homeless. (A program in Massachusetts that facilitates this process is Work without Limits.) Many employers are sympathetic to the needs of this population, and some have developed programs for hiring people with disabilities. For clients with a criminal record, probation and parole officers can be useful resources for identifying potential employers.

In addition, CMs should readily share information with employers about the state and federal tax incentives for hiring people with disabilities, homelessness, and/or low income. We advise CMs to familiarize themselves about incentives that vary by state, and information on federal incentives for hiring people with disabilities can be found at: *http://www.washington.edu/doit/Careers/ articles?261.*

Clients should also be encouraged to seek potential employment opportunities through personal and family contacts, previous employers, and standard job search mechanisms such as the Internet and local advertisements. CMs/PSSs can also help the client to identify job leads, write and send out resumes, and prepare for interviews, utilizing governmental and community resources, such as state Department of Labor (DOL) Career Centers, state Vocational Rehabilitation (VR) agencies, the Disabled Clients Outreach Program (DCOP), and the local chamber of commerce. In addition, MISSION teams can assist clients in understanding the requirements/restrictions for specific positions.

4) Obtain and assemble necessary employment documents and related personal items

Job applicants can easily be disqualified from a job opportunity if missing key documents that employers are looking for, such as social security cards, proof of citizenship, proof of graduation, and school transcripts. A resume is expected for many jobs, and an organized, well written resume is more likely to attract employers.

Having been homeless, MISSION clients may not possess a variety of personal hygiene products, the use of which may be vital to making a positive first impression on a job interview. In addition, clients may need help in selecting and buying appropriate interview attire.

5) Prepare for job interviews and related interactions

MISSION clients are more likely to be hired if they develop strong job interview skills. Clients will be more successful during the interview process if they:

- are appropriately dressed,
- present their job skills and strengths clearly,
- are prepared to respond when asked about resume gaps,
- express enthusiasm for the job, and
- when applicable, talk about their criminal history and their plan to avoid future legal problems.

The most effective way to prepare clients for job interviews is help them practice. MISSION CMs/PSSs can offer to play the role of a prospective employer by conducting "mock" interviews with the client. This gives the client a chance to receive safe but direct feedback on areas in which the client needs to improve. It may be useful for the mock interviews to take place in groups, since the client can learn how other clients effectively handle questions. To boost clients' confidence, CMs/PSSs can explain to them that employers often hire the most qualified person for the job, regardless of legal system involvement.

Clients who have a criminal record, should be encouraged to be direct and honest about their criminal history during job interviews. In addition, clients should be coached to accept responsibility for past mistakes

and to explain how s/he has become a law-abiding citizen to the interviewer. Clients can explain how they have been helped by treatment, by involvement in religious or volunteer activities, and by positive mentors. Clients should also be instructed on how to handle the employer's expressed knowledge of their arrests. Clients can explain the circumstances of the arrest, and can emphasize that an arrest is not a conviction nor evidence of a criminal act in a non-defensive manner.

6) Obtain references from trusted sources

The MISSION CM/PSS can help the client identify people whom he/she has positively impressed, especially past employers who know the client well, to serve as references. Other potential references include probation or parole officers, clergy, volunteer coordinators, and employment specialists. CMs/PSSs can help the client consider who might be the best references, depending on the job being sought.

7) Help clients make face-to-face contact with employers

Before clients formally apply for jobs, CMs/PSSs should consider helping them meet with employers in order to introduce themselves as competent people with solid job skills. This can be done through informal informational interviewing, attending job fairs, and volunteering. CMs and PSSs can offer to accompany clients as needed on job search related outings.

8) Help clients apply for the job

Mission CMs and PSSs should work with the client to determine what level of assistance the client would like from them during the formal job application process. CMs and PSSs can work with the employer directly around a job lead (which is often appreciated by the employer), or work behind the scenes, providing the client guidance and support as they go forward with the job application and interview phase. CMs/PSSs can also offer to accompany clients to job interviews and/or to meet with employers to vouch for clients' motivation and work ethic. Vocational rehabilitation programs can also provide valuable help in this area. In addition, an excellent resource is the Department of Labor's website: www.careeronestop.org.

9) Follow up to job applications or interviews

CMs should track the client's progress toward his/her employment goals. It may be especially helpful to use a spread sheet to track: (1) identified job leads, (2) jobs applied for, and (3) follow-up to job applications. This will help the CM, for example, to easily recognize when a client has not heard within a reasonable amount of time from an employer on the status of his/her application. The CM can then strategize with the client on the best way to follow-up with the employer (i.e., email, phone-call, etc.). Please see a sample follow-up letter to employers in Appendix M.

E. Vocational Rehabilitation Programs Referrals

State Rehabilitation Commissions

MISSION clients may benefit from formal job assistance for people with disabilities through a state government vocational rehabilitation (VR) program. The VR program provides and contracts for direct services to help people develop skills needed to find and maintain jobs. Typically, a VR counselor works with the client to develop an Individual Plan for Employment (IPE), which is organized around a specific employment outcome chosen by the client.

VR programs offer a range of employment services including job screening, background checks, application follow-up, job training supports, and job performance supports. Work transition programs can also be helpful since employers are likely to view a client's success in a transition program as an indication of successful rehabilitation. A list of all VR programs by state can be found at: http://wwhelp.wwrc.net/wwwebhelp/state_vocational_rehabilitation_vr_agencies.htm The table on the next page describes the services typically offered by VR programs.

Services Typically Offered by Vocational Rehabilitation Programs

- Medical and Psychological Assessment
- Vocational Evaluation and Planning
- Career Counseling and Guidance
- Training and Education After High School
- Job-Site Assessment and Accommodations
- Job Placement
- Job Coaching
- On-the-Job Training
- Supported Employment
- Assistive Technology and Devices
- Time-Limited Medical and/or Psychological Treatment

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F. Individual Placement and Support

Research findings support the effectiveness of Individual Placement and Support (IPS) for people with mental illness and co-occurring substance abuse (Lehman and colleagues, 2002). Therefore, MISSION clients who wish to work, should be assessed for eligibility for an IPS program. IPS is a manualized place and train approach driven by client preferences, and coordinated by an employment specialist who is a member of the client's integrated treatment team. The aim of IPS is to help people with psychiatric conditions achieve competitive employment based largely on their job preferences. In competitive employment, clients obtain jobs in the open job market at prevailing wages. In this model, clients work side-by-side with nondisabled employees, with supervision provided by personnel employed by the business (not sheltered work or segregated placements for people with disabilities). IPS emphasizes the avoidance of "lengthy" pre-employment preparation or training and does not screen people for work "readiness" or "employability". A summary of the eight principles of IPS follows. Further information on the model can be found at: http://sites.dartmouth.edu/ips/fidelity/fidelity-review-manual.

Individual Placement and Support Principles

Zero exclusion: Anyone who has stated a wish to work deserves help to achieve this goal, irrespective of their current clinical status or past work history.

Focus on competitive employment: Employment in the competitive, open job market is viewed as an attainable goal for clients seeking employment.

Integration of mental health and employment services: An integrated team will be able to apply a consistent, hopeful message about work while troubleshooting clinical issues that may impact work success, such as control of psychiatric symptoms, dealing with side effects of medication, and providing cognitive support for people with learning or social skill issues. Frequent communication may be needed between employment specialists and the person's treatment team.

Attention to client preferences: Client preferences are the primary value with regard to job seeking decisions, hours worked, how IPS services are provided, and whether or not to disclose one's disability on the job.

Benefits planning: Clients and their treatment team must think through and obtain reliable information on the potential impact of income on any disability benefits. People with COD may want to restrict their work for fear of losing health insurance or having benefits reduced, but there are alternatives to be considered. For more information, see *http://www.prainc.com/soar/.*

Rapid job search: The job search should begin shortly after (within one month) of the client's determining employment to be their goal. The job search should be tied to a simple vocational profile that specifies the client's preferred industry sectors, the type of job skills s/he has, and the number of hours per week desired. An IPS framework for developing an employment plan is supplied in Appendix M.

Continuous job support: Clients may need varying intensities of support for a long time in order to succeed, and cases can remain open indefinitely. Intensive supports typically include face-to-face contact on a weekly basis for at least the first month

of employment. Additional supports might include meetings with clients employers, help managing anxiety, and on-the-job coaching to learn new duties.

Systemic employer relationships: Employment specialists should develop a network of employers based upon their clients' work preferences. This includes multiple face-to-face visits to learn the needs and preferences of each employer.

G. Vocational Rehabilitation for Veterans

(VBA; Chapter 31)

Veterans with a service-connected disability of at least 10% who received an honorable discharge can apply for Vocational Rehabilitation and Employment (VR&E) or "VetSuccess" services. After assessment and determination of an employment handicap, a vocational rehabilitation counselor will work with the Veteran to develop a suitable employment goal and a rehabilitation plan to achieve that goal. The plan will describe the services and resources the Department of Veterans Affairs (VA) will provide to assist the Veteran in achieving his/her goals.

There are several vocational programs for Veterans provided through the VA and the Department of Labor. One noteworthy example is the Compensated Work Therapy (CWT) program for impaired, at-risk, and homeless Veterans who have multiple challenges, including psychiatric and substance abuse issues, physical limitations, ex-offender status, and/or family relationship issues. Veterans are eligible for CWT if they are homeless, have mental illness, physical disability, and/or are diagnosed with substance abuse. Veterans will need to be "clinically stable" and abstinent from substance use. A component of CWT operating in many VA Medical Centers (MC) is Transitional Work Experience (TWE), a pre-employment vocational assessment and experience program that operates in the VA MC and in local community businesses. In an approach very different from IPS, TWE participants are screened and assessed by vocational rehabilitation staff and matched to a work assignment for a limited time, as deemed clinically appropriate. TWE work assignments are not jobs that the Veteran competes for

with the rest of the labor force; rather, the job is typically arranged between the VA MC and the employer, and the VA will fill the job with a rotating set of workers. For information on making referrals to the CWT program in your area go to: *http://www.cwt.va.gov/.* To obtain additional information on vocational rehabilitation for Veterans please see The MISSION-VET Treatment Manual, Chapter IV. Vocational and Educational Supports, which can be accessed at: *http://www. missionmodel.org/wp-content/uploads/2013/09/M-VET-Trtmt.-Man.-Web-8.13.pdf.*

H. Supported Education

While education and training are often critical for job and career success, numerous MISSION clients have not completed college or technical training. Mental health problems often begin to occur in late adolescence and early adulthood, interrupting a person's educational, and thus career, trajectory. In addition, this population has relatively high rates of learning disabilities, which when undiagnosed or ineffectively treated lead to poor school performance and lower educational attainment.

The challenges MISSION clients face in attaining an appropriate education, particularly college, can be daunting. Obstacles to getting into college include difficulty deciding which college best meets their needs, trouble with negotiating the admission and enrollment processes, and not knowing about available public and private financial aid. Even when admitted, many MISSION clients may lack the necessary study skills, have difficulty keeping up with course demands, and/or feel isolated or stigmatized on campus.

Supported education (SEd) is an approach that CMs and PSSs can use to assist MISSION clients choose, attend and succeed in school in accordance with their individual educational and career goals.

Supported Education Principles

- Access to an educational program with positive, forward progress is the goal.

- Eligibility as based on personal choice.

- Supported Education services begin soon after consumers express interest.

- Supported Education is integrated with treatment.

- Individualized educational services are offered for as long as they are needed.

- Consumer preferences guide services.

- Supported Education is strengths-based and promotes growth and hope.

- Recovery is an ongoing process facilitated by meaningful roles.

. . . .

Once trained in SEd principles and practices, CMs and PSSs can use them to enhance their clients' educational experience and level of academic success. However, agency time constraints and the intensity of a client's need will dictate whether or not referral to specialized SEd program is warranted. Regardless, CMs and PSSs should familiarize themselves with SAMHSA's SEd implementation and training toolkit and supporting documents *(http://store.samhsa. gov/product/Supported-Education-Evidence-Based-Practices-EBP-Kit/SMA11-4654CD-ROM).*

The SEd model, with some minor modifications, can address the needs of people who are homeless. MISSION clients often need help with securing basic needs, such as a living place that is conducive to studying and accessing transportation. In addition, the majority of colleges now consider an applicant's criminal record when making admissions decisions. Therefore, it is suggested that CMs become familiar with this emerging concern and the related policies of colleges that their clients may be interested in attending. The CM should develop a working relationship with receptive school and training program administrators and help prepare them for MISSION client placements. Additional information on this topic

can be found at: *http://www.communityalternatives. org/pdf/publications/Criminal-History-Screening-in-College-Admissions-AttorneyGuide-CCA-1-2013.pdf.*

Based on the literature, we outline below an effective approach for utilizing SEd principles and practices when assisting people with COD who are or have recently been homeless.

- **Career planning:** explore career options and set intermediate and long term goals.

- **Academic skills assessment:** provide referral for a baseline assessment of academic skills, including the presence and relevance of learning disabilities.

- **Academic and Social Survival Skills:** provide information and linkages to college preparation programs, individualized tutoring and mentoring, time and stress management courses, peer support (i.e., current or former students), financial aid counseling, disability rights resources, social supports, and other reentry services.

- **Choosing where to apply:** provide clients with information about college and training programs, and work with existing partnerships among prisons/jails, probation and parole supervisors, and schools. The information should be based on the client's preferences and needs, with special attention to a college's use of criminal background information and acceptance of credits earned during a person's incarceration. Community Colleges can often be a good fit for MISSION clients because of their diverse populations, familiarity with students that have not had a typical educational trajectory, greater course flexibility and lower cost.

- **Direct assistance with enrollment:** assist with online admissions applications, online registration, financial aid; and with decisions regarding enrollment in college readiness classes, part-time or full-time attendance, number of classes, and course selection. Provide advocacy if concerns arise over the client's criminal record.

- **Basic needs:** find a living place that is conducive to studying and is accessible to transportation.

- **Outreach:** work collaboratively with campus resources, such as the Disability office and student mental health clinic.

- **Follow up:** monitor and support the client's academic progress, and provide information on "academic survival skills" as needed.

Like supported employment, ongoing support is recommended to help the MISSION client stay in school and succeed. Regular and periodic "check-ins" are useful to find out how the client is doing and to be proactive about identifying emerging problems. The need for support and advocacy will vary in intensity among clients, and is likely to diminish over time. Prior programs have shown that supported education services tend to be used most intensively in the first year of school enrollment and discontinued by the end of the second year.

Some clients find it helpful to have the PSS or vocational specialist accompany him or her to classes during the first week, as this is a vulnerable period when insecurities and fears can lead to increased anxiety, poor performance, or dropping out of classes. Once the client has begun to settle in, peer mentors or tutors can also play an important role in supporting the client and keeping him or her on track. Other helpful supports on campus can be obtained through the school student disability services office, which can arrange for any needed educational accommodations. Educational accommodations can include a note-taker in class, being allowed to record classes, being provided both written and verbal instructions, extended time for test taking, access to quiet spaces, or small groups for test taking and for classes. It may become necessary to make contact with specific instructors or professors to negotiate accommodations or to problem solve if the client is having trouble in a particular class. Establishing a link for the MISSION client to an advocate or support person who is on the campus can be very beneficial and is strongly recommended. The following table details helpful educational websites.

Helpful Education Support Websites

- Building Pathways from Criminal Justice to College: *http://www.changecenter.org/projects/long-term-research-collaborations/from-criminal-justice-to-college*

- SAMHSA's Supported Education implementation toolkit and supporting documents *http://store.samhsa.gov/product/Supported-Education-Evidence-Based-Practices-EBP-Kit/SMA11-4654CD-ROM*

- Dealing with colleges that assess criminal histories in their admissions process: *http://www.communityalternatives.org/pdf/publications/Criminal-History-Screening-in-College-Admissions-AttorneyGuide-CCA-1-2013.pdf*

- Federal Interagency Reentry Council: Education: *http://csgjusticecenter.org/wp-content/uploads/2013/06/SnapShot_Education.pdf*

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NOTES

VII. Trauma-Informed Care

Matthew Stimmel, Ph.D. • Andrea Finlay, Ph.D.

A. Incidents and Impact of Trauma: Considerations for Homelessness

Homeless individuals experience significantly greater exposure to traumatic events over their lives compared to the general population (Bassuk et al., 1998; Kim, et al., 2010), and have higher rates of mental health and substance use that often co-occur (Nunes & Quitkin, 1997). Homeless individuals with co-occurring mental health and substance abuse disorders (COD) frequently have histories of physical and/or sexual abuse in their lifetimes, with one study demonstrating that 100% of homeless women with a COD and 68.6% of homeless men with a COD in their sample reporting a trauma history (Christensen et al., 2005). Furthermore, the environmental stressors of being homeless include increased risks of being a victim of violence and/or witnessing violence (Fitzpatrick, LaGory, & Ritchey, 1999).

Trauma histories are a significant factor impacting care for both men and women who are homeless. Among homeless men, trauma history is significantly associated with increases in mental health problems and require services that proactively emphasize long-term continuity of care that is different than the care provided to homeless individuals who are struggling with substance use or healthcare issues alone (Kim et al., 2010). While the relationship between abuse and adult homelessness appears to be similar for men and women (Jainchill, 2000), homeless women and in particular homeless mothers, have more extensive histories of both childhood and adult violent victimization (Brown, 1993). Some studies estimate that 43% of homeless mothers were sexually assaulted as children, while 66% experienced physical violence (Bassuk, et al., 1996). These experiences contribute to increased rates of posttraumatic stress disorder (PTSD), substance dependence and major depression (Bassuk et al., 1996; Weinreb et al., 2006). Exposure to domestic violence as an adult also contributes to increased homelessness among women and increases in multiple episodes of homelessness (Bassuk et al. 2001; National Law Center on Homelessness and Poverty, 2006; Zorza, 1991).

Given the prevalent and significant trauma histories among homeless individuals, and their concomitant mental health and substance use treatment needs, the MISSION model takes a trauma-informed care approach to working with its clients. In this way, attention to trauma becomes an important feature in the underlying approach to the individuals served.

B. Enhancing Trauma Awareness

MISSION has substantially evolved since the original development of the model (see MISSIONmodel.org). Najavits's chapter in MISSION VET (2011) laid the groundwork for understanding trauma-informed care in special populations by focusing on Veteran-specific issues. The current chapter continues the evolution of understanding trauma-informed care in the MISSION model by adapting trauma-informed principles to fit a program that addresses the unique needs of homeless clients.

Trauma-informed care is defined as "a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010, p.133). Trauma-informed programs offer services to address other psychosocial needs (i.e., they are not trauma-specific treatment programs), but are attentive to the presence and impact of trauma in individual clients' lives (Covington & Bloom, 2006). According to the National Center for Trauma Informed Care (Substance Abuse and Mental Health Services Administration, 2014): "Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate,

so that these services and programs can be more supportive and avoid re-traumatization." MISSION follows these guidelines.

Trauma awareness begins with a program's initial decision at the leadership level, extended down to all program and services offered to become trauma-informed. Where possible, MISSION brings trauma awareness to stakeholders beyond the service team involved in delivering MISSION care. These may include a range of institutional personnel such as staff at homeless shelters, criminal justice settings (e.g., probation, local police, etc…) or other facilities utilized by homeless individuals. Essential features of trauma awareness include: staff education, training and consultation; using best practices to screen and/or assess for trauma; awareness of what trauma-specific services are offered by community service providers; recognition of the impact that hearing about trauma may have on providers within the program itself; and highlighting the need for staff to participate in self-care when necessary (Hopper et al., 2010; Miller & Najavits, 2012).

Below is a list of the core elements of trauma-informed care programs. The incorporation of these elements into MISSION is discussed below and select examples are provided. MISSION staff should remain aware that individuals with trauma histories often struggle with trust, hopelessness, low self-esteem, and impaired decision-making; and they should strive to incorporate the principles of trauma-informed care into every client interaction.

Trauma-Informed Care and its Components

1. Safety
2. Trustworthiness and transparency
3. Collaboration and mutuality
4. Empowerment
5. Voice and choice
6. Peer support and mutual self-help
7. Resilience and strengths based
8. Inclusiveness and shared purpose
9. Cultural, historical, and gender issues
10. Change process

(http://www.samhsa.gov/traumajustice/ traumadefinition/approach.aspx)

A primary component of trauma-informed care is safety. This involves making sure that the location where services are offered is safe and that clients are free from both physical and emotional threats. This includes avoiding, when feasible, procedures that may be re-traumatizing, and establishing trusting, open and authentic relationships between clients and staff, where privacy and trust can be established and maintained (Hopper et al., 2010). MISSION staff facilitate safety and trust by demonstrating to clients their willingness to meet them at whatever locations they are most comfortable (including on a park bench or under a bridge) and by sharing their own "been there, done that" experiences and "lessons learned". A complete sense of safety in some settings (e.g., homeless shelters) might be difficult to achieve, but MISSION providers can speak with clients about their sense of safety and make adjustments to the extent possible (e.g., seating arrangements, privacy, etc).

As a trauma-informed program, MISSION also strives to empower clients to collaborate with treatment providers and encourages clients to make their voice and choices known. In MISSION, clients are at the center of the development of their treatment plans and are urged to convey their needs and preferences in all decision making, such as job and housing selection. Even when aspects of care, housing, or employment, may be mandated (for clients in contact with the criminal justice system), giving voice to preferences and understanding a client's readiness for particular program elements can help empower clients to improve their engagement and sense of mastery of their destiny. Additionally, the MISSION Participant Workbook is provided to every client, and is specifically designed to empower clients in the recovery process by equipping them with tools to help foster their personal recovery. MISSION also encourages and supports client participation in mutual self-help groups and peer-based activities. For example, MISSION staff accompany apprehensive clients to recovery meetings and organize small group activities.

Although the clients' challenges are discussed, it is important to maintain a position with clients that is strength-based and focused on their resilience. MISSION enables clients to feel a sense of control over their treatment and a sense of mastery in working

towards their goals. By focusing on an individual's strengths, trauma-informed programs teach skills that maximize effective coping highlighting clients' resilience and recovery potential (Hopper et al., 2010). Finally, MISSION staff remain culturally-sensitive and inclusive, as clients are assisted in their individual change process toward recovery.

B.I. Trauma-Informed Care and MISSION

Role of providers within TIC approach in MISSION

1. Screen for and identify trauma related symptoms and disorders

2. Ensure that clients who need specialized treatment are referred to resources that are qualified to treat Posttraumatic Stress Disorder (PTSD) and other trauma-related disorders.

3. Serve clients with trauma histories who do not require specialized trauma-related treatment

4. Provide ongoing support for those participants receiving treatment from a specialized PTSD provider

5. Coordinate care with specialized PTSD providers

6. Coordinate trainings to court personnel and community supervising agencies (e.g., probation, parole) and others on trauma-informed service delivery models and the issues related to trauma for MISSION clients

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MISSION is a flexible, time-limited, and comprehensive treatment intervention designed to meet the mental health, substance use and other psychosocial treatment needs of homeless clients. Although MISSION provides comprehensive services to its clients, it is not an intervention that is specifically aimed at targeted treatment of trauma-related conditions such as PTSD. These treatments, such as Cognitive Behavioral Therapies, may be required in addition to MISSION services to assist the client in her/his recovery. However, as many homeless persons have experienced trauma

(prior to or during periods of homelessness), trauma-informed care considerations have been incorporated into the overall MISSION treatment model. MISSION case managers (CMs) and peer support specialists (PSSs) receive training on how to screen clients for trauma and how to coordinate care with specialized trauma clinicians, when needed, until trauma-related symptoms stabilize. MISSION CMs and PSSs can provide support to clients with elevated trauma symptoms; however, they are not expected to serve as primary providers of care for trauma-related disorders.

In order to be fully trauma-informed, MISSION providers must understand that their clients are at a high risk for trauma exposure while homeless. Furthermore, it is important for MISSION CMs and PSSs to understand that clients may be reluctant to discuss recent traumatic experiences though they can be a factor in their clients' presentations and need to be considered as a factor in treatment planning.

Another frame of reference for thinking about the consideration of trauma is also in thinking about early development, and whether homeless individuals also had a history of juvenile delinquency and childhood trauma. Adverse childhood experiences (ACEs) include verbal, physical, and sexual abuse as well as complex family dynamics such as having an incarcerated parent, having a parent or family member with mental illness or substance abuse issues, witnessing domestic violence in the home, or absence of a parent. Youth with trauma histories are at higher risk of becoming homeless as adults (Browne, 1993).

When working with MISSION clients, staff should recognize links between past trauma and present difficulties and be informed about pathways that appear to be gender specific. For example, homeless women are more likely to have experienced sexual abuse, emotional abuse, and deprivation growing up, while also being more likely to have been victims of domestic violence as adults (Bassuk et al., 1996; 2001). Therefore, MISSION providers need to be aware of and assess for the potential impact of interpersonal violence and continued maltreatment of female and male clients. This pattern of abuse history can lead to mental health problems such as depression, which can then result in substance abuse and subsequent adult intimate relationship problems (Chesney-Lind & Sheldon, 2004;

Salisbury & Van Voorhis, 2009). For both male and female clients who are homeless, the impact of their trauma and homelessness may contribute to further difficulties in their children, who are at risk for increased trauma exposure, increased impairment in physical and mental health, developmental delays, and poorer academic and social performance (National Center on Family Homelessness). MISSION therefore considers intimate relationships and whether clients also have parental responsibilities, in order to best support participants toward positive family well-being.

C. Assessment and Treatment

This section provides more specifics as to how MISSION providers can implement these goals through both assessment and treatment.

C.I. Assessment

Clients with extensive trauma histories and severe symptoms may require a more comprehensive assessment and referral to trauma-specific interventions. In the following section brief descriptions of common trauma-related disorders are provided.

The PTSD diagnostic criteria include 20 symptoms that are broadly grouped according to intrusion of traumatic memories and reactions to environmental cues that remind the individual of the trauma, avoidance of traumatic stimuli, negative cognitive appraisals and negative mood symptoms associated with the trauma (such as guilt, fear, shame, confusion, sadness, or diminished interest in activities or social withdrawal), and alterations in arousal and activity (e.g., sleep difficulties, irritability, recklessness, high startle response, aggressive behavior or hypervigilance).

Symptom Categories for PTSD:

- Intrusive memories or other reactions

- Avoidance of traumatic stimuli

- Negative cognition and negative mood symptoms related to the trauma

- Alterations in arousal and activity
(American Psychiatric Association, 2013).

Symptoms must be present for at least one month after the trauma, must have a significant impact on functioning, and must not be due to a co-occurring substance use disorder or medical condition (American Psychiatric Association, 2013).

Not all trauma symptoms result in full PTSD symptoms. The DSM-5 characterizes different patterns of trauma and stress-related symptoms in different ways. For example, shorter-term trauma symptoms from a major life stressor might be referred to as Acute Stress Disorder. An example of this is when one has a number of traditional posttraumatic symptoms but they last up to only one month following the trauma and then dissipate. Other disorders that one might experience include adjustment disorders, which include reactivity that can affect mood, anxiety and behavior after a type of stressor was experienced.

Anxiety conditions that do not fit neatly into these categories can have other types of diagnostic "labels". For example, there is also a cluster of trauma-related symptoms that result in impairments of different forms of self-regulation as it applies to emotions, interpersonal relationships, self-awareness, beliefs and physical health (e.g., Cloitre et al., 2011; Ford, Courtois, Steele, Hart, & Nijenhuis, 2005; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). This kind of symptom presentation is referred to as complex PTSD (or Disorders of Extreme Stress, Not Otherwise Specified) and is typically the result of childhood physical and sexual abuse.

The goal of the MISSION work related to trauma is to help clients recognize that trauma symptoms are real and impact a person in very significant ways, and the treatment manual and workbook exercises recognize that trauma may be at the root of some of the problems of program participants. In addition, referral to trauma-specific treatment may be necessary and is a reasonable goal for providers.

C.I.a. Trauma Symptoms in the Treatment Setting

MISSION CMs and PSSs need to be aware of the kinds of symptoms with which individuals with trauma histories present, separate from a formal diagnosis

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that may be given to the individual served. Effects of trauma can both be directly related to problems associated with previous traumatic experiences, such as hypervigilance to one's surroundings, and indirectly related through maladaptive coping responses, such as substance use (i.e., self-medication; Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005). Sensitivity to these symptoms and their impact on treatment and recovery are important aspects of providing trauma-informed care. Presented below is a table of the trauma symptoms in the treatment setting and description of each element.

Trauma Symptoms in the Treatment Setting

1. **Substance Use Disorders**
   Clients present with relapse behaviors or an increase in on-going use

2. **Avoidance**
   Clients avoid people, places or things that remind them of traumatic events

3. **Negative Thoughts and Feelings (Internalizing)**
   Clients present with negative emotions such as depression, anger, anxiety; and negative thoughts such as self-blame

4. **Acting out (Externalizing)**
   Clients present with increased irritability, anger, aggression and risk taking behavior

5. **Dissociation**
   Clients present with a lack of awareness of current circumstances and describe feeling as if the world is not real or their selves are not real

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Substance Use Disorders. Given the emphasis on dual recovery therapy in the MISSION model and that substance use and trauma are so closely related, understanding the origins of substance use as well as the current function it serves in our clients' lives is an important part of assessing clients' treatment needs. For clients presenting with relapse behaviors

or an increase in on-going use, CMs and PSSs should continue to screen for/ask about trauma-related symptoms because of their likely links with substance use behaviors. For example, if a client discloses that they have had a lapse and used substances recently, MISSION providers should inquire about the events (both internal and external) that led up to the behavior and the function of the substance use (e.g., was it in response to triggers related to trauma experiences, a way of coping with distress, or a pleasure-seeking experience with substance abusing peers?).

Avoidance. One common behavior of trauma is avoidance; avoiding people, places or things that remind an individual of a traumatic event is a hallmark of individuals with trauma-related distress. This may manifest itself in missed appointments, refusal to engage in activities related to one's treatment plan, or increased anxiety and agitation within sessions. While generally speaking this may look like treatment interfering behavior or the actions of a "difficult client", it may in fact be related to the client's fears of being reminded of previously traumatic experiences. For example, a client who has experienced trauma may be reluctant to participate in the dual recovery therapy exercises because the exercises might be a reminder of past experiences. While the behavior may be interfering with treatment, understanding when and how avoidance relates to trauma experiences allow the MISSION CM and PSS to address these issues in their care planning and support.

Thoughts and Feelings ("Internalizing"). Affect dysregulation is characterized in part by high intensity negative emotional reactions, such as depression, intense anger, overwhelming anxiety, and emotional numbing, and may be a factor that compromises treatment outcomes of individuals with trauma related distress. Other negative emotions including guilt, shame, disgust and sadness are also experienced by individuals with trauma histories, and these negative emotions may also impede treatment benefits or are associated with increased drop out rates (Cloitre et al., 2011; Dalgleish, 2004; Pitman et al., 1991). Clients may also present with negative thinking patterns, including increased thoughts related to self-blame for their traumatic experiences or negative beliefs about the world (e.g., "I am not safe anywhere"). For example, a

client who is missing sessions with his PSS or CM may be avoiding treatment, or may instead be disengaging because they are depressed and isolating and then blaming themselves for not showing up to sessions. Assessing for negative mood and associated behaviors is important so as to further understand treatment planning and target specific trauma-related symptoms to help the client re-engage in treatment.

Acting out ("Externalizing"). Increased irritability, anger, aggression and risk taking behavior can all be results of a traumatic history as well. Clients who have a short fuse, or who continue to engage in self-destructive behavior (including illegal activities, which can result in arrest, revocation of parole, and other sanctions), may actually be having a difficult time processing emotional responses to triggering experiences. For example, a client may quickly become agitated while describing verbal or physical altercations to their CMs or PSSs. This client may be responding to misperceived threats in his/her environment or experiencing feelings related to previous traumatic experiences and responding in similar fashions to when threats were actually present.

Dissociation. There is a small group of individuals who experience trauma, develop PTSD, and subsequently demonstrate dissociative symptoms. These symptoms are considered distinct from intrusive memories, or impairments in trauma-related memories that are psychogenic in nature. Individuals with dissociative symptoms usually present with a lack of awareness of current circumstances, sometimes through actual flashbacks in which they believe they are actually re-experiencing the traumatic event of the past and lose track of their current circumstances and surroundings. Additionally, dissociation can take the form of derealization (i.e., feeling as if the world is not real or that current circumstances are not real) and/ or depersonalization (i.e., feeling as if oneself is not real) (U.S. Department of Veterans Affairs, 2014b). Dissociation, though not fully understood from a biological perspective, can be one avenue by which an individual facing significant or repeated trauma separates their consciousness from what is happening to them at the moment. Individuals with derealization may present with decreases in emotional intensity, especially when discussing otherwise activating

experiences (U.S. Department of Veterans Affairs, 2014a). Individuals who present with depersonalization may describe having "out of body experiences" in which they see themselves observing their own body from above (U.S. Department of Veterans Affairs, 2014a). For example, when discussing difficult emotional events in session, a client may appear to be "somewhere else", not focusing on his/her CM or PSS, not responding to direct questions, or not demonstrating expected emotional expression despite describing emotional events. This client may need to use "grounding" tools (described below) and may describe feeling "disconnected" from the present moment.

C.I.b. Considerations for Special Populations or Issues

Women. Homeless women often endorse more frequent and persistent experiences of childhood sexual abuse, which is often associated with complex PTSD (cPTSD) and severe affect dysregulation (Ford et al., 2011). Affect dysregulation, dissociation, and interpersonal difficulties are core features of cPTSD as well as borderline personality disorder (BPD; van Dijke, 2012). However, although many individuals with BPD have a history of poly-victimization in childhood, not all individuals with BPD meet criteria for cPTSD and likewise not all individuals with cPTSD develop BPD (van Dijke, 2012). The core distinction between cPTSD and BPD are that individuals with BPD are more likely to present with greater impairments in the areas of a lack of self-identity, fear of abandonment, and suicidal and non-suicidal self-injurious behaviors. It is important for MISSION providers to understand the nature and complexity of the impairment in self-regulation processes that clients may present with, and resist the urge to label or classify clients, particularly female clients, as "borderline" without more fully understanding the nature of their traumatic histories and the role they play in current functioning and symptomatology.

Veterans. Veterans with mental illness and/or substance use disorders present with additional challenges stemming from their exposure to combat trauma as well as vulnerability to traumatic brain injury (TBI). Of Veterans screened for Military Sexual

Trauma (MST), 22% of women Veterans and 1% of men Veterans screened positive (Kimerling, Gima, Smith, Street, & Frayne, 2007), and women Veterans with sexual assault histories were at greater risk for developing PTSD (Yaeger et al., 2006). Complicating these clinical and social risks is the fact that many Veterans returning from service do not seek out appropriate treatment for their psychosocial needs. Although some studies have suggested that 80% of Veterans with PTSD who served in the Iraq and Afghanistan wars had at least one mental health visit at a VA treatment facility, less than 10% of these Veterans received the recommended amount of treatment within one year of their diagnoses (Seal, Bertenthal, Miner, Sen, & Marmar, 2007; Seal et al., 2010). Limited engagement in mental health treatment may increase the risk for homelessness and criminal justice involvement through untreated mental health symptoms that are manifested as destructive or aggressive behavior.

TBI. Further consideration must also be paid to individuals who may have a co-occurring TBI. TBI is the result of damage to the brain caused by an external force. The severity of TBI can range from mild to severe depending on the nature of an individual's response to the injury, such as the duration of loss of consciousness or length of post traumatic amnesia. Individuals at risk for TBI include Veterans, victims of interpersonal violence, and individuals who engage in assaultive behavior either in the community or while incarcerated. It is important to be aware of the possibility of head injuries in MISSION clients because symptoms associated with TBI often overlap with those associated with PTSD. This can include memory loss for the traumatic event (which may be organic in the case of TBI, but psychogenic in the case of PTSD), emotional avoidance/numbing, increased depression, anxiety and irritability, and reduced inhibition that can lead to self-destructive behaviors (R. Bryant, 2011). It is also important to be aware of the potential presence of TBI in MISSION clients because recent research has demonstrated that mild TBI is associated with an increased risk for developing PTSD (R. A. Bryant et al., 2010; Fann et al., 2004).

In addition to considering specific issues relevant to the populations discussed above, it is important to be sensitive to the roles culture and gender play in the client's understanding of the trauma and in his/ her comfort level in addressing it. There may be cultural restrictions on discussing personal histories; cultural differences in how an individual expresses trauma symptoms (as examples, individuals from some cultures tend to express psychological distress through physical symptoms versus emotional symptoms and men more often "externalize" symptoms, while women are more likely to "internalize" them); cultural differences that influence the role substance use plays in an individual's coping style; and cultural differences that affect treatment response (e.g., the counselor's awareness of cultural and gender issues may influence the level of engagement on the part of the client). Thus, MISSION CMs and PSSs are encouraged to seek training in cultural diversity and gender-based issues in order to provide the most compassionate and effective care possible to MISSION clients.

C.II. Treatment Issues

MISSION team members are trained to serve clients who may require referral to specialized trauma-related treatment and to provide ongoing support for those participants receiving treatment from a specialized PTSD provider, in consultation with that provider. It is important that the MISSION providers recognize trauma symptoms at any point in the client's MISSION enrollment and consider referrals to PTSD and other treatment programs when these symptoms are reported or observed. Of course, referral is contingent upon the client's willingness to participate in a specialized trauma treatment program. Depending on the type of program (e.g., inpatient, intensive residential) there may be a disruption in regular MISSION supports, and the MISSION teams will need to work with their supervisors to determine how to support clients during these types of other treatment interventions. After an acute situation, once symptoms have stabilized and the client has developed coping skills to better manage symptoms, MISSION services could continue at the usual level.

As noted, CMs and PSSs will not be conducting trauma-focused interventions with their clients. However, they operate from a trauma-informed perspective, screening for trauma or referring out for such screenings, and meeting with clients and assisting them in the development and utilization of present-focused coping skills to help mitigate the intensity of trauma-related symptoms (this will be dicussed in further detail below). Therefore, it is important to understand how the symptoms and problems listed above influence treatment, and perhaps more importantly, how to speak to and work with clients who have trauma-related distress. By becoming educated about trauma and trauma-related disorders, CMs and PSSs are better equipped to handle the diverse sets of problems with which clients may present.

First and foremost, it is important for service providers to understand how to discuss trauma with their clients in a safe and non-triggering manner. For CMs this includes being able to ask about the presence of traumatic events without forcing clients to discuss specific details about those events. It may also mean discussing their understanding and awareness of the potential impacts of trauma without forcing disclosure on the part of their clients. For PSSs, this includes being aware of the same issues as CMs, as well as understanding how self-disclosure of their own experiences may serve as triggers for clients, especially early in treatment.

If a client is particularly distressed during a meeting and is experiencing trauma-related symptoms, he or she must be assessed for safety risk. If the CM is a licensed mental health provider, he/she should assess the client for symptom exacerbation, suicidality, homicidality or aggression, and drug/alcohol relapse. If the CM is not

a licensed professional he/she should ensure that the client is assessed for safety by a trained professional. If the client is not in immediate risk the client's safety plan should be reviewed with him/ her and coping strategies for managing the distress should be discussed. **Clients who are suicidal or homicidal with a clear plan or intent should not be left unattended whenever possible and should be evaluated by a mental health professional immediately. Public safety personnel (e.g., police) should be contacted in an emergency where safety cannot be maintained.**

MISSION Clinical Supervisors should be immediately notified of any emergency situations that arise during the client's participation in MISSION. In cases where the Clinical Supervisor is unavailable or immediate action is necessary, the CM or PSS should either call 911 or escort the client to a walk-in mental health clinic or emergency room. Upon each client's enrollment in MISSION, the CM/PSS team should discuss safety risks/needs with their Clinical Supervisor and develop a comprehensive safety plan. Safety plans should be trauma-informed to prevent triggering trauma-related responses, which can make emergency intervention more difficult. The safety plan should be reassessed and amended in accordance with any changes in the client's status.

If a client is particularly distressed but is not at acute risk requiring emergency intervention, it is an excellent time to practice in the moment active coping skills, which can help a client feel a sense of control and reduce feelings of helplessness (U.S. Department of Veterans Affairs, 2014a). Below is a list of trauma-related symptoms and ways CMs and PSSs can address them in their interactions with clients.

Symptom	Intervention (with corresponding exercises from the MISSION workbook)
Intrusive memories or thoughts	Remind clients that they are only memories; that it's natural for them to occur; and that they are not in acute danger
Flashbacks and other types of dissociation	Have clients keep their eyes open and describe where they are and what they are seeing
	Keep clients engaged and talking
	Have clients stand up if necessary and move around
	Have clients splash water on their face
	Use grounding tools (e.g., describing the environment, counting, reading aloud, repeating a saying, touching objects around you, jumping up and down, stretching, breathing)
Sudden onset of intense emotional reactions	Allow clients space to express naturally occurring emotions
	Remind clients that these emotions are not dangerous
	Ask clients if they are also having scary thoughts and work with clients to help challenge those thoughts if appropriate (based on content and where clients are in their treatment)
	Practice deep breathing (MISSION Workbook 2.130)
	Progressive muscle relaxation (two exercises which are included in the MISSION Workbook 2.130)

*From "Coping with Traumatic Stress" (U.S. Department of Veterans Affairs, 2014a)

C.II.a MISSION Specific Tools

While the above guidelines can provide a general framework, all MISSION clients will be given a Participant Workbook with useful exercises and readings to help them address their trauma-related symptoms. These include self-guided exercises, checklists, DRT worksheets, and readings/reflections. Clients are encouraged to share their completed exercises with their MISSION CM, PSS, and peers, as well as their outside counselors and sponsors.

Elements of the MISSION Participant Workbook that may be particularly useful for individuals with trauma experience are:

- Relapse prevention plans
- Preventing and coping with stress worksheets
- Moving through the fear worksheets
- Creating the life that you want worksheets
- Developing strong communication skills
- Anger management
- Relationship related triggers

- Changing unhealthy thinking patterns
- Changing irrational beliefs
- Scheduling activities early in recovery
- Understanding PTSD
- Coping skills focusing on planning, self-esteem, relaxation, and anger management skills

In their meetings with clients, CMs and PSSs may want to refer to the work that a client has done in any one of these areas. When doing so, it is important to follow the guidelines listed above and make sure that it is appropriate given the client's current presentation.

C.II.b. Linkage and Treatment Options

Although MISSION is a trauma-informed program and there are ample opportunities for CMs and PSSs to help clients cope with trauma-related symptoms through the workbook and skills building, MISSION is not a specialized trauma program. Several authors have identified the importance of providers recognizing trauma prevalence in a homeless population and that referrals for further treatment can be helpful in these instances (Hopper, Bassuk, & Olivet, 2010). Therefore, as previously mentioned, it is important for MISSION providers to be aware of when symptoms are present that necessitate making a referral for specialized trauma-related treatment and consult with Clinical Supervisors if further treatment is warranted.

Referral options will vary based on the network of service providers available in a particular client's community. Additional considerations are: (1) whether the client should be referred to a residential or outpatient treatment program, (2) whether a client should be referred to a trauma-focused treatment program (e.g., where specific trauma memories are processed) or a trauma-informed treatment program (e.g., where coping skills related to trauma symptoms are learned), and (3) how to coordinate care between outside providers and MISSION providers.

Residential vs. outpatient trauma support.
Residential programs typically offer higher levels of care and are for clients who are suffering from more severe trauma-related symptoms. These programs are fewer in

number and in most cases should only be considered if outpatient treatment has not been successful, and/or clients need a higher level of supervision and greater intensity of skills building. Outpatient trauma treatment is available in many communities and should be considered a first line option. There are several empirically supported treatments for trauma and stress related disorders.

Treatments for trauma-related disorders and symptoms. There are several empirically supported treatments for trauma-related disorders and symptoms that vary in their emphasis on skills building and stabilization versus trauma-focused work where clients engage in activities that involve processing traumatic events themselves. Most of these treatments provide psychoeducation about trauma and trauma-related symptoms. Those that focus more on skills training provide interventions that often address coping and grounding, emotion regulation, interpersonal relationships, and cognitive restructuring. Such interventions include Seeking Safety (Najavits, 2002), Skills Training in Affect and Interpersonal Regulation (STAIR; Cloitre, Koenen, Cohen, & Han, 2002): Trauma Affect Regulation: Guide for Education and Therapy (TARGET; Ford & Russo, 2006) and Trauma Recovery and Empowerment Model (TREM; Fallot & Harris, 2002) Meanwhile, those interventions that focus on specific traumatic experiences involve some kind of structured recounting of those traumatic experiences either orally or through written narratives. Examples of evidence based trauma-focused interventions include Prolonged Exposure (PE; Foa, Hembree, & Rothbaum, 2007), Cognitive Processing Therapy (CPT; Resick & Schnicke, 1993), and Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1999). Nearly all of these treatments can be offered in both outpatient and residential settings, as well as in individual and group therapy.

 It is important to note that in addition to trauma-specific psychotherapies, psychopharmacological approaches to trauma symptoms can be a critical component of treatment (see Nisenoff, 2008 and Ravindran & Stein, 2010). Medications themselves can have side effects and clients may express concerns

about their medications. It is important that these issues get discussed with clients' psychiatrists or other prescribers. It may be useful to have clients write down their concerns so that at the time of their appointments they will have a tool that can assist them in articulating their questions. Going to a treatment provider can be stressful so strategies to help patients get their needs met can be helpful. Medications used to treat PTSD symptoms can include anti-anxiety medications, anti-depressant medications, and even what is called "anti-psychotic" medications that can be helpful with intrusive thoughts or some associated sounds or voices that people with PTSD sometimes hear. Also, some of the treatments that are used to treat anxiety symptoms can have addictive properties and where there are co-occurring substance use disorders, clients may need careful education about staying within the guidelines of a prescription.

In deciding which referrals to make, MISSION providers should be knowledgeable about the available treatment options in their community and discuss with their clients different referral possibilities.

C.II.c. How to Resume Treatment

When a client has been referred out for trauma-specific services their participation in MISSION is not over. MISSION providers should remain in contact with clients when appropriate and be ready to welcome them back into the program when trauma-related symptoms have resolved or abated. To help facilitate their transition back to MISSION, providers are encouraged to review treatment progress both as it is ongoing as well as when it is over. If possible, CMs are encouraged to obtain consent to speak to their clients' individual therapists. Coordinating care and being aware of treatment goals and progress is an important part of case management.

When clients have resumed working with their MISSION CMs, they should also review or develop safety

plans for how to proceed if or when trauma-related symptoms return, with clients encouraged to take the lead on their trauma care plans. Clients can describe the skills they learned that were most effective in coping with trauma symptoms, and identify potential triggers that may arise during their participation in MISSION. Approaching their return to the MISSION program in this manner can continue to empower clients and give CMs a helpful guide in understanding what was most helpful to clients and what they learned in treatment. It can also provide a guide for both clinicians and clients for when future referrals may be necessary.

D. Summary

This chapter has described trauma-informed care and its core components as utilized in the MISSION program. The primary roles of the MISSION CM and PSS are to screen for and identify trauma related symptoms and disorders; ensure that clients who need specialized treatment are referred to qualified resources to treat PTSD and other trauma-related disorders; serve clients with trauma histories who do not require specialized trauma-related treatment; provide ongoing support for those participants receiving treatment from a specialized PTSD provider; and coordinate care with specialized PTSD providers.

Trauma-informed care is a crucial element of the MISSION model because of the increased risks of trauma exposure among homeless individuals. The risks and needs of these individuals may be even greater among women and Veterans. Specific trauma-related disorders and examples of how their symptoms may manifest are described, including PTSD and other disorders, increased substance abuse, avoidance behaviors, negative thinking and emotional experiences, acting out, and dissociative reaction. Strategies for screening, assessing, and referring MISSION clients with trauma-related features are offered to help MISSION providers approach each client with an understanding of his/her unique trauma-related needs.

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VIII. Core Competencies for Clinical Supervisors

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A. Introduction and Overview

This chapter presents information and strategies for the Clinical Supervisor (CS) to provide ongoing clinical supervision to a MISSION clinical team consisting of a Case Manager (CM) and Peer Support Specialist (PSS). This chapter will address: selection of Clinical Supervisors; understanding the target populations; responsibilities and tasks of the CS; supervisory stance and structure; working effectively as a team; helping supervisees to make the most of supervision; and assisting supervisees with organizational skills and strategies to manage caseloads. Additional attention will be devoted to general clinical issues relevant for CMs and PSSs, as well as specific clinical issues relevant only to CMs; and specific clinical issues relevant to PSSs.

B. Selection of Clinical Supervisors

Ideally, a MISSION CS should have an advanced degree and license in mental health care (e.g. Licensed Clinical Social Worker, Psychologist), with expertise in case management, assessment and treatment of psychiatric disorders, substance use disorders (SUDs), and also in working with chronically homeless populations. Since a central role of the CS is to ensure that the clinical care provided is consistent with the MISSION model, he/she should have training in and a thorough understanding of MISSION, Motivational Interviewing (MI) style, Dual Recovery Therapy (DRT), Cognitive Behavioral Therapy (CBT), as well as the content covered in the peer-led sessions. The CS should also be familiar with community-level vocational, educational and housing resources available to help CMs and PSSs with the linkage of clients to needed services.

C. Understanding the Target Populations

There are two distinct target populations of the CS. First, the team members (CM and PSS) are direct recipients of the CS's services. Second, the clients who receive MISSION services are indirect recipients of the CS's contribution to the team's efforts.

1. Team Members (Case Mangers and Peer Support Specialists)

In general, the CS can expect that each team member has received training for MISSION in the following areas: an overview of the model, key components and how to use the MISSION Treatment Manual and Participant Workbook. This includes information on theory and application of all service components in the MISSION program (e.g., CTI, DRT, peer support, vocational/educational supports, and trauma-informed care), the respective roles of all staff in the delivery of these key components, and how the MISSION team functions as a whole to support clients. If this has not been done, we recommend that the CS assist the CM and PSS in obtaining these basic trainings. In addition, we would expect that the CMs and PSSs have training and a basic understanding of confidentiality, documentation, reporting, and crisis management policies and procedures.

However, each team member brings his/her own unique life experience, formal training and experience to his/her role on the team, and the CS should obtain a clear understanding of each new team member's training and experience. The CS should assess each new team member's MISSION protocol training and understanding of his/her roles and responsibilities, as well as the supervisee's strengths and weaknesses, role-specific learning needs and professional

development level (e.g. beginner, intermediate, experienced). Assessment of a supervisee's skills and training should be an interactive collaborative process that can include: asking the supervisee about his/her own strengths/weakness (self-assessment); having the supervisee provide responses to hypothetical clinical situations; and/or observing the supervisee in a real clinical situation such as an intake. This process can help streamline training and supervision by enhancing the supervisor's understanding of the supervisee's starting points in terms of knowledge, skills, and values or attitudes. The supervisor can then address gaps during ongoing supervision/training, and adjust supervision to meet the professional needs of novice to advanced team members.

a. *Case Managers (CMs)* are either Licensed Clinical Social Workers (L.C.S.W.) or licensed clinicians with experience working with people who have a history of mental health and substance abuse problems, and experience in providing direct case management services. They should have expertise in addictions and mental health case management, vocational support and community outreach with homeless individuals.

b. *Peer Support Specialists (PSSs)* are individuals who have faced their own addiction and/or mental illness, episodes of homelessness, and have demonstrated successful recovery with the ability to navigate public health systems. They bring a valuable set of skills in advocacy and engagement and receive training specific to the role of delivering services as a both a consumer and provider. (OF NOTE: Many of these training programs offer certificates upon completion). This type of training has become increasingly popular and is now available in many regions of the country. Specialized peer training enables PSSs to provide an array of practical/social supports to clients that can be useful during the implementation of MISSION's 11 peer-led sessions. The PSS team should be knowledgeable of community, social, and health service systems and have significant abilities to link, advocate, and help chronically homeless individuals with co-occurring disorders (COD) navigate these systems.

2. MISSION Clients

MISSION serves an ethnically and racially diverse population of chronically homeless adults with COD. Clients may also include special subpopulations of the homeless including, but not limited to, prisoners, Veterans, and/or pregnant women. Many MISSION clients have also experienced high rates of unemployment and crime, putting them at an even greater risk for chronic homelessness and related psychosocial problems such as ongoing substance abuse, persistent mental illness, and exposure to violence. Due to the broad range of clients' backgrounds and needs, CSs should be skilled in addressing their diversity of presenting problems (e.g. COD, unemployment, family problems, etc.).

D. Responsibilities and Tasks of the Clinical Supervisor

1. Caseload

Treatment team members work together, under the supervision of the Clinical Supervisor, to deliver MISSION. CMs and PSSs are equal members of the treatment team and all report to the CS. The number of CM/PSS treatment teams are dictated by the needs of the agencies implementing MISSION, but on average most agencies have 1-2 CMs, 1-2 PSSs, and 1 CS. Each CM/PSS team will typically have caseloads of up to 20 clients at any given time.

2. Tasks

CSs engage in both administrative and clinical supervision. The CS is responsible for recruiting and hiring full time qualified staff (CMs and PSSs) and for ensuring that program-specific training and ongoing supervision is comprehensive and timely. CSs play a role in organizing and overseeing initial training, and orient new team members to the organization, model, population and policies/practices. CSs may also train CMs to complete, write up, and present assessment intakes. CSs should meet weekly with the CM/PSS team to coordinate case management, and also meet individually every week with team members,

providing clinical direction and ensuring that each team member complies with applicable policies and legal requirements. Each supervision meeting lasts approximately 1-1.5 hours. In addition, CSs may meet with consultants and specialists to ensure a smooth interface between MISSION and linkage services.

3. What is the Difference between Training and Supervision?

CSs' responsibilities include both training and clinical supervision. Training refers to activities to impart acquisition of a new skill set and knowledge base needed to begin a particular type of work. CSs play a role in providing that foundation by reviewing confidentiality, documentation, reporting, and crisis management policies and procedures with new team members. Supervisors also train new staff in the theory and application of all service components in the MISSION program (e.g., CITI, DRT, Peer support, vocational/educational supports, and trauma-informed care considerations), the respective roles of all staff in the delivery of these five components, and how the MISSION team functions as a whole to support clients. Additional training activities can include reviewing organizational policies with staff, having staff members re-read the MISSION Treatment Manual, having staff attend peer support training, training CMs to administer the MISSION assessment battery, etc.

Once baseline training is complete, clinical supervision provides a method through which "on the job" training is accomplished. Its aim is to improve the competencies of the treatment team when working with clients and increasing the value of the therapeutic/support process in the client's best interest. Supervision provides staff with an ongoing evaluation of their skills and areas of strengths and weaknesses and an opportunity to learn new skills from their CSs as well as each other. CSs aim to observe, teach, mentor, coach, evaluate, and provide feedback in supervision meetings. These aims can be accomplished via group discussions, role-plays of client-CM or PSS interactions and modeling appropriate therapeutic responses and/or

communication skills. In effect, training introduces and teaches new skills, where clinical supervision monitors and enhances these skills in practice.

E. Supervisory Stance and Structure

1. Collaborative

The MISSION model emphasizes a collaborative relationship with the client, and the CS models this type of collaborative relationship with the CM and PSS, thus facilitating a strong supervisory alliance with the team members. A strong sense of shared tasks, goals, and bonds among treatment team members is important to be able to work in tandem to help each client on the CM/PSS caseload. Thus, each member's input, contribution, and ideas are welcomed and discussed and the team works in a collaborative manner to provide support and services to the clients.

2. Motivational Interviewing Style

Use of a Motivational Interviewing style (MI, Houck et al., 2012) incorporating global dimensions of acceptance, empathy, and MI Spirit (collaboration, evocation, and autonomy/support) (Vader et al., 2010), further facilitates alliance between the CS and his/her team members, as well as provides a model for the CM/PSS/client relationships. Supervisors can teach team members to use an MI spirit approach with clients, by assigning readings, providing examples, discussing the approach, and using MI in supervisory communications.

The approach prohibits a communication style that is critical or confrontational. For instance, CSs provide feedback using a positive and affirming style, first identifying what the supervisee has done well, and then giving specific guidance on what could be done differently. The CS can also provide a range of options for possible interventions with clients to foster collaboration and the supervisee's autonomy and involvement in decision-making. The CS uses empathy and validation to foster support for the team members, by being respectful and non-judgmental of supervisee's questions and decisions, and attempts to evoke the supervisee's perception and thoughts rather than dictating what to do.

The "Spirit of Motivational Interviewing" in Clinical Supervision: A Brief Vignette

PSS: I am not happy with the way this case is going. I feel like I'm the only one on the team who is helping this guy find a place to live.

CS: You're frustrated with the progress your client is making toward attaining housing.

PSS: Yeah. I don't know what more I can do.

CS: Sounds like you think there are ways to help your client find housing but that you want the team to work better together to make it happen. Tell me what's been going on with the housing search for this client.

PSS: I looked into supportive housing options and identified ones that he would be eligible for, and I engaged the client in discussions of getting into housing. He has been in supportive housing before, so I explored the pros and cons of each housing option to increase his motivation in applying for them, but the client is still not taking action. When I try to bounce these ideas off the rest of the team, no one says anything.

CS: You have several good ideas for pursuing potential housing options for this client, and you are feeling frustrated about the discussions in the meetings around these ideas?

PSS: Yeah, I feel like I have some good suggestions but no one listens. It's frustrating and it makes me angry too.

CS: I'm impressed by how much you care about this client and want to help him find housing as soon as possible. What are some ways you can communicate your ideas to the rest of the team in a way that might lead to a less frustrating discussion?

PSS: I guess I could try to write down my ideas and bring them to our team meeting, for everyone to read and talk about. That might help everyone take them more seriously.

CS: I agree - having a written list as a focus of attention for a discussion can be a good way to kick around ideas.

PSS: Yeah. Writing is not my strong suit but I can do my best.

CS: Which team meeting do you think you want to shoot for?

PSS: I guess I could have something ready for our meeting this week, since I really want to move ahead with getting this client some housing before it gets colder out.

CS: Great, I'll put that on our agenda then. Looking forward to it.

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3. Observing Supervisees

In addition to supervision meetings, it is extremely useful for CSs to observe supervisees work with clients whenever possible, to most efficiently and effectively improve performance on specific skills. Observation also provides an opportunity for the CS to learn specific strengths and weaknesses in supervisee performance and thus, fine tune the focus of supervision going forward. CSs might try to observe at least the first clinical intake assessment and at least one of the 13 DRT sessions conducted by a new CM, and at least one of the 11 peer-led sessions of each PSS's first cases. If observation is going to happen, the CS should discuss the observation in advance with the supervisee to clarify the purpose of providing in-vivo training, supervision and feedback. Additionally, the CS should inform the supervisee that s/he might jump in during the observation (particularly in an assessment) to provide support (e.g. clarifying client symptom presentation if the supervisee has missed something). If possible, provide brief feedback on the day of the observation and schedule a supervisory session to provide detailed feedback. CSs should also provide relevant readings to CMs and PSs to complement supervision discussions and feedback.

F. Working Effectively as a Team

Each MISSION client is assigned to a team including a CM, PSS, and a CS. This section highlights areas in which the CS can impact effective functioning of the team in terms of communication, case information sharing, roles and responsibilities of each team member, tapering supervision over time, evaluation, team dynamics, burn out, and turnover.

1. Communication Skills: Setting and Maintaining a Tone of Positive Team Communication

a. Parallel Process: Use the Same Good Communication Skills that we teach the Client. CSs model and train CMs and PSSs to recognize effective and problematic communication styles and to use the "elements of good communication" outlined in the DRT protocol. CSs can set the tone of team communication by reviewing DRT communication skills with their team, modeling these skills in supervision and giving positive or corrective feedback regarding the team's communication. In other words, team members strive to use the same good communication skills that they teach the clients to use in daily living.

b. Addressing Conflict or Disagreement Among Team Members. Tension between CMs and PSSs is counter-productive to teamwork, and can negatively affect the work they do with clients. To prevent and/or reduce conflict, clear mechanisms for communication about conflict should be outlined and reinforced in supervision. CSs can clarify that team members bring different ideas, goals, values, beliefs and needs to their teams and that these differences are a primary strength of teams, but may also lead to some disagreement/conflict. Team members should be encouraged to use DRT communication skills or outside supervision to discuss any conflict or disagreement.

Dual Recovery Treatment Elements of Good Communication
(Smelson, Kline, Ziedonis, Hills, Woods, 2007)

- Be polite and considerate. Treat your team member with respect, don't judge

- Stop and think before commenting on things that bother you: Don't bring up issues unless they are really important.

- Decide not to "kitchen sink" or bring up other problems when discussing one problem. Try to resolve one issue at a time.

- Make sure to express positive feelings and to reward your team member rather than taking for granted things that are going well.

- Avoid destructive criticism or complaining. Phrase change requests in a positive way. Use good listening skills: Look at your team member when he/she speaks to you. Don't interrupt! Take turns talking and listening. Validate what your team member says even if you don't agree ("I can understand why you're upset about the client asking me to attend this meeting and not including you. Maybe we can decide together how we should approach this issue in the future").

- Try to be assertive - not aggressive. Think about what you want before you speak. Start with a positive statement and then use "I" statements. For example, instead of, "You're disorganized and this case is going to fail. Get it together!" try, "You are working really hard to make this case work – it's a difficult one. I'm worried about how the case is going, because it's so complex. I would like us to try to figure out a way we can work together to get the client the help he needs?"

2. Information Sharing Among Team Members: Strategies for "How To"

While verbal communication is important to team functioning, a centrally shared system to communicate clinical updates and updates on shared clients is essential. Team members should have regular and structured ways of sharing information about clients. For example, team members can choose to have a brief check in daily to exchange timely updates regarding clients. If the agency requires daily documentation of client contact and related content with shared access by all team members, the PSS/CM can choose to create notes within that documentation system to alert the other of important updates. Development of an information sharing system should take into account each member's availability (e.g. are team members in the office at the same time), preferred style of communication (e.g. some teams prefer to communicate verbally, rather than including notes in their documentation), and confidentiality policies.

3. Information Sharing Between Team and Others

When delivering MISSION services, there will be times when a number of different providers including probation officers, vocational counselors, psychiatrists, social workers, the MISSION CM and PSS, and housing support counselors are involved in the provision of the client's integrated care. However, confidentiality is important to consider when communicating with any outside providers. First, the client should be asked to sign a consent form to release/provide information before any information

regarding the client is shared with other providers or agencies outside the MISSION team. MISSION CMs/PSSs should have explicit discussions with clients regarding what will and will not be shared with other providers. After consent is received from the client, MISSION team members should be mindful to release only information that is directly relevant to the client's care. For example, if the client has provided consent, it would be appropriate for a MISSION team member to inform the client's vocational counselor of the client's interest in a prospective job, but not inform them that the client has recently been divorced. For justice system-involved clientele, the team must also request clear direction from other agencies and providers what the limits of confidentiality are, for instance, whether the Probation Officer needs the CM to report if the client is positive on a drug screen.

4. Maintaining Clear Team Member Roles and Responsibilities

Although the MISSION model places emphasis on a team approach to the work, when teams form, CSs should orient each team member to his/her unique role and responsibilities within the team. There should be delineated roles, responsibilities, and expectations. When overlap does occur in team member's roles/responsibilities, CSs should provide some direction on how to coordinate these. Generally, when one team member assumes a primary role in a certain area, the other team member provides assistance and serves in lead capacity only when the primary team member is temporarily unable to fulfill that duty (for example, due to absence or sickness).

Primary Responsibilities of Clinical Supervisor	Primary Responsibilities of CMs, with input from PSSs	Primary Responsibilities of PSSs, with input from CMs	Responsibilities Shared by CMs and PSSs
• Orientation/introduction to CMs and PSSs • Training and on-going supervision of CMs and PSSs • Evaluation of CMs and PSSs • Clinical Intakes/ Assessments • Oversight of treatment fidelity • Overseeing management of clinical crises • Clinical and administrative leadership • Clarify role perceptions and expectations of each team member • Identify each member's personal and professional competencies • Explore overlapping responsibilities and provide guidance on how to address the overlap • Re-negotiate role assignments if necessary • Check in consistently about roles/ responsibilities.	• Orientation/introduction, mid-program progress check, transition to community, and discharge plans • Management of clinical crises • Delivery of DRT psychoeducation at each session • Identify, monitor, and provide referrals for trauma-related symptoms • Provide vocational/ educational supports as needed: interview skills training, resume building, linkages to education and training programs • Facilitate linkage to other clinical services • Communicate with clinical service providers • Review and work through benefits and entitlements issues (social security income and social security disability)	• Help clients advocate for themselves with providers and ensure effective two-way communications • Recreational planning and modeling healthy living using free or low-cost community resources • Linkage to community mental health and substance abuse recovery programs (NA/AA) • Accompany veterans to clinical appointments, job interviews, recreational activities, and self-help group meetings • Increase motivation toward recovery goals • Assist with Participant Workbook exercises and readings, discuss material, and reinforce insights	• Weekly team meetings with staff providing care at inpatient/residential treatment facility • Discharge session from the treatment facility • Linkage to needed community services, including vocational/ educational supports and trauma-related treatment resources • Assistance with Housing search and maintenance • Ongoing monitoring of symptoms, psychoeducation and training in symptom management, coping skills, medication compliance, problem solving, and relapse prevention • Transportation assistance • Provide support during job stresses • Provide support during clinical crises • Refer out as appropriate during exacerbation of symptoms

5. Supervisory Intensity is Tapered Over Time

Similar to the tapered dependence of clients on the CM and PSS over time in the CITI model, this supervision model assumes increasing independence of CM and PSS as their level of the competence, knowledge, and confidence increase over time. Thus, it is expected but not required that as each CM and PSS gains experience and on the job training, the intensity of supervision needed tapers over time (or should, if CM and PSS learning and implementing appropriately). For instance, supervision is more intense for beginning CM and PSS, (i.e. attend first DRT group session); the supervisee is expected to seek help and assistance often in addition to weekly supervision meetings, and supervisor interventions should be very structured, providing significant directive feedback and support. With accumulated experience and increased expertise, supervisees should acquire strong skills, be stable in their delivery of care and reach a level of proficiency where they have some level of autonomy in their work. They can nicely focus and integrate all aspects of the work including the client, the process, the CM/PSS team and their own contribution. They are aware of their own and their team's strengths and weaknesses and understand when to seek help. Supervisory interventions should be balanced so that autonomy and independence are fostered while support and structure are still available at all levels of supervisee experience and expertise. CSs can use the following methods to monitor supervisee's progress in learning the MISSION materials and appropriately implementing it: observation, role play, skills training, modeling, assigning reading and discussing it, providing opportunities for peer supervision. Like CMs and PSSs closely monitor clients and gradually encourage independence as clients build skills/confidence, supervisees become more independent from supervisors as expertise and experience accumulates.

6. Evaluation of Supervisee Performance

Inherent in this supervision model is the continuous monitoring of CM and PSS performance. CSs can implement a quarterly evaluation of each CM and PSS to summarize and review progress and performance in expected areas. This should be a structured process, where the CS reviews the table of roles and responsibilities and provides direct feedback to each CM and PSS individually. Ideally, this feedback would be written and reviewed verbally. CSs can also integrate a self-assessment (completed by each CM and PSS evaluating their own performance) based on the table of roles/responsibilities. In the evaluation process, CSs should solicit CMs and PSSs understanding of the evaluation and ask them to add their thoughts (i.e. clinical development goals). CSs can also use fidelity methods (described later in this chapter) to identify areas in which clinicians need improvement or additional support and provide feedback. If the CS identifies areas in which the CM or PSS is especially deficient, the CS should institute a remedial plan and perform more frequent oversight of their performance.

7. Preventing Splitting of Team by Client

The term "splitting" is used to denote the pitting of one entity against another. For example, it can occur when a client expresses polarized views of their CM/PSS team members, viewing the CM as "all bad" and the PSS as "all good". Team members play a role in preventing splitting. First, by communicating regularly about shared clients, so that all communications are transparent across all parties, CMs and PSSs can avoid intra-team conflict or miscommunication related to clients. Second, CMs and PSSs should never gossip about or "badmouth" other team member to clients. Third, CMs and PSSs should not discuss or disclose dissatisfaction or resentments or conflicts among the client's team, to the client. If clients disclose polarized views regarding a team member, team members should acknowledge (not confirm or collude with) the client's concern, coach client on appropriate ways to handle and communicate their concerns directly (e.g. encourage the client to talk to the other team member), discuss this issue with the team member directly and/or discuss in supervision. It should be noted that splitting can also occur when working with providers outside of the team. The clients may have an "all good" view of the CM/PSS team and an all bad view of his/her psychiatrist, for instance. Teams should follow the steps outlined above to prevent splitting in these situations.

8. Managing CM and PSS Stress and Burnout

CMs and PSSs will encounter and listen to very distressing stories and the immensely difficult life situations of their clients. Given team members' exposure to potentially distressing situations, stories, and information on a day-to-day basis, it is important to identify the signs of burnout and compassion fatigue in team members. Burnout is a prolonged response to chronic emotional and interpersonal stressors on the job. Compassion fatigue is a form of burnout characterized by physical, emotional and spiritual exhaustion accompanied by emotional pain. Compassion-fatigued helpers often continue to give themselves fully to their clients, but find it increasingly difficult to maintain a healthy balance of empathy and objectivity. It can lead to serious issues for helpers and can compromise client care. Therefore, it should be monitored and addressed by the CS.

Additionally, in organizations addressing substance use there is often a significant number of helpers in recovery as well. In MISSION, PSSs are generally all in recovery from mental illness, substance abuse, or both. CSs should be mindful and monitor substance use relapse warning signs and slips of team members. For PSSs in recovery, being exposed to high risk situations and familiar personal triggers (active drug/alcohol users, street life, talking about client's triggers, depressing events, etc.) might put them at increased risk for relapse themselves. This should be attended to and discussed to generate a plan and a commitment to communicate with the CS about slips and relapse.

CSs should provide space and create a safe atmosphere in their meetings where CMs and PSSs can feel comfortable to discuss these issues. To facilitate this atmosphere, CSs can start by alerting CMs and PSSs to the potential for burnout, highlighting the causes, signs and methods to prevent it, as well as its impact on client care.

Managing Burnout and Stress

- Discuss it in supervision

- Consider it in case assignments

- Encourage and Model the Following:

  - Engage in things that bring joy and relieve stress.

  - Decide on a time of the day when not to engage in helping-related work and, instead, focus on leisure.

  - Take time each day to relax, even if it is only for a couple minutes of deep breathing.

  - Avoid taking on extra clients if your caseload is full. Just say "no" to yourself.

  - Avoid taking on extra work-related responsibilities if you are feeling overwhelmed or spread too thin.

  - Keep your supervision appointments and receive supervision regularly, discussing your concerns.

  - Receive counseling of your own to manage any difficult feelings you are experiencing.

  - Routinely assess where you stand in regard to burnout and compassion fatigue.

  - Debrief with team members after a challenging experience/situation.

9. Dealing with Staff Turnover

Burnout and staff turnover go hand in hand. Helpers who are "burned out" are more likely to leave their positions. Therefore, prevention of burnout is key in preventing staff turnover. Identifying signs of burnout or burnout risk in team members, providing feedback about this in the weekly individual supervisee meeting, and collaborating on a plan to manage the variables contributing to development of burnout can help avoid a negative outcome for the team member and thus help to prevent turnover. If turnover does occur, determine

the cause of it by asking the departing team member what led to their decision to leave, or by evaluating what system issues led to having to terminate the team member.

G. Helping Supervisees to Make the Most of Supervision

1. Balancing Independent Work with Seeking Supervision when Necessary

It is important to define when a supervisee should work independently versus seek supervision. In general, supervisees can work more independently if their report in supervision and the client's objective progress indicates that the supervisee has a clear understanding of the presenting problem and is effectively implementing the treatment plan. No matter what level of expertise, supervisees need to seek immediate supervision in the event of emergent issues including: client suicidality or homicidality, concern about a child, elder abuse and domestic violence, acute intoxication, and withdrawal risk issues. CSs should be available to respond to emergent issues and/or identify a "back-up" supervisor if they are not available.

2. Efficient Use of Supervision Time

Team and individual supervision meetings only occur once a week for about 1-1.5 hours each. This will not provide enough time for an in depth review of every case on the team's caseload. Therefore supervision meetings should be structured to optimize the time. Preparing for supervision and structuring the meeting can help optimize the time. Below are ways in which this can be accomplished.

Efficient Use of Supervision Time: Supervisor Responsibilities

- Set an agenda at the start of each supervision meeting. Ask the supervisees what they would like to add. This models a core CBT skill for supervisees and keeps the meeting on task.

- Demonstrate time management in the supervision session. This is another skill that is good to model for supervisees. After collaboratively setting the agenda with the supervisees, divide the time among the items on the agenda.

- Discuss clients who are using and where there are clinical concerns first. Clinical concerns include: lack of taking care of daily care needs, lack of progress in the case, lack of cooperation, criminal activity or arrest, warning signs of relapse or recidivism, increasing symptoms of mental illness.

- Have template letters/documents that can be easily modified by clinicians (e.g. letter regarding treatment attendance to the court). Supervision time can be drained by spending time drafting documents from scratch.

- Keep a running list of re-occurring themes and responses to commonly occurring issues/questions. This is helpful to prevent "recreating the wheel" during the meeting and providing consistent responses to your supervisees.

Efficient Use of Supervision Time: Supervisee Responsibilities

- Take notes during the week on important clinical issues to discuss in supervision.

- If there is a complex clinical concern, take a few minutes before supervision to conceptualize the issue concisely. Present key points only. Do not focus on unrelated details. Your presentation should be limited to about 5 minutes.

- Bring client session notes, updated use graph/data, abstinence plan, and intake to supervision. It is important to present weekly updated accurate alcohol/drug use data at every session. This data is essential in developing appropriate abstinence plans and /or making decisions regarding need for higher level of care. The first question a good

supervisor will ask is: "What did the client drink/use this week? (looking for frequency and quantity info, and patterns of drinking/use situations).

- Bring questions to supervision sessions, about a specific case, or more generally related to therapy skills (e.g. case formulation, use of MI skills, etc.) or strategy (e.g., how does one motivate a client to seek additional social support for recovery).

- Record what has been discussed in supervision in relation to your client and implement it in the next session. You should refer back to these notes before supervision to address how you used feedback from the prior supervision session.

H. Assisting the CM and PSS with Organizational Skills and Strategies to Manage Caseload

Organizational skills, including systems to promote accurate and timely case recordkeeping/ clinical documentation, impact the quality of care. It is important for supervisees to receive training and supervision in how to keep track of each case's weekly activities, overall week by week treatment plan, contacts with clients, issues, etc. Each agency has its own unique clinical documentation system and supervisees should be trained in how to use these systems. CSs should continually assess supervisees' timely and accurate submission of clinical documentation and general competency in clinical organizational skills. CSs should model and reinforce organizational skills. For example, CSs can create a binder, which they bring to each supervision session. The binder contains agendas from each supervision session with notes on what was discussed and decided. Therefore, as treatment progress and plans are reviewed the CS can easily track client progress and assess the supervisees' implementation of clinical recommendations from previous meetings. This models a system for tracking clients. CSs should explicitly advise CMs and PSSs on best practices in tracking clients and supervision issues (e.g. keeping a

supervision notebook with notes, noting supervision questions that come up in the field on a smart phone, etc.). In providing these tips, supervision sessions should also reinforce the importance of following all confidentiality policies.

I. Ensuring Fidelity to the MISSION Treatment Manual

While CSs are responsible for ensuring fidelity to the model, it may be possible that this is also done by the MISSION model developers. This is particularly true for research projects that involve testing of the model. In either case, fidelity is defined as the accuracy and consistency with which the MISSION model is delivered to ensure it is implemented as prescribed and that each component is delivered in a comparable manner to all clients over time and across various MISSION providers. Poor fidelity to the model can lead to poor client outcomes. Through ongoing assessment, monitoring, and corrective feedback, CSs can impact fidelity. Some specific methods to assess and monitor protocol fidelity include: training and orientation, familiarity and consistent use of the treatment manual, direct observation of interactions between staff and clients, group and individual supervision meetings, and conceptualizing cases using CTI and DRT.

1. Tracking Fidelity

As an adjunct to the processes described above to track fidelity, MISSION utilizes the following two standardized instruments to assist Clinical Supervisors in tracking the fidelity of clinical practice to the MISSION model.

- The MISSION Services Delivery Record: a computerized checklist which case managers and peers use to record each client contact along with the types of services they deliver during that contact. Each clinician's Services Delivery Record for each active client should be accessible to project management on a shared computer drive, allowing Clinical Supervisors to conduct quick spot checks on the level and types of service delivery activity in which clinicians are engaging.

- The MISSION Fidelity Index is more often used in studies where the MISSION model is being tested to assesses the extent, as well as the quality, of delivery of key MISSION service components and the quality of clinician record keeping. For example, the measure assesses the extent to which a CM or PSS follows up on identified client problem areas. The index is completed a number of times over the course of the study (often dictated by the design of the project) by study staff and done on a random selection of patients on each CM and PSS caseload. If this is being done, it is important to note that the MISSION project staff will notify you that this is part of the project and that you should expect fidelity monitoring to be conducted at your site.

J. General Clinical Issues Relevant to Case Manager and Peer Support Personnel

1. Therapeutic Alliance with Client

A collaborative and strong therapeutic relationship is the foundation of an effective treatment experience. Changing maladaptive behavior is quite difficult for clients to accomplish, and a positive therapeutic alliance helps to motivate the client to learn and practice the skills covered in the model. Some clients will come to treatment having had a disappointing experience with a provider, failed attempts at sobriety, been given conflicting information about the root of their addiction, etc. This may result in feelings of frustration, disappointment, and anger that may be expressed or projected onto the CM and/or PSS. Following are some techniques to foster therapeutic alliance with the client.

Developing a Positive Therapeutic Stance and Alliance with Clients

- Speak clearly and slowly. Use terms the client will understand.

- Ask the client what he/ she would like to be called when you first meet.

- Don't jump directly into the manualized material. Spend some time getting to know the client, developing a mental picture of his/her daily life.

- Integrate what you know about the client's case conceptualization into everything you choose to say. For instance, if a client is generally passive and unassertive, and he/she reports saying no to someone during the week, say, "wow, that's great – that must have been really hard for you to say no! You did a great job! In your family, you never had all that much of a voice to say no, but you are doing much better with that now".

- Ask the client during agenda setting if there is anything he/she would like to add.

- Integrate the client's experiences, triggers, and case conceptualization when providing intervention rationale to highlight how each intervention may be helpful to each particular client.

- Provide praise for change attempts.

- If the client tends to go off tangent, re-direct the conversation by linking what they are saying to the skill at hand.

- Normalize clients' experience, validate, but don't collude with victimization, helplessness, etc.

- Utilize MI/MET/CBT concepts to motivate and teach skills to clients.

- Assess, encourage, and enhance self-sufficiency of the client.

- Identify service gaps and be responsive by providing appropriate referrals.

- Together develop a vision of the potential each client can strive to reach, and map out a plan for him/her to achieve those goals.

2. CM and PSS Therapeutic Stance

In general, use a non-confrontational, non-judgmental therapeutic style, integrating a Motivational Interviewing "spirit". It is important that the CM and PSS convey warmth and empathy by acknowledging the difficulties clients have faced along the way, as well as ambivalence about change, acknowledging the client's strengths in the face of these challenges, and fostering hope and motivation for change.

a. Psycho-education. By having a sound foundation in addictions and mental illness, the clinician can integrate psycho-education as a way to engage the client and possibly counter the client's "negative self talk" about their addiction (e.g. I can't quit because I am lazy").

b. Taking a Collaborative, Coaching Stance. It is essential for clinicians to provide positive reinforcement for positive changes. Every session, the CM or PSS should provide some praise for positive movement toward behavior change and use this movement towards positive change as a motivational tool. Don't confuse positive reinforcement for behavior change with overuse of reassurance for lack of behavior change. Validate but don't collude.

c. Importance of Empathy, Validation, and Reflective Listening. Empathy, the ability to understand experiences from another person's point of view, is essential to developing a strong and engaging therapeutic relationship. Empathy is an important part of building rapport and facilitates feelings of trust and mutual respect between the patient and therapist. Demonstrating empathy and understanding of a client's world helps to validate his/her experiences. Beginning CMs and/or PSSs often view making direct statements about the client's challenges as counterproductive to an empathetic stance. They fear being critical and rupturing the therapeutic relationship and thus, may err on the side of caution and avoid direct discussion of important issues like continued drinking, and treatment non-adherence.

CMs and PSSs must be trained to use validating responses to show empathy towards a client, but not encourage unhealthy patterns/behaviors. For example, a client comes in very upset and says, "My husband is horrible. He made me drink this whole week". A novice CM/PSS may respond by saying "He sounds pretty mean. What did he do that made you drink?" This response reinforces to the client that it is OK to be reactive to her husband and also reinforces that her husband is in control of her drinking. The CS can suggest an alternative response, a reframe that helps the client learn to take responsibility for her own drinking behavior: "sounds like you had a rough week, and were really angry at your husband. Let's talk about the triggers related to your husband that led to your deciding to drink, and what you might do differently if the same situation comes up this week."

3. Case conceptualization

Case Conceptualization is key in understanding the client and their current problems; informing treatment and intervention techniques; assessing client progress; and helping to establishing rapport with clients. The case conceptualization should be based on the initial assessment, each team member's input about the client, the client's needs and resources, pre-homeless highest functioning, and realistic, measurable goals for what each client might be able to achieve (i.e. highest potential expected). These components of the case conceptualization help in the development of clinical hypotheses that will guide the treatment planning process. These hypotheses may require adaptation as new information reveals itself during treatment.

Clinical hypotheses can be used by the team to guide case management and/or can be shared with clients. For example a CM could share the following clinical hypothesis for a person with depression and alcohol dependence: "Would it be helpful for me to share with you my observations? Since you moved to this area, it seems that you have experienced many life changes and some very upsetting losses. Your problems sort of accumulated over time. After a while, you realized that savings have been spent, and your relationship with your girlfriend ended leaving you sad, lonely and without a place to live. Understandably, your thoughts, which used to be pretty optimistic, are now very

negative, especially about your future. In reaction to your low mood, you have stopped doing things you liked to do. Instead, you started to spend your time drinking, and stopped interacting with your family. What parts of these observations ring true to you and what don't? "It is important to note that prior to sharing a clinical hypothesis with a client, CMs and PSSs should get their supervisor and team member's input regarding the hypothesis. This minimizes the chance of inaccurate hypotheses and also keeps CM/PSS teams on the same page regarding their conceptualization of the client.

4. Treatment Planning

The case conceptualization leads to the development of the treatment plan. A sound treatment plan should be an integration of the presentation and causes of the client's difficulties into a specific set of steps to address these issues. Specifics should include: housing needs, length of treatment; need for initial level of care for substance use disorder (withdrawal risk); need for initial level of care for mental health problem (stability); triage of client's needs (i.e. treatment and services needed); as well as an assessment of vocational and educational needs. Once the plan has been discussed and approved in supervision, it should be presented to the client. When presenting the plan, actively involve the client and incorporate his or her feedback.

In this population, withdrawal risk is essential to consider to treatment planning. If not managed properly withdrawal from drugs and alcohol can be fatal. While the CM/PSS may not be managing withdrawal risk themselves, they are often the eyes and ears of

physicians who may be working with the client. For that reason we have included the following criteria that physicians and programs will want to consider using when deciding whether the client needs a higher level of care (inpatient detoxification or rehabilitation) and are based on ASAM (Lee, 2013) guidelines:

- Clients at particularly high risk for complicated withdrawal (i.e. 3 prior withdrawal episodes, history of severe withdrawal symptom).

- Clients at high risk for biomedical complications: Presence of biomedical problem(s) requiring inpatient diagnosis and treatment, such as, impending hepatic decompensation, acute pancreatitis or other condition requiring parenteral therapy, active gastrointestinal bleeding, cardiovascular disorder requiring monitoring, etc. Chemical use gravely complicating existing biomedical condition, or worsening of a condition making immediate abstinence critical to avoid severe morbidity or mortality.

- Clients at high risk for psychiatric or behavioral complications: Uncontrolled behavior endangering self or others. Impairment of cognitive function, mental confusion or fluctuating orientation, or extreme depression such that activities of daily living are impeded. Evidence of disorientation to self, alcoholic hallucinosis, or toxic psychosis within the past 24 hours or currently. Chemical use complicating existing psychiatric condition, or worsening of a condition making immediate abstinence critical to avoid severe morbidity or mortality.

Withdrawal Symptoms (Center for Substance Abuse Treatment, 2006)

Drug	Onset	Duration	Symptoms
Alcohol	24–48 hours after blood alcohol level drops	5–7 days	Irritability, restlessness, anxiety, depression, insomnia, tremor, increase in blood pressure, heart rate, temperature, nausea/vomiting/diarrhea, seizures, delirium, death
Benzodiazepines	1-7 days after ceasing use	2-8 weeks (depends on type: long vs short acting)	Anxiety, depression, diarrhea, constipation, bloating, insomnia, irritability, muscle aches, poor concentration and memory, restlessness, perceptual disturbances, panic attacks (less common), seizures, psychosis
Cocaine	Depends on type of cocaine used: for crack will begin within hours of last use	3-4 days	Sleeplessness or excessive restless sleep, appetite increase, depression, paranoia, decreased energy, stroke cardiovascular collapse, violence
Cannabis	3-4 days	Up to several weeks	Irritability, appetite disturbance, sleep disturbance, nausea, concentration problems, involuntary eye movement, diarrhea
Methamphetamine	4-12 hours after last use	1-2 weeks	Depression, anxiety, fatigue, paranoia, aggression
Opiates/Heroin	Within 24 hours of last use	4-7 days	Depression, anxiety, irritability, muscle aches (particularly in the back and legs), sensitivity to pain, overproduction of bodily fluids (such as sweat, tears, and a runny nose) diarrhea, nausea, vomiting

5. Handling Clinical Emergencies

One can't always predict and prevent them in this work, but when crises do occur, there should be a plan in place for how to handle crises. CSs must review plans for handling emergent issues with all CMs and PSSs before they meet with their first client. Plans should be reviewed in orientation, training and supervision.

a. Suicide Risk. If a CM or PSS suspects that a client might be suicidal, they should discuss their concerns and options with the client. Assessment of suicidality should follow this format: assess thoughts, means, plans, and history of attempts. If the client presents as a suicide risk (with a clear plan or definite intent), the MISSION CS should be notified immediately and the CM or PSS should escort the client to meet with the CS as soon as possible. If the CS is unavailable, the client should be escorted to the closest facility with walk-in emergency psychiatric services. Clients should not be left alone during this time. MISSION CMs and PSSs should stay with the client until they are able to see a mental health clinician for evaluation. MISSION CMs and PSSs should also remind clients of emergency contact options throughout the course of treatment as well as during emergent situations. Examples of emergency contact options include: emergency psychiatric services, 911, and 24-hour national suicide prevention lifeline, 1-800-273-8255 (talk).

b. Intoxication During Sessions with MISSION Team. Clients may show up to sessions intoxicated. Therefore, there should be a plan in place to handle an intoxicated client. The organization may have a method for assessing intoxication such as a breathalyzer or drug screen at the beginning of each session. Others may subjectively assess by observing signs of intoxication.

Signs of Intoxication (Center for Substance Abuse Treatment, 2006)

Drug	Signs
Alcohol	Slurred speech, unstable movement and walking, smell of alcohol on breath or skin, glazed or bloodshot eyes, flushed skin
Benzodiazepines	Drowsiness, double vision, impaired balance, impaired motor function, anterograde amnesia, and slurred speech
Cocaine	Anxiety and agitation, chest pain or pressure, increased energy, paranoia, decreased appetite, fatigue, enlarged pupils, sweating, tremors, confusion, hyperactivity, hyperthermia (elevated body temperature)
Cannabis	Lower Blood pressure, increased heart rate, pressure around the eyes, reddening of the eyes, bleary/shiny eyes, talkative, giggling
Methamphetamine	Increased heart rate, increased blood pressure, large wide pupils, jaws grinding
Opiates/Heroin	Pupillary constriction, drowsiness, nodding off, slurred speech, Impairment of attention, goosebumps

If the client is intoxicated, the CM or PSS should not proceed with the session. There may be instances when the client is clearly intoxicated but denies being under the influence.

Do not engage the client in confrontational interchanges around the use of alcohol/drugs or not. Simply inform

the client that the policy is to reschedule the session. If the client is intoxicated and possibly could be driving impaired, work with the client to make arrangements to get home or to an ER safely without operating a vehicle. Organizations should create a form outlining these procedures to follow in this situation. If the client's level of intoxication could be potentially dangerous there are additional considerations. At these levels, the client may need medical attention. The safest option is to have the client call a friend or family member to come pick him/her up and take him/her to the nearest emergency room (ER). Or, the client can take a taxi to the nearest ER. In some cases, the client may agree to go directly to a detox or inpatient rehabilitation unit. CMs and PSSs can help in making arrangements to transport the client to the treatment facility, through a friend, family member or taxi. Some treatment facilities provide pick up service.

c. Serious Psychiatric Symptoms. If a CM or PSS believes that a client might be presenting with serious mental health symptoms (active psychosis, mania, severe depression), he or she should thoroughly assess these symptoms. If there are imminent concerns, the CM or PSS should notify their CS immediately to obtain guidance. If the CS is unavailable and the client is reporting symptoms that could pose a risk to self or others, the client should be escorted to the closest facility with walk-in emergency psychiatric services, or the CM/PSS should call 911 or an acute psychiatric call-line. Clients should not be left alone during this time. MISSION CMs and PSSs should stay with the client until they are able to see a mental health clinician for evaluation. If the client's symptoms are not posing an imminent risk, the CM or PSS should discuss their concern with the client, develop a safety plan (including emergency contact options and information), inform the client's family of the concerns and emergency plan (if the client's provides consent), and inform the supervisor of the concerns and plans immediately after the session.

d. Homicidality or Threats to Hurt Another. Clients may manifest violent intentions toward an individual or a potential group of individuals, and CMs and PSSs are obligated to assess these situations thoroughly. Assessment of homicidality should follow this format: assess thoughts, means, plans, history of attempts. PSSs and CMs should follow procedures dictated by their licensing/certifying organizations and their agency regarding duty to warn or protect. CSs should be aware of their and their team's duties to warn/protect. CSs and other team members should be informed immediately.

e. Violence. If a CM or PSS becomes aware that the client has been involved in violence outside of the meetings, gather details about the incident from the client (e.g. initiation of violence, victim and perpetrator injuries, etc.). If the client is the victim of violence (i.e. domestic violence), create a safety plan and connect the client to appropriate services. If the client is the perpetrator of the violence, utilize tools from the intervention to reinforce anger management skills to prevent future violence, review the limits of confidentiality (staff member may need to report), and/or report immediately to the police if violence led to serious bodily harm or fatal injuries. CSs and team members should be informed immediately.

f. De-escalating Anger or Violence During Sessions with MISSION Team Member. Anger and violence may occur during MISSION sessions. It's important that CM and PSS are trained in de-escalation strategies. De-escalation strategies aim to facilitate the gradual resolution of a potentially violent and/or aggressive situation through the use of verbal and physical expressions of empathy, alliance and non-confrontational limit setting. De-escalation techniques include: observing for signs and symptoms of anger and agitation; approaching the person with caution in a calm and controlled manner; using distraction; using verbal techniques to calm the person down (using clear, calm and respectful language; using open-ended sentences; avoiding challenges and promises). In these types of situations, CMs and PSSs should make note of exits in the vicinity should they need to leave immediately, avoid vulnerable positions, such as turning one's back to the client or positioning the client between the team member and the door.

g. Arrest, Incarceration, Unanticipated Interaction with the Legal System. CMs and PSSs should gather details about any arrest (e.g. reason, terms of release, etc.), as an arrest indicates the need to revise the treatment plan. All involvement with the legal system should be shared with the CS and other team member.

6. Dealing with Family Members

With the client's permission and signed consent, the CM/PSS team may involve the client's family members in providing support and responding to crises. Additionally, the CM might provide emotional support to the family or engage in psycho-education about mental illness, substance abuse, and MISSION services. However, family therapy, if needed, is accomplished by referral.

Positive family engagement/involvement can boost treatment outcomes. CMs and PSSs may need to motivate the client to consider involving family members. Prior to talking with family members, team members should acquire the client's signed consent. The treatment teams contact with family members can range from practical, crisis and/or legal reasons or they may engage the family by explaining to families how to handle the rehabilitative needs of the client; identifying gross family dysfunction and making a referral; and identifying family members who might be helpful to incorporate into treatment planning. CMs and PSSs who are actively engaging families should: ask questions that elicit family members' expressions of concern and feelings related to the client's condition and its effect on the family; empathically listen to family members' concerns and feelings and, where appropriate, normalizing them; forming a preliminary assessment of the family's level of functioning as it relates to the client's problem; encouraging family members to seek support in their efforts to cope with their situation as a family.

7. Trauma-Informed Care

CMs and PSSs should be trained to screen clients for symptoms of trauma and refer clients as needed to treatment providers who are specialized in the use of evidence-based treatments for trauma-related disorders. They should also be trained to provide ongoing support for clients while clients are receiving treatment from a specialized trauma program and to serve clients who are not acutely symptomatic and do not require specialized treatment services.

a. What Is Post-Traumatic Stress Disorder (PTSD)? CMs and PSSs should receive training on the diagnostic criteria for PTSD. PTSD can develop following a traumatic event that threatens the client's safety or makes them feel helpless. Usually these events are outside the realm of normal human experience. Most people associate PTSD with Veterans—and military combat is the most common cause in men—but any overwhelming life experience can trigger PTSD (i.e. sexual assault, witnessing or being the victim of a violent crime, etc.), especially if the event feels unpredictable and uncontrollable.

The following Three Groups of Symptom Criteria are Required to Assign the Diagnosis of PTSD:

- Recurrent re-experiencing of the trauma (for example, troublesome memories, flashbacks that are usually caused by reminders of the traumatic events, recurring nightmares about the trauma and/or dissociative re-living of the trauma)

- Avoidance of places, people, and experiences that remind the client of the trauma and/or a general numbing of emotional responsiveness

- Chronic physical signs of hyper-arousal, including sleep problems, trouble concentrating, irritability, anger, poor concentration, blackouts or difficulty remembering things, increased tendency and reaction to being startled, and hyper-vigilance (excessive watchfulness) to threat

b. How to Assess PTSD Symptoms (warning signs). The severity of trauma symptoms can change over time, and therefore, it is important for CMs and PSSs to recognize PTSD early warning signs that may be an indication that symptoms are getting worse. Trauma symptoms do not usually just pop up out of the blue, they are usually preceded by some warning signs. These warning signs can range from the experience of certain emotions, changes in thoughts, or changes in behavior. Below are some common warning thoughts.

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Common Trauma Symptom Warning Thoughts

Changes in Thinking

"I am in danger."

"I am thinking about it (the traumatic event) all the time."

Changes in Mood

"I am beginning to feel really jumpy and on edge."

"My mood keeps changing rapidly. In minutes, I can go from feeling really happy to really terrified."

Changes in Behavior

"I don't want to be around people anymore. I've been isolating myself."

"I've been drinking more, but just to take the edge off of my feelings a little."

. . . .

c. *When Is It Time to Refer?* If the CM and/or PSS suspect that the client may be exhibiting warning signs for PTSD and these symptoms are impacting social, emotional and vocational functioning, it's important to refer the client for immediate assessment and treatment. For example, if the client is engaging in unhelpful thought processes and behaviors to avoid painful memories and feelings (i.e. avoiding social events), it is time to refer. The sooner PTSD is addressed, the easier it is to treat.

d. *Discussing Trauma with Clients.* The goal of screening clients for trauma is to connect the client with the proper treatment provider who will conduct a thorough evaluation. The treatment team should not attempt to identify, in as much detail as possible, the traumatic events that occurred. Asking the client to go into exhaustive detail about the trauma can intensify trauma symptoms/re-traumatize the client and vicariously traumatize the CM and

PSS. Once the client has been referred, they will have an opportunity to complete a trauma-related assessment with a qualified trauma specialist who can systematically and effectively assess the details and context of the trauma. Therefore, the MISSION CM and PSS should be trained to leave the "heavy lifting" of assessing and exploring the trauma to those providers who have received specialized training.

8. Ethical and Legal Considerations

a. *Confidentiality.* CMs and PSSs should be trained in the organization's confidentiality policies. Clients should be informed that their confidentiality is protected, but that this is not an absolute. There are some exceptions under the law when the CM or PSS is required to share information about the client. Exceptions to confidentiality include the following: (1) Imminent Harm to Self - If a team member has reason to believe that the client is in danger of physically harming themselves, the staff member may have to report this to the appropriate agency and may have to make an involuntary referral to a hospital, (2) Imminent Harm to Others - If a team member has reason to believe that the client is seriously threatening physical violence against another person, or if the client has a history of physically violent behavior, and the team member believes that the client is an actual threat to the safety of another person, the team member may be required to take some action (such as contacting the police, notifying the person against whom threat has been made, seek involuntary hospitalization, or some combination of these actions) to ensure that others are protected, (3) Child Abuse or Elder Abuse - If the client reports anything about a child under the age of 18 being abused or neglected, or a vulnerable adult being abused or neglected, present or past, CMs and PSSs are required to make a report to Child Protective Services or Adult Protective Services.

b. *Consent.* As mentioned previously, every client's information should be kept confidential. Client information can only be released with their permission. CMs and PSSs should be trained to request verbal and written consent from the client to release and receive client information to/from

other providers and family members. In releasing information, team members should be clear with the client what information will and will not be released. Team members should also be mindful to not release information to providers that is irrelevant to the treatment of the client.

c. *Working with Vulnerable Populations.* In many cases, pregnant women and inmates are eligible for MISSION services. These two groups are considered by many ethics committees to be vulnerable populations. Thus, CMs and PSSs should receive supervision and training that explicitly explores team members' perceptions and values regarding women who use substances during pregnancy; reviews the effects of substance use during pregnancy, and its effect on infant and child development; and increases knowledge of community resources and services available for pregnant women. Teams working with clients who have been incarcerated should be trained in the legal system and process.

9. Diversity Issues

One goal of supervision is to increase team members' cultural competence, their sensitivity and responsiveness to diversity issues among staff, with clients and between staff and clients. Cultural competence is an ongoing interactive and reflective process experience through education and training, supervision, and ongoing working with diverse populations. CSs should initiate discussions of differences in race, ethnicity, gender, religion, socioeconomic status, sexual orientation, or disability regarding both clinical work with clients, as well as supervisory and team relationships. These discussions can promote awareness of diversity and cultural issues and allows the CS the opportunity to model culturally competent behaviors. Some areas to explore in these discussions include:

- Unintentional racism, sexism, ageism, homophobia, etc. Well-intentioned CMs and PSSs who are unaware of how their own racial, gender, or sexual identity affects their relationships with clients may avoid talking about race, gender, age, or sexuality.

- Communication issues. Differing communication styles among cultural groups can result in

misunderstandings between team members and clients and among team members.

- Cultural Differences. Attitudes toward mental illness/addictions vary among individuals, families, ethnicities, cultures, and countries. Cultural and religious teachings often influence beliefs about the origins, nature of, and treatment of mental illness/addictions. These differences should be considered during case conceptualization and treatment planning.

- Gender differences. Men and women differ in their development and maintenance of mental illness and substance use disorders. CMs and PSSs should be trained on these gender-specific differences and on how to implement interventions in a way that effectively incorporates gender specific issues.

K. Specific Clinical Issues Relevant to Case Managers

1. Intake Assessment and On-going within Protocol Assessment.

Assessment is an important part of the MISSION model as it relates to case conceptualization, level of care determination, abstinence planning, and treatment planning. Assessment also provides a baseline of functioning and use against which to measure progress throughout treatment via continuous within-treatment assessments of target behaviors. CSs are responsible for performing comprehensive assessments. The CS evaluates substance abuse, severity of psychiatric symptoms, and functioning in other life domains (e.g., physical health, family, social, and legal). In some programs, the CM may also conduct intakes under close supervision by the CS. Assessment is an ongoing process and all staff should be trained in assessment activities. Conducting an unbiased and accurate assessment is critical in making accurate diagnoses and in developing well-rounded treatment plans.

a. *Ongoing Assessment: Monitoring Client's Progress.* Ultimately, effective clinical supervision ensures that clients are competently served and progressing towards their treatment goals. CSs should monitor each client on the team's caseload consistently. CSs

should ask supervisees' for verbal reports of their impressions of client progress; utilize objective data (e.g. drug screen results, client's use of other services, etc.) to confirm accuracy of each supervisee's report; assist supervisees to identify clients not making progress; and engage in regular discussion of clients progress towards the goals of treatment.

b. Assessment Stance. It is not easy to walk the balance of empathic interviewing/ good assessment-rapport, so training must include ongoing monitoring and supervision in this area. This can include observing a CM conducting an intake, having a CM observing the CS conduct an intake, and providing feedback during and/or after the observation, or in supervision.

c. How to Write up a Clinical Intake Summary. After completing the assessment, an intake report should be written. It should concisely summarize the client's current and past use, relevant current/past mental health, withdrawal profile, medical and treatment history, family history, and diagnoses. CMs should present their clinical intake reports at supervision. As the CM presents an intake, supervision should provide feedback on the accuracy and quality of the assessment (i.e., Did the CM get adequate quantity/frequency information?) and provide initial thoughts on the client's abstinence plan and case conceptualization.

Suggested format for intake reports:

Demographic Information:

Client's name: AR
Date: 10/17/2013
Clinician: Jen Connelly, LCSW

Age: 70   Marital Status: Widowed

Ethnicity: Caucasian

Spouse's Occupation: n/a

Address (Town, State): Metro Boston Area, Staying with various friends

Occupation: Unemployed, odd jobs when available
Prior Occupation: Handy Man

Children (ages): 54, 53, 51, 45(bio)

Weight: 140 lbs. Height: 5'5"

Breathalyzer: BAL=0.0

Oral Drug Test: Negative

Annual income: $5,000.00   Insurance: Medicare

Presenting Problems:

AR is 70 year old widowed, unemployed, chronically homeless man. He is concerned that his drinking and depression are adversely impacting his ability to maintain stable housing and employment. He reports that he stays with friends and family in the Metro Boston Area when he can, but when he is asked to leave he sleeps on the streets and occasionally goes to a shelter. He is usually asked to leave because of his drinking.

Mental Status.

AR arrived on time for the assessment session. The client appeared his stated age. He was dressed in a disheveled way and personal hygiene was poor. Eye contact, speech, mood/affect were appropriate. Although he did not present with cognitive or age-inappropriate memory disturbance, he reported experiencing memory difficulties because of his age. Orientation was intact for person, time and place. He appeared somewhat anxious and fidgety and reported he was nervous about the assessment. No thought disorder, no psychotic symptoms, no suicidality or homicidality were evident.

Current Psychiatric Symptoms and Lifetime History of Psychiatric Problems:

AR reported a history of depression. He believes his depression started when his wife died and worsened as he faced housing and employment problems. He reports being hospitalized once for depression about 1 year ago. He reported that his previous counselor at the shelter believed that he was so depressed he would kill himself. He was involuntarily admitted to an inpatient psychiatric hospital. He stayed for 3 days and was released. He adamantly denies past and current suicidal ideation. He reported that he "distrusts" counselors because of this "forced" hospitalization.

Current Drinking and Drug Use Pattern and Consequences:

AR is a daily drinker. He generally drinks 5 shots of whiskey (Standard Drinks (SD=5)) from 6-10 pm (Blood Alcohol Level (BAL=.10)). He has been drinking in this pattern for 5 years. The client had his last drink less than 48 hours before the interview, 5 shots of whiskey (5.12 SD) from 5-8 pm (BAL=.11). He denied any lifetime or current use of non-ETOH drug use. He reported the following negative consequences related to drinking: his children refuse to speak to him because of his daily drinking, double vision at night when drinking, hangovers, blackouts, one fall, feeling out of control (unable to control his alcohol intake), spending substantial time each week drinking or being drunk, tolerance, giving up other activities in order to drink, having to borrow or steal money to pay for alcohol.

He presents with moderate depression and mild anxiety.

> Beck Depression Inventory (BDI) II: 30. He didn't endorse suicidality.

> Beck Anxiety Inventory (BAI): 13

Alcohol and Drug History:

Prior to his current pattern, he was a daily drinker, but at lower levels of daily quantities. The client would consume 1 shot of whiskey from 6-10 pm (1SD, BAL=.00). This pattern lasted 8 years. He reported that he started drinking "heavily" following his wife's death (client was age 52) and believed that drinking helped him deal with the loss and sleep issues. The client had his first independent drink at age 15. He met criteria for current alcohol dependence with physiological dependence starting at age at 55. The client denied using any other substances. He reported that he has received alcohol treatment: he has been in the "drunk tank" and then transferred to detox several times throughout his life; attended AA inconsistently for the last 5 years; and completed a mandated outpatient substance use counseling program as a requirement of another housing program about 1 year ago.

Family/Personal/Relationship History:

AR was married for 34 years and has been widowed for 23 years. He received grief counseling for 6 months following his wife's death. He has 4 adult children who live in other states and has limited contact with them. His children are concerned about his drinking and his living situation. The client reported feeling very lonely in life. He has been chronically homeless for 10 years. He is able to find temporary housing with friends, family, and shelters throughout the Metro Boston area. When he is unable to find temporary housing, he sleeps under a bridge along the Pike. He occasionally stays at shelters, but reported that he has had "bad experiences" at shelters (i.e. shoes and other belongings stolen). He reported that his depression and anxiety worsen when he doesn't have stable housing.

He has a positive family history of alcoholism: father and 2 brothers.

Medication/Health:

The client reported that he believes he has high blood pressure. He was diagnosed with hypertension a couple years ago when he was admitted to the Emergency Department (ED) after being arrested for public drunkenness. While he was in inpatient treatment for depression, he reported that the doctor prescribed him medication for depression and hypertension. Once he was released from the hospital, he did not fill the prescription. He reports pain in his feet and back.

Current Need for Detoxification:

Over the past 15 years, the client has been able to abstain from drinking about 5 times, when he was in stable housing. He abstained for about 3 weeks each time. Approximately 3 weeks ago, he stopped drinking for 4 days. He has been treated in the Emergency Department several times for acute withdrawal. Due to the client's age (70), long history of daily drinking at very high levels (for his age), and high blood pressure, he was referred to detox. Additionally since his last drink was less than 48 hours ago, there is concern about withdrawal risk, since he could still have a seizure within 72 hours after last drink.

Provisional Diagnoses:

Axis I: Alcohol Dependence with Physiological Dependence (DSM-IV)

[Alcohol Use Disorder, Severe, with Physiological Dependence (DSM-5)]

Major Depressive Disorder, Recurrent

Dysthymia

Axis II: Deferred

Axis III: Hypertension, Hypothyroidism, Allergies

Axis IV: Problems with Primary Support Group, Chronic Homelessness

Axis V: 50

d. How to Present a Clinical Intake in Group Supervision. Intake presentations should be no longer than 10 minutes of presentation and discussion. The CM should review the clinical intake summary in the order written, read at a steady and efficient, but not rushed pace, be open to feedback and questions from the CS and other team members. Discussion and feedback should focus on withdrawal profile risk, psychiatric symptoms, level of care determination, level of housing need urgency, case conceptualization, and case management plan. The CS can write notes on the intake, indicating changes the CM will need to make to the intake before it is finalized (e.g. including more detail about DUI history).

e. Providing Supervision on Dual Recovery Therapy Protocol. CSs should be familiar with and if possible experienced and proficient with DRT implementation with this population. CSs should read the DRT manual (contact the authors of this chapter to obtain a copy), attend training on DRT and use it with some clients to achieve proficiency.

2. Providing Supervision for the 13 DRT Sessions

CSs should be familiar with and if possible experienced and proficient with implementation of the 13 DRT sessions used in MISSION. CSs should thus read the Case Manager chapter in this MISSION manual for a description of the 13 DRT sessions and attend any related training on DRT to develop proficiency with this content.

L. Specific Clinical Issues Relevant to the Peer Support Specialist

1. Setting and Maintaining Boundaries Around Relationship with Clients

Setting and maintaining boundaries with clients is essential to effective and ethical treatment. This can be an issue for both CMs and PSSs. This may be a more pressing issue for PSSs because they have more exposure to the client outside the traditional therapeutic setting and relationship. PSSs act as an advocate, a mentor, a "one way friend" to clients but not a friend in the sense of two people on same level of power and at same level of personal disclosure with each other. PSSs are para-professionals and should conduct themselves accordingly. CSs should provide training on boundary issues. Training should include the rationale for boundaries in relationships with clients, disclosure (what is appropriate and not appropriate to disclose), discussion of clear boundary violations (e.g. intimate relationships with clients), discussion and role-plays of how to handle less clear boundary issues. Less clear boundaries may need to be negotiated in supervision. For example, can a PSS receive or give a small gift to or from the client? Different teams may come to different decisions about these kinds of questions, depending on the treatment setting and other factors. Recognizing and discussing these less clear-cut boundary issues is an important part of supervision.

Appropriate and Inappropriate PSS/Client Disclosures and Behaviors		
	Appropriate	**Inappropriate**
Disclosures/Behaviors	• Disclosing detailed information regarding substance use history mental health history, struggles to overcome problems, dealing with the system, life experience • Attending a recovery meeting with a client • Ride the bus with the client to educate them on the city's transportation system	• Disclosing home address • Bringing the client to a team member's home • Introducing team member's family members to client • Intimate relationships • Business relationships • Borrowing from or lending money to a client

2. Providing Supervision for the 11 Peer Led Sessions

CSs should be familiar with and, if possible, experienced and proficient with implementation of the 11 peer-led sessions with this population. CSs should thus read the Peer Support chapter in this MISSION manual for a description of the 11 sessions, read the Participant Workbook, and attend any related training on the 11 topic sessions to develop proficiency with this content.

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Dr. David Smelson is a Professor of Psychiatry at University of Massachusetts Medical School and the Director of Translational Research at Edith Nourse Rogers Memorial Veterans Hospital and VA New England Health Care System (Network 1). He has devoted his career to studying novel treatments for addiction and mental health problems and received grants from such agencies as National Institute of Health/National Institute of Drug Abuse and National Center for Complementary and Alternative Medicine, Substance Abuse and Mental Health Service Administration/Center for Substance Abuse Treatment and Center for Mental Health Services along with numerous other foundations. The majority of the work on the MISSION Service Delivery Project and MISSION Manual Development Fidelity Project was done while Dr. Smelson was at the Department of Veterans Affairs New Jersey Health Care System, the University of Medicine and Dentistry, Robert Wood Johnson Medical School and the University of Medicine and Dentistry School of Health-Related Professions. He remains indebted to them for their ongoing support and assistance with these projects.

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Dr. Ziedonis is Professor and Chair of the Department of Psychiatry at the University of Massachusetts Medical School and UMass Memorial Health Care. Dr. Ziedonis has dedicated his career to better understanding and treating individuals with co-occurring mental illness and substance use disorders, including research in mental health, addiction, and primary care settings. He is an internationally recognized leader in co-occurring mental illness and addiction, including recovery and wellness. He has received many NIH, SAMHSA, and Foundation research grants, including support to develop and evaluate behavioral therapy approaches such as Dual Recovery Therapy (DRT) and organizational change studies to help agencies better address co-occurring disorders, including tobacco. He has been active in Veterans Affairs related initiatives, including serving on the Institute of Medicine's (IOM) Committee on Gulf War and Health: Smoking Cessation in Military and Veteran

Populations. Dr. Ziedonis has served as an advisor to President Bush's New Freedom Commission on Mental Health and SAMHSA on numerous Co-Occurring Disorder activities, including the Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders and TIP 42, Substance Abuse Treatment for Persons with Co-Occurring Disorders. He served as Senior Fellow for the SAMHSA Co-Occurring Disorder Center for Excellence. He served on the American Society of Addiction Medicine's Patient Placement Criteria Co-occurring Disorder Workgroup that developed the Dual Diagnosis Capable/Enhanced concepts. He has written over 150 peer reviewed and other publications, including co-edited 3 books and 5 behavioral therapy manuals for co-occurring disorders. He serves on the Editorial Boards of The Journal of Groups in Addiction & Recovery and The Scientific World Journal.

Contributing Authors

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Patty Angevine became involved in homeless outreach and advocacy 10 years ago as a volunteer and grant writer for the St. John's Free Meal program and Medical Clinic in Worcester, MA. She joined the Homeless Outreach & Advocacy Program at Community Healthlink (CHL) in Worcester in 2007, originally as a case manager and then as Program Director for the CHL Triage & Assessment Center, an emergency shelter and comprehensive homeless service model informed by Housing First principles. Currently, Patty is the MISSION case manager at Community Healthlink and a member of HOAP's behavioral health team. She has an MSW from Salem State University.

Leah Bradley, M.S.W., L.C.S.W.

Leah Bradley is the former Director of Housing and Program Development for Community Healthlink, Inc. in Worcester, MA. Ms. Bradley began working to address homelessness over 15 years ago overseeing an emergency shelter and two transitional housing programs for homeless families. For over 10 years,

Ms. Bradley has been working to address housing and service needs of homeless individuals, primarily chronically homeless individuals. Ms. Bradley has experience managing over $4 million of HUD funding including McKinney Vento Homeless Assistance funding, Section 202 funding, Section 811 funding and Housing Opportunities for Person with AIDS. She previously led the local, state and federal advocacy effort for Community Healthlink's Housing First program – Home Again – to obtain sustained funding for affordable housing and case management for chronically homeless individuals.

Roger Casey, Ph.D., L.C.S.W.

Dr. Casey is the Director of the VA 's National Homeless Providers Grant and Per Diem (GPD) Program and Director of Education, National Center on Homelessness Among Veterans. Prior to joining the Center, Dr. Casey worked with the U.S. Departments of Housing and Urban Development (HUD) and of Health and Human Services (HHS) to develop and provide guidance and administrative oversight for the VA component of the Collaborative Initiative to end Chronic Homelessness (CICH), served as Principal Investigator for the VA Homeless After-Care Study, initiated actions to create the Council of Network Homeless Coordinators, and developed administrative procedures to enhance contract residential treatment under the Health Care for Homeless Veterans (HCHV) Program. Dr. Casey's research interests include homelessness, residential treatment models, and development and implementation of community-based practices that address the needs of individuals diagnosed with mental illness.

Matthew Chinman, Ph.D.

Matthew Chinman is an Investigator at the National Center on Homelessness Among Veterans where he is co-leading an evaluation of the Getting To Outcomes (GTO) intervention to support the implementation of an evidence-based co-occurring disorders treatment protocol within HUD-VASH, funded by the Mental Health Quality Enhancement Research Initiative (QUERI).

Dr. Chinman is also a Research Scientist at the Pittsburgh VA Mental Illness, Research, Education and Clinical Center (MIRECC) and a Senior Behavioral Scientist at the RAND Corporation. His research focuses on models and interventions that support the implementation of evidence-based research practices in clinical treatment settings. Dr. Chinman received his Ph.D. in Clinical/Community Psychology from the University of South Carolina.

Jonathan Delman, Ph.D., J.D., M.P.H.

Jonathan Delman, PhD, JD, MPH is a principal at Reservoir Consulting Group and Research Faculty at the University of Massachusetts Medical School, Department of Psychiatry. At UMass, Dr. Delman is the Director of the *Program for Recovery Research and the Associate Director for Participatory Action Research at The Learning & Working during the Transition to Adulthood Rehabilitation Research & Training Center.* Dr. Delman's vocational research and development projects focus on the needs of particularly vulnerable populations of people with mental illness, such as transition age youth, people who are homeless, and those who are court-involved. He also studies the workplace conditions that lead to employment and career success for people with mental illness, and in particular peer specialists. Delman also develops and leads projects on recovery-oriented care, consumer outcomes measurement, and activating consumer participation in both treatment decisions and policy development. Dr. Delman has regularly advised SAMHSA (Substance Abuse Mental Health Services Administration) and NIMH on these matters, and most recently was appointed to the Institute of Medicine's Committee on Developing Evidence-Based Standards for Psychosocial Interventions for Mental Disorders.

Dr. Delman is a mental health consumer researcher and a 2008 recipient of a Robert Wood Johnson Community Health Leader award, one of ten awarded nationally, for "individuals who overcome daunting obstacles to improve health and health care in their communities." He has received several awards from DMH for "Distinguished Service", and is a member of the editorial board of the Psychiatric Rehabilitation Journal.

Elizabeth E. Epstein, Ph.D.

Elizabeth Epstein, PhD is a Research Professor and Director of the Clinical Division at the Center of Alcohol Studies (CAS), Rutgers University, is on the Contributing Faculty, Graduate School of Applied and Professional Psychology (GSAPP) and The Department of Psychology at Rutgers University, and is an adjunct Clinical Associate Professor in the Department of Psychiatry, Rutgers Medical School. Dr. Epstein teaches graduate level courses on the assessment and treatment of alcohol use disorders as well on Cognitive Behavioral Therapy (CBT) for adult psychopathology. She is formerly Director of the Program for Addictions, Consultation, and Treatment (PACT) at CAS and GSAPP, Rutgers University. In addition, she is a Senior Clinical Associate with the Freehold Psychology Group. Dr. Epstein received her PhD in Clinical Psychology at the University of Connecticut and is a licensed psychologist in the state of New Jersey. She is Principal Investigator and/or co-investigator on several past and current clinical research grants funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and National Institute on Drug Abuse (NIDA). Her primary research activities involve development and testing of CBT models and mechanisms of change for substance use disorders, and in individual differences among substance abusers and impact on treatment response. She has published and lectured widely on the treatment of substance use disorders.

Andrea Finlay, Ph.D.

Dr. Finlay is a Special Advanced Fellow in Health Services Research & Development at VA Palo Alto Health Care System, an Implementation Research Coordinator for the VA Substance Use Disorder Quality Enhancement Research Initiative, and a Postdoctoral Fellow at Stanford University School of Medicine. She received her PhD in Human Development & Family Studies from the Pennsylvania State University. Her research focuses on justice-involved Veterans with mental illness, with an emphasis on identifying and addressing gaps in access and engagement in mental health treatment.

Ayorkor Gaba, Psy.D.

Dr. Gaba is the Project Manager of the Women's Treatment Project at the Center of Alcohol Studies (CAS) at Rutgers University and a Clinical Supervisor at the Rutgers Psychological Clinic at the Graduate School of Applied and Professional Psychology (GSAPP), Rutgers University. She is formerly Co-Director of the Program for Addictions, Consultation, and Treatment (PACT) at CAS and GSAPP, Rutgers University. In addition, she is a licensed clinical psychologist with a private practice in Highland Park, NJ. Dr. Gaba received her Psy.D. in Clinical Psychology at Rutgers University. She completed her doctoral internship at the University of Medicine and Dentistry of New Jersey (UMDNJ) and is a licensed psychologist in the states of New Jersey and New York. Dr. Gaba has provided clinical training and supervision to mental health trainees, professionals, and para-professionals, and has conducted research in addictions and public health. She has presented on a wide range of topics related to addictions, cultural issues in psychology, and cognitive behavioral therapy. She is a member of the American Psychological Association (APA) and served on the board of the New Jersey Psychological Association Foundation. She is also an APA appointed representative to the United Nations.

Vince Kane, M.S.S.

Mr. Kane is currently the Director of the VA's Supported Housing Program and National Center on Homelessness Among Veterans. Prior to accepting this role, Mr. Kane was the Acting Director for HUD -VASH (August 2008 to January 2010) and served as the Administrative Officer for the Office of Mental Health (April 2007 to October 2008) where he assisted in the implementation of VHA Directive 1160.01, the Mental Health Uniform Services Handbook. From June 2005 to April 2007 he was the VISN 4 Mental Health and Homeless Service Manager. Mr. Kane also functioned as the administrator for the MIRE CC Centers of Excellence and Evaluation Centers for the Office of Mental Health Services. He also served as the VISN 4 Mental Health and Homeless Coordinator. Previously, he held various positions at Allegheny Hospitals in

Philadelphia and Pittsburgh including Instructor in the Department of Psychiatry, Director of Ambulatory Services and Family Studies, and Manager of Social Work and Outpatient Services. He has over 23 years of experience as a clinician, educator, and administrator. He has been a site Principal Investigator on several national research projects including the VA 's Homeless After Care Study and the Federal Partners Initiative for Chronic Homeless Veterans. He holds a M.S.S. from Bryn Mawr Graduate School of Social Work and Social Research, a BA in Psychology from De Sale University, and has published in peer reviewed journals.

Anna Kline, Ph.D.

Dr. Kline is the former Director of Dual Diagnosis Development at the Department of Veterans Affairs, New Jersey Health Care System. She is also an Adjunct Associate Professor at the Robert Wood Johnson Medical School, and an Affiliate in the Department of Psychiatry at the University of Massachusetts Medical School. Prior to joining the VA, Dr. Kline served as Director of Research for the New Jersey Division of Addiction Services, where she conducted epidemiological research focused on addiction and mental health problems as well as program evaluations examining the effectiveness of state addiction treatment services. Dr. Kline also served on the Community Epidemiology Work Group, an initiative sponsored by the National Institute of Drug Abuse to track trends in substance abuse throughout the U.S. Dr. Kline's current research focus is on the development and evaluation of innovative programs for dually diagnosed Veterans and Veterans at risk of suicide.

John Kuhn, M.S.W., M.P.H.

Mr. Kuhn is the VA National CHALENG Coordinator and the newly appointed National Director of VA Homeless Prevention Services. As the co-author of the CHALENG report, Mr. Kuhn is responsible for developing and assessing the VA national assessment on the needs of homeless Veterans. As a Center Investigator, Mr. Kuhn will be involved in efforts to develop strategies to meet these needs. Mr. Kuhn has a BA in Psychology from Brown University, a MSW from Columbia University,

and an MPH from Rutgers University. He has been working with the homeless for over 20 years and has developed a broad range of services addressing housing, vocational, legal, health, and mental health needs, including the use of "positive" addictions in the treatment of substance use disorders. Mr. Kuhn has made extensive use of community partnerships to create Veteran run businesses, peer services, and housing programs.

Ann Elizabeth Montgomery, Ph.D.

Ann Elizabeth Montgomery has been conducting research with the National Center on Homelessness Among Veterans and the University of Pennsylvania since 2009. In her role with the Center, Dr. Montgomery collaborates with researchers to develop and implement a diverse research agenda, emphasizing homelessness prevention, interventions to end homelessness among high-need populations, and the demography and epidemiology of homelessness among Veterans. Dr. Montgomery has been particularly involved in developing and piloting a system-wide Homelessness Screening Clinical Reminder. Dr. Montgomery holds Master's Degrees in Social Work and Public Administration from Columbia University and a doctorate from the University of Alabama at Birmingham School of Public Health.

Elizabeth Rogers, M.S.W.

Liz Rogers is the Housing Stabilization Special Initiatives Manager for the Massachusetts Department of Housing and Community Development. Liz is responsible for developing policy and programming associated with providing emergency and housing services to homeless individuals and other identified special populations. This includes oversight of the statewide plan to end Veterans' homelessness, participation on the Special Commission on Unaccompanied Homeless Youth and oversight of the Youth Count, serving as point-person for the Social Innovation Finance Initiative, co-chair of the Older Adult Steering Committee, participation on the Interagency Supportive Housing Working Group, and participation on the Integration Task Force to serve survivors of domestic violence. In addition, Liz manages the Secure Jobs Initiative.

Previously Liz served as Executive Director of the Interagency Council on Housing and Homelessness from 2009-2014. In this role, Liz worked with the ICHH to lead a 5-year strategic plan to end homelessness in the Commonwealth, a major initiative of the Patrick-Murray Administration. This included managing an initiative to develop regional approaches to end homelessness via Regional Network, and fostering improved collaboration and coordination of state agencies and other community-based partners to bring about greater efficiency to end homelessness.

Prior to the ICHH, Liz was Senior Director of Community Impact at United Way of Massachusetts Bay and Merrimack Valley. Liz is a graduate of University of Delaware, and has a M.S.W. from Boston College.

Matthew A. Stimmel, PhD

Dr. Stimmel is a Clinical Psychology Postdoctoral Fellow in PTSD at the VA Palo Alto Health Care System. He received his PhD in Clinical Psychology from Fordham University. He specializes in evidence-based treatment for trauma-related disorders working in both residential and outpatient settings at the VAPAHCS. His research interests include forensic assessment, understanding mechanisms of change in treatment of PTSD, the relationship between PTSD and affect regulation, and providing trauma-informed care within criminal justice settings.

Glossary of Acronyms and Terms

AA: Alcoholics Anonymous

ACT: Assertive Community Treatment

ADL: Activities of Daily Living

AHAR: Annual Homeless Assessment Report to Congress

CBT: Cognitive-Behavioral Therapy, a form of intervention that focuses on changing thought processes.

CHALENG: Community Homeless Assessment Local Education and Networking Group.

CHQOER: Center for Health Quality, Outcomes, and Economic Research

CM: Case Manager

CMHS: Center for Mental Health Services, a branch of the Substance Abuse and Mental Health Services Administration.

COD: Co-occurring psychiatric and substance use disorders

CSAT: Center for Substance Abuse Treatment, a branch of the Substance Abuse and Mental Health Services Administration.

CTI: Critical Time Intervention, a time-limited intervention designed to facilitate linkages with social supports and community resources for people with mental illness who have moved from a shelter, the streets, a psychiatric hospital, or the criminal justice system to the community.

DOL: Department of Labor

DOM: Domiciliary Residential Program, a program in the Department of Veterans Affairs that provides approximately 14 weeks of housing and associated services to homeless Veterans.

DRT: Dual Recovery Therapy, the integrated mental health and substance abuse treatment model of care used in the MISSION and MISSION programs.

DSM-V: the Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition, a classification manual to quantify symptoms in order to diagnose a mental health condition.

DVOP: Disabled Veterans Outreach Program

EMDR: Eye Movement Desensitization and Reprocessing

GDP: Grant and Per-diem Program

HBM: Health Belief Model

HHS: U.S. Department of Health and Human Services

HSR&D: VA Health Services Research and Development Service

HUD-VASH: Department of Housing and Urban Development and the Department of Veterans Affairs Supportive Housing Program

IOP: Intensive Outpatient Program

IPS: Individual Placement and Support

MET: Motivational Enhancement Therapy, a component of both the DRT and CTI approaches. It includes ways to identify the level of motivation for recovery and potential intervention strategies based on that level of motivation.

MH RRTPs: Mental Health Residential Rehabilitation and Treatment Programs

MI: Motivational Interviewing

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

MISSION-VET: Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking: Veterans Edition

NA: Narcotics Anonymous

NAPS: National Association of Peer Specialists

OIF: Operation Iraqi Freedom

OEF: Operation Enduring Freedom

ORD: VA Office of Research and Development

PE: Prolonged Exposure

Peer Support: social, emotional, and practical support offered between individuals with similar life experiences.

PSS: Peer Support Specialists, individuals in recovery from mental illness and/or addictions who have been trained to provide and foster development of peer support services, and who are often referred to as "consumer providers."

PHA: Public Housing Authority

President's New Freedom Commission: a commission appointed by President Bush to evaluate the mental health treatment system in the United States and offer suggestions regarding areas to improve the health care system.

PTSD: Post-Traumatic Stress Disorder, a DSM-V diagnosis that refers to a set of specific symptoms that develop in response to experiencing an unusual traumatic event such as a car accident or seeing someone injured in combat.

SAMHSA: Substance Abuse and Mental Health Services Administration, supports clinical research in addictions. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

SE: Supported Employment

SMI: Serious Mental Illness

TIC: Trauma-Informed Care

TLC: Time-Limited Case Management, a program that served as the foundation for MISSION.

TW: Transitional Work

VA: Veterans Administration, sometimes called the Department of Veterans Affairs or DVA.

VANJ: VA New Jersey Health Care system

VISN 1: VA New England Healthcare system

Vocational Support: Case managers in MISSION offer linkages to vocational services as well as ongoing assistance with employment retention such as managing conflicts on the job.

VR: Vocational Rehabilitation

Appendices

Appendix A: Key Clinical Outcomes

After examining the MISSION model through several studies (Smelson et al., 2005; Smelson et al., 2007; Smelson et al., 2010; Smelson et al., 2013), we have found that the MISSION intervention helps clients address their co-occurring substance abuse and non-psychotic mental illness and other psychosocial issues, including problems with housing, employment, family, and the criminal justice system. The model is a flexible service delivery platform for helping these clients transition from residential care or the shelter system to outpatient community based care and keeps clients focused on sobriety from substance use and mental health recovery while they are also dealing with housing and other psychosocial needs. While some readers might be interested in reviewing the articles published in the literature, which includes a large randomized controlled matched attention trial (Smelson et al., 2010), below is a quick snapshot of one of our larger projects completed to date that enrolled 406 homeless individuals. As can be seen below, a comparison of outcomes of MISSION and participants receiving Treatment as Usual (TAU) in residential treatment at 12 months post-baseline showed that both groups made significant improvements as a result of treatment. However, individuals who received MISSION treatment services achieved better outcomes in a number of key domains including treatment engagement, behavioral outcomes such as substance use and mental health symptoms, housing stability, and satisfaction of services received during the 12-month evaluation period.

From baseline to 12 months follow-up, participants who received MISSION treatment services showed the following improvements:

- Reduced use of illicit drugs (71% to 13%)

- Reduced use of alcohol to intoxication (19% to 8%)

- Reduced symptoms of depression (66% to 34%), symptoms of anxiety (72% to 35%), and any mental health symptoms (88% to 57%)

- Fewer hospitalizations for psychiatric reasons (6.5 days prior to enrollment to 2.7 days 12-months post baseline)

- Fewer problems controlling violent behavior (15% to 7%)

Furthermore, improvements were found in the number of individuals receiving MISSION services at 12-months post baseline who:

- Obtained full time employment (5% at baseline to 46%)

- Were living in stable housing (0% to 83%)

- Were still in contact with their case manager (81%) and peer support specialist (61%)

MISSION participants also performed better than those who received TAU in the following service areas at 12-month follow-up:

- Lower use of costly inpatient (22% vs. 31%) and somewhat higher use of outpatient (29% vs. 20%) services

- Receipt of housing assistance (46% vs. 32%)

- Employment assistance (36% vs. 21%), including 31% vs. 20% who received employment counseling and 9% vs. 5% who received vocational training

- Financial assistance and help with government benefits (21% vs. 15%)

Overall MISSION participants also reported higher satisfaction in their receipt of services with particular respect to:

- Mental health services (67% vs. 53%)

- Medical services (72% vs. 55%)

- Dental services (57% vs. 43%)

The following figures illustrate some of our most important key target outcomes comparing those who received MISSION treatment services to those who received TAU alone.

Figure 1: Mean Days of Psychiatric Hospitalization during the 12 Months Pre-Admission, and the 12 Months Post-Admission: MISSION vs. TAU

Psychiatric Hospitalization Length (Days)
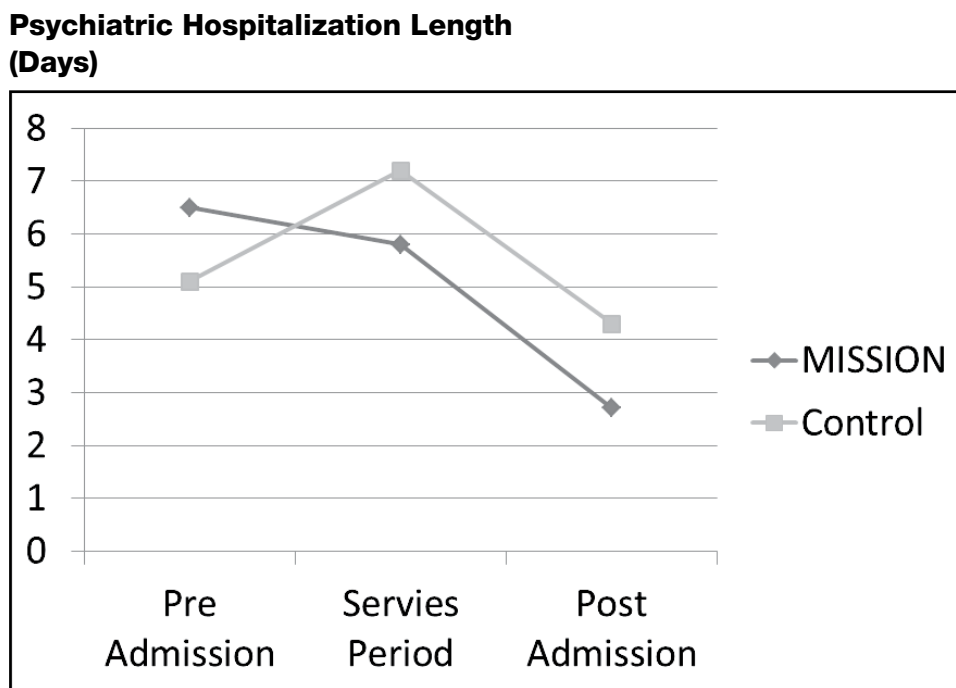
Figure 1 illustrates the significant reduction in hospitalization days among the MISSION group as compared to those receiving TAU.

Figure 2: Trouble Controlling Violent Behavior in the Last 30 Days at Baseline, 6-Months, and 12-Months Post-Baseline: MISSION vs. TAU

Trouble Controlling Violent Behavior in the Last 30 Days
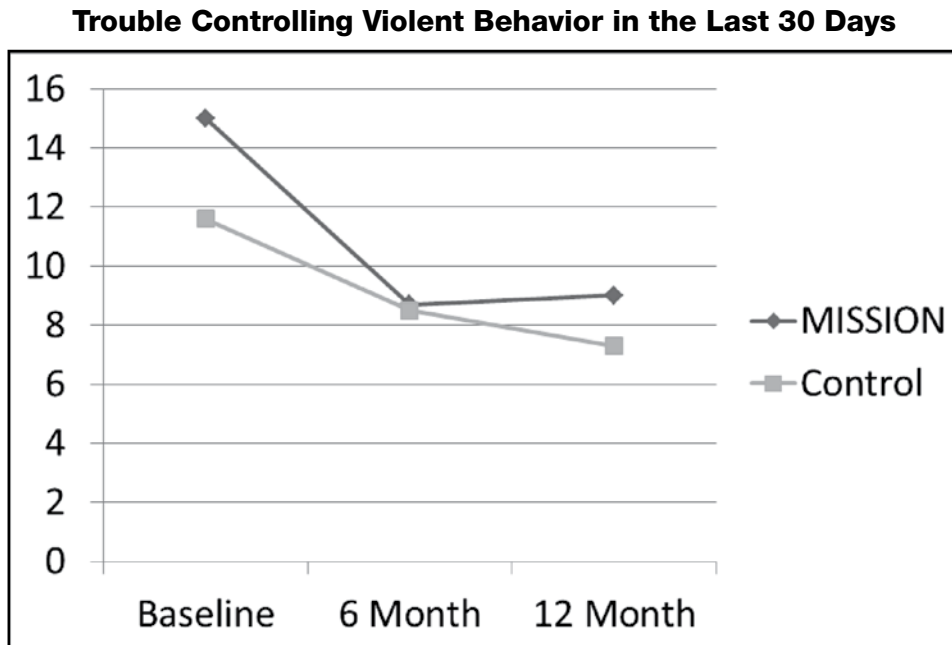
Figure 2 shows the significant improvement among individuals receiving MISSION services in controlling violent behavior at the end of the study compared to those receiving TAU.

Figure 3: Use of Alcohol to Intoxication in the Last 30 Days at Baseline and 12-Months Post-Baseline: MISSION vs. TAU

Percent of MISSION and Control Participants Using Alcohol to Intoxication
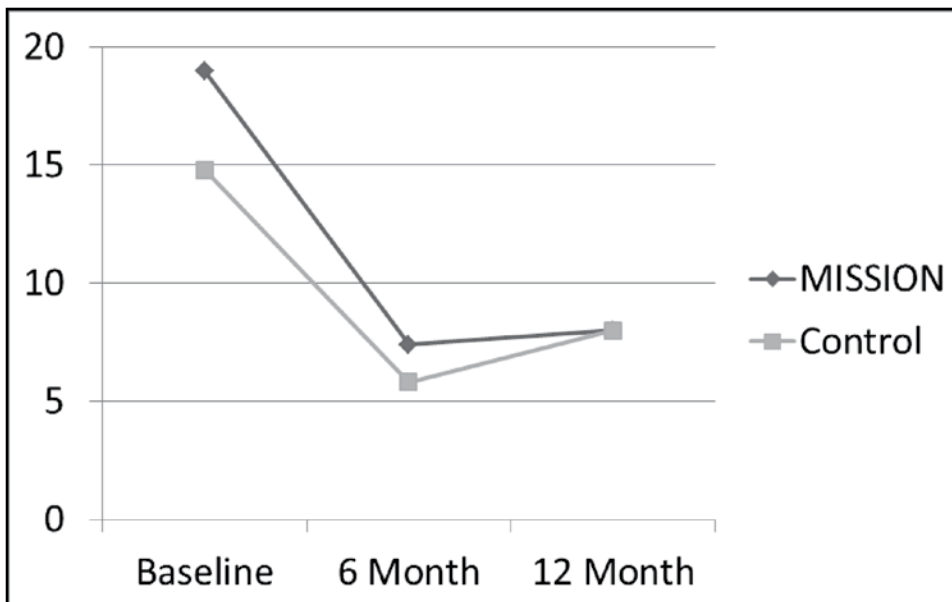
Figure 3 illustrates the reduction in drinking to intoxication in the MISSION group as compared to those receiving TAU.

Figure 4: Proportion of Participants Who Felt They Received All the Services They Needed at 12 Months Post-Admission, by Service Type: MISSION vs. TAU

Feels Received Services Needed
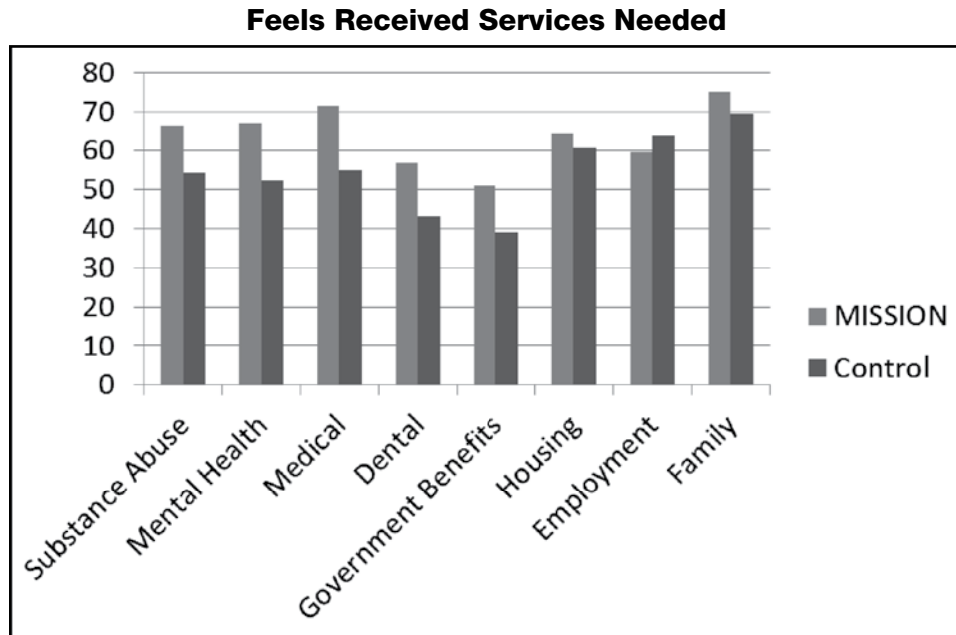
Figure 4 illustrates that compared to TAU, those in MISSION felt more satisfied with receiving key services that reflected their baseline treatment plan requests on the majority of the domains.

Note: These data were presented in a Final Project Report prepared by Drs. Smelson and Kline and submitted to SAMHSA. Initial results were also presented at the 2008 Annual VA QUERI Meeting and College on Problems and Drug Dependence Annual Meeting 2012. Portions of these results also appear in the Smelson et al, 2013 Publication cited below:

Smelson, D.A., Kline, A., Kuhn, J., Rodrigues, S., O'Connor, K., Fisher, W., Sawh, L., & Kane, V. (2013). A wraparound treatment engagement intervention for homeless veterans with co-occurring disorders. *Psychological Services,* 10(2),161-7.

The following journal articles regarding MISSION might also be of interest:

Smelson, D.A., Losonczy, M., Castles-Fonseca, K., Stewart, P., Kaune, M., & Ziedonis, D. (2005). Preliminary outcomes from a booster case management program for individuals with a co-occurring substance abuse and a persistent psychiatric disorder. *Journal of Dual Diagnosis,* 3(1), 47-59.

Smelson, D.A., Losonczy, M., Ziedonis, D., Castles-Fonseca, K., & Kaune, M. (2007). Six-month outcomes from a booster case management program for individuals with a co-occurring substance abuse and a persistent psychiatric disorder. European *Journal of Psychiatry,* 21(2), 143-152.

Kline, A., Callahan, L., Butler, M., St. Hill, L., Losonczy, M., & Smelson, D. (2009). The relationship between military service era and psychosocial treatment needs among homeless veterans with a co-occurring substance abuse and mental health disorder. *Journal of Dual Diagnosis,* 5(3), 357-374.

Smelson, D.A., Kalman, D., Losonczy, M., Kline, A., Sambamoorthi, U., Hill, L., Ziedonis, D. (2010). A brief treatment engagement intervention for individuals with co-occurring mental illness and substance use disorders: Results of a randomized clinical trial. *Community Mental Health Journal,* 1-6.

Appendix B: Theoretical Framework Underlying the MISSION Model

The theoretical framework of the MISSION model is derived from the Health Belief Model (HBM) (Rosenstock, 1966; Becker & Maiman, 1975; Janz & Becker, 1984), which presents a broad structure for understanding the major components of the health decision-making process. Originally proposed to explain preventive health behavior, the HBM has been found to predict compliance with treatment regimens as well as utilization of services for preventive and therapeutic purposes (Janz and Becker, 1984). The HBM has provided a valuable framework for understanding treatment compliance among the severe and persistent mentally ill (Budd et al., 1996; Nageotte, et al., 1997; Perkins, 1999; Adams & Scott, 2000; Perkins, 2002) as well as those with co-occurring psychiatric and substance use disorders [COD] (Mulaik,1992; Fenton et al., 1997). Researchers have also applied the model to outpatient psychiatric attendance for people with bipolar disorder (Connely, 1984), compliance with discharge plans after psychiatric ER visits (Porter-Tibbetts, 1986), decisions to abuse drugs (Lindsay & Rainey, 1997; Minugh et al., 1998), participation in recovery programs (Weisner, 1987;

Bardsley and Beckman, 1988), and treatment attrition (Rees, 1985).

The HBM posits a rational-choice explanation of health seeking in which individuals weigh the costs of performing a health action against the possible benefits. In addition to actual financial costs, treatment costs may include such situational barriers as provider inaccessibility, scheduling conflicts, transportation problems, etc. Benefits include the potential physical, psychological, and lifestyle improvements deriving from treatment. In the original formulation of the HBM, the cost/benefit calculation was influenced by the individual's "readiness" or motivation to engage in health-seeking behavior. Readiness to act was dependent on two factors: (1) perceived susceptibility to a condition (or, belief in the accuracy of an existing diagnosis); and (2) perceived severity of the condition, including evaluations of both medical (e.g. pain, death, disability) and social (e.g. effects on work or family) consequences if the condition were contracted or left untreated (Janz and Becker, 1984). More recent formulations of the HBM have synthesized concepts from other health behavior models as indirect, mediating influences. These include self-efficacy beliefs regarding one's ability to perform the

Figure 1. The Health Belief Model
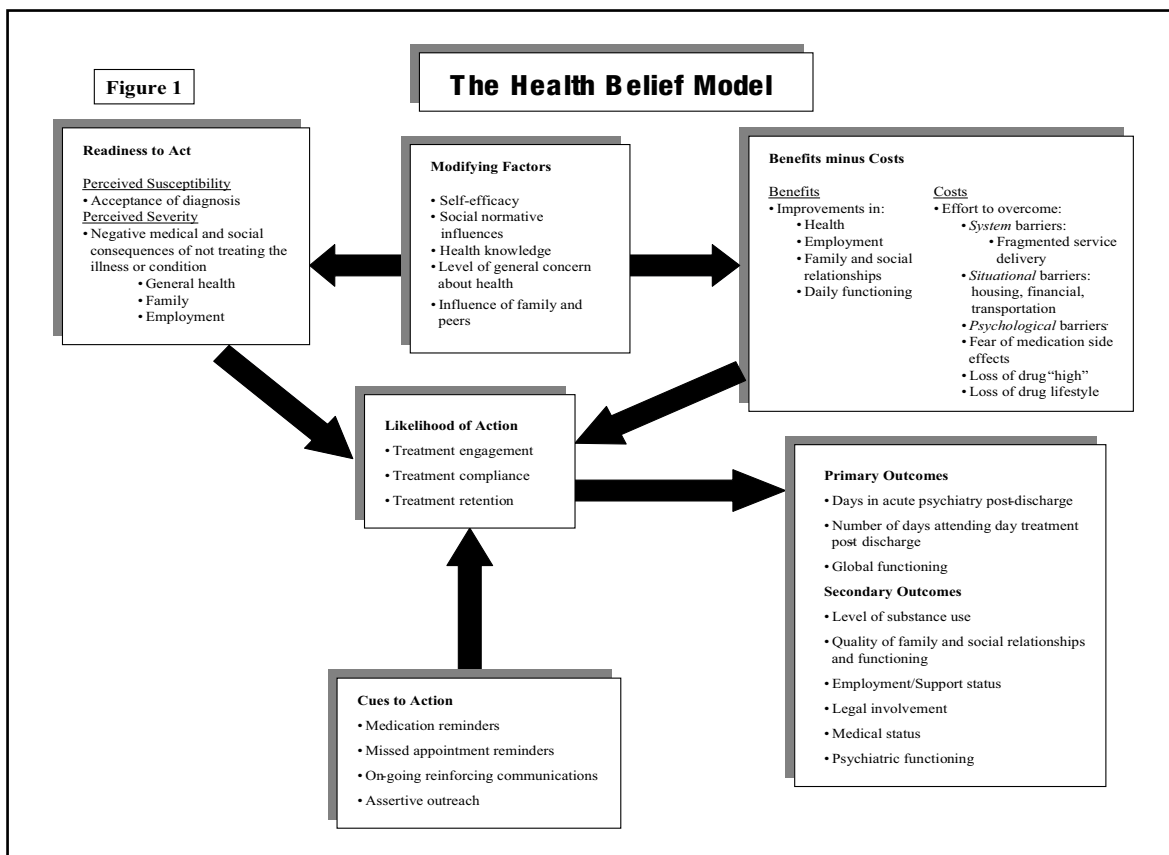
required action, social normative beliefs regarding how peers and other "influentials" would perceive the action, "cues to action," which may be either external or internal stimuli that trigger the individual to act and a basic level of health knowledge (Janz and Becker, 1984). The combination of DRT, CTI, and Peer Support in addition to the attention on employment, education and trauma needs, which are all part of the MISSION model, are designed to address each of the key HBM constructs in an effort to increase treatment readiness, decrease perceived treatment costs, and increase perceived treatment benefits. A formulation of the HBM in terms of the specific health behaviors and psychosocial influences targeted by MISSION appears in Figure 1 above.

As indicated in Figure 1, the primary health behaviors we are attempting to promote include engagement and retention in psychosocial and pharmacological treatments. We expect these actions to result in positive outcomes, including reduced re-hospitalizations, reduced substance use, enhanced daily functioning, and improvements in other life domains, such as family relationships, employment, legal involvement, and physical health. Factors affecting treatment compliance will be influenced by the extent to which individuals acknowledge their substance use and mental health problems and understand the severe health and social consequences of leaving these problems untreated. Mediating factors include the feelings of self-efficacy in refraining from substance use and following treatment regimens, the influence of peers and others in reinforcing beliefs that such actions are not only desirable, but possible, and access to sufficient information about the disease to promote informed decision-making. We expect individuals to identify improvements in health and social functioning as possible benefits of treatment and to identify a variety of potentially limiting barriers, or costs, including fears about medication side-effects, relinquishing the desirable physical and psychological feelings associated with substance use and the difficulty of negotiating possible institutional and situational barriers to treatment. Finally, we identify cues to action, in the form of communications from providers to encourage compliance.

DRT, CTI, and Peer Support, as used in MISSION, dovetail nicely with the constructs of the HBM and are designed to intervene in key aspects of the health decision-making process to promote treatment retention and compliance. These more active treatment components of MISSION, DRT, CTI, and Peer Support, however, also facilitate the client addressing their employment, education and trauma needs. The relationship between our intervention strategies and the HBM constructs is described in detail in Figure 2 below.

Health Belief Model Constructs   **MISSION Component**

Readiness to Act	Perceived Severity	DRT • Diagnostic Assessment • Psychoeducation About Mental Illness and Substance Abuse • 12-Step Therapy • Peer Counseling • Mentoring
	Perceived Susceptibility	DRT • Evaluation of Psychiatric Vulnerabilities • Psychoeducation • Analysis of Substance Abuse Relapse Patterns • 12-Step Therapy • Relapse Prevention • Peer Counseling • Mentoring

Modifying Factors	**Self-Efficacy**	DRT • Motivational Enhancement Therapy • Skills Training • 12-Step Therapy CTI • Professional Support • Life Skills Training • Gradual Reduction in Outreach • Peer Counseling • Peer-to-Peer Support
	Social Norms	DRT • Skills Training • 12-Step Therapy CTI • Community Reintegration • Peer Counseling • Mentoring
	Health Knowledge	DRT • Psychoeducation • Skills Training • Relapse Prevention • 12-Step Therapy • Peer Counseling • Mentoring
	Community Resources Knowledge	CTI • Identification and Utilization of Community Resources
Perceived Benefits	**Improvements in Health**	DRT • Motivational Enhancement Therapy • Psychoeducation • Medication Management Training • 12-Step Therapy • Relapse Prevention • Peer Counseling • Modeling
	Improvements in Social Functioning	DRT • Motivational Enhancement Therapy • Skills Training • 12-Step Therapy • Relapse Prevention CTI • Facilitation of Family Involvement • Professional Support • Peer Counseling • Modeling • Peer-to-Peer Support

Health Belief Model Constructs		MISSION Component
Perceived Costs	**Medication Side Effects**	DRT • Psychoeducation • Medication Management Training CTI • Facilitating Linkages Among Patient, Physician, and Pharmacy
	Loss of Drug "High"	DRT • Motivational Enhancement Therapy • 12-Step Therapy • Peer Counseling • Modeling • Mentoring • Peer-to-Peer Support
	Institutional Barriers	CTI • Identification of and Linkage with Community Resources • Early and Consistent Involvement with the Patient • Patient Advocacy
	Personal and Practical Barriers	CTI • Assertive Outreach • Transportation Assistance • Money Management • Housing Assistance • Facilitation of Family Involvement • Patient Advocacy • Vocational and Educational Assistance
Cues to Action	**Follow-up on missed appointments**	CTI • Assertive Outreach
	Medication checks	CTI • Professional Support • Facilitating Linkages Among Patient, Physician, and Pharmacy DRT • Psychoeducation • Medication Management
	Ongoing reinforcing Communications	DRT • 12-Step Therapy to Provide Support and Feedback CTI • Professional Support and Feedback • Peer counseling • Peer-to-Peer Support and Feedback

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DRT, through its use of Motivational Enhancement Therapy (MET), psychoeducation, 12-step facilitation, relapse analysis, and medication management, will enhance beliefs about disease severity and susceptibility, will increase self-efficacy and health knowledge and will promote a more favorable analysis of the costs and benefits of treatment. DRT, for example, includes a Dual Recovery Status Exam, which monitors medication compliance and provides individuals with support and feedback regarding their medication management. CTI will affect perceived treatment costs/benefits by enhancing treatment accessibility and reducing fragmented service delivery through coordinated treatment planning. CTI will also address situational barriers to treatment and will provide cues to action in the form of additional medication monitoring, follow-up phone calls for missed visits, and ongoing encouragement and positive reinforcement. Peer Support will affect social normative attitudes by providing social reinforcement for continued abstinence and compliance with treatment protocols. Interaction with Peer Support Specialists [PSS] who have had similar problems yet achieved a successful recovery will reinforce the normative value of maintaining sobriety and add to the client's sense of self-efficacy in being able to achieve comparable goals. The PSS will also assist clients in accepting and understanding the severity of their addiction problems and understanding the benefits of treatment. Finally, PSS provide cues to action through frequent communication with participants around treatment compliance issues.

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Appendix C: MISSION Sample Position Descriptions

Generic Case Manager Position Description

Major Duties and Responsibilities

- Case management and community outreach with homeless and formerly homeless individuals with co-occurring substance abuse and mental health problems in the MISSION (Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking) program. This will consist of meetings with clients to discuss their needs in the community (e.g., connecting them with mental health and substance abuse services, recreational opportunities, self-help groups, transportation resources, etc.). The incumbent will also provide vocational/educational support to help clients maintain employment and find new employment/educational opportunities.

Factor 1: Scope and effect

- The objective of this position is to provide case management and outreach services to homeless and formerly homeless individuals with co-occurring mental health and substance abuse problems for the MISSION program under the direction of a Clinical Supervisor. These tasks will contribute to the overall effectiveness of the MISSION program.

Factor 2: Knowledge Required by the Position

- The incumbent will have experience working with people with a history of mental health and substance abuse problems.

- The incumbent must have experience providing case management services.

Factor 3: Supervisory Controls

- The incumbent works under the supervision of a Clinical Supervisor. The incumbent is required to function independently, but he/or she also meets regularly with his/her Clinical Supervisor to provide regular updates and status reports regarding contact with clients in the MISSION program.

Factor 4: Guidelines

- Guidelines include regional and organizational directives, manuals, bulletins and proposals, as well as established program policies. Written and oral instructions will be received from the Clinical Supervisor. Incumbent uses these guides as a base, but functions flexibly depending on the client's problem or situation.

Factor 5: Complexity

- Working with homeless and formerly homeless individuals with co-occurring mental health and substance abuse problems requires a sensitive individual who has theoretical knowledge and experience to provide case management and assertive outreach. He or she must also have the ability to quickly assess a situation and follow protocol for handling emergency situations.

Factor 6: Personal Contacts

- The incumbent will have direct contact with homeless and formerly homeless clients with co-occurring mental health and substance abuse problems. He/she may also contact the family members/friends/employer of clients (with the permission of the client). He/she will also have direct contact with the staff of the MISSION program and other treatment providers.

Factor 7: Purpose of Contacts

- The incumbent will contact clients to help them maintain residence, engage in treatment services, and locate/maintain employment in the community. He/she will contact the family members/friends/ employer of clients to promote the tenure of the client in the community and in their job. The incumbent will contact other treatment providers to promote the smooth integration of MISSION services with other providers.

Factor 8: Physical Demands

- The physical demands of the position will be minimal. The incumbent will be required to drive to the communities of the clients in the MISSION program.

Factor 9: Work Environment

- The incumbent will have a designated workspace. However, he/she will spend the majority of his/her time in the community meeting with clients and members of various community programs.

Generic Peer Support Specialist Position Description

Major Duties and responsibilities

- The Peer Support Specialist (PSS) is a full member of the MISSION program treatment team and provides peer support services to clients with co-occurring psychiatric and substance use disorders. Under supervision of the MISSION Clinical Supervisor, the Peer Support Specialist functions as a role model to clients; exhibits competency in personal recovery and use of coping skills; and serves as a consumer advocate, providing consumer information and peer support for clients in both the residential and community settings. The PSS performs a wide range of tasks to help clients regain independence within the community and mastery over their own recovery process. Recovery resources such as the Participant Workbook, tapes, pamphlets, and other written materials are utilized by the Peer Support Specialist in the provision of services.

The PSS assists the client's recovery by...

- Using a formal goal-setting process to help him or her articulate personal goals for recovery. By providing one-on-one and group sessions, the PSS supports clients and helps them identify objectives, create goals, and develop recovery plans. The PSS and the client will discuss the skills, strengths, supports, and resources that are necessary to help achieve these goals.

- Encouraging and facilitating an effective working and treatment relationship with the client's MISSION Case Manager.

- Prioritizing the formation of new and/or sustainment of existing self-help (mutual support) groups. The PSS works to help the client locate and join existing support groups, and will attend initial meetings with the client if desired, therefore stressing the importance of joining and regularly attending these groups.

- Using tools such as the MISSION Participant Workbook, to assist clients in achieving their own recovery and treatment goals. Independently, or with periodic assistance from the MISSION Case Manager or other providers, teach, through instruction and/or example, problem solving skills to both individuals and groups. The PSS also leads discussions that encourage clients to share common problems of daily living and methods they have employed to manage and cope with these problems. As individuals who can relate to the clients through their own experiences, PSSs highlight the skills, strengths, supports, and resources they share and/or have used. As much as is helpful, the PSSs will share their own recovery stories and, as facilitators of these sessions, demonstrate how they have directed their own recoveries. Use ongoing individual and group sessions to teach clients how to identify and combat negative self-talk. By using identified literature, DVDs, etc., PSSs help clients gain hope, learn to identify their strengths, and combat negative self-talk. Through this process, the PSS will help clients identify their fears, insecurities, and underlying barriers to success, and develop action plans to counter these. Supporting clients' vocational choices and assisting them in choosing a job that matches their strengths. Recognizing the likely presence of job-related anxiety, the PS will help the client by reviewing job applications, locating resume-building volunteer and/or temporary job opportunities, coaching the client through an interview process, and by recommending strategies for achieving

job expectations and, therefore, maintaining employment. Assisting with the development of social skills that, when applied in the community, will enhance job acquisition and tenure, encourage continued involvement in community and self-help groups, and improve quality of life.

- Keeping records that document the client's treatment/recovery plan, including:

  - identified person-centered strengths, needs, abilities, and recovery goals;

  - interventions to assist the client with reaching his/her goals for recovery; and

  - progress made toward goals.

- Maintaining a working knowledge of current trends and developments in the mental health field through review of books, journals, and other relevant materials.

- Attending continuing education seminars and other in-service training when offered.

Drawing on recovery experiences, the PSS will

- Assist the client in obtaining safe, stable, and affordable housing of his/her choice in the most integrated, independent, and least intrusive or restrictive environment possible. The PSS will facilitate this by accompanying the client on housing searches, either by driving the client or riding with them on public transportation.

- Serve as a recovery agent by providing and advocating for any effective recovery-based services that will aid the client in daily living. The PSS's role is critical as he or she models effective coping techniques and self-help strategies.

- Assist in obtaining services that advance the client's recovery needs. By providing points of contact and relevant information for community resources, self-help groups, and other useful services, the PSS serves as an information conduit, relaying information about community and natural supports and how these can be used in the recovery process. These may include, but are not limited to, connections with federal government agencies, such as Social Security offices; state and local programs, such as child welfare and social services agencies; local community organizations such as the YMCA or JCC; public libraries; neighborhood and community associations; and other relative organizations and community resources.

- Empower clients to combat stigma through self-advocacy. By attending regular group and individual meetings with clients, and employing role play and modeling techniques, Peer Support Specialists create an environment that is conducive to sharing how they and other clients have handled difficult recovery situations. As the PSS models respect for each client's individual recovery experience, s/he demonstrates appropriate social interactions, problem-solving skills, and techniques for managing interpersonal relationships.

Factor 1: Knowledge Required by the Position

a. Familiarity with substance abuse recovery processes and the ability to facilitate recovery in clients using established standardized mental health and peer support processes.

b. Strategies for treatment and engagement that encourage basic problem solving skills and self-directed recovery.

c. Ability to recognize the signs and symptoms of mental illness, and the concomitant ability to assist the client to address these symptoms using mental health providers.

d. Incorporation of relapse prevention strategies, including the ability to recognize signs of substance abuse relapse and mental health symptom instability, and the ability to initiate appropriate responses.

e. Awareness of and connections to community resources that facilitate a client's independent living and ability to teach those skills to other individuals with histories of mental illness, substance abuse, and homelessness.

f. Organization and management skills that will facilitate formation and/or maintenance of self-help (mutual support) and educational groups.

g. As a valid driver's license is required for this position, due to the requirement of some driving and/or transportation of clients to medical appointments, job sites, social activities, and other community resources, the PSS must also be able to maintain a safe driving record and help clients establish or re-establish their own abilities to obtain public or private transportation.

h. Preferably a certification as a peer support specialist or the equivalent. The system employing the PSS might also have specific certification requirements and should be considered at the time of employment.

Factor 2: Supervisory Controls

The Peer Support Specialist is administratively assigned to the MISSION program and will receives supervision from the MISSION Clinical Supervisor. While the supervisor provides regular supervision and generally helps the treatment team guide and prioritize issues, the incumbent is expected to handle routine duties independently and to establish common priorities for his/her assignments. Some teaching and facilitation work may be performed with the assistance of other mental health treatment team members. Work is reviewed by the supervisor to ensure that it is technically correct and that it conforms to established policies and previously given instructions. Assignments that are routine and repetitive are not reviewed by the supervisor unless there are problems. The incumbent will follow all legal, medical, and organizational policies as mandated by the MISSION program.

Factor 3: Guidelines

Established procedures and specific guidelines are available to the PSS to cover the work assignment. Guidelines are applicable and specific to most situations. The incumbent will use judgment in determining the most appropriate standard and/or instruction for the circumstances and for tailoring his or

her information gathering procedures as required.   In situations where existing guidelines are not applicable, or where norms do not exist or are unclear, the PSS refers the problem to the Clinical Supervisor.

Factor 4: Complexity

The work involves provision of support services for the client by helping him or her to establish goals and means to reach those goals. Decisions on establishing goals and formal action plans will always be made in conjunction with the client and MISSION Case Manager with the Clinical Supervisor. It is important to understand that the mental health and substance abuse recovery needs of clients are extremely complex; therefore, the PSS is expected to draw on all resources at the client's disposal.

Factor 5: Scope and Effect

The PSS assists and guides clients toward the identification and achievement of specific goals as defined by the client and specified in the Individual Treatment Plan (ITP). The work involves a variety of routine, standardized tasks that facilitate work performed by higher-level providers. Work performed by the incumbent will promote sobriety, community socialization, recovery, self-advocacy, self-help, and development of natural supports.

Factor 6: Personal Contacts

Personal contacts include clients, family members and significant others, treatment team members and other clinical staff, to include all disciplines. In addition, contacts may be with private citizens, landlords, community leaders, and staff of community, federal and state agencies. Contacts may be in person, by telephone, or by written communication.

Factor 7: Purpose of Contacts

Personal contacts are made to give or exchange information; resolve issues; provide services; and to motivate, influence, and advocate on behalf of the client. Contacts with clients are for the purpose of assisting them in managing their sobriety and emotional and behavioral symptoms, teaching them independent

living skills, and identifying and achieving their individual recovery goals.

Factor 8: Physical Demands

The work is primarily sedentary. However, there may be some walking, standing, bending, carrying of light items such as books and papers, accessing transportation, and driving involved.

Factor 9: Work Environment

Work will be performed in a wide range of settings, including a medical center; in a client's place of residence (both inpatient and in the community); group or family homes; in community-based outpatient settings and/or community agencies; in government transport vehicles (public or government), and elsewhere. Work areas are often noisy, irregular, and unpredictable and can be stressful at times. As participating clients demonstrate varying levels of recovery and symptoms, including many environmental triggers, the MISSION Peer Support and Case Management teams must be aware of these issues, and have alternate plans in place.

Other Significant Requirements:

Customer Service

Consistently communicates and treats customers (patients, visitors, volunteers, and all Medical Center staff) in a courteous, tactful, and respectful manner. Provides the customer with consistent information

according to established policies and procedures. Handles conflict and problems in dealing with the customer constructively and appropriately.

ADP Security

Protects printed and electronic files containing sensitive data in accordance with the provisions of the Privacy Act of 1974 and other applicable laws, federal regulations, and agency statutes and policy. Protects the data from unauthorized release or from loss, alteration, or unauthorized deletion. Follows applicable regulations and instructions regarding access to computerized files, release of access codes, etc. Comprehension is indicated and compliance is pledged with the employee's signature on a standard agreement.

Age-Related Competency Statement

Provides care and/or services appropriate to the age of the clients being served. Assesses data reflective of the client's status and interprets the information needed to identify each client's requirements relative to their age-specific needs and to provide care needed as described in the policies and procedures.

Computer Knowledge - Word Processing (MS-Word)

Uses MS Word or comparable word processing software to execute several office automation functions such as storing and retrieving electronic documents and files; activating printers; inserting and deleting text; formatting letters, reports, and memoranda; and transmitting and receiving e-mail.

Appendix D: MISSION Sample Service Delivery Schedules

Schedule for MISSION Service Delivery:

The following provides an overview of the sequence of services provided by MISSION over 2-month, 6-month, or 12-month treatment windows.

Screening and Orientation to MISSION

- Individual is identified as a potential MISSION program participant by MISSION staff or treatment provider from another program or community treatment provider.

- Individual is approached by MISSION staff about eligibility.

- Individual receives a comprehensive co-occurring disorder evaluation.

- Individual is deemed eligible.

- Individual meets with Case Manager/Peer Support Specialist team for "orientation to the MISSION program" including overview of DRT Sessions and overview of both Case Manager and Peer Support Specialist roles in MISSION program.

Groundwork and Relationship Building

- Clients participate in DRT psychoeducational co-occurring disorders treatment sessions. If initiated in an inpatient/residential treatment setting, it is important to note that clients may participate in DRT sessions while receiving inpatient/residential treatment services. DRT sessions are designed so clients can begin at any time, so if delivered in a group setting he/she does not have to wait for a new group of other clients to enroll in MISSION to begin DRT sessions.

- Clients participate in Peer-led sessions with Peer Support Specialist (PSS).

- Clients participate in regular "check-in" sessions with PSS regarding Participant Workbook exercises.

- If client is receiving inpatient/residential treatment services, MISSION staff attends treatment team meetings with inpatient/residential staff and provides input on the client's treatment plan and discharge plan from the facility.

- PSS has an "open door policy" for informal discussions with clients on caseload.

- MISSION staff ensures individuals are linked to appropriate addiction, mental health, vocational/educational, and trauma-informed care treatment services via referrals to community programs.

Further Defining Relationship with MISSION Treatment Team

- Clients continue to participate in DRT sessions facilitated by Case Manager.

- Clients continue to participate in Peer-led sessions with Peer Support Specialist (PSS).

- If client is still receiving inpatient/residential treatment services, MISSINON staff continue to attend treatment team meetings with the inpatient/residential treatment staff and provide input on the client's continuing treatment and discharge plan.

- PSS maintains "open door policy" for informal discussion with clients on caseload.

- Linkages to appropriate addiction, mental health, vocational/educational, and trauma-informed care treatment services are tested and confirmed.

- MISSION staff continue to meet with clients to discuss issues related to recovery. Yet, because the ultimate goal of MISSION is to facilitate self-sufficiency, clients interact with the MISSION team more often during the initial stages of service delivery. By gradually decreasing frequency of contact, clients begin using community resources and service linkages more heavily.

Transitioning to Community-based Services

- The MISSION Case Manager and peer conduct outreach sessions together. Focus of these sessions is on mental health stability and

abstinence from substance use, adjustment to community, and employment obtainment and maintenance. Modifications to treatment plans are made as new needs arise.

- The MISSION PSS participates in community activities with the client (going to 12-step meetings, social events, lunch, recreational activities, etc.)

- The MISSION Case Manager and PSS conduct outreach weekly to every other week as needed by the client. These meetings can also be supplemented by telephone contacts if necessary. MISSION staff continue to focus on "fine-tuning" community linkages and conducting DRT co-occurring disorder "booster" sessions as needed, providing ongoing employment/educational support, including conflict resolution and stress management and provide connections to Department of Vocational Rehabilitation or Department of Labor resources as needed.

Note: the MISSION Case Manager and PSS can schedule additional sessions as needed if client is having difficulty completing tasks on their own.

Transfer of Care

- MISSION Case Manager and PSS outreach sessions are less frequent. Sessions may occur every other week to monthly or less, depending on the needs of the client. Supplemental telephone contacts occur as needed.

- MISSION case Manager and PSS facilitate use of community-based supports, health care services, and other resources to prepare the client for completely transitioning to independent community living. MISSION staff work through issues around termination from MISSION program, foster self-

determination, and build client's confidence in independent community living. The MISSION case Manager provides DRT booster sessions if needed.

- PSSs continue to participate in community activities with clients such as attending 12-step meetings and/or social events.

Note: Termination is often difficult for those receiving treatment services and brings up such core issues as loss, dependency, etc. The CTI manual can serve as an additional resource for this component of treatment and is seen as a critical component of the treatment process. Furthermore, should a client begin to show exacerbation in their mental health and substance abuse problems, sessions could be increased, but with a focus on engaging with their new community supports and providers and empowering the client to identify additional support as needed. Again, it must remain clear to the client, case manager, and PSS that the goal in the transitional phase in this stage of treatment is to empower clients to believe that they can live independently in the community, without the assistance they have been receiving from the MISSION Case Manager and PSS.

Discharge from MISSION

- The MISSION case manager and PSS review progress and goals; discuss the client's strength, resiliency, and available resources; and reinforce the use of community supports. Then MISSION staff say goodbye to the individual.

Note: Preparation for discharge really begins during Transfer of Care, however care is transferred gradually. Should the client relapse at this point during treatment or request more services, the individual is encouraged to use community-based supports to meet these needs.

MISSION 2-MONTH PROGRAM TIMELINE

Acute Psychiatry (approximately 10 days)
- Diagnostic assessment, medication stabilization, and psycho-educational groups

CTI Phase 1: Transition Planning
- Identification of needed community services and resources through comprehensive evaluation
- Establish connections with community supports

DRT: Onset of Problems (delivered over 2 sessions)
- Introduction to DRT
- Development of individualized treatment plan
- Identify patterns of use and interaction with MH symptoms

Peer-led session focuses on reinforcing completion of exercises in MISSION Participant Workbook

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Week 1

CTI Phase 1: Transition Planning
- Ensure that community supports are in place in preparation for discharge
- Identify vocational rehabilitation programs
- Probe for any trauma-related issues

DRT Sessions: Motivation to Change & Personal Recovery Plan
- Clarification of steps needed for recovery
- Elicitation of self-motivation statements
- Identification of triggers and early warning signs of relapse

Peer-led session focuses on reinforcing completion of exercises in MISSION Participant Workbook

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Week 2

CTI Phase 1: Transition Planning
- Provide linkages to community supports

DRT: Problem Areas Worksheet to Address (delivered over 2 sessions)
- Motivate clients to develop a change plan and and/or actively stop using
- help client commit to COD treatment upon discharge

Peer-led session focuses on reinforcing completion of exercises in MISSION Participant Workbook

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Week 3

CTI Phase 1: Transition Planning
- Discharge session
- Transportation from the hospital after discharge

DRT Sessions: Decisional Balance & Communication Skills
- Pros/Cons of behaviors
- Work to improve communication with important people

Peer-led session focuses on reinforcing completion of exercises in MISSION Participant Workbook

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Week 4

CTI: Try Out
- Identification of gaps in support and additional needs
- Assertive outreach

Peer Support Group
- One Session: Self-monitoring of substance abuse triggers and craving levels

CTI Phase 2: Tryout
- Assertive outreach
- Fine-tune connections with community supports
- Identify barriers and fix issues
- Empower client to tackle issues on their own
- Ongoing monitoring of vocational/educational needs and trauma-related issues

DRT Sessions: 12-Step & Anger Management
- Provide orientation to 12-step programs and facilitate attendance
- Help control reactions

Peer-led session focuses on reinforcing completion of exercises in MISSION Participant Workbook

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Week 5

CTI Phase 2: Tryout
- Assertive outreach
- Continue to monitor that client is engaged in community treatment and rehabilitation programs

DRT: Relapse Prevention & Triggers
- Recognize signs of relapse
- Monitoring of substance abuse triggers and craving levels

Peer-led session focuses on reinforcing completion of exercises in MISSION Participant Workbook

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Week 6

CTI Phase 3: Transfer of Care
- Case manager may meet with client and community providers to discuss transfer of care and long-term goals
- Long-term community-based linkages established and finalized including vocational/educational and trauma-related services

DRT Session: Unhealthy Thinking & Irrational Beliefs
- Application of CBT techniques through role plays

Peer-led session focuses on reinforcing completion of exercises in MISSION Participant Workbook

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Week 7

CTI Phase 3: Transfer of Care
- Final session acknowledging completion of MISSION
- Case manager explains individual must use community providers for support
- Transfer of care is complete
- Case manager says goodbye

DRT Session: Activity Scheduling
- Time management
- Activities w/o drugs or alcohol

Peer-led session focuses on reinforcing completion of exercises in MISSION Participant Workbook

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Week 8

MISSION 6-MONTH PROGRAM TIMELINE

CTI Phase 1: Transition to Community

Month 1

Case manager comprehensively assesses service needs in treatment plan

<u>CTI</u>: Provide linkages to encourage community stability including housing maintenance, COD treatment, vocational/educational support, trauma-related services and other needed supports

Case manager conducts DRT sessions 1-4

PSS facilitates Peer-led sessions (1-4)

Month 2

Case manager conducts DRT sessions 5-8

PSS facilitates Peer-led sessions (5-8)

Follow up on vocational/educational service linkages

Coordinate trauma-related care with other providers if necessary

MISSION team continues to establish connections with community providers

CTI Phase 2: Tryout

Month 3

Case manager fine-tunes linkages that were provided during Phase 1 addressing any issues and gaps in service

<u>CTI</u>: Provide linkages to encourage community stability including housing maintenance, COD treatment, vocational support, and other needed supports

Case manager conducts DRT sessions 9-12

PSS facilitates Peer-led sessions (9-11)

Ongoing monitoring of vocational/educational needs and trauma-related issues

Month 4

Case manager conducts DRT session 13

DRT booster sessions provided as necessary

PSS accompanies client to appointments and twelve-step meetings

Ongoing monitoring of vocational/educational needs and trauma-related issues

Client participates in scheduled community activities with peer (and possibly other clients)

CTI Phase 3: Transfer of Care

Month 5

Case manager provides final fine-tuning of linkages and confirms that connections are in place and begins discussing the process of termination of MISSION services

DRT booster sessions provided as necessary and future COD treatment referrals are made

Linkages to Vocational/Educational rehabilitation programs and trauma-related services needed by the client beyond MISSION are made

PSS continues to provide support and engage with client in community through social activities, twelve-step meetings, etc.

Month 6

Case manager and peer review necessary steps with client for completion of program

Vocational/Educational & Trauma-Related support services are terminated and referred out to other providers as needed

DRT booster sessions are terminated and client receives referral for ongoing COD treatment

Case manager conducts final session acknowledging completion of MISSION. Case manager explains that individual must now use community providers for ongoing support. Then say goodbye.

MISSION 12-MONTH PROGRAM TIMELINE

CTI Phase 1: Transition to Community

CMs and PSSs should have weekly contact with client

(Note CTI begins immediately if services initiated in community)

Case manager comprehensively assesses service needs in treatment plan

Case manager orients client to MISSION and provides Participant Workbook

Case manager conducts DRT sessions 1-12

PSS conducts peer-led sessions 1-11 and works with client on Participant Workbook

Provide linkages to encourage community stability including housing maintenance, COD treatment, vocational support, and other needed supports

Assess for any trauma-related issues and make appropriate referrals and continue to monitor symptoms

Vocational/Educational needs assessed. Plan care in coordination with community rehabilitation programs and continue to monitor needs

MISSION team continues to establish connections with community resources and other treatment providers

CTI Phase 2: Tryout

CMs and PSSs should have biweekly contact with client

Case manager fine-tunes linkages that were provided during Phase 1 addressing any issues and gaps in service while offering guided support in the attainment of these goals and empowering the client to begin to independently tackle some of these issues

Care coordination continues with decreased frequency of contact between MISSION staff and client

Attend to any crises/issues that arise

Conduct *in vivo* needs assessment in community to examine support structure

Resolve identified issues

Adjust systems of support as needed

Conduct final DRT Session 13

After Session 13, case manager conducts DRT "Booster" sessions as needed/reinforces connections to community supports

Ongoing monitoring of vocational/educational needs and trauma-related issues

Peer continues work in community with client accompanying him/her to medical/therapy appointments, job interviews, 12-step meetings, etc.

CTI Phase 3: Transfer of Care

CMs and PSSs should have monthly contact with client

Case manager provides final fine-tuning of linkages and confirms that connections are in place

Case manager can conduct DRT Booster sessions as necessary and makes any necessary referrals to COD treatment providers in preparation for termination of MISSION services

Vocational/Educational supports and trauma-related services needed by the client are finalized

Case manager may meet with client and community providers to discuss transfer of care and long-term goals

Transfer of care is complete. Case manager conducts final session acknowledging completion of MISSION. Case manager explains to individual that he/she must now use a community providers for ongoing support. Then say goodbye.

Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12

If MISSION initiated in residential setting, CTI Phase 1 begins a few weeks before discharge

If MISSION initiated in residential setting, CTI Phase 2 begins between month 6 and month 7

If MISSION initiated in residential setting, CTI Phase 3 begins between months 9 and 10

Appendix E: Leading Exercises in Dual Recovery Therapy

The following section presents exercises as they appear in the Participant Workbook. ***Please note that we have included a section called "Notes for the Session Facilitator" that might be useful for identifying the key points in setting the stage for facilitating each DRT session.** Of course, each leader may want to make adaptations based on the particular session, group, time limits, and/or other factors.

1. Onset of Problems

What's it for?

To help you recognize when your psychiatric and substance abuse problems began and relate them to what was happening in your life. Timelines of each symptom or psychological problem can be developed in order to help understand the factors involved in the problems. This can help you see patterns so you know how one set of problems in your life might impact other areas; then you can take actions that work for you to prevent this from happening.

Why does it work?

This exercise lets you look at patterns on a single page where it is easy to see how one thing relates to another.

When to use it:

You can consult the timeline you did in class anytime to give you insight on how your life experiences in one area relate to those in another area. You may want to try the same exercise at another time and see if you make more discoveries that you can use.

How to use it:

The following pages show three different timelines. First, you will see a sample; then, you will see timelines you can fill out based on your own experiences.

- One of these timelines is for psychiatric symptoms. This timeline asks you to remember when you have experienced them in your life.

- Another timeline is for interpersonal problems, such as quarreling more than usual with family members, having trouble at work, or falling into debt.

- The third timeline is for substance abuse. When were you using or drinking?

Once you have all three timelines, you can use them to explore what was happening at the same time in your life. What triggered what? Did you start using to control psychiatric symptoms? Did something in your personal life stress you out, causing symptoms to flare up? Once you can name these patterns, you can more easily make choices to put yourself in control.

Notes for the Session Facilitator:

Explain to client that there is usually a pattern to when symptoms begin and that symptoms for substance abuse and mental problems are often interrelated. After showing the client how to fill out the timelines and going over the example, give participants time to fill out their own timelines. If completed in a group environment, you can ask the client to share his or her insights, leading to a discussion of common patterns and useful discoveries.

2. Life Problem Areas

What's it for?

To help you see where the problems are in your life that you want to change.

Why does it work?

Sometimes things can seem overwhelming, but just naming them can help.

When to use it:

You can consult the list you did in DRT class anytime so you can see how things are changing for you and what areas need more work.

How to use it:

Every few months, you might want to look at the problems you listed in class and ask yourself:

1. What's getting better? What helped me change?

2. What's about the same? Why? What else could I do to make it better?

3. What's worse? Why? What can I do to change that? Who could help?

Notes for the Session Facilitator:

Explain that this exercise will help the client, peer support specialists, and case managers understand how problems related to mental health and substance abuse are affecting each person's quality of life. The exercise will help everyone "get on the same page" in working toward change. Explain that these problems will recur in discussions throughout the DRT sessions. Give clients about 30 minutes to work on the worksheet, then begin sharing around problems in each area, focusing on areas one at a time and asking for examples from group members. You may want to ask them to continue with the exercise for homework and continue the discussion in the next session.

3. Motivation, Confidence, and Readiness to Change

What's it for?

To help you look at something you want to change in your life and see whether you have the motivation, confidence, and readiness to make something different happen. This can include changes in substance abuse, mental health, family, and other interpersonal relationships.

Why does it work?

We know that we need all three of these things working in our favor to be in the best position to move ahead. When we honestly admit we're just not there, we can ask ourselves what we need to do differently to increase our motivation, confidence, or readiness to change. For

example, maybe you would be more confident about making a change if you had a good role model rooting for you.

When to use it:

When you are thinking about change in your life - or wondering why it isn't happening - you can return to this exercise. It's really helpful to look at the way you filled out the rulers for the same subject area (for example, drinking) a few months later and see where you are now. Once you're out in the community again, for example, are you more or less confident? Why?

How to use it:

Whenever you want to look at a change in your life, circle the numbers on the rulers and think about where you are with the change. What would it take to make the number a little higher? How can you get more going in your favor?

Notes for the Session Facilitator:

Explain to clients that a sense of importance, confidence, and readiness are all different aspects of motivation. Encourage them to answer honestly for each area they choose to address. You may want to have extra copies of the worksheet or extra note paper so they can easily use the rulers to explore different areas in which change is needed in their lives. The problem areas discussed in the previous session will be helpful as participants fill these out. If in a group environment, consider encouraging clients to share around some of the problems explored, the motivation clients find to address them, and implications for recovery.

4. Developing a Personal Recovery Plan

What's it for?

To help you think through - and commit to - the things you want to do to recover. When you have mental health and substance abuse problems, they affect many areas of your life.

It can seem overwhelming. But you can use this tool to get a handle on how to address them so things get better and better over time.

Why does it work?

Instead of having all the different things you need to do stressing you out, perhaps even causing mental health problems or making you want to use substances, this exercise helps you take control in a calm, thoughtful manner. It will help you see what you can do and think through where you might need to ask others to help you carry out your plan.

When to use it:

You will want to look at your personal plan periodically - maybe every three months - and redo it. Some problems will be resolved, but you may need new strategies to address others.

How to use it:

This may be an exercise that you do a little at a time, so you can really think through each problem area. You may want to use Exercise 3 in Part 1, section A of this manual, the "PICBA" Approach to Problem Solving, to decide how you want to address each set of problems.

Notes for the Session Facilitator:

This exercise builds on the life problem areas identified in the second session. Encourage participants to refer back to their answers and identify positive steps they can take to address the problem. Encourage them to share their thoughts with their peer support specialists, their primary case managers in the residence, and others who play a key role in their hopes for recovery. Provide an opportunity for sharing around various strategies participants have suggested for themselves in each area.

5. Decisional Balance

What's it for?

If it were easy to make changes in our behavior, we probably wouldn't be doing a lot of the things that make trouble in our lives. It isn't easy because the same things that cause problems also have some benefits. We have to look honestly at what we're getting out

of the behavior and what's driving it. Then maybe we can think of another way to meet the same need that doesn't cause us so much trouble.

Why does it work?

We can't just change by snapping our fingers. We have to decide. This tool helps us lay out and look at why we're doing what we're doing, what benefits it gives us, and what problems it's causing.

When to use it:

When there is a behavior you feel ambivalent about changing, even though it has a definite down side.

How to use it:

Identify the behavior you're thinking about changing (for example, substance abuse) and write down honestly the benefits and the negative consequences of that behavior.

Notes for the Session Facilitator:

This session marks the beginning of the skills building phase of DRT. Ask the client to pick the biggest problem area in his or her life. What behavior is at the root of these problems? How could it be changed? What are the benefits and negative consequences of change? Then encourage sharing if in a group environment.

6. Developing Strong Communication Skills

What's it for?

As we become stronger in recovery, we are increasingly able to have healthy relationships. A critical element in relationships that work well and feel good is skillful communication. The better we are able to communicate what we think, what we need, and what we are experiencing, the more likely we are to be understood and to have our needs met. The better we are at listening well to others, the more likely it is that others will show us the same empathy and respect in return.

Why does it work?

The simple lists that follow can do nothing on their own. But if you read them thoughtfully and relate them to your own life, they can help you identify areas where you can make improvements that will help you have better relationships with the people that matter to you.

When to use it:

It is especially helpful to review this material when you're working on improving communication with people who are important in your life - whether they are family members, friends, counselors or clinicians, significant others, or people you work with.

How to use it:

Review the "Elements of Good Communication" and "Elements of Poor Communication". Which patterns of good communication would you like to adopt? Which elements of poor communication apply to you?

One way to change your patterns of communication for the better is to pick just a couple changes to practice at a time. Stay conscious of them as you interact with other people and keep it up until the new behavior becomes part of you. Then keep trying a few more new ones. You may want to record your experiences in your journal.

It is important to remember that people who are stressed or who have some problems of their own may not respond to your efforts to communicate well with healthy communication. They will make their own choice, just as you make yours. Don't give up. Keep your commitment to a strong recovery and strong, respectful, honest relationships.

Notes for the Session Facilitator:

After clients identify the elements of poor communication they believe apply to them and the elements of good communication they would like to use, it is often helpful to encourage discussion of why they have used the forms of poor communication they employed in the past. Sometimes, for example, people mistake aggressive and hurtful forms of communication for assertiveness and necessary self-protection. Men in particular often find it difficult to "let their guard down." To give people a chance to practice new ways of communicating, you may want to improvise a role play using good and poor communication skills. Let them know that if they really want new behaviors to sink in, they should begin now to practice them regularly, so they can get useful feedback.

Elements of Good Communication

1**. Be polite and considerate.** Treat your partner with the same basic respect you show towards acquaintances!

2. **Stop and think** before commenting on things that bother you. Decide not to bring up issues unless they are really important.

3. **Decide not to "kitchen sink"** or bring up other problems when discussing one problem. Try to resolve one issue at a time.

4. Make sure to **express lots of positive feelings** and to reward your partner rather than taking things for granted when they are going well.

5. Decide on **fun activities together** ("I'll do what you want today in exchange for you doing what I want over the weekend").

6. **Go out of your way to offer to do tasks around the house.** Give to the other without expecting anything back and without saying "I'll do it only if you do."

7. **Avoid destructive criticism or complaining.** Phrase change requests in a positive way. Avoid complaining just for the sake of complaining.

8. **Use good listening skills.** Look at your partner when he/she speaks to you.   Don't interrupt! Take turns talking and listening. Validate what your partner says even if you don't agree ("I can understand why you're worried about my spending a lot of money. Maybe we can decide together how much cash I should have each week").

9. Try to be **assertive - not aggressive.** Think about what you want before you speak. Start with a positive statement and then use "I" statements. For example, instead of, "You're a spendthrift and we'll end up in the poorhouse. Try being a responsible adult!" try, "I'm very worried about the amount of money we're spending. I would like to try to figure out a way we can stop spending money and start saving. What do you think?"

Elements of Poor Communication

1. Don't listen: Don't look at partner when he/she is speaking. Ignore what they said.

2. Mindreading: Assume you know what the other person is thinking, and base your response on that rather than checking out what they are really thinking or what they mean.

3. Cross-complaining: Complain in response to your partner's complaint. "I hate it when you don't come home when you say you will." "Well I hate it when you complain all the time."

4. Drifting away from the point of the conversation: Bring up another issue before resolving the first one.

5. Interrupting: Talk over your partner. Don't let him or her finish a sentence.

6. "Yes butting": Agree but don't address the issue. "Yes but what about when you embarrassed me that day"or"yes but you've embarrassed me lots of times…"

7. Heavy silence (standoff routine): Try to punish the other person by ignoring him/her.

8. Escalate arguments: Become louder and louder, and more and more vicious.

9. Never call a time out or ask for feedback: Forget to stop the conversation if it's getting too heated. Forget to ask partner what he/she really meant.

10. Insult each other (character assassination): Call each other names, "you always…you never… you're a….")

11. Don't validate: Say things like "That's ridiculous…" "You're just creating problems. If you would just leave me alone everything would be okay." "You're crazy to think that."

12. "Kitchen sinking": Throw in more and more accusations and topics until you don't know what it is you're arguing about.

13. Not take responsibility: Always talk about what your partner is doing wrong instead of what you are doing.

7. Orientation to 12-Step Programs

What's it for?

This section will help you use a powerful tool: the support of peers who are also in recovery. People who use this proven program, or others like it, are more likely to be able to practice new behaviors and claim the lives they want.

Why does it work?

Seeing others further down the road who have overcome obstacles like our own can inspire us and give us hope. The twelve steps have helped many people find the spiritual strength and insight they need to stay in recovery. Eventually, when our healthier habits and lifestyle have become a stable pattern in our lives, we may take deep satisfaction in being role models for others.

When to use it:

Many people practice the 12 steps and attend groups their entire lives. Most people find it especially important to attend groups more frequently in early recovery. A regular pattern of attendance is a gift to yourself. It gives you allies and tools to help you stay on track.

How to use it:

Read this material carefully. If you have been part of a 12-step group in the past, reflect on your experience and discuss it with peers and counselors. If you have not, ask someone to go with you to your first meeting (perhaps one of the peer support specialists). Research local groups and make a commitment to attend regularly.

Notes for the Session Facilitator:

You will probably find this to be a lively session (particularly in group environments), since many people in recovery have experienced 12-step groups. Encourage them to share their experiences, role play ways to overcome any barriers to attendance, and share information about types of groups and meeting times in the immediate area. You may also want to encourage them to talk about each step and what it means to them.

Alcoholics and Narcotics Anonymous (AA/NA)

AA historians trace the genesis of AA to the meeting of Bill Wilson and Dr. Bob Smith in 1935. Both men found that, with mutual assistance, they were able for the first time to remain abstinent from alcohol. Shortly thereafter, they went on to found AA groups in Akron, Cleveland and New York. Since that time, Twelve Step programs have grown at an astonishing rate. Recent data suggest that there are approximately 100,000 chapters of various Twelve Step groups worldwide, approximately two-thirds of which are AA groups. Despite rapid growth, AA and other Twelve Step recovery programs have steadfastly maintained a stance of independent non-professionalism, mutual assistance, and adherence to original principles.

AA and NA emphasize complete abstinence from substances of abuse through a combination of mutual support, spiritual practices, and a personal dedication to a structured program of recovery known as the Twelve Steps. Most individuals recovering from alcoholism or other addictions view "working the steps" as the cornerstone of recovery:

- **Step One:** We admitted that we were powerless over alcohol and/or drugs and that our lives had become unmanageable.
- **Step Two:** Came to believe that a power greater than ourselves could restore us to sanity.
- **Step Three:** Made a decision to turn our will and our lives over to the care of God as we understood God.
- **Step Four:** Made a searching and fearless moral inventory of ourselves.
- **Step Five:** Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
- **Step Six:** Were entirely ready to have God remove all these defects of character.
- **Step Seven:** Humbly asked Him to remove our shortcomings.
- **Step Eight:** Made a list of all persons we had harmed, and became willing to make amends to them all.
- **Step Nine:** Made direct amends to such people wherever possible, except when to do so would injure them or others.
- **Step Ten:** Continued to take personal inventory and when we were wrong promptly admitted it.
- **Step Eleven:** Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
- **Step Twelve:** Having had a spiritual awakening as a result of these steps, we tried to carry this message and to practice these principles in all our affairs. AA/NA members are fond of noting that only the First Step mentions alcohol and/or drugs, and that the remaining steps emphasize the importance of self-improvement, confession, and the cultivation of a spiritual life. They are also quick to distinguish between spirituality and religion. While both the language and the history of AA/NA are steeped in Christianity, members have become increasingly tolerant of almost any spiritual inclination that cultivates humility and fellowship.

The past two decades have witnessed an explosive proliferation of Twelve Step offshoots. Emotions Anonymous, Nicotine Anonymous, Cocaine Anonymous, Al-Anon, and Ala-Teen are only a few of the groups open to those seeking to recover from a variety of disorders and emotional conditions. All closely follow the Twelve Steps and have adopted them virtually verbatim, with only a minimum number of necessary changes in language. Therefore, clients in a variety of Twelve-Step recovery programs share a common set of principles and a common language. The following is a brief lexicon of commonly encountered Twelve Step terms and concepts:

- **Dry drunk** - a state of mind characterized by abstinence without spiritual and emotional growth.

- **Earth People** - those not involved in Twelve Step Recovery.

- **Friend of Bill** - fellow Twelve Step program member.

- **HALT** - Hungry, angry, lonely, and tired. A quick checklist of mood states that can act as triggers. It is often said in AA that "alcoholics can't afford to get angry."

- **On the tracks** - flirting with disaster by spending too much time around people, places and things.

- **Pigeon** - a newcomer who is working with a sponsor.

- **People, places, and things** - stimuli associated with using drugs and alcohol.

- **Serenity Prayer** - "God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference." Recited at every meeting, this prayer is used frequently by members as a meditation.

- **Slogans** - Phrases commonly heard or prominently posted in AA/NA meetings.

- **Bring the Body and the Mind Will Follow** - Advice to the newcomer who may be onfused, overwhelmed, or disoriented.

- **Don't Drink and Go to Meetings** - bottom line advice for remaining abstinent, even during the toughest of times.

- **Live and Let Live** - promotes tolerance and a spiritual mindset.

- **Think!** - Admonishment aimed at combating impulsivity.

- **One Day at a Time** - a crucial concept to AA/NA members, who generally attempt to remain sober for only 24 hours at a time. This slogan can help to inspire a present-centered, mindful attitude.

- **There but for the Grace of God go I** - a reminder to always keep some "gratitude in your attitude."

- **Sponsor** - An AA/NA "old-timer" who can act as a guide and support to the newcomer. It is recommended that sponsors be 1) sober for at least one year 2) of the same sex as their protégés 3) emotionally stable.

Another recent development has been the founding of meetings appropriate for particular populations. Newcomers in highly populated areas often find that they can choose from meetings specifically targeting professionals, gay and lesbians, men, women, or people with mental illness. Nonetheless, three basic formats remain predominant. Speaker meetings showcase one or more members in recovery chronicling their active addiction and recovery. Speaker meetings can be

open meetings (welcoming to visitors who are not working toward recovery) or closed meetings (restricted to those working toward recovery). Step meetings focus on reading and discussing one of the Twelve Steps. Discussion meetings explore in-depth personal experiences with a specific recovery-oriented topic. Both step and discussion meetings are likely to be closed meetings.

In addition to their involvement in specific programs, those in Twelve Step recovery often endorse a vision of change different than that typically embraced by the mental health and medical treatment communities. For those in Twelve Step programs, recovery is a powerful and meaningful word. There is neither a single agreed upon definition of recovery nor a single way to measure it; it is simultaneously a process, an outlook, a vision, or a guiding principle, and is symbolic of a personal journey and a commitment to self-growth and self-discovery. Recovery is a complex and typically non-linear process of self-discovery, self-renewal, and transformation in which a client's fundamental values and worldview are gradually questioned and often radically changed. The overarching message is that hope and restoration of a meaningful life are possible, despite addiction or mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society. Recovery is often linked with 12-Step recovery; however, there are different roads to recovery, and recently consumers with a mental illness have adopted this word to describe their journey. This trend has been accelerated by the involvement of the dually diagnosed in Twelve Step recovery programs.

8. Anger Management

What's it for?

To help identify the things that makes you angry so that you can gain control over your reactions and choices.

Why does it work?

Often anger takes us by surprise. Reacting in the moment, we can damage friendships, hurt ourselves or others, abuse substances, or lose our ability to assess what is really going on. When we have a good sense of what our triggers are, we will still have that flash of rage or anger, but then we can say, "whoa."

When to use it:

Because anger is sudden and can make us feel out of control, we need to thoughtfully identify our triggers in advance based on past experience.

How to use it:

Fill out the worksheet, then come back to it when something makes you angry and refine your answers as needed. Knowing your triggers will help you to reflect on them, perhaps in your journal. You can work with counselors to see how you can best give yourself the space to respond in a way that is in your best interest.

Notes for the Session Facilitator:

Good questions to start the discussion are:

- Why is it that one person gets really angry at something where another person just gets annoyed at the exact same thing?

- How do you know when you're getting really angry?

- What is the difference between anger and frustration? Sometimes people use the word "angry" for a wide variety of feelings and emotions; it can be helpful to distinguish between annoyance, frustration, impatience, irritation, anger, real rage, and other feelings. Ask the client to mention some of the negative consequences that could occur if a person becomes angry and out of control.

After they fill out the worksheet that follows on things that anger them, share some techniques for "cooling down." How can they hit the "pause" button?

9. Relapse Prevention

What's it for?

Preventing relapse is much easier than trying to recover after one, retracing difficult steps and refighting the same battles. We can learn to recognize the signs that a relapse could happen and then take action to avoid it. This exercise can help.

Why does it work?

The more we become conscious of the signs that indicate we might be about to relapse, the more we are able to take control and "steer away" from trouble.

When to use it:

Work through this carefully when you are not in immediate danger of relapse and can think clearly. It helps to discuss your experiences and plans with others.

How to use it:

Review the chart on warning signs of relapse and discuss it with others. Read through the material on safe coping strategies and mark those you think would be especially helpful for you. Then work on a change plan that you have faith in and believe can help prevent a relapse. Then - use it!

Notes for the Session Facilitator:

You will want to talk through the chart on relapse prevention that follows, eliciting examples of several of the boxes. (This should be easy.) After reviewing the coping strategies, ask them to share some of the others they have found effective, as well as their experience using the ones listed. Take time to fill out the worksheet on the "Change Plan" and encourage the client to get started practicing some of the good coping strategies in the weeks to come.

Warning Signs for Relapse

Preventing relapse is different from helping someone to stop using initially. The action stage of quitting involves helping an individual to formulate a positive action planning for quitting, whereas relapse prevention involves identifying proactive ways to minimize the tendency to backslide. As relapse appears to be the last link in a chain of warning signs leading to a high-risk situation, prevention involves identifying, analyzing and managing warning signs.

During the initial quitting stage, major warning signs for relapse are either physiological or psychological withdrawal symptoms, depending on the substance of abuse.   As physical discomfort begins to ease, warning signs are due more to psychological l factors. The flowchart identifies major psychological warning signs.


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                    ┌──────────────────────────┐
                    │  Psychological Precursors │
                    │        of Relapse         │
                    │      "Warning signs"      │
                    └──────────────────────────┘
```

Psychological Precursors of Relapse "Warning signs"

Great desire to gratify cravings now	Remembering pleasures of using	Excitement of quitting diminishing	Problem in tolerating/managing emotions	Mental fatigue setting in
Physical discomfort intensifying	Pain of using replaced by its perceived beneifts	Elation turning to boredom, an uphill struggle	Overreacting to situations	Weary of resisting cravings

Unexpected Trigger
75% of relapses are due to negative emotions, interpersonal conflict, and social pressure

Lack of a coping strategy
None developed; used half heartedly; forgotten

Lapse

Abstinence violation effect
- **One lapse = a user:** I used once…I am a user again
- **Defensive self-talk:** Using is not that bad for me. I feel normal now; Everyone else uses.
- **Decreased self-efficacy:** I am powerless; I have no will power. I'll never be able to stop.

Full blown relapse

Safe Coping Strategies to Try

People who experience powerful emotions often try to cope by using a variety of strategies. Unfortunately, some of these strategies are self-destructive or self-defeating, and only make matters worse. When you are faced with thoughts, feelings, or memories that are hard to handle, we suggest that you try the following:

Stop! - Avoid doing anything impulsive. Remember the first rule of recovery - safety first. When people are scared, they react quickly and automatically. You have the power to decide to react differently - use it!

Think! - Ask yourself: "Do I really want to react this way? What is it that I am afraid of? What can I do differently to make myself feel better?" Make a decision to act, rather than react.

Cope! - Do something healthy that will help you to stay safe and feel more in control of your emotions. Consider one of the following:

- **Ask for help** - call someone who cares and who can help.

- **Delay** - postpone doing something destructive (such as using or hurting yourself).

- **Ask "what can I learn here?"** - turn an upsetting moment into a learning experience.

- **Take care of your body** - eat, sleep, drink, and exercise healthily.

- **Take a bath** - warm water can be relaxing and calming.

- **Set limits** - say "no" when necessary.

- **Speak kindly** - to yourself and others.

- **Avoid extremes** - move towards the opposite if you find yourself overdoing anything.

- **Seek healthy control** - look for things you can change, and let go of things you can't.

- **Stay in the moment** - avoid anticipating disaster.

- **Breathe** - regularly, deeply. Focus on your breathing to shut out overwhelming thoughts and feelings.

- **Remember your values** - avoid actions that will bring regret later.

- **Don't give up** - keep trying, even when discouraged.

10. Relationship-Related Triggers

What's it for?

To help identify some of the things that other people do that can trigger your substance abuse and understand why you react the way you do.

Why does it work?

Sometimes we don't really "get" what's happening with people we care about. They can always get under our skin. It helps to get specific about what the triggers are that really get to us and say honestly what it is we're really feeling when those things happen or those words are said.

When to use it:

When you feel an urge to use, you can think about what just happened that set it off. If there's another person involved you care about, maybe they will be willing to change what they're doing in some way so it doesn't get to you so much.

How to use it:

Fill out the first three questions on the worksheet. When you're feeling calm and ready to listen, approach the other person. Explain the trigger and how it makes you feel. Find out if the other person sees a way to change what they are doing. Or maybe you'll understand why they do this better and it will not bother you so much.

Notes for the Session Facilitator:

Give participants time to finish the reading that comes just before the worksheet. Elicit some additional examples of "chain" reactions. Then ask the client to answer the first two questions. If in a group environment, encourage the group to share their answers.

11. Changing Unhealthy Thinking Patterns

What's it for?

To help you think about and change the ways you think about problems.

Why does it work?

The thinking patterns we get used to can keep us from changing, undermining our attempts to change. But if we build new ones and practice them, we can feel better.

When we change the way we're thinking, we change the way we feel and act. But we can't pull this off until we go through an exercise of listening to ourselves and really hearing what we are telling ourselves - and questioning it. We need to begin to recognize when we are giving ourselves friendly counsel and when the old ways of thinking can keep us in a trap.

When to use it:

This is a good exercise to use every once in a while as you move through recovery to see where you're making progress, where you need to remind yourself of something you want to change, and where you're falling back into old habits.

How to use it:

Read through the examples of old ways of thinking from your DRT class, and read through the worksheet in which you thought about how you wanted to change. How are you doing? Have you had the old negative thoughts lately? Are you beginning to use the new messages more? If not, it's time to bump up the level of consciousness of what you want to change and let it happen.

Notes for the Session Facilitator:

You may want to start by taking turns reading the description of each of the various forms of unhealthy thinking. There is likely to be some laughter as people recognize each one! Then, discuss the examples of "stinking thinking" and give each person time to write at least one example on the worksheet. Share a few of these, then give examples of healthier responses. Explain that we actually have a choice in how we think

about something that happens, and some thoughts help us feel better and make better choices. You may want to assign participants to think of healthy responses for some of their unhelpful ways of thinking as homework to be discussed next week, if you run out of time. This is an important topic that is worth returning to collect new examples and new ways of thinking.

12. Changing Irrational Beliefs

What's it for?

To help notice and change things that we believe get in the way of recovery.

Why does it work?

Human beings are pretty smart, but we're also smart enough to lie to ourselves and get away with it sometimes. We just have to catch ourselves at it and say, "no way!"

When to use it:

This is good to do whenever we just did something self-destructive or hurtful to someone else. That's usually when we tell ourselves something that isn't true to justify what we did, or to make sense of an action that really just wasn't a good or fair choice.

How to use it:

Read through the list of irrational beliefs and you'll get the idea. Think about which of them ring true and put them in your own words, or think of other things you tell yourself. Write them down, just the way you think them sometimes. Then write down a true statement, one that will be healthy and help you recover.

Notes for the Session Facilitator:

Ask clients to read through the examples of irrational thoughts and check those they find apply to them. Review the examples with the clients. If in a group environment, challenge the group as a whole to think of different ways to "reframe" each of the examples. Go over the sample worksheet and give group members time to think of different, healthier ways of thinking for each type of irrational thought they have experienced. Share several of these with the group as a whole.

10 Popular Irrational Beliefs

When we live by rigid, irrational rules, we set ourselves up for disappointment, overreaction to problems, and needless unhappiness. When we challenge those beliefs and think of how we want to change, we take another step toward recovery and make our lives a little easier. In fact, a lot easier. And more fun!

Here are ten irrational beliefs that people often believe anyway.

1. I must be loved, or at least liked, and approved by every significant person I meet.

2. I must be completely competent, make no mistakes, and achieve in every possible way, if I am to be worthwhile.

3. Some people are bad, wicked, or evil, and they should be blamed and punished for this.

4. It is dreadful, nearly the end of the world, when things aren't how I would like them to be.

5. Human unhappiness, including mine, is caused by factors outside of my control, so little can be done about it.

6. If something might be dangerous, unpleasant, or frightening, I should worry about it a great deal.

7. It's easier to put off something difficult or unpleasant than it is to face up to it.

8. I need someone stronger than myself to depend on.

9. My problem(s) were caused by event(s) in my past, and that's why I have my problem(s) now.

10. I should be very upset by other people's problems and difficulties.

13. Scheduling Activities in Early Recovery

What's it for?

To help organize your time so that your life is full and rewarding - without the need for drugs or alcohol.

Why does it work?

This exercise is especially helpful when you are in early recovery and building the habits that will help you stay in recovery. If you just let yourself drift without any plans for the days and weeks to come, it is very easy to slide into the old habits that caused so much trouble before.

When to use it:

Before you return to the community, plan how you want to structure your time using the worksheet that follows. It will help you make room for all that life offers that is real and rewarding. Reclaim the sports, caring friendships, relationships, and good health you enjoyed at good times in your life. If you haven't had those good times - it's time to start!

How to use it:

Answer each question thoughtfully. If you're not sure, talk over options with a trusted friend or counselor. Then revisit the plan periodically to see how it's working and add things you find that work for you. Reflect on what you're doing in your journal. If you write about what you did and how it worked, or how it didn't work, you can learn a lot about yourself.

Notes for the Session Facilitator:

This activity is extremely important-even potentially life-saving. As consumers move back into the community, they each need a strong guiding vision of what they want their lives to be like and how they want to use their time. Encourage clients to be as concrete and realistic as possible. It is easy to create a cotton-candy reality that just won't happen. Instead, clients need to think of choices that really appeal to them and activities they really would enjoy.

Appendix F: Helpful Therapeutic Techniques Underlying MISSION Components

MISSION Case Managers will need to employ several core therapeutic techniques to appropriately facilitate sessions. MISSION Peer Support Specialists should be familiar with these techniques as well. Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, and Behavioral Role Plays techniques are discussed.

DRT blends and modifies core addiction therapy approaches with core mental health therapy approaches.

- Core addiction therapy approaches included in DRT are

    - Motivational Enhancement Therapy (MET)

    - Relapse Prevention and

    - 12-step Facilitation.

- Core mental health therapy approaches included in DRT are

    - Cognitive Behavioral Therapy, and

    - Skills Training.

As MISSION staff use this integrated approach, we encourage them to

- Be client-centered; demonstrate respect and empathy.

- Be aware of coping and personality styles.

- Be flexible.

- Be active.

- Be aware of how disorders interact.

- Provide education.

- Assess and enhance client motivation.

- Maintain a focus on recovery.

- Ensure that treatment is recovery stage-appropriate.

- Incorporate spirituality.

- Recognize the interpersonal context of change and involve significant others in treatment.

- Provide gender and culturally competent services.

- Be open to the complementary and alternative approaches that interest the client.

- Focus on problem solving and developing skills.

- Integrate more active learning therapy techniques.

However, there are some specific considerations when working with a population of currently or formerly homeless individuals who have been diagnosed with substance abuse and other mental health disorders. These changes are particularly evident in **Motivation** and **Assessment**.

Motivation

Motivating clients over the duration of DRT involves the following considerations:

- Motivation changes over time.

- Motivation is affected by therapist behavior.

- Motivation is not "all or nothing." Clients may have different levels of motivation to address mental health and substance abuse issues.

- Motivation is influenced by the treatment setting.

- Treatment strategies should be based on the client's stage of readiness to change.

Given this, modifications to MET could increase its efficacy for clients who have been diagnosed with co-occurring disorders. The client, faced with the complex challenges of dual recovery, may

- Have more problems to address;

- Have a longer engagement period;

- Experience lower self-efficacy/confidence;

- Need modified feedback and Change Plans;

- Be limited by cognitive abilities;

- Require greateer therapist activity;

- Need brief, simple, and repetitive statements;

- Need integrated mental health and substance abuse treatments;

- Be aided by assessing motivation to change for each issue on the problem list;

- Require increased support when selecting and sequencing Change Plan interventions;

- Need continuation of MET spirit when making transition to other modes of treatment.

- **Dimensions of Assessment**

- Substance use

- Mental health symptoms

- Symptom interaction

- Motivation

- Spirituality

- **Assessment Strategies**

  - Time-line (prior history of both)

    - Onset

    - Periods of stability/sobriety

    - Periods of Exacerbations

    - Impact on life/self, others, legal, employment

  - Prior treatment (each, integrated care)

  - Information from Significant Others

  - Family History

  - Symptom scales and diagnostic tools

- Stages of Change Assessment

- *Pre-contemplation:* not considering change in the foreseeable future

- *Contemplation:* ambivalent, but considering the possibility of change

- *Preparation:* expresses commitment and is developing a specific plan for change

- *Action:* is engaged in active and sustained efforts to quit

- *Maintenance:* has successfully sustained change (for at least six months)

- **Component of Treatment Plan in MISSION and Other Providers**

- *Address type of treatment provided* (e.g., individual therapy, group therapy, medication management)

- *Address amount of treatment provided* - How often will treatment be provided? How long will treatment last? How long does each treatment session last? In what program?

- *Describe the focus of treatment.* What will the treatment address? Treatment cannot and should not attempt to address all problems simultaneously.

- *Define goals and objectives of treatment.* It is important here to distinguish between goals and objectives. Goals are desired ends…what is it important for the client to achieve? Objectives are means towards these ends, the strategies by which goals will be achieved.

- **Dual Recovery Therapy Sessions**

- 13 structured sessions

- Front loaded in treatment for early skills development

- Provided as adjunct to residential program

- Booster sessions delivered as needed by case managers in the community

- Peers reinforce skills of sobriety, use of 12-step therapy and offer hope

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- **The Dual Recovery Status Exam - Framework for each session**

- Set agenda for session (client and counselor).

- Check-in with regard to any substances used since last session.

- Assess substance use motivational level.

- Track symptoms of depression or anxiety etc.

- Explore compliance with medications prescribed.

- Ask about attendance at Twelve Step groups, other treatment plan elements.

- Discuss the primary agenda topic (s) for the session.

- **Cognitive Schemes**

- *Catastrophization* - turning relatively minor disappointments into major catastrophes.

- *All-or-none thinking* - viewing the world in absolute, mutually exclusive terms.

- *Personalization* - relating external events to oneself based on little or no evidence.

- *Arbitrary inference* - drawing inappropriate conclusions based upon faulty, insufficient, or contradictory information.

- *Disqualifying the positive* - rejecting positive experiences by interpreting them as trivial or undeserved.

- *Emotional reasoning* - assuming that negative emotions invariably reflect the true state of the world.

- **Relapse Prevention**

- Identifying cues / triggers for substance use

- ID early warning signs of mental illness recurrence

- Goal to improve self-efficacy to handle specific people, places, things, moods

- Examples:

  o Drug refusal skills

  o Seemingly irrelevant decisions

  o Managing moods / thoughts

  o Stimulus control

- **Behavioral Role Plays**

- *Stages of a Role Play*

  o **Discuss rationale and gain client commitment.**

  o **Learn about others significant to the client.**

  o **Discuss the goals, skills to be learned, and criteria for success.**

  o **Do the role play.**

  o **Elicit and give feedback.**

- **Role Plays Continued: The Clinician's Role**

- Actively help the patient to set specific interpersonal goals.

- Promote favorable expectations and motivation before role playing begins.

- Assist the patient in building possible scenes in terms of emotion and setting.

- Structure the role play by setting the scene and assigning roles.

- Use the role play to model alternative behaviors.

- Prompt and cue the patient during the role-play.

- Use an active style of training through coaching and support.

- Give positive feedback for specific verbal and nonverbal behavioral skills.

- Identify specific verbal and nonverbal behavioral deficits or excesses and suggest constructive alternatives.

- Shape behavioral improvements in small, attainable steps.

- Elicit or suggest alternative behaviors.

- Give specific and attainable "homework" assignments.

- **Modifying 12-Step for COD**

- Recovery concepts supports increased sense of hope and connection to others

- Shared Experience (experience, strength, and hope)

- Recovery is not cure, but rather a way of living a meaningful life

- Recovery is a process of restoring self-esteem a personal commitment to growth, discovery, and transformation

- **The Role of Medications**

- *Medications are not a panacea.* Substance abusing clients are accustomed to addressing complex problems with simple answers and to viewing pills as the ideal solution to a variety of problems.

- *Medications can take time.* Clients often have little ability or willingness to delay gratification and tend to "want what they want when they want it."

Without considerable support and education, they are prone to lose patience.

- *Illegal substances can make a medication ineffective.* Clients often want the best of both worlds – the emotional stability or relief from anxiety or depression provided by a medication and the euphoria obtained through illicit drugs. It is important to realize that the therapeutic effects of a medication can be easily overwhelmed by simultaneously misusing other substances.

- *Some types of dependence are healthy.* For clients committed to abstinence, the idea of relying upon any substance may seem distasteful or even frightening. They may view all medications as "mind-altering" or "addictive" and need to be educated about the important differences about therapeutic medications and drugs of abuse.

- **General Treatment Issues**

- Empathic and therapeutic alliance

- Brief Interventions: Feedback, Advice, Choices, Optimism, Responsibility, and Follow-up

- Managing resistance

- Monitoring for relapse/relapse prevention

- Involving families/significant others

- Recovery Tools: treatment plan & contract, self-help groups, medications, & therapy

Appendix G: Supplemental Materials for Case Managers

Developing Relationships with a Broad Network of Community Agencies

"Systems brokering" - building relationships with community agencies that provide the services clients need to adjust to community life is the responsibility of the entire MISSION team, but MISSION Case Managers (CMs) are seen as being in a unique position to foster these relationships. Clients benefit from the connections that are established with community agencies already maintained by staff at the inpatient, residential, or outpatient treatment programs. For example, the facility strives to place each client in employment or education programs and coordinates with a number of potential employers or colleges to accomplish this goal. In turn, staff from these programs also have community contacts that help secure housing. Often, needed contacts are found through "someone who knows someone." As such, networking skills are essential ingredients in successful implementation of the MISSION program.

Second, MISSION CMs enter their jobs with existing relationships in the community and areas in which they are particularly suited to build and maintain certain kinds of relationships. For example, one of the MISSION CMs joined the MISSION team with experience in vocational rehabilitation and connections that helped facilitate employment; she also had years of experience in vocational counseling. We encourage a team approach, in which MISSION CMs pool their strengths so that each CM can be a resource for the others based on their unique background, experiences and professional training.

Third, MISSION CMs often build relationships "from scratch" through Internet searches or referrals from others in the field who know of useful resources. MISSION CMs divide the responsibility to research programs that address certain needs. Such teamwork has helped them identify resources that can help clients prepare resumes and acquire tools needed for work; nonprofit agencies that give furniture to clients free of charge; contacts for employment and housing; a public program that provides half-price public transportation for persons with disabilities; and agencies that provide quality clothing free or inexpensively. MISSION CMs documents this shared knowledge and explain the process for applying for services or goods to clients.

Training Needs

Training is seen as essential for personal growth and development, and all staff are required to participate in MISSION training activities. MISSION CMs receive ongoing internal training through group sessions and individual sessions led by their clinical supervisor. In addition, they receive:

- Internal training, to help them implement the program in accordance with the organization's expectations.

- Supplementary training from outside sources, to help them build clinical skills and acquire the knowledge they need to help enrolled clients navigate health care systems and access community services. They may also receive training on pertinent techniques and subjects, such as Motivational Interviewing and employment issues for persons who have a criminal or legal history.

Internal Training

In addition to basic orientation offered to all employees (such as timekeeping), the MISSION program provides training to MISSION CMs on a number of topics relevant to their job, including:

- Confidentiality policies

- Research integrity

- Documentation policies

- Crisis management

- Expectations of the position

Supplementary Training

In addition, it is recommended that MISSION CMs receive and retain certification from the Red Cross on cardiopulmonary resuscitation. Consistent with their own credentials and professional affiliations, MISSION CMs are encouraged to attend continuing education training events both within and outside of their employer. MISSION CMs are also strongly encouraged to attend mental health grand rounds when possible. Additional trainings may be provided by psychologists, doctors, social workers and others who are very familiar with all of the topics listed below.

SUPPLEMENTARY TRAINING TOPICS OF INTEREST

- Assessment and Prevention of Suicidal Behavior
- Counseling and Interviewing Skills
- Motivational Interviewing
- Harm Reduction
- Drug Craving
- DSM-V Axis I and II Disorders
- Trauma, PTSD, and Treatment
- Mental Health Research
- Employment Challenges for Ex-Offenders
- Drugs of Abuse and Their Impact on Psychiatric Disorders
- Public Benefits Packages and Systems
- Culture, Mental Health, and Counseling
- Psychiatric Medications

Case Examples

The next section offers examples of situations MISSION CMs may encounter in their work with clients. Each example presents a problem and is followed by strategies MISSION CMs might employ to assist clients during different phases of the CTI model highlighted in Chapter III: Case Management.

CTI Phase 1: Transition to community

Due to the flexibility of the MISSION program, clients may begin receiving services while in an institutional setting, such as an inpatient or residential treatment facility, or after their transition into the community while trying to acquire stable housing. During the first phase of CTI, MISSION CMs follow clients in each of these settings closely. For example, MISSION CMs function as a secondary provider, collaborating with inpatient or residential treatment staff by attending weekly meetings to discuss treatment progress. In doing so, the MISSION CM supports the treatment team and the client, by providing specialized co-occurring disorder treatment; assistance with regard to discharge planning; and identification of resources needed to facilitate a successful community transition. As clients prepare for discharge, they will need a lot of support from their MISSION CMs to ensure that their treatment plan links them to the community resources necessary for a successful recovery and that this plan is implemented once the client transitions into the community. Similarly, if MISSION services begin in the community, the MISSION CM may be either the primary or secondary provider of care, depending on whether the client is enrolled in a structured outpatient treatment program, such as an Intensive Outpatient Program (IOP). Ultimately, the common goal of the first phase of CTI is to identify and begin to implement additional and critical community resources that will help promote the successful recovery of each MISSION client in a supportive environment.

Example 1. A client, who is about to transition to the community, voices concerns with her MISSION case manager about the lack of public transportation in her community and how this might impact her work.

Specifically, the client explains that she needs to rely on public transportation until she can regain her license, but that the buses are infrequent and that she worries about getting to work late and losing her job. If she were leaving from her family home, she would get there more easily, but program staff feels she needs the support provided in transitional housing for a while. The case manager contacts a community agency that is able to arrange transportation on a short-term basis. She also researches train schedules and finds an alternate way for the client to get to work when needed, easing the client's anxiety.

Example 2. Due to a miscommunication about his home address, a client has not received the medications he needs to control severe pain. The MISSION case manager realizes that the client is in danger of starting to drink again to relieve the pain. The case manager straightens out the problem with the address, elevates the priority given to fulfilling the prescription by contacting the client's primary care provider and ensures that the medication arrives before the client relapses.

CTI Phase 2: Try Out Phase

As the client's transition to the community becomes more securely grounded, MISSION CMs gradually decrease the frequency of their visits with the client. The client's goals often change, and new kinds of obstacles present themselves. Clients may find they have taken on more than they can handle in their financial obligations, especially rent. They may feel overwhelmed by responsibility or have difficulty managing relationships. Spouses and friends may seem nagging and unsupportive. The MISSION CM plays a steadying role in fostering independence, while helping clients see the way forward. For example, the MISSION CM may suggest that the client and his/her significant other enroll in couples counseling, help with money management, or suggest a way for the client to gain the skills that would qualify him or her for a higher-paying job. The continuity of the relationship with the MISSION CM encourages the client and increases the likelihood that he/she will stay on course long enough to stabilize.

Example 3. During an early session with his case manager, a client who elected to move in with a girlfriend reports that the relationship isn't working out and she wants him to move out immediately. The client explains that although he thought he had a job, it has fallen through. He has no refrigerator or furniture and no one else who is willing to give him a place to live temporarily. He is feeling overwhelmed and frustrated, and even admits that he is tempted to commit a robbery. The case manager uses connections with the local housing authority to help him find a place to live quickly. She also gives him a referral to a nonprofit agency that will give him a refrigerator and some basic furniture. She works with him on his resume and helps him set up several job interviews. Soon, he has his confidence back and is settling into the community successfully.

Example 4. A client who has not seen his children or spoken to his former spouse for years wants to see the children again. The case manager helps this client (who tends to become inpatient and have angry outbursts) to stay calm, focus on the goal, and avoid antagonizing his ex-wife. The case manager reinforces the anger management skills this client learned while he was in the DRT group sessions. The case manager also helps the client get the information he needs to request visitation rights properly through the court system. The client is able to handle his frustration, keep focused on his goal, and attain visitation rights. He is now enjoying getting to know his children again and they have become a stabilizing and motivating factor in his recovery.

Example 5. A client who has been enrolled in the program for almost six months had stopped coming to appointments with his peer support specialist and clinical case manager. "I have too many people to see and too many appointments… so I just stopped going to all of them." Before enrolling in the MISSION program, this client reported he had medical and mental health services at a local community health center (that was located near where he had been living outside for five years). The client had a history of engaging sporadically with his providers there, noting that he would "see a different doctor every time he went in."

During this period when the client was not engaging with MISSION team members, he nevertheless continued to meet with his homeless services outreach worker on a regular basis. This clinician regularly met with the client in a local park in a non-threatening environment. The MISSION Case Manager asked this clinician to help her engage with the client, and offered to meet with him in that same outdoor setting each week. The CM and PSS have been meeting regularly ever since. Since engaging with him, the CM has been able to better understand how to meet his healthcare and housing support needs – without overwhelming him to the point of walking away from services. For example, identifying as many outreach services as possible minimized his anxiety about coming to appointments that required coming to buildings (which requires waiting, being around people, and other discomforting and "triggering" factors for him).

MISSION staff also worked on streamlining his service providers and connecting him with providers who are experienced in treating patients who are dually-diagnosed. As this client also had serious medical issues (including uncontrolled hypertension), he was overwhelmed by the number of appointments he needed to remember and attend.

Since responding to this client's specific needs for service delivery and better coordination, he has made all his appointments in the last few months and most importantly, his health and substance use behavior has improved. He is regularly taking medications for both hypertension and mood disorder, as well as a medication that helps curb his alcohol cravings. He is now engaging in individual therapy weekly in a community setting, and has identified one of his primary goals as integrating into the community, including engaging with mainstream service providers.

CTI Phase 3: Transfer of Care to Community Supports

In this phase, MISSION case management support continues to decrease in intensity and gradually "tapers off" as the client's supports within the community stabilize. Meetings stretch from weekly to every other week. Towards the end of a client's participation in MISSION, meetings may be as infrequent as once a

month. MISSION CMs should vary the frequency of their meetings according to the client's needs: some are reluctant to let go of the friendly hand, while some are self-determined and independent. For some, it may make sense to replace in-person contact with telephone contact on occasion. The goal is to have less frequent sessions with the client and to foster independence and reliance on available community supports that have been reviewed with the individual by their MISSION CM. This will also assist with his/her termination from MISSION, the process of which begins slowly as sessions become less frequent.

The MISSION CM should first and foremost, make sure that he or she has the correct telephone numbers and addresses to contact the client (both at present and in the community) including numbers for family members or others likely to know where the client is if he or she moves. In their meetings with clients, the MISSION CM should also devote time towards the MISSION Participant Workbook readings that focus on transitioning to the community. Though the client's discharge plan remains the primary responsibility of the inpatient or residential care provider, sessions that address the client's transition back into the community will allow MISSION CMs to contribute valuable input to their client's discharge plans. For high-risk cases, the MISSION CM may meet with the primary care provider to ensure they are "on the same page" about how best to manage the client's critical transition back to the community and ensure that needed supports are in place. In rare cases, the MISSION CM may need to provide additional support in locating housing, a job, or other resources needed for the client's transition at this stage; in this circumstance, assistance would be coordinated with the primary care provider.

Effective aftercare to ensure that functional community supports are in place is central to the MISSION program. The support provided by the MISSION CM changes to match the individual's status, usually evolving as the period of community living continues. In some cases, a client receiving MISSION services may leave their primary treatment programs prematurely, usually because he or she has relapsed. It is important to underscore that while a relapse to substance use is not a reason for termination from the MISSION

program, by policy, it is a reason for immediate discharge from some residential facilities. If this occurs, the MISSION CM begins immediately to provide supportive assistance. While this is obviously not an ideal situation, some individuals have successfully completed their transition to community life despite a precipitous early start.

The MISSION CM may present a list of local resources and referrals for reference at the closing meeting, if the client has not received those before. Often, MISSION CMs send a positive, personalized closing note that thanks each client and expresses good wishes. Depending on the institutional policy, one might even encourage these former clients to call and "check in" after three months. This offer has helped some individuals who have participated in MISSION, as it conveys the MISSION CM's continuing interest in their welfare and continued progress with sobriety, managing mental health issues, other health related issues, obtaining employment and maintaining healthy family and other personal relationships.

EXAMPLE OF COMPLETED MISSION TREATMENT PLAN

This completed example of a MISSION treatment plan is provided as a guide for MISSION CMs; however, each MISSION client will have unique considerations that will need to be accounted for by MISSION CMs.

Considerations for MISSION Treatment Planning

Date:

01/01/2013

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
- Other Needed Services
  - Housing Needs: currently receiving residential care; transition to community
  - 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
  - Support for dealing with a trauma
  - Dental Services
  - Benefit Entitlements
  - Vocational Support: increase job-related experience; link to services
  - Other

Considerations for MISSION Treatment Planning (cont'd)

MISSION Service Delivery

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

Treatment Goal & Objectives: Client is currently receiving care in a residential substance abuse treatment program. Client has identified the following treatment goals/objectives below:

Treatment Goal #1: maintain abstinence from drugs

Treatment Goal #2: gain job-related experience

Treatment Goal #3: transition to independent housing

Next appt: Mon Tue Wed **Thu** Fri Sat Sun   **Time:**   _11_:_00_   am/pm

Provider: Helena Rogers, MISSION Case Manager

Location: Bubbling Brook Medical Center

EXAMPLE OF MISSION CASE MANAGER NOTE

The MISSION Case Manager Note is based on the client's MISSION Treatment Plan. Below is an example of a MISSION Case Manager Note.

SAMPLE CASE MANAGER NOTE FROM MISSION ORIENTATION SESSION

Date: 12/3/2012

Individual Session: Orientation to the MISSION Program

The client attended an orientation session with this MISSION Case Manager to learn the goals, structure, and schedule of the MISSION program. The client was given the opportunity to ask questions about the program and these questions were answered to his satisfaction. The client's goals during his treatment in the 14-week MISSION program and following completion of the program were discussed. The client stated that his primary goals were to maintain his abstinence from drugs, gain job-related experience, and to transition to independent housing during his participation in the MISSION program. After completing the program, he hopes to get a part-time job while completing his GED. The client also agreed to continue his attendance at NA meetings, to continue his adherence to his psychiatric medication regimen, and to continue outpatient psychotherapy. His strengths are his stable work history and his commitment to his faith and sobriety. His barriers to success include his tendency to relapse during times of emotional stress and a lack of social support.

The client reported feeling hopeful about his future and less depressed than when he was initially admitted to the MISSION program. Despite this improvement, his affect continues to be somewhat sad and constricted. The client denied any suicidal/homicidal ideation*, as well as, any intent or plans to hurt himself or others. The client denied any current alcohol or drug use. His thought process was goal-directed and linear.

This MISSION case manager will contact the client's primary care provider, the purpose of which is to communicate information gathered during the MISSION orientation session to aid in the development of his treatment plan.

In the event that a client indicates that he/she is suicidal with a clear plan or definite intent, the client should be escorted to his/her current therapist, if possible. If his/her therapist is unavailable, the client should be escorted to the walk-in mental health clinic to be seen by the next available clinician. Clients should not be left alone. Case managers should stay with clients until they are able to see a mental health clinician for evaluation. Case managers should also remind clients of emergency contact options: current therapist (during business hours)/ walk-in mental health clinic, 911, and the 24-hour National Suicide Hotline, 1-800-273-8255 (TALK).

In the event that a client indicates clear intent and a definite plan to harm a specific person, the client should be directed to his/her current therapist, if possible. If his/her therapist is unavailable, the client should be escorted to the walk-in mental health clinic to be seen by the next available clinician. Local police and targeted person may also need to be notified to ensure the safety of all involved.

EXAMPLE OF A TEMPLATE NOTE FOR A DRT SESSION

TEMPLATE FOR NOTES ON INDIVIDUAL PARTICIPATION IN DRT

Group: Dual Recovery Therapy for MISSION Program

Date: 7/12/2013

Agenda: Relapse Prevention

GROUP BEHAVIOR RATING:	LOW	MEDIUM	HIGH
SEEMED INTERESTED IN THE GROUP	()	()	()
INITIATED POSITIVE INTERACTIONS	()	()	()
SHARED EMOTIONS	()	()	()
HELPFUL TO OTHERS	()	()	()
FOCUSED ON GROUP TASKS	()	()	()
DISCLOSED INFORMATION ABOUT SELF	()	()	()
UNDERSTOOD GROUP TOPICS	()	()	()
PARTICIPATED IN GROUP EXERCISES	()	()	()
SHOWED LISTENING SKILLS/EMPATHY	()	()	()
OFFERED OPINIONS/SUGGESTIONS/FEEDBACK	()	()	()
SEEMED TO BENEFIT FROM THE SESSION	()	()	()
TREATMENT CONSIDERATIONS ADDRESSED	()	()	()

COMMENTS: The client participated in the Dual Recovery Therapy group that is a component of the MISSION Program. Group members discussed methods of relapse prevention.

DRT Status Exam Checklist

Note: framing questions with a positive spin can help set an encouraging tone for the session. For example, asking "How many days in the past week have you not used?" instead of asking "How many days did you use?

Set agenda for session (client and counselor)

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 Twelve Step groups and other elements of the treatment plan

Additional notes

Sample MISSION Case Note Template

MISSION Clinical Case Manager Note

Person Served Name:_____ Person Served #:

DOB:_____

Location: _____ Staff Name:_____

Health Insurance Provider Name:_____

Date of Service:_____

Authorization from third party payor obtained ☐ No (File in Chart) ☐ Yes (Submit to billing)

Enrolled in MISSION ☐ No ☐ Yes   Date of MISSION Enrollment:_____

HOURLY/BILLING INFORMATION (enter # of units - all units are 15 minutes)

Cancellation ☐ (check if appropriate)

For MISSION Use Only
CONTACT LOCATIONS/Use number
_____ *Community*
_____ *Treatment Facility*
_____ *Phone outreach*
_____ *Other: (Describe)*

Service/# Units

___ Face to face with person served at home

___Face to face with person served at inpatient facility

___Face to face with person served at all other community settings

___All travel to/from person served including unscheduled appts.

___Phone contact with family/friends/other providers

___Mtg/Consult without person served present

___Clinical Documentation, internet research, record review, all other non-direct case management services

___Supervision

___No Show (in community)

_____ **TOTAL UNITS**

DRT Session Conducted on this date
(note number of times each service provided today)

Number	Type of Service	Number	Type of Service
	Onset of Problems		Anger Management
	Life Problem Areas		Relapse Prevention
	Motivation, Confidence, and Readiness to Change		Relationship-Related Triggers
	Developing a Personal Recovery Plan		Changing Unhealthy Thinking Patterns
	Decisional Balance		Changing Irrational Beliefs
	Developing Strong Communication Skills		Scheduling Activities in Early Recovery
	Orientation to 12-Step Programs		

Group Session ☐   Individual Session ☐

Other MISSION Services Provided on this date
(note number of times each service provided today)

Number	Type of Service	Number	Type of Service
	CTI Sessions		Life Skills/Money Mgmt (skill building)
	Assessment for Case Mgmt Needs/ Services		Recovery Coaching (skill building)
	Pre-employment (skill building)		Information and Referral (reduce risk)
	Employment Coaching (skill building)		Transportation (skill build/reduce risk)
	Service Coordination (reduce risk)		Self Help/Support Group (skill build)
	Housing Support (reduce risk)		Community Social Event (skill building)
	Family Support (Increase natural support)		
	Other: (describe)		

MISSION Referrals Made:

Number	Type of Referral	Number	Type of Referral
	Medical		Mental Health
	Substance Abuse Treatment		AA/NA
	Dental		Employment
	Education		Training
	Housing		Food Stamps
	General Assistance (EAEDC)		Medicaid/Medicare
	SSI/SSDI		Legal Assistance
	Emergency Room Referral		Psychiatric Hospitalization Referral
	Medical Hospitalization Referral		Other Hospital Referral (e.g. IOP/PHP)
	Other: (Describe)		

Progress Toward Goals in Treatment Plan:

New Assessed Need:

Plan/Additional Information:

Person Served Signature: _____

Clinician Signature: _____

Date: _____

Collateral Signature: _____

MISSION Peer Support Specialist Note

Person Served Name: _____ Person Served #:

DOB:_____

Location: _____ Staff Name:_____

Health Insurance Provider Name:_____

Date of Service:_____

Was the Case Manager present during this visit? ☐ No ☐ Yes.

    If yes, how many units with CM?_____

Authorization from third party payor obtained ☐ No (File in Chart) ☐ Yes (Submit to billing)

Enrolled in MISSION ☐ No ☐ Yes

Date of MISSION West Enrollment:_____

HOURLY/BILLING INFORMATION (enter # of units - all units are 15 minutes)

Cancellation ☐ (check if appropriate)

Service/# Units

___ Face to face with person served at home

___Face to face with person served at inpatient facility

___Face to face with person served at all other community settings

___All travel to/from person served including unscheduled appts

___Phone contact with family/friends/other providers

___Mtg/Consult without person served present

___Clinical Documentation, internet research, record review, all other non-direct case
   Management services

___Supervision

___No Show (in community)

____ **TOTAL UNITS**

> **For MISSION Use Only**
>
> CONTACT LOCATIONS/Use number
> _____ *Community*
> _____ *Treatment Facility*
> _____ *Phone outreach*
> _____ *Other: (Describe)*

Peer Support Session Conducted on this date
(note number of times each service provided today)

Number	Topic(s) discussed	Number	Type of Service
	Willingness		Significance of Honesty
	Self-Acceptance and Respect		Courage
	Gratitude		Patience
	Humility		Medicine Maintenance
	Dealing with Frustration		Making a Good Thing Last
	Handling Painful Situations		

Group Session ☐   Individual Session ☐

MISSION Services Provided on this date
(note number of times each service provided today)

Number	Type of Service	Number	Type of Service
	Review of Workbook		Life Skills/Money Mgmt (skill building)
	Attend AA/NA with Client		Relapse Prevention (skill building)
	Pre-employment (skill building)		Recovery Coaching (skill building)
	Employment Coaching (skill building)		Information and Referral (reduce risk)
	Service Coordination (reduce risk)		Transportation (skill build/reduce risk)
	Housing Support (reduce risk)		Self Help/Support Group (skill build)
	Family Support (Increase natural support)		Community Social Event (skill building)
	Other: (describe)		

MISSION Referrals Made:

Number	Type of Referral	Number	Type of Referral
	Medical		Mental Health
	Substance Abuse Treatment		AA/NA
	Dental		Employment
	Education		Training
	Housing		Food Stamps
	General Assistance (EAEDC)		Medicaid/Medicare
	SSI/SSDI		Legal Assistance
	Emergency Room Referral		Psychiatric Hospitalization Referral
	Medical Hospitalization Referral		Other Hospital Referral (e.g. IOP/PHP)
	Other: (Describe)		

Progress Toward Goals in Treatment Plan:

New Assessed Need:

Plan/Additional Information:

Person Served Signature: _____

Clinician Signature: _____

Date: _____

Collateral Signature: _____

Appendix H: Leading Peer-Led Sessions

The following sessions were designed based upon collaboration between previous MISSION Peer Support Specialists [PSS] and clients. The goal of these sessions is to focus on a different topic each week but impose a minimum amount of structure in order to promote free discussion and provide an alternative to the many structured activities in which these clients engage during time spent in their treatment programs.

Each session includes a brief description, a few learning goals, some suggestions on how to introduce the topic, and some questions to spark discussion. Because the purpose of each session is to get clients talking and to share their experiences, the PSS facilitating the session should feel free to use other introductory material or questions to get clients talking about the day's topic. Regardless of the session's individual goals, an overriding goal for every session is to increase the clients' willingness to seek support from and provide support to their peers.

Some of the descriptions below also include a short passage written by a client who has previously participated in that particular session. If desired, the PSS facilitating the session can read these passages as a way to spark discussion, asking the individual if they've had similar feelings or experiences.

1. Willingness

Description: A discussion of how willingness can be the key to recovery and maintaining a healthy lifestyle. The desired outcome is for clients to pursue a course of action leading to recovery through their own choice.

Learning goals: Clients will

(1) become informed that willingness is an important part of recovery;

(2) comprehend that willingness is necessary for change; and

(3) understand that willingness is the basis of maintaining a quality way of life.

How to introduce the topic: Make sure clients understand that the assistance people are offering them will be helpful only if they are willing to accept it. With willingness, the journey to a new life can begin, and change will come.

Questions to spark discussion:

- What are some things that you have been willing to change in your life? Unwilling to change?

- Would you agree that willingness is an important part of the recovery process?

- Have you acted on your willingness?

- What are some results from taking a course of action based on your will?

2. Self-Acceptance and Respect

Description: A discussion on how self-acceptance and respect are important in recovery from addiction and promotion of mental health.

Learning goals: Clients will

(1) understand that denial of one's illnesses and lack of respect for oneself inhibits recovery;

(2) become informed that self-acceptance of their addiction and mental health issues is needed in order to grow and maintain their recovery;

(3) grasp the idea that through self-respect they will become more comfortable with themselves and others;

(4) perceive that acceptance and respect of self can help them overcome stigma and prejudice in society; and

(5) understand that self-acceptance and respect can turn around someone's perception of them.

How to introduce the topic: Make sure that clients understand that denial and being down on oneself is common, but by gaining self-acceptance and respect, they begin their healing process.

Question to spark discussion:

- Are you having difficulty accepting the fact that you are living with addiction and mental health issues?

- Where are you on a scale of 1 to 10, 1 being the lowest and 10 being the highest, with self-acceptance and respect for yourself?

- Can you describe something that you have already accepted about yourself?

- Could you explain how you have increased your respect for yourself?

Here's what a client who previously participated in this session wrote:

It's taken me most of my life to admit the truth about myself, to be honest, and accept me as me. The moment I did that, it seemed like a switch went off in my head. It was like I could see things I could not see before my thinking changed. I was able to handle things better and make better decisions. Once I was able to be honest with myself and see myself for who and what I was, I could adjust and make changes to improve myself, my attitude, and my outlook on my life.

Self-respect is my ability to accept myself and to project a positive image, to hold my head up with pride and dignity, to treat myself as well as others as human beings. When things aren't going right I need to keep myself together, hold onto my composure, and remain humble. I've learned that I must respect myself, I must respect others, and I must respect my disease. If I don't, I'm doomed to fail. I must have respect for myself or no one else will.

3. Gratitude

Description: In order to maintain motivation in recovery, clients should learn to recognize and be mindful of what they have to be thankful for.

Learning goals: Clients will

(1) grasp the meaning of gratitude;

(2) learn to identify how they react with others when they are not grateful;

(3) understand how their interactions when ungrateful affect them; and

(4) learn strategies for being more grateful in chaotic and stressful situations.

How to introduce the topic: Make sure that clients know that acknowledging others (or a higher power) is normal, and the goal is not to be overwhelmed but to help them become more comfortable with gratitude.

Questions to spark discussion:

- Have you experienced gratitude in situations pertaining to your recovery?

- Has being grateful brought about change for you?

- What can you say about your gratitude for recovery?

4. Humility

Description: A discussion of the quality of humility and its benefits to a person in recovery.

Learning goals: Clients will

(1) come to recognize situations in which humility can be helpful;

(2) learn to identify how they react with others when they are not humble;

(3) understand how their interactions when not humble affect them; and

(4) learn strategies for being humble in chaotic or stressful situations.

How to introduce the topic: Make sure the client understands that being humble is a positive thing. Do not portray being humble as being passive.

Questions to spark discussion:

- Who do you know who is humble, and how has it helped them?

- Can you think of a way to relate humility to personal growth?

- Has humility been a factor in your change?

5. Dealing with Frustration

Description: A discussion of methods of processing frustration and developing coping skills.

Learning goals: Clients will

(1) come to recognize situations in which they need to deal with frustration;

(2) learn to identify how they react with others when they do not use tools to deal with frustration;

(3) understand how their interactions when frustrated affect them; and

(4) learn strategies for dealing with frustration in chaotic or stressful situations

How to introduce the topic: Make sure clients are aware that frustration happens, it is normal, and the goal is to help people become more aware of their issues with frustration and improve their resolve when dealing with frustration.

Questions to spark discussion:

- Can you share a situation that was frustrating to you?

- How did you resolve it?

- How did you feel after resolving the situation?

- Have you dealt with frustration with emotion or with intellect?

- What was the result from dealing with the situation with emotional behavior?

- What resulted from use of a rational approach to the situation?

- Which resulted in a better outcome in dealing with frustration, the emotional or the rational approach?

6. Handling Painful Situations

Description: A discussion of how to handle circumstances, conditions, and surroundings that cause extreme uneasiness or pain.

Learning goals: Clients will

(1) identify types of situations that are particularly painful for them;

(2) learn to identify how they react when they are not aware of how they handle painful situations;

(3) understand how their interactions when handling painful situations affect them; and

(4) learn strategies for not becoming stressed while handling painful situations.

How to introduce the topic: Make sure that clients know that experiencing great discomfort, uneasiness, or anxiety in certain situations is normal, and the goal is not to surrender to the situation but to develop a way to acknowledge, cope, and deal with the issue or issues causing the situation.

Questions to spark discussion:

- How did you handle a circumstance that was painful?

- Would you say that processing your thoughts and feelings through a painful situation has been beneficial to the recovery process?

- Would you say that communication is an important factor in working through a painful situation?

7. Significance of Honesty

Description: A discussion of the ways in which honesty to oneself and others is necessary in building a new way of life.

Learning goals: Clients will

(1) come to realize situations in which they need to be honest;

(2) learn to identify how they react with they are not honest;

(3) understand how their interactions when honest or dishonest affect them; and

(4) learn strategies for maintaining honesty in chaotic or stressful situations.

How to introduce the topic: Make sure that clients know that honesty is something that is not always rewarded or recognized, but it is placed in high value. Clients should not retreat from situations where honesty is needed.

Questions to spark discussion:

• When feeling cornered or trapped in a situation where honesty is needed, how do you handle it?

• When you use honesty in a trying circumstance, how do you feel?

• When you can be honest with yourself do you feel that you can be honest with others?

• Would you agree that being honest helps you grow in recovery?

Here's what one participant wrote:

Being honest with myself allows me to see me for who I really am, and sometimes it hurts. Also, hearing what other people think or feel when I ask a question is not easy, but it is not as hard as using drugs every day, lying just to kill the pain, and seeing how I have screwed up my life, with so many years wasted. If I feel bad, I want to say I feel bad, and when I say no, I don't mean yes: I mean no.

Since my last relapse and returning to residential treatment, I'm choosing to be honest about myself. I don't ever want to live that kind of life again, so I must remain true "to [mine] own self." I know there is going to be a whole lot of life's honesty coming at me, and this time I'm ready.

8. Courage

Description: An exploration of various types of courage—for example, courage needed to deal with life on its terms, cope with mental health and addiction issues, adjust to changes in life, and let go of the past.

Learning goals: Clients will

(1) come to recognizee situations in which they need courage

(2) learn to identify how they react with others when they are not courageous;

(3) understand how their interaction when not courageous affects them; and

(4) learn strategies for being courageous even in chaotic and stressful situations.

How to introduce the topic: Make sure that clients know that the lack of courage may be normal in some situations. The goal is not to undermine people but to help them understand the need for courage.

Questions to spark discussion:

• Can you share a time when you needed to call on your courage?

• Would you agree that it takes courage to stand up for yourself?

• How is courage needed in your recovery process?

Here's what one participant wrote:

I spent the latter part of high school just making it by a thread. Courage and eagerness to be the best got lost in transition, and not making the grade seemed to be a tool of defiance. Once I gave up my will to give the best attempt at success, then failure turned into the acceptable thing to do.

After not fulfilling what should have been, it seemed the only thing to do was give up! The importance of being number one just wasn't there anymore, and like anything you practice well, I got good at being bad.

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Courage now is thoroughly needed in my life, in order to change my way of being, in hopes of finding the spirituality so needed, and to have the self-confidence to turn around and make what's left of my life meaningful.

9. Patience

Description: A discussion of how patience can improve relationships and an exploration of ways to build patience.

Learning goals: Clients will

(1) come to recognize situations in which they are not patient;

(2) learn to identify how they react with others when they are not patient;

(3) understand how their interactions when impatient affect them; and

(4) learn strategies for being more patient in chaotic or stressful situations.

How to introduce the topic: Make clients know that impatience is normal, but the goal here is to help them become more patient. Consider starting with an anecdote to which clients can relate - perhaps the desire for recovery to happen more quickly than it does.

Questions to spark discussion:

• How often do you wish your recovery was going faster?

• When has wanting something too fast interfered with getting it at all?

• What do other people say about you when you're impatient?

• Have you ever lost a job or ended a relationship because of impatience?

• What do you do to calm yourself when you're impatient?

Here's what one participant wrote:

Currently I try to practice patience because I find myself wanting to do too much in the course of the day. I do realize that if I did attempt to do everything in one day that I would be doing nothing more than bringing unnecessary stress upon myself and probably would make more mistakes than accomplishments due to this added stress. This exact behavior played a role in my relapse. So I am grateful to have learned something from that. In practicing patience I put forth effort, but I don't rush the results. I just gradually watch them fall into place at God's timing.

10. Medicine Maintenance

Description: Reinforcement of the urgent importance of maintaining a medicine schedule and discussion of how medicine relates to the recovery process.

Learning goals: Clients will

(1) come to realize that because of their diagnosis they need to maintain the medicine schedule prescribed for them;

(2) learn to identify how they react with others when they are not in compliance with their medicine regimen; and

(3) learn strategies for keeping up with their schedule on a day-to-day basis and managing chaotic or stressful situations.

How to introduce the topic: Make sure clients know that medicine maintenance is part of life for people living with co-occurring mental illness and substance use disorders, and the goal is not to cause alarm but to become more knowledgeable of the importance of using helpful medications as prescribed.

Questions to spark discussion:

• Would you say that you have difficulty keeping up with your medication maintenance sometimes?

• Is the reason why that you may not want to?

- How about the side effects? Do they turn you away from taking your dosage?

- Do you understand the importance of your medication and taking it regularly?

- What strategies do you use for remembering to take your medication or anything else you need to do regularly?

11. Making a Good Thing Last

Description: Discussion of how to develop a lifestyle that supports mental health and recovery from addiction, as well as the benefits of living clean. Clients should understand the importance of using the skills they have learned in order to keep what is good in their lives.

Learning goals: Clients will

(1) come to recognize situations in which they will have better experiences because of maintaining their recovery;

(2) learn to identify how they react with others when they stay the course of a good decision;

(3) understand how their interactions when they make the right decisions affect them; and

(4) reflect on how good things are evolved from living life on its terms even through chaotic and stressful times.

How to introduce the topic: Make sure clients know that wanting a good thing to last is normal, but making a good thing last requires work.

Questions to spark discussion:

- What good things in your life are you working to keep?

- Did anything good ever come easy for you?

- Would you say that keeping this good thing was difficult?

- Are there times when you have had to contribute more of yourself in order to maintain a good thing?

- Do you feel that it is really worth it to put in the effort of maintaining the good things in life?

Here's what one participant wrote:

With past adventures left in the past, I've moved on, taking new responsibilities in my life. I'm accepting the un-manageability I've experienced in my life and using it as a learning tool, to find the success I know my heart calls for.

It doesn't take much to understand the places you really don't want or need to be in your life, so today I've learned to appreciate life on life's terms. Making a good thing last takes a decision, dedication, perseverance, and a large amount of courage. Starting with my change of attitude and new respect for spirituality, I have faith in myself, which gives hope a more positive space in my head, allowing for the successes as well as the setbacks to become motivators and a means to an end.

Appendix I. Supplemental Materials for Initiating Peer Support

We have learned many lessons in the process of doing peer support within MISSION, particularly before peer support was as popular as it is today. We hope this appendix serves as a valuable resource regarding these lessons and some of the key issues one might consider when setting up peer support services. It is, however, not meant to be exhaustive, but rather a starting point.

First and foremost, we have learned that Peer Support Specialists [PSS] are incredibly valuable members of the treatment team. Having said that, the role of MISSION's PSS evolved over time. It started out in a more limited way than originally intended due to certain issues associated with aspects of program design, funding limitations which affected the applicant pool and the introduction of this service component within a system that was early in adopting a full recovery orientation. Thus, from a strategic standpoint, this component evolved slowly but steadily.

At the outset, MISSION's program design valued recruitment of individuals who had completed a residential treatment program over consumers who had not, but were already trained and experienced consumer-providers.   While the value of this additional layer of shared experience appears to have some obvious benefit, we have now learned that it also significantly limited the applicant pool, and resulted in the need for extensive on-the-job peer support training. It also meant that until training was completed, some PSS activities were significantly curtailed. This presented significant challenges associated with people's understanding of the role of the PSS, the acceptance of PSSs as full team members, and the achievement of their full potential.

The system in which we did one of the first 12-month MISSION studies was just beginning to embrace the role of peers as equal team members. Thus, the PSS initially did not have access to agency client record systems, which necessitated that the case manager be the conduit for all information collected by the PSS and required that the case manager be counted upon to relay any relevant medical record information to the PSS. The delay in access to client record systems impeded the PSS's ability to act as—and feel like—a full member of the treatment team.

Likewise, concerns regarding safety and independent judgment began to surface, resulting in policy decisions to temporarily limit the independent work of peer specialists in the community until lengthy training could be completed. This deficit in training prior to employment inadvertently set up a dynamic of peers and case managers not recognizing that they hold equal value on the team and that they perform different, but equally important roles. This was perhaps one of the most difficult struggles for the team to overcome. Since then, a more formalized MISSION on-the-job training program (including "shadowing assignments") has been implemented, and existing PSS have completed on-the-job training. Presently, given that the peer support workforce has substantially grown, we encourage agencies to hire peer staff whom have formal training and perhaps even a certificate.

These experiences are shared as a means of conveying "lessons learned" from which others replicating MISSION services may benefit. As stated above, the employment of PSS is an emerging practice and a key aspect of mental health systems transformation towards a recovery-orientation of services.   As with any occupation, recruitment of personnel already trained in the foundational aspects of their position is recommended over sole reliance on on-the-job training.

The unique qualifications and roles associated with these positions often raise important questions and issues that are best addressed by specific training for PSSs as well as supervisors and other team members. Some questions do not have clear-cut answers that can be universally applied, since the size and culture of both the organization and the wider community often influence the development of local policies and practices.   The answers to some frequently asked questions, are much more straight-forward and are, in fact, a matter of law.

The following questions are among some of the most common we have heard. We offer our answers as a first step towards guiding policy and practice

development for those wishing to replicate the MISSION program.

1) Hiring criteria: What are appropriate hiring criteria for the PSS?

- Is a certain type of mental illness required, or not?

- Should the PSS be free of substance use? For how long?

- Should the PSS not have been hospitalized for some period of time?

- How should the above be documented?

- Is hiring "from within" a good practice or not?

It is essential for administrators to understand that the Americans with Disabilities Act prohibits employers from asking applicants about their medical/psychiatric conditions or history. Rather, the hiring criteria for PSSs should be based on the knowledge, skills, abilities, and personal characteristics required to perform the duties of the position. Position descriptions and recruitment announcements should describe the population served and the expectation that the PSS will utilize their own recovery experiences as a means of role-modeling successful community integration and providing peer support to foster achievement of clients' recovery goals. Employment application forms and interview questions should be carefully designed to elicit the necessary information to determine if the applicant's training and personal experiences have afforded them the knowledge and skills necessary to successfully perform the duties of a PSS. Examples of key knowledge, skills, and abilities and some suggested interview questions identified for the MISSION PSS position description can be found at the end of this Appendix.

It is generally recommended that organizations aggressively recruit individuals who are not currently, or have not recently received mental health services from the same organization in which they would be employed. Most organizations do not strictly prohibit this, and the negative impacts of doing so are minimized in large organizations where PSS can be employed in a program that is remote from where they have recently received or currently receive their own mental health services. Should the selected candidate be one who currently receives services from the same organization, it is generally advised they make every effort to distance their personal service providers from their supervisor and direct co-workers. Under no circumstances should a PSS also be that person's mental health services provider.

PSS training and certification programs may have criteria that specify the need for particular types of diagnoses and/or periods of sobriety or non-hospitalization; however, such criteria cannot legally be applied directly in the hiring process.

2) Confidentiality: Is there a different level of confidentiality for the PSS than for other service providers? Does everything that gets stated to a PSSs by a client automatically get transmitted to the rest of the team?

PSSs are members of a treatment team. As such, they are expected to help the client share information with the rest of the team that is pertinent to the team's effort to support the client's treatment/recovery goals. In the case of critical information conveyed in peer support groups (which are confidential by their nature), the Peer Support Specialist would generally raise discussion with the client outside of the peer support meeting as a means of processing with the client the value and importance of including the team in addressing the issue. Should the client refuse to share information with the team that is deemed vital to their safety, the PSS would be expected to inform the client that they must (and will) convey such information to the team anyway.

3) Fraternization: Can the PSS spend time with their clients after hours? What are the boundaries of clients and PSS giving money to each other? Can a PSSs buy a client a cup of coffee or not?

PSSs are staff of the mental health system in which they are employed, and any organizational policies regarding financial transactions, intimate relationships, etc. that apply to other providers would also apply to the PSS.

The fact that PSSs may more often live, socialize, attend meetings, etc. where clients are likely to be, does not change organizational policies designed to protect both the mental health system employee and the clients served by that system.

Most all friendships outside of the work environment have the potential to influence behaviors within the work setting and should therefore be avoided. PSSs are, however, likely to have more social contact with clients than traditional healthcare providers, and peers have a more mutual relationship with clients in the context of their work. It is therefore recommended that there be a safe environment for PSSs to discuss these situations with their supervisor as they may arise, and to include assistance with how to discuss healthy boundaries with clients. Like all employees (and perhaps even more so), it is important that PSSs balance and have a healthy separation between their work and their personal lives. Where a strong personal friendship may have previously been established between a PSS and a new client coming into the program, the PSSs (as would be expected of a case manager as well), should disclose this relationship with the clinical supervisor, and every effort should be made to assign that client to a different case management/peer specialist team. Where assignment to another team is not possible, the employee and their supervisor should discuss appropriate boundaries to minimize real or perceived conflicts of interest that could jeopardize the PSS/client relationship and goals of the program.

4) Supervision/performance appraisal: How does a supervisor appraise the performance of a PSS?

Performance standards for PSSs should be developed based on the work of the position, as with any other staff member.   In the case of MISSION PSS, the supervisor's appraisal should focus on the PSS's effectiveness in developing supportive relationships with clients that foster successful personal and community integration skills and the development of natural supports.

5) Sick leave policy: One of the top concerns organizations may have about a PSS is what will happen if the PSS relapses. Should special sick leave policies be in place for them?

The sick leave policy should be no different for the PSS than for any other employee. Employers should not probe for personal medical information, nor require medical documentation beyond existing organizational policies that apply to all employees. A PSS, like any other employee, should be oriented as a part of his or her general employment orientation to their rights and responsibilities under the American's with Disabilities Act. As such, PSSs might wish to identify themselves as persons with a disability who require accommodation. If this is the case, it would be advisable for supervisors to consult with their human resources office or organization's legal counsel.

6) Disclosure of mental health status: To what extent is a PSS required to disclose his/her personal history of mental illness/addictions in the context of their work with clients?

Unlike more traditional mental health providers, such as social workers, psychologists, etc. who may also be (and disclose their personal experience as) consumers of mental health services, the unique role of the PSS requires them to do so. Their training as a PSS should comprehensively address how to utilize their own experiences effectively, so as to connect with, empathize with, and support clients. PSS training also generally includes learning to "tell one's story" from a recovery versus an illness perspective, and how to ensure that their self-disclosure is pertinent to the situation and does not dominate the conversation. Under no circumstances should a PSS feel compelled to disclose aspects of their personal experiences that they would be uncomfortable sharing.

Knowledge, skills, and abilities considered essential for the MISSION PSS position include:

1. Knowledge of the recovery process and ability to facilitate recovery dialogues.

2. Knowledge and skills to teach and engage in problem solving and conflict resolution strategies.

3. Knowledge of community resources to facilitate community integration.

4. Knowledge of co-occurring mental illness and addictions diagnoses, including signs and symptoms and current trends and developments in the mental health field including self-help/peer support arenas.

5. Ability to teach self-advocacy through role-playing and role-modeling techniques, including the role-modeling of personal experiences to assist clients in their recovery process.

6. Ability to communicate orally and in writing with wide variety of individuals (people experiencing a variety of psychiatric illnesses, family members, professional staff, community agencies, etc.)

Sample interview questions pertinent to the MISSION PSS position

1. The position you have applied for is a Peer Support Specialist. Please describe what you believe a Peer Support Specialist's role should be and what you would envision yourself doing in this role. Give an example of how you have provided this type of service in the past.

2. Please share a couple of specific examples of progress you've made in personal and/or work life where you experienced a setback or challenge and then turned the situation around to a positive outcome.

3. Please provide specific examples of how you have provided informal or formal support to one or more of your peers.

4. Please discuss a specific time when you had to negotiate with a group of people to obtain their cooperation. Tell us specifically who you negotiated with and what the outcome was. What did you learn from the situation?

5. Think of a time when you had to communicate something that you knew the other person did not want to hear. How did you go about communicating it? What was the outcome?

6. Please describe a time when you assumed a leadership role (in any context). What sort of problems came up? What did you learn about yourself?

7. What was the most recent skill that you set out to learn? How did you go about it?

8. Give an example of an important goal that you have set for yourself in the past. What did you do to reach it? How did you measure your success in reaching that goal?

9. On a scale of 0 (lowest) to 10 (highest), please rate your personal knowledge in the following areas and give examples of how you have acquired and utilized this knowledge:

Knowledge of community resources_____

Knowledge about mental health and addiction problems_____

Knowledge of recovery issues and processes_____

10. How does being a Peer Support Specialist in the MISSION program fit in with your overall life plan goals for yourself? Please be specific.

Monthly Budget for [_____] Month Year			
	Planned	**Actual**	**Variance**
Income			
Income Source 1	$	$	$
Income Source 2	$	$	$
Income Source 3	$	$	$
Total Income	**$**	**$**	**$**
	Planned	**Actual**	**Variance**
Expenses			
<u>Fixed Costs</u>			
Rent	$	$	$
Childcare	$	$	$
Other	$	$	$
Other	$	$	$
Total Fixed Costs	$	$	$
<u>Variable Costs</u>			
Electricity Expense	$	$	$
Telephone Expense	$	$	$
Cable / Internet	$	$	$
Groceries	$	$	$
Transportation	$	$	$
Cell Phone	$	$	$
Medications	$	$	$
Other Healthcare	$	$	$
Personal Care/Hygiene	$	$	$
Entertainment	$	$	$
Clothing	$	$	$
Miscellaneous	$	$	$
Other	$	$	$
Other	$	$	$
Total Variable Costs	$	$	$
Total Expenses	$	$	$
TOTAL BUDGET	**$**	**$**	**$**

Appendix K: Housing Preference Tool

Client Pre-Housing Interview

Preferences

Type of Housing (1BR, Studio, Room, etc.)_____

Neighborhood preference? _____

Neighborhood preferred to avoid?_____

Transportation Needs (public transit, downtown area, etc.)_____

Ground floor or upper floor? _____

Potential Barriers to Housing

Criminal History_____

Family members potentially living in unit_____

Restrictions with subsidy-type_____

Available budget (including utilities, security deposit, rent after subsidy, etc.) $_____

Special Accommodations:

Grab bar in bathroom

Wheelchair accessible

Other Accommodations: _____

_____

Appendix L: Homelessness Among Veterans

This appendix is a chapter taken from MISSION-VET (2010) regarding specific information about homelessness among the Veteran population. It was included in case you wanted more information about homelessness among Veterans and available resources. In the chapter we refer to the program as MISSION-Vet, but it is essentially MISSION using language critical for Veterans and tailored to meet their unique needs. *Note we included this so you would not have download or reprint the entire MISSION-VET manual. Nonetheless, should you want more information beyond this chapter, it is available.

HOMELESSNESS AMONG VETERANS

Vincent Kane, M.S.W.
John Kuhn, M.S.W., M.P.H.
Nancy Campbell, M.S.W., L.I.S.W.
Leon Sawh, M.P.H.
Kevin Casey, L.I.C.S.W.

MISSION staff working with Veterans using the MISSION-VET model will want to ground their work in a thorough understanding of the problem of homelessness among Veterans, as well as the programs and initiatives designed to address this national challenge. This chapter includes a description of the Department of Veterans Affairs (VA) plan to end homelessness among Veterans as well as Opening Doors: Federal Strategic Plan to Prevent and End Homelessness. It provides an overview of the problem of homelessness among Veterans and describes some of the key programs that are designed to assist these Veterans. Since the MISSION-VET program relies on linkages with other programs serving the same population, it is particularly important for all MISSION-VET staff to be familiar with their goals and eligibility requirements.

A. The Federal Plan to Prevent and End Homelessness

In 2009, the VA took decisive action toward its goal of ending homelessness among our nation's Veterans within five years. To achieve this goal, the VA, under the leadership of Secretary Eric Shinseki, developed a Five-Year Plan to End Homelessness among Veterans that will assist every eligible homeless Veteran and Veterans who are at risk for homelessness. The plan helps Veterans acquire safe housing and provides access to primary care and specialty mental health care, substance use disorder treatment, support services, and homelessness prevention services. It also provides direction for Veterans who wish to return to employment and obtain needed benefits assistance. These services are provided to end the cycle of homelessness by preventing Veterans and their families from entering homelessness, as well as help those who have become homeless to return to fulfilling lives in their communities as safely and quickly as possible.

In May 2010, the United States Interagency Council on Homelessness, announced Opening Doors: Federal Strategic Plan to Prevent and End Homelessness. This plan outlines an interagency collaboration that aligns mainstream housing, health, education, and human services to end current homelessness and prevent Americans from experiencing homelessness in the future. Developed through the leadership of the United States Interagency Council on Homelessness (Secretary Shaun Donovan, U.S. Department of Housing and Urban Development; Secretary Kathleen Sebelius, U.S. Department of Health and Human Services; Secretary Eric Shinseki, U.S. Department of Veterans Affairs; and Secretary Hilda Solis, U.S. Department of Labor), the plan is based on the firm tenets that "no one should ever experience homelessness" and "no one should ever be without a safe, stable place to call home." It states four key goals.

Successful implementation of this Plan will result in housing stability and permanency for the more than 640,000 homeless men, women, and children, including the 107,000 Veterans, who are homeless in America on any given night (AHAR, 2009; CHALENG, 2009). As a firm believer that no Veteran should ever live on the streets, President Obama charged the VA with ending homelessness among Veterans by 2015, and this mandate has led to the development of new programs and resources, including a major expansion of the HUD-VA Supportive Housing (HUD-VASH) program and the development of new VA initiatives to increase access to VA and community housing, employment, and mental health services.

In light of a renewed, national commitment to end homelessness among Veterans, new models of clinical intervention, particularly those that focus on transitioning Veterans to the community, are of increasing interest to the VA. Successful implementation of MISSION-VET requires close cooperation with Veterans Administration Medical Centers (VAMCs), state and local governments, Veteran Services Organizations (VSOs), community programs, and health care providers to meet the unique service needs of homeless and formerly homeless Veterans who have co-occurring psychiatric and substance use disorders (COD).

The need for affordable housing is well documented, and VA housing initiatives continue to expand to address this need. Previous research has demonstrated that stable housing is instrumental in the effective delivery of health care and other social services to facilitate recovery. It is, in effect, the foundation upon which people rebuild their lives after experiencing homelessness. Supportive housing – housing in which tenants receive treatment and other supports – has been shown repeatedly to be a critical adjunct in helping chronically homeless persons retain housing (www.csh.org).

Homelessness exacerbates poor physical and behavioral health while increasing the likelihood of contact with the criminal justice system (Greenberg & Rosenheck, 2008). Without a safe and affordable place to live, it is extremely difficult, if not impossible, to achieve good health outcomes. For many homeless individuals, lack of stable housing leads to costly "revolving door" use of emergency services (Young, et al., 2005). Evaluations of permanent supportive housing models have demonstrated reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated (Culhane, et al., 2002; Rosenheck, et al., 2003).

Recognizing that stable housing must first be obtained before services can be delivered effectively, the VA's National Center on Homelessness Among Veterans has created a Model Development Core that is charged with determining the most effective treatments and delivery platforms for homeless Veterans with COD, thereby addressing the underlying causes of housing loss. The Model Development Core is working to improve the resources and procedures available for securing timely housing placements and subsequent services for Veterans who need them.

B. Overview of Homelessness Among America's Veteran Population

Recognizing the importance of treating homelessness among our nation's Veterans, in 1987 the VA began to provide specialized treatment services to homeless Veterans. These services were intended to complement all of the existing medical and mental health services routinely offered to eligible Veterans through the Veterans Healthcare Administration (VHA). Given the disproportionately high rate of homelessness among Veterans, these programs have grown dramatically and now serve over 100,000 Veterans annually, making the VA the largest single provider of homeless services in the country. In terms of cost, Rosenheck and Seibel (1998) found that 26% of all

inpatient mental health expenditures in the VA system were for the care of homeless Veterans.

Despite the wide array of homeless services offered, homelessness among Veterans remains an urgent issue in the United States. In order to better serve these Veterans, and in response to President Obama's mandate to end homelessness among Veterans, VA Secretary Shinseki has taken the lead in developing housing interventions and support strategies to eliminate existing homelessness and prevent future homelessness among Veterans. However, several challenges lie in the way of accomplishing this goal. The most common challenge is the high rate of mental health issues among homeless Veterans, including substance abuse, mood disorder, PTSD, and schizophrenia (Mares & Rosenheck, 2006).

Substance abuse is one of the most common co-morbidities among individuals with severe mental illness (SMI), including those who are homeless (Brunette, et al., 2004; Adams, et al., 2007). Approximately half of all individuals with SMI, such as schizophrenia and bipolar disorder, have lifetime substance use disorders; of those, 30% also meet the diagnostic criteria for a current substance use disorder (Regier, et al., 1990; Essock, et al., 2006). With regard to the types of substances of abuse, the most commonly used substances include nicotine, alcohol, marijuana, cocaine, and heroin. Furthermore, many Veterans are polysubstance users, meaning that they use cocaine and/or other drugs, drink alcohol, and smoke cigarettes simultaneously. Recent data from the HUD-VASH program illustrate that over 60% of Veterans who apply to the program suffer from alcohol abuse or dependence, and that over two-thirds will have at least one psychiatric diagnosis (O'Connell, et al., 2010).

COD results in increased symptom severity, treatment dropout, increased affective instability, poor community integration, and more frequent use of costly services like emergency rooms and inpatient units (Nunes & Quitkin, 1997; Rounsaville, et al., 1987; Kranzler, et al., 1996). Furthermore, studies of labor participation suggest that both alcohol and illicit drug use worsen work performance and job retention, with COD having an even greater negative impact than either the

presence of substance abuse or mental illness alone (French & Zarkin, 1992; McCarty, 1990; Mullahy & Sindelar, 1995).

The MISSION-VET treatment approach was developed specifically to target the unique housing stabilization, addiction, mental health, treatment engagement, vocational, and care coordination needs of homeless and formerly homeless Veterans with COD by systematically combining evidence-based treatment approaches into a comprehensive system of care and delivery platform. The MISSION-VET approach is assertive and community-based. In addition, the goals of the MISSION-VET program naturally dovetail with the six pillars of the Federal Strategic Plan to Prevent and End Homelessness in America (see "MISSION-VET Services in Line with the Federal Strategic Plan's Six Pillars to Prevent and End Homelessness" table). In line with the Federal Strategic Plan, MISSION-VET is an integrated, multifaceted, cooperative approach that draws on community partners as well as existing VA homeless programs and resources. For example, MISSION-VET services can begin either in an inpatient/residential setting, and then follow the Veteran through their transition to independent community living or MISSION-VET service delivery can be initiated as Veterans enroll into the HUD-VASH program.

The overall flexibility, found in the MISSION-VET program, assures that Veterans are receiving care aligned with the first two pillars of the five-year plan to end homelessness, which include receiving individual goal-based service planning (pillar one), and benefiting from ongoing support services connected to mainstream resources (pillar two). In addition, the MISSION-VET treatment program employs Case Managers (CM) and Peer Support Specialists (PSS) to help Veterans establish independent living skills (pillar three) by promoting adherence to medical, mental health, and substance abuse treatment regimens, as well as, coaching Veterans in valuable life skills (such as money management). In turn, MISSION-VET CMs and PSSs facilitate important connections within the community (pillar four) through the encouragement of participation in community mental health and substance abuse treatment programs as well as 12-step supports such as AA and NA, to provide ongoing support as Veterans transition through the MISSION-VET program and become self-sufficient. In conjunction

with these services, Veterans are linked to vocational and educational rehabilitation programs to promote employment and achievement of educational goals (pillar five). Furthermore, MISSION-VET CMs and PSSs closely monitor the Veteran to ensure housing stability (pillar six).

MISSION-VET Services in Line with the Federal Strategic Plan's Six Pillars to Prevent and End Homelessness

- **INDIVIDUALIZED GOAL-BASED SERVICE PLANNING:** Ensures that the care Veterans receive is both flexible and goal-oriented in order to promote successful recovery.

- **ON-GOING SUPPORT SERVICES CONNECTED TO MAINSTREAM RESOURCES:** Ensures that Veterans are offered support in establishing connections with important community programs that they can continue to keep as they transition through homelessness programs and work to establish independence.

- **INDEPENDENT LIVING SKILLS TRAINING:** Ensures that Veterans are engaged in the acquisition of useful and valuable life skills training, such as money management, that will facilitate empowerment and promote independence.

- **CONNECTIONS TO SUPPORTIVE AND TRUSTWORTHY ADULTS AND SUPPORT NETWORKS:** Ensures that Veterans are linked to medical and mental health professionals, case managers, peer support specialists, community providers and groups, such as AA/NA meetings, that will collectively offer supportive services to facilitate individualized goals that will promote recovery.

- **EMPLOYMENT AND EDUCATION:** Ensures that Veterans are linked to services that will help eliminate barriers and promote success toward the attainment of vocational and educational goals.

- **HOUSING:** Ensures that Veterans are linked to services that will promote the acquisition and retention of stable housing, as well as, monitor/intervene in any situations that may threaten housing stability.

C. Existing Homeless Programs and Resources

Other homeless programs and resources currently exist that are also aligned with the six pillars described in the table. This section provides descriptions of some key VA homeless treatment programs and resources that might be helpful for various care providers. It is however, not meant to be exhaustive. A list of available VA homeless services can be found at www1.va.gov/homeless.

HUD-VASH

HUD-VASH is a joint program between the U.S. Departments of Housing and Urban Development (HUD) and Veterans Affairs (VA) designed to address the needs of the most vulnerable homeless Veterans. In general, the program:

- assists the Veteran with accessing treatment and benefit services;

- helps the Veteran locate and secure safe, stable, and affordable housing;

- helps the Veteran follow and adhere to landlord and public housing authority (PHA) procedures;

- provides planning assistance for the Veteran's move into the community; and

- ensures perpetual access to the housing voucher, case management, and treatment services, provided the Veteran continues to meet program criteria.

The primary goal of HUD-VASH is to move Veterans and their families out of homelessness. As such, it is unique among VA treatment interventions, offering placement not only to Veterans, but also to all family members in the Veteran's household. A unique feature of HUD-VASH is that the Veteran can reside with his or her family member while they are engaged in treatment. As a result, over 5000 Veterans are currently living or planning to live with dependent family members through the program.

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Since HUD-VASH was developed for homeless Veterans, eligible families must include the Veteran in the household. However, any member of the household with a Lifetime Sexual Offender Registry status is not eligible to live in the housing unit. HUD-VASH does not require a set period of sobriety in order for a Veteran to be considered eligible for the program, nor does noncompliance with HUD-VASH necessarily lead to loss of the housing voucher. Rather, ongoing case management provides critical continuity of care and an opportunity to continue to assist the Veteran in his or her recovery from substance abuse and/or mental illness.

Veterans must meet the criteria in the table to be eligible for HUD-VASH.

HUD-VASH ELIGIBILITY CRITERIA

1. Eligible for VA Health Care services

2. Meet the definition of homelessness according to the McKinney-Vento Act

3. Require case management support services to obtain and sustain permanent housing

4. Able to complete the daily activities required of independent living

5. Does not require a set period of sobriety in order for a Veteran to be considered eligible for the program

Eligibility for HUD-VASH is determined on a case-by-case basis by the designated HUD-VASH Case Manager from the participating VAMC. HUD-VASH Case Managers determine clinical eligibility by screening and assessing mental illness, substance use, and other psychosocial factors, such as whether or not the Veteran is responsible for children and/or other family members. Concurrently, the local PHA determines legal eligibility (including income and criminal behavior) of each Veteran who wishes to enroll in the program. Since there is no minimum period of sobriety for

eligibility, treatment services are often critical to housing maintenance among participating Veterans.

Veterans who would like to be evaluated for the program should contact the HUD-VASH program coordinator at their local VAMC directly or obtain a referral from a case manager or clinician in another VA or community homeless program. Following referral and acceptance by the VA HUD-VASH Case Manager, the Veteran must complete a PHA application. Adherence to PHA guidelines, including eligibility based on income level, is required; participating Veterans are also expected to follow landlord guidelines after housing is secured.

Distribution of the Housing Voucher and Initiation of Clinical Treatment Services

In order to facilitate the services mentioned above, Case Managers from participating HUD-VASH VAMCs and community agencies must work closely with PHA Housing Specialists and other community sources, including landlords, in order to locate safe, permanent and affordable housing for the Veteran. The time required to locate and secure stable housing for Veterans and their immediate families depends on several factors, including the availability of housing units in a desired community, willingness of landlords in those communities to rent to individuals with housing vouchers, and issues related to renting to individuals with damaged credit histories.

Unlike other housing vouchers, HUD-VASH vouchers are portable from the time they are issued, meaning that Veterans in the HUD-VASH program can live in communities of their choice outside of the jurisdiction of the PHA as long as it is within the catchment area and within reasonable traveling distance to a VAMC. Vouchers expire 120 days after they have been issued, so finding a suitable housing option is the first priority upon successful entry into the HUD-VASH program. Given these requirements, it is essential for PHAs and HUD-VASH Case Managers to work closely with local community agencies and homeless programs in order to establish relationships with: landlords, organizations that can provide families or individual Veterans with furniture, and other community organizations or local businesses that can assist with initial down payments or deposits required before the Veteran can move in to the new residence.

Although a period of sobriety is not an eligibility requirement, continued substance abuse after housing placement and extensive treatment has been found to predict heightened risk of housing loss among formerly homeless persons diagnosed with COD (Gonzalez & Rosenheck, 2002; Kertesz, et al., 2009; Lipton, et al., 2000; Mares & Rosenheck, 2004; Tsemberis & Eisenberg, 2000; Hurlburt, et al.; 1996; Orwin, et al., 2003). Given the high rate of COD among the population enrolled in HUD-VASH, it is evident that COD issues often threaten HUD-VASH housing sustainability, impeding the program's success. This underlines the need for a comprehensive intervention that augments existing HUD-VASH case management resources (O'Connell, et al., 2010). Because of MISSION-VET's unique approach to treating both substance abuse and mental illness and its focus on providing continuing services upon the Veteran's placement in his/her new community, MISSION-VET has been identified as a potentially useful treatment model to deliver in conjunction with HUD-VASH.

Health Care for Homeless Veterans Program (HCHV)

HCHV provides outreach services delivered by VA social workers and other mental health clinicians that identify homeless Veterans who are eligible for VA services and facilitates access to services such as healthcare and benefits. In addition to its core mission, HCHV also functions as a mechanism to contract with providers for community-based residential treatment for homeless Veterans. For more information, please visit the HCHV website: http://www.va.gov/homeless/hchv.asp

National Call Center for Homeless Veterans

The VA's National Call Center for Homeless Veterans hotline was established to ensure that homeless Veterans or Veterans at-risk for homelessness have free, 24/7 access to trained counselors. The hotline is available for homeless Veterans and their families; VA Medical Centers; federal, state and local partners; community agencies; service providers; and others in the community. To be connected with a trained VA staff member, call **1-877-4AID VET (877-424-3838)**.

CHALENG

The Community Homelessness Assessment, Local Education, and Networking Groups (CHALENG) for Veterans is a nationwide initiative in which VAMCs and regional office directors work with other federal, state, and local agencies and nonprofit organizations to assess the needs of homeless Veterans, develop action plans to meet identified needs, and develop directories that contain local community resources for homeless Veterans. In 2009, 16,512 people participated in Project CHALENG meetings, which bring together homeless and formerly homeless Veterans, providers, advocates, local officials, and other concerned citizens to identify the needs of homeless Veterans and then work to meet those needs through planning and cooperative action.

For more information, please visit: *http://www1.va.gov/HOMELESS/chaleng.asp*

Grant and Per Diem Program

The VA's Homeless Providers **Grant and Per Diem Program (GDP)** is offered annually (as funding permits) by the Department of Veterans Affairs Health Care for Homeless Veterans (HCHV) Programs. Community agencies that provide services to homeless Veterans are eligible to receive funding. The purpose is to promote the development and provision of supportive housing and/or supportive services, which help homeless Veterans achieve residential stability, increase their vocational skill levels and/or income, and achieve greater self-sufficiency. For more information, including sample applications, please visit the GPD website: *http://www1.va.gov/HOMELESS/GPD.asp*

Health Care for Re-entry Veterans (HCRV)

The Health Care for Re-entry Veterans (HCRV) program is designed to address the community re-entry needs of incarcerated Veterans. HCRV's goals are to prevent homelessness; reduce the impact of medical, psychiatric and substance abuse problems upon community re-adjustment; and decrease the likelihood of re-incarceration for those leaving prison. To support this, VA staff across the United States has developed state-specific resource guides that identify steps that Veterans can take prior to their release.

HCRV services include

- Outreach and pre-release assessment services for Veterans in prison;

- Referrals and linkages to medical, psychiatric, and social services, including employment services upon release;

- Short-term case management assistance upon release.

For more information on the Health Care for Re-entry Veterans Program please visit: *http://www1.va.gov/ HOMELESS/Reentry.asp*

Domiciliary Care for Homeless Veterans (DCHV)

The Domiciliary Care for Homeless Veterans (DCHV) program provides residential biopsychosocial treatment and rehabilitation services to homeless Veterans. The average stay is four months, during which domiciliary staff provides outreach, referrals, vocational counseling and rehabilitation, and post-discharge community support services. The Domiciliary Care program houses approximately 5,000 homeless Veterans with health problems each year.

Mental Health Residential Rehabilitation and Treatment Programs (MH RRTPs)

The MH RRTPs provide state-of-the-art, high-quality, residential rehabilitation and treatment services for Veterans with multiple and severe medical conditions, mental illness, addiction, or psychosocial deficits.

The MH RRTP identifies and addresses goals of rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specific treatment of medical conditions, mental illnesses, addictive disorders, and homelessness. The residential component emphasizes incorporation of clinical treatment gains into a lifestyle of self-care and personal responsibility.

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Appendix M: Vocational and Educational Support Materials

This appendix is meant to accompany Chapter VI, Vocational and Educational Supports. The supplementary material found in this appendix is intended to provide the MISSION team with a list of resources to help ensure that MISSION clients make successful strides towards employment, education, and recovery goals.

SAMPLE INDIVIDUAL EMPLOYMENT PLAN

DATE: _____

OVERALL EMPLOYMENT GOAL:

_____

_____

STRENGTHS, SKILLS, RESOURCES:

_____

_____

_____

OBJECTIVE 1:

_____

INTERVENTIONS:

_____

_____

_____

_____

_____

PERSONS RESPONSIBLE:

_____

_____

TARGET DATE: _____

DATE ACHIEVED: _____

SIGNATURES/DATES:

OBJECTIVE 2:

_____

INTERVENTIONS:

_____

_____

_____

_____

_____

_____

PERSONS RESPONSIBLE:

_____

_____

TARGET DATE: _____

DATE ACHIEVED: _____

SIGNATURE/DATES:

ADAPTED WITH PERMISSION FROM:

Swanson, S. J., Becker, D. R., Drake, R. E., & Merrens, M. R. (2008). *Supported employment: A practical guide for practitioners and supervisors.* Kearney, NE: Morris Publishing.

JOB START FORM

CLIENT:

CASE MANAGER:

EMPLOYMENT SPECIALIST:

EMPLOYER:

EMPLOYER'S ADDRESS:

START DATE:

HOURS PER WEEK:

JOB TITLE:

JOB DUTIES:

PAY:

BENEFITS:

UNION POSITION: _____ YES   _____ NO

DISCLOSURE: _____ YES. CLIENT HAS AGREED TO EMPLOYER CONTACT AND HAS SIGNED A
                    RELEASE. HOWEVER, CLIENT DOES NOT WANT TO DISCLOSE THE FOLLOWING:

                    SUPERVISOR'S NAME:

                    _____ NO.   CLIENT DOES NOT WISH EMPLOYMENT SPECIALIST TO HAVE CONTACT
                    WITH EMPLOYER.

STAFF SIGNATURE   DATE

ADAPTED WITH PERMISSION FROM:

Swanson, S. J., Becker, D. R., Drake, R. E., & Merrens, M. R. (2008). *Supported employment: A practical guide for practitioners and supervisors.* Kearney, NE: Morris Publishing.

SAMPLE LETTER TO EMPLOYER

October 29, 2010

Mr. John Smith

Sunnyside Bowling Lanes

One Employment Way

Bedford, MA 07130

Dear Mr. Smith,

Thank you very much for taking the time to meet with me today in regards to Henry Miller's application for a cashier position at Sunnyside Bowling Lanes. Although you do not have cashier openings at this time, I encourage you to consider Mr. Miller for future positions. He is very interested in working at Sunnyside Bowling Lanes in particular because he lives in the neighborhood and has had prior experience working in a similar position. I believe you will find him to be a reliable and responsible employee.

I will contact you again about future openings for him. Thank you for your time and consideration.

Sincerely,

Jane Taylor

Case Manager

444-4444

RECOVERY ASSESSMENT SCALE (RAS)

Name or ID Number_____ Date _____

PLEASE ANSWER THESE ITEMS ON AN AGREEMENT SCALE WHERE 1 IS "STRONGLY DISAGREE" AND 5 IS "STRONGLY AGREE."

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. I have a desire to succeed.	1	2	3	4	5
2. I have my own plan for how to stay or become well.	1	2	3	4	5
3. I have goals in life that I want to reach.	1	2	3	4	5
4. I believe I can meet my current personal goals.	1	2	3	4	5
5. I have a purpose in life.	1	2	3	4	5
6. Even when I don't care about myself, other people do.	1	2	3	4	5
7. Fear doesn't stop me from living the way I want to.	1	2	3	4	5
8. I can handle what happens in my life.	1	2	3	4	5
9. I like myself.	1	2	3	4	5
10. I have an idea of who I want to become.	1	2	3	4	5
11. Something good will eventually happen.	1	2	3	4	5
12. I'm hopeful about my future.	1	2	3	4	5

RECOVERY ASSESSMENT SCALE (RAS) (CON'T)

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
13. Coping with my mental illness is no longer the main focus of my life.	1	2	3	4	5
14. My symptoms interfere less and less with my life.	1	2	3	4	5
15. My symptoms seem to be a problem for shorter periods of time each time they occur.	1	2	3	4	5
16. I know when to ask for help.	1	2	3	4	5
17. I am willing to ask for help.	1	2	3	4	5
18. I ask for help, when I need it.	1	2	3	4	5
19. I can handle stress.	1	2	3	4	5
20. I have people I can count on.	1	2	3	4	5
21. Even when I don't believe in myself, other people do.	1	2	3	4	5
22. It is important to have a variety of friends.	1	2	3	4	5

`

The RAS Score Sheet

Name or ID Number_____ Date _____

Factor scores are obtained by adding up the parenthetical items which load into each factor.

_____ Personal Confidence and Hope (Sum of items 7, 8, 9, 10, 11, 12, & 19)

_____ Willingness to ask for Help (Sum of items 16, 17, & 18)

_____ Goal and Success Orientation (Sum of items 1, 2, 3, 4, & 5)

_____ Reliance on Others (Sum of items 6, 20, 21, & 22)

_____ Not Dominated by Symptoms (Sum of items 13, 14, & 15)

RECOVERY-PROMOTING RELATIONSHIPS SCALE (RPRS)

The following statements describe different aspects of the relationship people with psychiatric conditions might have with a mental health or rehabilitation provider.

Please think of the relationship you have with _____

Please circle the answer that best describes your relationship with this provider.

1. My provider helps me recognize my strengths.
DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

2. My provider tries to help me see the glass as "half-full" instead of "half-empty."
DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

3. My provider helps me put things in perspective.
DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

4. My provider helps me feel I can have a meaningful life.
DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

5. I have a trusting relationship with my provider.
DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

6. My provider helps me not to feel ashamed about my psychiatric condition.
DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

7. My provider helps me recognize my limitations.
DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

8. My provider helps me find meaning in living with a psychiatric condition.
DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

9. My provider helps me learn how to stand up for myself.
DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

10. My provider accepts my down times.
DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

11. My provider encourages me to make changes and try things.
DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

12. My provider reminds me of my achievements.
DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

13. My provider understands me.

DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

14. My provider tries to help me feel good about myself.

DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

15. My provider helps me learn from challenging experiences.

DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

16. My provider really listens to what I have to say.

DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

17. My provider cares about me as a person.

DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

18. My provider treats me with respect.

DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

19. My provider helps me feel hopeful about the future.

DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

20. My provider helps me build self-confidence.

DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

21. My provider sees me as a person and not just a diagnosis.

DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

22. My provider helps me develop ways to live with my psychiatric condition.

DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

23. My provider has helped me understand the nature of my psychiatric condition.

DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

24. My provider believes in me.

DISAGREE   SOMEWHAT DISAGREE   SOMEWHAT AGREE   AGREE   NOT APPLICABLE

Appendix N: Trauma-Informed Care Resources

This appendix is meant to accompany Chapter VII: Trauma Informed Care. As previously noted at the beginning of the chapter on trauma informed care, MISSION is not a PTSD intervention or one designed to treat co-occurring PTSD and addiction. Clients with severe or chronic PTSD should first be referred to a program that specializes in PTSD treatment. The supplementary material found in this appendix seeks to provide the MISSION team with a list of resources to help assist MISSION clients with PTSD issues that may occur during the course of treatment.

What is PTSD?

Posttraumatic Stress Disorder (PTSD) is an anxiety disorder that can occur following the experience or witnessing of a traumatic event. A traumatic event is a life-threatening event such as military combat, natural disasters, terrorist incidents, serious accidents, or physical or sexual assault in adult or childhood. Most survivors of trauma return to normal given a little time. However, some people will have stress reactions that do not go away on their own, or may even get worse over time. These individuals may develop PTSD.

People with PTSD experience three different kinds of symptoms. The first set of symptoms involves reliving the trauma in some way such as becoming upset when confronted with a traumatic reminder or thinking about the trauma when you are trying to do something else. The second set of symptoms involves either staying away from places or people that remind you of the trauma, isolating from other people, or feeling numb. The third set of symptoms includes things such as feeling on guard, irritable, or startling easily.

In addition to the symptoms described above, we now know that there are clear biological changes that are associated with PTSD. PTSD is complicated by the fact that people with PTSD often may develop additional disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health. These problems may

lead to impairment of the person's ability to function in social or family life, including occupational instability, marital problems, and family problems.

PTSD can be treated with psychotherapy ("talk" therapy) and medicines such as antidepressants. Early treatment is important and may help reduce long-term symptoms. Unfortunately, many people do not know that they have PTSD or do not seek treatment. This handout will help you to better understand PTSD and the how it can be treated.

How does PTSD develop?

PTSD develops in response to a traumatic event. About 60% of men and 50% of women experience a traumatic event in their lifetime. Most people who are exposed to a traumatic event will have some of the symptoms of PTSD in the days and weeks after the event. For some people these symptoms are more severe and long lasting. The reasons why some people develop PTSD are still being studied. There are biological, psychological and social factors that affect the development of PTSD.

What are the symptoms of PTSD?

Although PTSD symptoms can begin right after a traumatic event, PTSD is not diagnosed unless the symptoms last for at least one month, and either cause significant distress or interfere with work or home life. In order to be diagnosed with PTSD, a person must have three different types of symptoms: re-experiencing symptoms, avoidance and numbing symptoms, and arousal symptoms.

Re-experiencing Symptoms:

Re-experiencing symptoms are symptoms that involve reliving the traumatic event. There are a number of ways in which people may relive a trauma. They may have upsetting memories of the traumatic event. These memories can come back when they are not expecting them. At other times the memories may be triggered by a traumatic reminder such as when a combat veteran hears a car backfire, a motor vehicle accident victim drives by a car accident or a rape victim sees a news report of a recent sexual assault. These memories

can cause both emotional and physical reactions. Sometimes these memories can feel so real it is as if the event is actually happening again. This is called a "flashback." Reliving the event may cause intense feelings of fear, helplessness, and horror similar to the feelings they had when the event took place.

Avoidance and Numbing Symptoms:

Avoidance symptoms are efforts people make to avoid the traumatic event. Individuals with PTSD may try to avoid situations that trigger memories of the traumatic event. They may avoid going near places where the trauma occurred or seeing TV programs or news reports about similar events. They may avoid other sights, sounds, smells, or people that are reminders of the traumatic event. Some people find that they try and distract themselves as one way to avoid thinking about the traumatic event.

Numbing symptoms are another way to avoid the traumatic event. Individuals with PTSD may find it difficult to be in touch with their feelings or express emotions toward other people. For example, they may feel emotionally "numb" and may isolate from others. They may be less interested in activities they once enjoyed. Some people forget, or are unable to talk about, important parts of the event. Some think that they will have a shortened life span or will not reach personal goals such as having a career or family.

Arousal Symptoms:

People with PTSD may feel constantly alert after the traumatic event. This is known as increased emotional arousal, and it can cause difficulty sleeping, outbursts of anger or irritability, and difficulty concentrating. They may find that they are constantly "on guard" and on the lookout for signs of danger. They may also find that they get startled.

How common is PTSD?

PTSD is common. In the entire population, an estimated 6.8% of Americans will experience PTSD at some point in their lives. Women (9.7%) are more than two and a half times as likely as men (3.6%) to develop PTSD. About 3.6% of U.S. adults (5.2 million people) have PTSD during the course of a given year. This is only a small portion of those who have experienced at least one traumatic event. In people who have experienced a traumatic event, about 8% of men and 20% of women develop PTSD after a trauma and roughly 30% of these individuals develop a chronic form that continues on throughout their lifetime. The traumatic events most often associated with PTSD for men are rape, combat exposure, childhood neglect, and childhood physical abuse. The most traumatic events for women are rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse.

PTSD is more common in "at-risk" groups such as those serving in combat. About 30% of the men and women who served in Vietnam experience PTSD. An additional 20% to 25% have had partial PTSD at some point in their lives. More than half of all male Vietnam veterans and almost half of all female Vietnam veterans have experienced "clinically serious stress reaction symptoms." PTSD has also been detected among veterans of other wars. Estimates of PTSD from the Gulf War are as high as 10%. Estimates from the war in Afghanistan are between 6% and 11%. Current estimates of PTSD in military personnel who served in Iraq range from 12% to 20%.

Who is most likely to develop PTSD?

Most people who experience a traumatic event will not develop PTSD. However, the risk for developing PTSD increases if people:

- were directly exposed to the traumatic event as a victim or a witness

- were seriously injured during the trauma

- experienced a trauma that was long lasting or very severe

- saw themselves or a family member as being in imminent danger

- had a severe negative reaction during the event, such as feeling detached from ones surroundings or having a panic attack

- felt helpless during the trauma and were unable to help themselves or a loved one

Individuals are also more likely to develop PTSD if they:

- have experienced an earlier life threatening event or trauma

- have a current mental health issue

- have less education

- are younger

- are a woman

- lack social support

- have recent, stressful life changes

Some research shows that ethnic minorities, such as Blacks and Hispanics, are more likely than Whites to develop PTSD. One reason for these differences is that minorities may have more contact with traumatic events. For example, in Vietnam, Whites were in less combat than Blacks, Hispanics, and American Indians. Researchers are trying to understand other reasons for the differences in PTSD between the ethnic groups. A person's culture or ethnic group can affect how that person reacts to a problem like PTSD. For example, some people may be more willing than others to talk about their problems or to seek help.

How long does PTSD last?

The course of PTSD is variable. This means it can be different for different people and that it can change over time. PTSD usually begins right after the traumatic event but it can also be delayed for many years. For most people symptoms improve over the first year. Treatment also reduces symptoms but for some symptoms can last a lifetime. Roughly 30% of individuals develop a chronic form.

PTSD usually involves periods of symptom increase followed by remission or decrease, although some individuals may experience symptoms that are long lasting and severe. Some older veterans, who report a lifetime of only mild symptoms, experience significant increases in symptoms following retirement, severe medical illness in themselves or their spouses, or

reminders of their military service, such as reunions and anniversaries.

What other problems do people with PTSD experience?

It is very common for other conditions to occur along with PTSD, such as depression, anxiety, or substance abuse. More than half of men with PTSD also have problems with alcohol. The next most common co-occurring problems in men are depression, followed by conduct disorder, and then problems with drugs. In women, the most common co-occurring problem is depression. Just under half of women with PTSD also experience depression. The next most common co-occurring problems in women are specific fears, social anxiety, and then problems with alcohol.

People with PTSD often have problems functioning. In general, people with PTSD have more unemployment, divorce or separation, spouse abuse and chance of being fired than people without PTSD. Vietnam veterans with PTSD were found to have many problems with family and other interpersonal relationships, problems with employment, and increased incidents of violence.

People with PTSD also may experience a wide variety of physical symptoms. This is a common occurrence in people who have depression and other anxiety disorders. Some evidence suggests that PTSD may be associated with increased likelihood of developing medical disorders. Research is ongoing, and it is too soon to draw firm conclusions about which disorders are associated with PTSD.

PTSD is associated with a number of distinctive neurobiological and physiological changes. PTSD may be associated with stable neurobiological alterations in both the central and autonomic nervous systems, such as altered brainwave activity, decreased volume of the hippocampus, and abnormal activation of the amygdala. Both the hippocampus and the amygdala are involved in the processing and integration of memory. The amygdala has also been found to be involved in coordinating the body's fear response.

What treatments are available?

PTSD is treated by a variety of forms of psychotherapy (talk therapy) and pharmacotherapy (medication). There is no single best treatment, but some treatments appear to be quite promising, especially cognitive-behavioral therapy (CBT). CBT includes a number of diverse but related techniques such as cognitive restructuring, seeking safety exposure therapy, and eye movement desensitization and reprocessing (EMDR). See the SAMHSA National Registry of Evidence-Based Program and Practices (www.nrepp.org), which lists various treatments related to PTSD including those named above as well as the seeking safety website (www.seekingsafety.org).

I think I have PTSD. What can I do now?

Many people who might need help for something like PTSD are afraid to go for help. One out of five people say they might not get help because of what other people might think. One out of three people say they would not want anyone else to know they were in therapy. But almost 50% of people say that there is less shame in seeking help now than there has been in the past.

A study that's been done of soldiers coming home from Iraq found that only 40% of service members with mental problems said they would get help. In many cases this was due to the soldiers' fears about what others would think, and how it could hurt their military careers.

If you think you have PTSD there are a number of things you can do. You may want to be evaluated for PTSD by a psychiatrist, psychologist, or clinical social worker specifically trained to assess psychological problems. You could also discuss your symptoms with your doctor. Talk to your doctor about the treatments discussed in this handout.

If you do not want to be evaluated but feel you have symptoms of PTSD you may choose "watchful waiting." Watchful waiting means taking a wait-and-see approach. If you get better on your own, you won't need treatment. If your symptoms do not improve after 3 months and they are either causing you distress or are getting in the way of your work or home life, talk with a health professional.

In a few cases, your symptoms may be so severe that you need immediate help. Call 911 or other emergency services immediately if you think that you cannot keep from hurting yourself or someone else. 1-800-273-TALK (8255) is a 24 hour national suicide prevention hotline staffed by trained professionals that is also available to help you during an immediate crisis.

Source: adapted from *http://www.ptsd.va.gov/public/pages/what-is-ptsd.asp* (National Center for PTSD)

Alcohol, Medication, and Drug Use

Some people increase their use of alcohol, prescription medications, or other drugs after a trauma. You may feel that using drugs and alcohol seem to help you escape bad feelings or physical symptoms related to stress responses (for example, headaches and muscle tension). However, they can actually make these things worse in the long term because they interrupt natural sleep cycles, create health problems, interfere with relationships, and create potential dependence on the substance. If your use of alcohol or drugs has increased since the trauma or is causing problems for you, it is important for you to reduce your level of use or seek help in gaining control over your use.

Managing alcohol, medication, and drug use:

- Pay attention to any change in your use of alcohol and/or drugs.

- Correctly use prescription and over-the-counter medications as indicated.

- Eat well, exercise, get enough sleep, and use your family and others for support.

- If you find that you have greater difficulty controlling alcohol/substance use since the trauma, seek support in doing so.

- Consult with a healthcare professional about safe ways to reduce anxiety, depression, muscle tension, and sleep difficulties.

- If you believe you have a problem with substance abuse, talk to your doctor or counselor about it.

- If you feel like using larger amounts of either prescribed or over-the-counter medications, consult a healthcare professional.

If you have had an alcohol, medication, or drug problem in the past:

For people who have successfully stopped drinking or using drugs, experiencing a trauma can sometimes result in strong urges to drink or use again. Sometimes it can lead them to strengthen their commitment to recovery. Whatever your experience, it is important to consciously choose to stay in recovery.

- Increase your attendance at substance abuse support groups.

- If you are receiving counseling, talk to your counselor about your past alcohol or drug use.

- Increase your use of other supports that have helped you avoid relapse in the past.

- Talk with family and friends about supporting you to avoid use of alcohol or substances.

- If you have a 12-Step sponsor or substance abuse counselor, talk to him or her about your situation.

- If you are new to the community, talk to your counselor, family, or friends about helping to locate nearby alcohol or drug recovery groups.

GROUNDING: technique that can be therapist or client guided to help redirect attention from internal experiences, or emotional pain, by shifting one's attention to the external world. MISSION clients can think of this as turning the dial on their radio to find a different radio station and listen to a different song. MISSION clients should keep their eyes open during the exercise and are encouraged to notice their surroundings. Practice is encouraged. Grounding can be easily employed at any time and in any setting. MISSION clients are encouraged to rate their level of emotional distress on a scale from 1-10 both before and after to gage efficacy of the exercise. Grounding is NOT relaxation.

EXAMPLE

This is the Five Countdown.

Count out five things you can touch. Touch each one as you name it and count it off.

Count out five things you can see. Look at each one as you name it and count if off.

Count out five things you can hear. Listen to each one as you name it and count if off.

Count out five things you can taste or smell. Taste/smell each one as you name it and count it off.

Now...

Count off four things you can touch. Touch each one as you name it and count it off.

Count off four things you can see. Look at each one as you name it and count it off.

Count off four things you can hear. Listen to each one as you name it and count it off.

Count off four things you can taste or smell. Taste/smell each one as you name it and count it off.

Now...

Count off three things you can touch. Touch each one as you name it and count it off.

Count off three things you can see. Look at each one as you name it and count it off.

Count off three things you can hear. Listen to each one as you name it and count it off.

Count off three things you can taste or smell. Taste/smell each one as you name it and count it off.

Now...

Count off two things you can touch. Touch each one as you name it and count it off.

Count off two things you can see. Look at each one as you name it and count it off.

Count off two things you can hear. Listen to each one as you name it and count it off.

Count off two things you can taste or smell. Taste/smell each one as you name it and count it off.

Now...

Count off one thing you can touch. Touch it as you name it and count it off.

Count off one thing you can see. Look at it as you name it and count it off.

Count off one thing you can hear. Listen to it as you name it and count it off.

Count off one thing you can taste or smell. Taste/smell it as you name it and count it off.

You can repeat this exercise. It works best with someone guiding you through each step to help you maintain your focus.

SOURCE:

Adapted with permission from http://www.ptsdforum.org/content/308-Grounding-Exercise-for-Dissociating (10/23/10)

Tips for Relaxation

Tension and anxiety are common after experiencing a trauma. Unfortunately, they can make it more difficult to cope with the many things that must be done to recover. There is no easy solution to coping with post-trauma problems, but taking time during the day to calm yourself through relaxation exercises may make it easier to sleep, concentrate, and have energy for coping with life. These can include muscular relaxation exercises, breathing exercises, meditation, swimming, stretching, yoga, prayer, exercise, listening to quiet music, spending time in nature, and so on. Here are some basic breathing exercises that may help. However, some trauma survivors find breathing and body-focused exercises triggering, so if you notice distress, stop doing the exercise.

For Yourself:

1. Inhale slowly (one-thousand one; one-thousand two; one-thousand three) through your nose and comfortably fill your lungs all the way down to your belly.

2. Silently and gently say to yourself, "My body is filled with calmness." Exhale slowly (one-thousand one, one-thousand two, one-thousand three) through your mouth and comfortably empty your lungs all the way down to your abdomen.

3. Silently and gently say to yourself, "My body is releasing the tension."

4. Repeat five times slowly and comfortably.

5. Do this as many times a day as needed.

PTSD Screening Questions

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?

                YES   NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

                YES   NO

3. Were constantly on guard, watchful, or easily startled?

                YES   NO

4. Felt numb or detached from others, activities, or your surroundings?

                YES   NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items. Above questionnaire is an example of a brief screen.

Prins, A., Kimerling, R., Cameron, R., Oumiette, P.C., Shaw, J., Thrailkill, A., Sheikh, J. & Gusman, F. (1999). The Primary Care PTSD Screen (PC-PTSD). Paper presented at the 15th annual meeting of the International Society for Traumatic Stress Studies, Miami, FL.

http://www.ptsd.va.gov/public/pages/trauma-symptom-checklist.asp

PTSD Checklist-Civilian Version* (Weathers et al., 1993)

Instructions:

1) List here the trauma (stressful event) that is being rated:

_____

[Clinician: be sure to check that the trauma listed fits criterion A – see DSM-IV or DSM-V]

2) Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully, and check off the box to indicate how much you have been bothered by that problem *in the past month, in relation to the trauma you listed in "1" above.*

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience?	1	2	3	4	5
2.	Repeated, disturbing *dream*s of a stressful experience?	1	2	3	4	5
3.	Suddenly *acting or feeling* as if a stressful experience were *happening again* (as if you *were* reliving it)?	1	2	3	4	5
4.	Feeling very *upset* when *something reminded you* of a stressful experience?	1	2	3	4	5
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded* you of a stressful experience?	1	2	3	4	5
6.	Avoiding *thinking about* or *talking about* a stressful experience or avoiding *having feelings* related to it?	1	2	3	4	5
7.	Avoiding *activities or situations* because they *remind you* of a stressful experience?	1	2	3	4	5
8.	Trouble *remembering important parts* of a stressful experience?	1	2	3	4	5
9.	*Loss of interest* in activities that you used to enjoy?	1	2	3	4	5
10.	*Feeling distant or cut off from other people?*	1	2	3	4	5
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	1	2	3	4	5
12.	Feeling as if your *future* will somehow be *cut short*?	1	2	3	4	5

PTSD Checklist-Civilian Version* (Weathers et al., 1993)

13.	Trouble *falling* or *staying asleep*?	1	2	3	4	5
14.	Feeling *irritable* or having angry *outbursts*?	1	2	3	4	5
15.	Having *difficulty* concentrating?	1	2	3	4	5
16.	Being *"super-alert"* or watchful or on guard?	1	2	3	4	5
17.	Feeling *jumpy* or easily startled?	1	2	3	4	5

PCL-M for DSM-IV (11/1/94)   END OF TEST

Citation: *This is a government document in the public domain.

The instructions have been adapted by Lisa Najavits, Ph.D. to include the listing of the trauma, and to include the scoring below. For other information on the measure, go to www.ncptsd.org.

Please note that this instrument can be used to obtain baseline and follow-up data regarding individual PTSD symptoms to track symptom severity over time.

Before administering, remove scoring below

--Scoring for PC-C--

Scoring: any item endorsed at 3 or higher counts as a symptom. PTSD Criterion B: 2 or more from items 1-5; criterion C: 3 or more from items 6-12; criterion D: 2 or more from items 13-17.

Stressful Life Experiences Screening

Please fill in the number that best represents how much the following statements describe your experiences. You will need to use two scales, one for how well the statement describes your experiences and one for how stressful you found this experience. The two scales are below.

Describes your Experience:

0	1	2	3	4	5	6	7	8	9	10
did not experience	a little like my experiences				somewhat like my experiences					exactly like my experiences

Stressfulness of Experience:

0	1	2	3	4	5	6	7	8	9	10
not at all Stressful	not very stressful				somewhat stressful					extremely stressful

Describes your Experience	Life Experience	Stressfulness Then	Stressfulness Now
	I have witnessed or experienced a natural disaster like a hurricane or earthquake.		
	I have witnessed or experienced a human-made disaster like a plane crash or industrial disaster.		
	I have witnessed or experienced a serious accident or injury.		
	I have witnessed or experienced chemical or radiation exposure happening to me, a close friend or a family member.		
	I have witnessed or experienced a life threatening illness happening to me, a close friend or a family member.		
	I have witnessed or experienced the death of my spouse or child.		
	I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).		
	I/or a close friend or family member, have been kidnapped or taken hostage.		
	I/or a close friend or family member, have been the victim of a terrorist attack or torture.		
	I have been involved in combat or a war or lived in a war affected area.		
	I have seen or handled dead bodies other than at a funeral.		
	I have felt responsible for the serious injury or death of another person.		
	I have witnessed or been attacked with a weapon other than in combat or family setting.		
	As a child/teen I was hit, spanked, choked or pushed hard enough to cause injury.		
	As an adult, I was hit, choked or pushed hard enough to cause injury.		
	As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.		
	As a child/teen I was forced to have unwanted sexual contact.		
	As an adult I was forced to have unwanted sexual contact.		
	As a child or adult I have witnessed someone else being forced to have unwanted sexual contact.		
	I have witnessed or experienced an extremely stressful event not already mentioned. Please explain: _____ _____		

Resources [listed alphabetically]

- EMDR International Association (www.emdria.org) and EMDR Humanitarian Assistance Program. The first of these, EMDRIA, is a membership organization of mental health professionals dedicated to the highest standards of excellence and integrity in EMDR (eye movement desensitization and reprocessing therapy for trauma and PTSD). The second, EMDRHAP, is a global network of clinicians who travel anywhere there is a need to stop suffering and prevent the after-effects of trauma and violence. Their primary focus is on training local therapists within crisis or underserved communities to treat trauma using EMDR (Eye Movement Desensitization and Reprocessing).

- International Society for Traumatic Stress Studies *(www.istss.org).* Professional society devoted to science, practice, and policy related to trauma and PTSD.

- International Society for the Study of Dissociation *(www.issd.org).* Professional society devoted to science, practice, and policy related to trauma and dissociation.

- National Center for Trauma-Informed Care *(http://mentalhealth.samhsa.gov/nctic).* Site developed by the Substance Abuse Mental Health Services Administration to provide resources for trauma-informed care.

- National Child Traumatic Stress Network *(www.nctsn.org)*. Joint effort by university, government and community agencies to provide materials, education, and resources to improve care for traumatized children and families.

- National Resource Center on Domestic Violence *(www.vawnet.org).* An online resource for advocates working to end domestic violence, sexual assault, and other violence.

- Seeking Safety *(www.seekingsafety.org).* Offers resources on trauma and substance abuse, including general information as well as material to implement the Seeking Safety model.

- Sidran Foundation *(www.sidran.org).* Provides information related to recovery from traumatic stress (including PTSD), dissociative disorders, and co-occurring issues, such as addictions, self injury, and suicidality.

- VA National Center for PTSD *(www.ptsd.va.gov).* This site is provided by the US Department of Veterans Affairs to offer education and materials related to trauma and PTSD. It also includes the PILOTS database (the world's largest literature base on PTSD and related disorders).

- Witness Justice *(www.witnessjustice.org).* Created by survivors for survivors. Their mission is to provide support and advocacy for victims of violence and trauma.

APPENDIX O: MISSION Fidelity Index

This fidelity index is designed to document services delivered as indicated by the MISSION approach. Therefore any services the client has been receiving prior to enrollment should be noted as such and not recorded as a referral. Additionally, this fidelity index should be completed based ONLY on the documentation contained in the medical record.

**If an individual is incarcerated or is in inpatient treatment during a particular time period, or if no service was needed or necessary, mark 'N/A' for relevant questions.

1. Comprehensive Assessment

A) Did the client have an <u>orientation session</u> to the MISSION program? Yes Somewhat No

B) Did the MISSION Case Manager develop a comprehensive <u>treatment plan</u>?

(Treatment plan should include a list of problem areas to address such as Mental Health, Substance Abuse, Employment, Housing Stability, and other service needs) Yes Somewhat No

C) Did the client receive a MISSION <u>workbook</u>? Yes No

D) Did the case manager meet with the client to review program <u>goals and expectations</u>? Yes No

Core Services

2. Housing Services

A) Did the case manager provide a referral for <u>housing services</u>? Yes No

B) If YES ☐ Did the MISSION team follow up on the referral for <u>housing services</u>? Yes No

3. Case Management Services

A) Did the client meet with his/her case manager weekly in months 1-3? Yes No

B) Did the client meet with his/her case manager bi-weekly in months 4-8? Yes No

C) Did the client meet with his/her case manager monthly in months 9-12? Yes No

D) Please circle each DRT co-occurring disorder treatment session the client attended:

(1) Onset of Problems

(2) Life Problem Areas

(3) Motivation, Confidence, and Readiness to Change

(4) Developing a Personal Recovery Plan

(5) Decisional Balance

(6) Developing Strong Communication Skills

(7) Orientation to 12-Step Programs

(8) Anger Management

(9) Relapse Prevention

(10) Relationship-Related Triggers

(11) Changing Unhealthy Thinking Patterns

(12) Changing Irrational Beliefs

(13) Scheduling Activities in Early Recovery

E) Were at least 7 DRT sessions attended?   Yes   No

4. Peer Specialist Services

A) How many times did the PSS discuss the workbook?   #_____

B) Please circle each peer support specialist-led session the client attended:

(1) Willingness

(2) Self-Acceptance and Respect

(3) Gratitude

(4) Humility

(5) Dealing with Frustration

(6) Handling Painful Situations

(7) Significance of Honesty

(8) Courage

(9) Patience

(10) Medicine Maintenance

(11) Making a Good Thing Last

C) How many peer-scheduled community activities did the client participate in?
    (e.g. museum tours, fishing trips, etc.)   #_____

D) How many AA/NA meetings did the client attend with the peer specialist?   #_____

5. Mental Health and Substance Use Services

A) Did the MISSION team provide a referral for additional mental health
   co-occurring disorders services beyond that of MISSION?   Yes   No

B) If YES ☐ Did the MISSION team follow up on the referral for
   additional mental health co-occurring disorders services?   Yes   No

C) Did the MISSION team provide a referral for additional substance use
   services beyond that of MISSION?   Yes   No

D) If YES ☐ Did the MISSION team follow up on the referral for additional
   substance use services?   Yes   No

6. Termination

A) Did the case manager conduct a MISSION discharge session with the client in which they reviewed discharge plan and goals?   Yes   No

B) Are linkages in place to ensure ongoing care of client post-MISSION discharge?   Yes   No

Other Services*

Circle N/A if service not indicated in treatment plan

7. Psychiatric Services

A) Was the client already enrolled in psychiatric services prior to the MISSION program?   Yes   No   N/A

B) If NO ☐ Did the case manager provide a referral for psychiatric services?   Yes   No   N/A

C) If the case manager provided a referral for psychiatric services, did the MISSION team follow up on the referral for psychiatric services?   Yes   No   N/A

8. Trauma Services

A) Was the client already enrolled in trauma-specific services prior to the MISSION program?   Yes   No   N/A

B) If NO ☐ Did the case manager provide a referral for trauma-specific services?   Yes   No   N/A

C) If the case manager provided a referral for trauma-specific services, did the MISSION team follow up on the referral for trauma-specific services?   Yes   No   N/A

9. Vocational/Educational Rehabilitation Service Needs

A) Was the client already enrolled in employment/educational services prior to the MISSION program?   Yes   No   N/A

B) If NO ☐ Did the case manager provide a referral for employment/educational services?   Yes   No   N/A

C) If the case manager provided a referral for employment/educational services, did the MISSION team follow up on the referral for employment/educational services?   Yes   No   N/A

10. Medical Services – Primary Care/Specialty Care/General Health

A) Was the client already enrolled <u>medical services</u> prior to the MISSION program?   Yes   No   N/A

B) If NO ☐ Did the case manager provide a referral for <u>medical services</u>?   Yes   No   N/A

C) If the case manager provided a referral for <u>medical services</u>, did the MISSION team follow up on the referral for <u>medical services</u>?   Yes   No   N/A

11. Criminal Justice Services

A) Was the client already enrolled <u>criminal justice services</u> prior to the MISSION program?   Yes   No   N/A

B) If NO ☐ Did the case manager provide a referral for <u>criminal justice services</u>?   Yes   No   N/A

C) If the case manager provided a referral for <u>criminal justice services</u>, did the MISSION team follow up on the referral for <u>criminal justice services</u>?   Yes   No   N/A

12. Assistance with Benefits Services

A) Was the client already enrolled in <u>assistance with benefits services</u> prior to the MISSION program?   Yes   No   N/A

B) If NO ☐ Did the case manager provide a referral for <u>assistance with benefits services</u>?   Yes   No   N/A

C) If the case manager provided a referral for <u>assistance with benefits services</u>, did the MISSION team follow up on the referral for <u>assistance with benefits services</u>?   Yes   No   N/A

Please note that this fidelity measure is a shortened version from the original form in the 2007 and 2010 Veteran editions. It is suggested that this fidelity measure is used in place of all previous fidelity measures.