

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



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Finally, we thank you for your interest in using our manuals to implement the MISSION treatment services. Please do not reproduce copies without permission from the authors. For questions regarding use of manuals or related to the MISSION program itself, please contact:

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The following institutions are affiliated with the MISSION Program:

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- Edith Nourse Rogers Memorial Veterans Hospital (Bedford VA)
- VA New England Health Care System (Network 1)

Dedication:

We dedicate this treatment manual to those who serve homeless individuals with mental health and substance abuse problems and hope that this provides a clear roadmap that facilitates the journey of recovery. We also dedicate this manual to the many homeless individuals whom we feel privileged to have served.



By providing aftercare to help formerly homeless persons with co-occurring disorders re-establish their lives in the community, Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION) has achieved encouraging outcomes. This *MISSION Treatment Manual* has been prepared to enable others who work with a similar population to implement, learn from, and make adaptations of the MISSION services in their own settings and with their own resources. This book describes the MISSION program's theoretical foundations, which include the integration of three evidence-based practices and provide a practical and pragmatic reference for team members as they carry out their roles.

The manual contains both general information on the program and specific information targeted to each person who plays a key role in implementation. Specifically:

- The *Overview of the Program* and *MISSION's Model of Care* provide general background of interest to anyone considering replication.
- Separate chapters highlight guidance to help administrators implement the program and to assist personnel holding each of the major staff positions: supervision, case management, and peer support.

Overview of Contents

The *MISSION Treatment Manual* contains the following chapters:

1. *Overview of the Program*: The opening chapter provides a brief orientation to the program, including its goals, target population, and the intervention itself.
2. *Replicating MISSION Program: Guidance for Administrators*. The chapter provides information of particular interest to administrators who are considering adapting the program for use in particular settings. It discusses the target audience, treatment setting, service components, outcomes achieved, program funding, staffing and supervision, staff training requirements, and logistical requirements.
3. *MISSION's Model of Care*. This chapter will be of interest to all staff involved in replicating the intervention, but especially the supervisor. It explains the tenets of each of the proven elements MISSION incorporated and adapted to meet the needs of its target population in its service setting.

4. *Clinical Supervision*. This chapter is intended to guide the supervisor who oversees and supports the work of the case managers and peer support specialists. It includes an overview of the supervisor's role and a description of how each of this team member's primary areas of responsibility is fulfilled in the MISSION program. These primary areas include diagnostic assessment; identification, prioritization, and management of high-risk cases; and clinical coordination and supervision.

5. *Case Management*. This chapter details the work of the case managers. Following an overview of their role, it explains how they work with other team members and how they interact with and support their clients, both within the residential facility and after their transition to the community. Examples of interventions with clients are provided to illustrate both frequently encountered problems and ways case managers can respond to them effectively.

6. *Peer Support*. This chapter explains the unique role of peer support specialists. Following an overview of their role and essential personal characteristics that help them fulfill this role, the chapter explains how they work with other team members and shows how they interact with consumers as role models and as sources of encouragement and concrete support. Examples are given to illustrate how peers assist consumers, both within the residential facility (where peers facilitate group discussions on topics of particular concern) and through visits to consumers living in the community.

Resource materials that immediately follow the last chapter include biographical sketches of the authors, a list of a few key resources for further exploration of related topics and for technical support, references, and a glossary of acronyms and terms.

The manual also contains several Appendices that will assist with implementation and service delivery of the MISSION Program. These include:

Appendix A. Topics for Peer-Led Group Sessions. These topics are addressed in group sessions facilitated by peer support specialists. We encourage programs to use these ideas as inspiration rather than gospel; it is important that peers be able to plan and lead programs that speak to the immediate issues relevant to the consumers they support.

Appendix B. Leading Group Exercises in Dual Recovery Therapy. Dual Recovery Therapy (DRT) is an important component



of MISSION. These structured group exercises are conducted by a case manager while clients are housed in the residential treatment facility. These exercises are also used during the community transition phase to reinforce skills previously learned in residential care in order to facilitate ongoing sobriety and recovery from mental health and addiction problems.

Appendix C. MISSION Sample Policies and Procedures. These policies and procedures on key topics may suggest areas that replicating agencies will want to address. We recognize that all systems have unique needs regarding policies and procedures and included these in an effort to facilitate the development of new ones in your system.

Appendix D. Position Descriptions. This appendix presents a generic description of a case manager's and a peer specialist's job in the MISSION program. Again, we recognize that systems have unique needs regarding the position descriptions and include these samples simply as a resource.

Appendix E. Peer Support: Lessons Learned and Issues to Consider. This appendix reviews some of the lessons learned early on in MISSION when setting up the peer support component and suggests some issues you may wish to consider in your setting.

Appendix F. TLC Data. These data represent findings on Time-Limited Care Coordination, a systematically integrated and tested combination of three evidence-based therapeutic interventions that preceded and informed MISSION's approach.

Appendix G. Sample Notes. Case workers regularly write notes on meetings with clients to help coordinate care and provide a means of tracking significant issues. Templates or samples are included for several of these.

Appendix H. MISSION Fidelity Index. This index is used to monitor fidelity to the intended model of services. Its use is described in Chapter 4. Clinical Supervision.

How to Use This Manual

This manual is either being provided as a spiral-bound printed document or downloaded from the Web. The printed document is spiral bound in order to facilitate copying of individual sections. Similarly, the Web version allows you to download individual chapters as needed.

Most members of the team (with the probable exception of administrators) will want to receive the entire manual for

reference. However, certain sections will be of greater relevance to particular team members than others.

Administrators. If you are an administrator, you may want to review the entire manual; however, the following sections will be particularly relevant to your concerns:

1. Overview of the Program, and
2. Replicating the MISSION Program: Guidance for Administrators

Supervisors. If you are a supervisor, you will want to review the entire manual carefully. However, you will find your own role as supervisor described in detail in the following section:

4. Clinical Supervision.

The roles of your supervisees are detailed in:

5. Case Management, and
6. Peer Support.

You will also be particularly interested in the policies and procedures detailed in Appendix C and in the MISSION program position descriptions (Appendix D), both of which will doubtless need to be adapted for use in your service setting.

Case Managers and Peer Support Specialists. If you are a case manager or peer support specialist, you will want to pay particular attention to these sections:

1. Overview of the Program,
5. Case Management, and
6. Peer Support.

Case managers and peer support specialists should be thoroughly familiar with each other's roles and responsibilities in order to assure the smoothest possible working relationship. In addition, peer support specialists will find suggested topics for peer-led group sessions in Appendix A. Case managers who lead group exercises in dual recovery therapy should refer to Appendix B. Both peer support specialists and case managers use the *Consumer Workbook* to reinforce the client's determination to recover and skills to aid in recovery. The use of this *Consumer Workbook* is described in detail in Chapter 5.

Consumers. A separate *Consumer Workbook* has been developed for program participants. This *Consumer Workbook* should be given to each participant when he or she enters the program. It collects exercises used by the program and provides reading material intended to help program participants as they prepare to transition to the community.



1. Overview of the Program

This section provides a basic introduction to the MISSION program that will be of interest to all readers. After a review of the intervention's goals and initial evaluation findings, the overview includes a brief description of the intervention, the models of care employed, and the staffing used in the original program to achieve the results described. More detailed information is found in other chapters within this guide. In particular, Chapter 2 provides information on treatment settings where this model may be appropriate and advice on possible adaptations to meet specific program needs. Please see the Foreword for guidance on the sections that will address your specific areas of interest.

Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION) is a 12-month integrated treatment intervention based on the Time-Limited Care Coordination Model (formerly called Time-Limited Case Management) (Smelson et al, 2005; Smelson et al, 2007). It is designed to help formerly homeless individuals with co-occurring addictive disorders and nonpsychotic mental illnesses transition successfully from residential treatment to independent living in the community. While originally implemented with a target population of veterans, program developers believe its principles and approach may readily be adapted to serve other similar populations.

➤ **Goals and Outcomes**

The MISSION model of care systematically integrates three evidence-based practices. It is specifically designed to treat individuals who have experienced homelessness and who have co-occurring substance abuse disorders and nonpsychotic mental illnesses such as depression, anxiety, and PTSD. It is our experience that the service needs of this population are not always effectively met in one comprehensive program, leading to fragmented care. Also, the programs that do provide these services are often based in hospital or residential settings and do not offer transitional care that continues through the outpatient transition to help clients maintain stability in the community. Persons with co-occurring disorders face significant barriers to housing, employment, and other important life goals, particularly when they are not engaged in treatment for both disorders and actively working to maintain sobriety. These barriers often can be overcome, however, by continuity of care, coordination of service linkages, and sustained support as the individual transitions to a healthy lifestyle.

Specific MISSION treatment goals include:

- Reducing the number of homeless days and increasing community tenure through housing stability;
- Reducing re-hospitalizations;
- Enhancing dual recovery by reducing addiction slips/relapses and psychiatric symptoms/relapses;
- Increasing the number of days employed and the wages earned; and
- Improving access to services through systems coordination and ongoing tracking.

The efficacy of the program approach is currently being assessed through a comprehensive evaluation that compares 12-month outcomes of MISSION patients to those of a comparison group of veterans who received services from the residential treatment facility but did not receive the additional services offered by MISSION. At the time of writing this manual, the current MISSION program has enrolled 278 MISSION clients, and we have 12-month outcome data available on 155 of our anticipated 480 study participants. The available data suggests that 12-month follow-up rates have been excellent, consistently averaging above 80% (88% for MISSION clients and 73% for the comparison group), and early results have demonstrated positive effects of the MISSION program on patients' access to services and outcomes in the community. Outcome data available at the time of this writing are presented in Chapter 2. These data are robust and consistent with the findings from our other studies.

The MISSION program was developed based on our experiences creating and studying Time-Limited Care Coordination Model, which integrates the same three evidence-based practices, for many years, including in a randomized trial with an attention control condition (Smelson et al, 2005; Smelson et al, 2007). See Appendix F for additional data. Please feel free to contact the authors to inquire about additional data that becomes available following the writing and publishing of this manual.

➤ **Description of the Intervention**

As originally implemented, MISSION services are facilitated by a partnership with a residential treatment program for homeless people with co-occurring disorders, with the expectation that



the residential treatment program will help the clients cease active substance use, engage with mental health treatment, obtain employment, and secure transitional or permanent housing at discharge. Each client who enters the program is assigned to one case manager and one peer support specialist, who provide support over a 52-week period to help each client make a successful transition to community life. Each case manager and peer support specialist serve about 25 clients at a time.

The program begins with 14 weeks of temporary housing and services. The staff of the residential treatment program serves as a “Primary Provider” for clients during their stay in the facility, but MISSION staff provide some initial services, including a comprehensive assessment of all service needs, specialized co-occurring mental health and substance abuse disorders treatment, and post-discharge treatment planning designed to establish relationships and build skills that will be useful once the client transitions into the community.

During their residence, those eligible for MISSION who choose to enter the program participate in structured Dual Recovery Therapy (DRT) group sessions that integrate mental health and substance abuse issues. These sessions are led by a case manager and described in Appendix B of this manual. MISSION participants also benefit from open group discussions led by peer support specialists and focused on peer-identified topics of concern (contained in Appendix A). The peers and case managers also facilitate the use of the *Consumer Workbook* during the residential phase of the 12-month MISSION intervention.

In the last four weeks of the residential treatment component, MISSION clients meet with MISSION and residential staff and focus on post-residential treatment discharge planning. As MISSION is responsible for overseeing the implementation of the discharge plan and providing support and aftercare when the MISSION client re-enters the community, MISSION staff strive to build a relationship that will reinforce the hope of recovery and help clients access other essential supports during the critical period following treatment. Case managers monitor “their” clients’ progress through the residential program by attending care coordination meetings led by residential staff. Upon the client’s transition to the community, the MISSION case managers and peer support specialists seize the “baton” from the residential staff and assume the lead role in providing support.

Once the consumer re-enters the community, case managers provide ongoing care coordination, psychoeducation using the Critical Time Intervention (CTI) and Dual Recovery Therapy (DRT) principles, and ongoing support over the 38 weeks

remaining of the intervention’s 12-month period. They work to address ongoing needs that might otherwise be unmet, undermining recovery: ongoing substance abuse services, linkages to medical care, mental health services, housing assistance, vocational support, and emotional and practical support. The support provided decreases in intensity over time as staff facilitate the client’s engagement with community resources and foster consumer independence.

In addition, consumers benefit from peer support provided by formerly homeless individuals who have also grappled with co-occurring mental health and substance abuse problems. These trained peer support specialists serve as role models for personal recovery and successful community integration. They help consumers regain control over their own lives and encourage them to self-determine and pursue their personal recovery goals. Peer providers are instrumental in fostering the development of strategies and natural supports that promote wellness, prevent relapse, and help consumers secure and maintain satisfying housing and employment.

While MISSION developers believe that a partnership with the residential program is critical to facilitate the intervention, they do not believe 14 weeks of residential care frontloaded in treatment is essential and can envision adaptations in other settings with similar populations that would work equally well. In fact, the Time Limited Care Coordination Model (TLC), which serves as the foundation for the MISSION Program, is a care coordination approach that more generally transitions individuals across levels of care or assists with community integration.

This approach will benefit persons with co-occurring disorders who have been homeless and are returning to a life in the community after a sustained intervention to initiate treatment. An estimated 50 percent of people with mental illnesses who are homeless have co-occurring substance use disorders. While the original TLC model is designed to meet the needs of persons with serious mental illnesses and co-occurring substance abuse disorders, MISSION has modified it for homeless clients who have less serious (i.e., nonpsychotic) forms of mental illness. The MISSION program has chosen to exclude individuals with a serious mental illness such as schizophrenia and bipolar I disorder for the following reasons:

- People with serious mental illnesses have specialized treatment needs that are different from those with a less severe mental illness, and
- The literature does not support the treatment of these two populations (those with severe and less severe mental illnesses) simultaneously (Ziedonis et al, 2000; Drake et al, 2001).



Models of Care

“Time Limited Care-coordination” (TLC), the foundation of the MISSION intervention, has been used successfully by Veterans Administration programs in New Jersey and around the country. The TLC model, initially developed in New Jersey, systematically integrates several evidence-based practices and has been recognized by the mental health section of the Department of Veterans Affairs as a promising best practice. The integration of the TLC model interventions is designed to offer more synergy than each delivered separately and to systematically facilitate the successful transition of people with co-occurring disorders into the community. Three proven strategies woven together in TLC include:

- Critical Time Intervention (CTI) case management, an intensive but time-limited intervention designed to promote engagement in services and supports available in the community;
- Dual Recovery Therapy (DRT), an approach to counseling people with co-occurring mental health and substance abuse disorders that involves teaching clients self-management skills and reinforcing them through follow-up; and
- Peer Support, including emotional and practical assistance and role modeling provided by people who have demonstrated successful recovery and community integration following diagnoses and life experiences similar to those of the clients.

In addition, the MISSION program stresses Vocational Support, which helps clients succeed at employment – a major stabilizing element in recovery. For more information on these models and their theoretical foundations, please see Chapter 3.

Essential MISSION Staff

As originally piloted, the MISSION program consists of a part-time program director, who has overall responsibility for budget management, hiring, and final decisions on the project; a part-time supervisor of clinical staff; three case managers (approximately 1 per 25 clients); three peer support specialists (with the same ratio to clients as case managers); and an evaluation team. Other programs that are not required to follow a formal, documented evaluation plan may well be able to combine the function of the program director and the supervisor into a single role. Depending on the number of the clients served, programs may also be successful with fewer case managers and peer support specialists.

Sample Service Delivery Schedule

The following provides an overview of the sequence of services provided by MISSION throughout the full 52-week course of the intervention.

Week 1: Screening and Orientation to MISSION

- Client is admitted into the Residential Facility.
- Client is also identified as a potential MISSION participant in residential team meeting.
- Client is approached by MISSION staff about eligibility.
- Client receives a comprehensive co-occurring disorder evaluation.
- Client is deemed eligible.
- Client meets with case manager for “orientation to the MISSION program” including the DRT Sessions and overview of case manager’s role.
- Client meets with peer for separate orientation to program and peer support services.

**Note:* The initial introduction of the *Consumer Workbook* is usually part of the case manager’s orientation session, but this can be done by the peer if necessary.

Weeks 2-10: Group Work and Relationship Building

- MISSION client participates in DRT Groups (DRT Groups are psychoeducational and client can begin at any time; he/she does not have to wait for a new group of MISSION patients to start and thus can go into a group immediately).
- MISSION client participates in Peer Support Group.
- MISSION client “check-in” session by peer regarding *Consumer Workbook* Exercises.
- MISSION staff attend weekly Residential Facility Team Meetings and provide input on MISSION client.
- Peers have “open door policy” for informal discussion with MISSION client.
- Client continues to receive addiction and vocational services through the residential treatment program and medical services via a referral to VA facility.

Weeks 11-13: Initiation of Discharge Planning

- MISSION client continues to participate in DRT Groups.



- MISSION client continues to participate in Peer Support Group.
- MISSION staff attend weekly Residential Facility Team Meetings and provide input on MISSION client.
- Peers have “open door policy” for informal discussion with MISSION client.
- Client continues to receive addiction and vocational services through the residential treatment program and medical services via a referral to VA facility.
- The MISSION case manager initiates weekly discharge planning session with clients to facilitate discharge plan. This includes the reinforcement of the use of the *Consumer Workbook* readings that focus on transition to the community (Part 2). Peers also check in with the clients regarding these readings.

**Note:* It is critical for the MISSION client, MISSION case manager, MISSION peer, and residential facility case manager to have good communication regarding the discharge planning and implementation process. Also, MISSION views this as the beginning of the discharge process and the CTI component commences; the team works together to minimize anxieties about the transition.

Week 14-20: Transition from Residential Care to the Community

- MISSION casemanager and peer outreach sessions together (weekly). Focus on discharge plan follow-through, mental health and substance abuse stability, community issues, employment issues. Modifications to discharge plans are made as new needs arise in the community.
- MISSION peer participates in community activities with the client (going to 12-step meetings, social events, coffee, etc.)

**Note:* The MISSION case manager and peer can schedule additional sessions as needed. For example, the peer may accompany the client to a 12-step meeting. Either the peer or case manager may accompany the MISSION client to a VA entitlement appointment or Section 8 housing appointment.

Week 21-36: Continuing Aftercare

The MISSION case manager and peer conduct outreach weekly to every other week as needed by the client. These meetings can also be supplemented by telephone contacts. Staff continue to focus on discharge plan modifications or “fine-tuning” DRT mental health and substance abuse booster sessions as needed

and provide ongoing employment support, including conflict resolution on the job and links to Department of Vocational Rehabilitation or Department of Labor resources.

**Note:* The MISSION Case Manager and peer can schedule additional sessions as needed.

Week 37-51: Ending Aftercare: Transfer of Care to Community

- MISSION case manager and peer outreach sessions are less frequent. They may occur every other week to monthly or less, depending on client needs. Continued supplemental telephone contacts.
- MISSION case manager and peer facilitate use of community supports, health care, resources, etc. to prepare the client for the transition. Work through termination and build client confidence in termination and community living. DRT booster as needed.
- Peers continue to participate in activities with clients such as 12-step meetings and social events.

**Note:* Termination is often difficult for the MISSION client and brings up such core issues as loss, dependency, etc. The CTI manual can provide an additional resource for this component of treatment and is seen as a critical component of the treatment process. Further, should clients 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, peer, and case manager that the goal in the transitional phase is to empower clients to believe that they can live independently in the community and without the MISSION staff.

Week 52: Discharge from MISSION

The MISSION case manager and peer specialist review progress and goals; discuss the client’s strengths, resiliency, and resources; and reinforce the use of community supports. They say goodbye.

**Note:* Preparation for discharge really begins during the previous stage, “Ending Aftercare: Transfer of Care to Community.” Care is transferred slowly. Should the client relapse at this point or request more services, the client is encouraged to use community supports to meet these needs. This should be an uncommon occurrence because of the length of the termination phase and the emphasis on steady reinforcement of those resources.



2. Replicating the MISSION Program: Guidance for Administrators

This section builds on the Overview of the Program to provide additional information that will be of interest to administrators who are considering replicating the MISSION program. After a brief summary of the program, the chapter reviews each of the key elements essential to consider in adapting this service for other settings: the target population served, the treatment setting, the service components included in the program, outcomes (benefits) realized through MISSION, sources of funding, staffing and supervision needed, staff education and training requirements, and logistics relevant to implementation. Throughout the chapter, we explain how the MISSION program has been implemented in its initial form, but we also suggest possible adaptations for providers based in other settings with unique needs. More detailed information on the models of care that inform the MISSION intervention and on the roles of staff involved in making it successful will be found in other chapters within this guide.

Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION) is a model of care designed to help homeless, unemployed people with co-occurring addiction disorders and nonpsychotic mental illnesses transition successfully from residential treatment into the community. The intervention is intensive but time-limited; it is designed to continue for 12 months, including the time in residential treatment. MISSION was supported by a grant from the Substance Abuse and Mental Health Service Administration and originated as an institutional collaborative effort of the Department of Veterans Affairs, University of Medicine and Dentistry, Rutgers University and with additional individual collaborations with experts at Columbia University and University of Massachusetts Medical School.

Key objectives include providing clients with support for dual recovery, linking them to community resources, supporting them in housing and employment, and providing emotional and practical support. MISSION is effective in improving outcomes related to substance use, psychiatric functioning, housing, and employment. The MISSION team consists of a program director, clinical supervisor, case managers, and peer support specialists and combines several interventions to address the needs of the target population. As described below, the original MISSION team believes strongly that the program can be replicated in a variety of other settings with similar populations and service needs.

➤ A. Target Population

MISSION is an appropriate intervention for homeless people who are undergoing residential treatment for co-occurring addiction disorders and nonpsychotic mental illnesses. In the MISSION program, we define homelessness as a lack of a fixed, regular, adequate nighttime residence, which includes persons residing in shelters, transitional housing, in other public facilities, or on the street. People are also eligible for the program if they are in imminent danger of homelessness because they are residing in temporary, shared housing.

In addition to being homeless, clients accepted into the current MISSION program must be:

- 18 years of age or older;
- Unemployed at admission despite being available for, and actively pursuing, employment;
- Able and willing to live in the community;
- Willing to take part in the service; and
- Diagnosed with co-occurring substance abuse and a mental illness—such as depression, anxiety, or PTSD—that does not involve a psychotic thought process.

Demographics of the MISSION Population

MISSION serves clients who have experienced significant periods of homelessness. Clients entering MISSION report that their first episode of homelessness occurred, on average, nine years prior to their admission to the program. Approximately 4 percent of patients entering MISSION report *never* being housed since their first homeless episode. Of those who experienced sporadic housing since their first episode, the average time since last being housed was two years.

The MISSION program will serve a total of 480 homeless dually diagnosed veterans between 2004 (the year the program was initiated) and 2009. Of the 278 homeless veterans enrolled in MISSION to date, demographics are as follows:

- 96 percent are male;
- The average age is 47;
- 64 percent are African American, 25 percent are white (non-Hispanic), 7 percent are Hispanic, and 4 percent are of another race/ethnicity;



- High school diplomas or their equivalents were earned by 94 percent of the sample, with 43 percent continuing their education beyond high school;
- 43% report being unemployed or working less than full time during the three years prior to their admission; and
- 8 percent of the veterans were married at the time of entry, and 54 percent had been married at some time during their lifetimes.

Please also see additional information on the target population in the section below entitled “Populations for which the MISSION Service Model may be Appropriate.”

The Population’s Need for Services

MISSION serves a population with service needs that are not effectively addressed through other programs. In 1995, 3.5 million Americans experienced homelessness (National Coalition for Homelessness, 2007). Mental illnesses and substance abuse have been recognized as important contributing factors to chronic homelessness, especially when these conditions co-occur (North et al, 1996). For these clients, the difficulty of accessing services is complicated

both by the presence of dual disorders and by the lack of a stable living situation. They face significant barriers to housing, employment, and achievement of important life goals, particularly when they are not engaged in treatment for both disorders – a situation difficult for persons living with poverty to achieve in most systems of care – and actively working to maintain sobriety.

On any given day, 250,000 veterans are living on the streets or in shelters, and approximately twice that number experience homelessness sometime during the year (Department of Veterans Affairs [DVA], 2003). Recent estimates suggest that veterans comprise 25 percent of the total adult homeless population in the United States and 33 percent of the male homeless population (DVA, 2003). Nationally, approximately 45 percent of homeless veterans have been found to suffer from a mental illness and 68 percent have alcohol or drug problems (DVA, 2003).

Table 1 shows data collected from MISSION clients that demonstrate some of the obstacles to recovery they have faced in the period immediately preceding program admission. Please note that it will be of interest to compare these data to Figure 1, which follows in the section of this chapter on “Benefits and Outcomes Received.”

Table 1: MISSION Clients Self-reported Need for Services and Receipt of Services in 6 Months prior to Admission

Service	Percent who Needed the Service	Percent who Received the Service
Mental health Services	66.9	35.4
Employment services	66.2	16.1
Dental care	76.3	23.4
Medical care	63.7	43.2
Legal assistance	53.3	16.8
Educational services	37.4	2.2



The experiences of MISSION clients reflect those of many veterans. Homeless veterans who have co-occurring substance abuse and mental illnesses that cannot be classified as serious mental illnesses do not qualify for some of the more intensive community-based programs that might help them achieve stability in the community.

Intake into the MISSION Program

Clients who appear to meet MISSION’s diagnostic criteria (e.g., addiction and nonpsychotic mental illness) are referred to MISSION staff by the residential program. Within three days of the client’s admission to residential treatment, these clients are referred to the clinical supervisor for the MISSION program, who performs a comprehensive assessment that confirms client eligibility for the program eligibility. The interviewer evaluates substance abuse, severity of psychiatric symptoms, and functioning in other life domains (e.g., physical health, family, social, and legal). Any inconsistent findings between the assessments made by the residential treatment staff and the MISSION staff are discussed in treatment team meetings. Because program goals and contracted responsibilities to SAMHSA/CSAT require a study of outcomes, the program uses the following standardized tools at intake: the Structured Clinical Interview for DSM-IV Diagnosis (SCID, Clinician’s Version); the Addiction Severity Index (ASI); and the Behavior and Symptom Identification Scale (BASIS-32). While we have found them very helpful clinically, they are also time consuming. Programs with limited resources should consider substituting a comprehensive assessment that includes questions regarding mental health, substance abuse, homelessness, employment, and other associated psychosocial problems. It is likely that these data are already being collected by the treatment facility for its own use.

Once a client is deemed eligible for MISSION, he or she is referred by the supervisor to a case manager, who provides them with program information and obtains signed study consent forms from those who choose to participate. Experience with MISSION and the other similar time limited care-coordination programs and services suggests that at least 85 percent of those offered MISSION services will agree to participate.

Populations for which the MISSION Service Model May be Appropriate

MISSION has been studied on veterans with mental health problems, excluding those with psychosis, who need housing assistance, employment supports, integrated mental health

and substance abuse treatment, other medical health and dental care, and community supports in order to remain sober, employed, and housed. However, MISSION does not see any reason why the model could not assist a nonveteran population. The issues of MISSION clients are similar to those within the same diagnostic clusters who are not veterans. It is also important to highlight that most of the individuals served in the MISSION do not receive VA entitlements, which is often one of the potential concerns for the population differences between VA and non-VA cohorts.

There is also no reason to believe that MISSION would not work for individuals with a psychotic disorder, since the three core interventions, Dual Recovery Therapy, Critical Time Intervention Case Management, and Peer Support are routinely used with this population. However, because it has not been tested on individuals with a psychotic illness, we are not endorsing it at the moment for use with this population and believe that testing the approach with this population might necessitate some minimal modifications to the materials. For example, replicators might want to add additional exercises regarding medication issues as well as illness management. (Possible modifications could be discussed with the authors if necessary.) Lastly, while the veteran population with which the MISSION Program was implemented is primarily male, the program delivered services to female veterans as well. The MISSION team has examined outcomes more carefully among the women population and found no differential response to treatment or satisfaction with care by gender.

➤ B. Treatment Setting

In its original form, MISSION is a transitional program; it helps people succeed in the community after a stay in a residential treatment program. While clients are undergoing residential treatment, the staff of that program is primarily responsible for their care, with the MISSION team providing some enhanced services. The residential treatment program offers the following:

- Comprehensive clinical evaluations;
- Mental health services, including therapy, psychiatric treatment, and medications as indicated;
- Substance abuse services, including 12-step and other groups;
- Comprehensive health and dental care;
- Prevocational counseling, including interviewing skills, resume preparation, and advice on how to address such concerns as work history, substance abuse, or the presence of a criminal record;



- Significant assistance with securing employment (at VA, most clients participate in transitional work during residential treatment and have recently obtained competitive employment upon discharge to the community); and
- Significant assistance with securing housing (at VA, most clients have transitional or permanent housing in place at discharge, as clients are required to save 80 percent of their earnings toward security deposit, rent, utilities, and other start-up costs).

During the residential portion of the intervention, the MISSION team initiates a relationship with clients. A case manager offers group sessions in Dual Recovery Therapy and peer support specialists facilitate group sessions on topics of common interest. A *Consumer Workbook* is given to the client and its use is facilitated and monitored by the peer and case manager to lay the groundwork for the transition to the community. Throughout the residential stay, MISSION staff cooperates with the residential treatment staff and monitors the progress of participating clients in the following ways:

- They participate in the development of the treatment plan and access it as needed through the electronic record;
- They participate with residential staff in weekly team meetings;
- They contribute to the development of the housing plan;
- They participate in the development of the discharge plan; and
- They play a key role in helping to facilitate the discharge plan.

Once clients transition to the community, both peers and case managers continue to meet with them in the community at decreasing levels of frequency. Meeting sites vary depending on the client's specific situation, but at least one meeting is held in the client's place of residence. Staff supplement face-to-face meetings with telephone contact.

Treatment Settings for which the MISSION Service Model May be Appropriate

The MISSION team suggests that administrators consider the use of the model in any setting in which members of a similar target population are leaving an institutional setting or intensive phase of treatment and are in need of extensive community supports to achieve stable housing and successful community integration. It is important to underscore that

while the residential program in which the MISSION program was studied offers approximately 14 weeks of housing, varying lengths of residential care may work equally well; facilities that have longer or shorter length of stays in residential care should not find this as a deterrent to the implementation and delivery of MISSION services.

For residential programs that do not have the luxury of a 14-week residential stay, the authors suggest maintaining the year-long model, but adjusting the timeline regarding the contact in the residential treatment phase. For example, the community transition sessions that are normally delivered in weeks 11-13 of the residential treatment component of MISSION could simply be moved up or back to correspond to the last month of residential care in your setting. If possible, it would be best to allow the client to complete the thirteen DRT sessions while still in residential care, since these are group sessions that help convey the skills and insights needed to prepare the client for community living. Because of the assertive nature of the MISSION program and built-in flexibility, however, other modifications can be considered regardless of the length of the residential program and based on the needs of the facility.

As noted above, a transition from residential care to the community is not a necessary requirement for MISSION program replication. The service components described below are intended to reinforce clients' ability to sustain their recovery through a critical transition period, which need not be from a specific facility. For example, MISSION's service delivery structure is flexible enough to be used in partnership with an intensive outpatient program to sustain treatment gains and to foster a lifestyle of recovery and self-care that includes stability and satisfaction within life domains of housing, employment, and social connectedness. It should be noted, however that such adaptations of the model would likely require some modification to the treatment manual and may require additional program staff and/or partnering with other providers. One might even consider an additional evaluation component to address adaptations. Please feel free to contact the authors if you would like any feedback regarding adaptations to the model.

➤ C. Service Components

The MISSION program builds on and adapts the comprehensive service structure known as Time-Limited Care Coordination (TLC), an approach that is used by several other programs at VA and nationwide. The core components of TLC, described below, are Critical Time Intervention (CTI) case management,



Dual Recovery Therapy (DRT), and peer support. These three components are reinforced by a fourth element, vocational support, which is designed to support clients as they seek and strive to maintain employment – a key element in stable recovery.

Critical Time Intervention Case Management

Critical Time Intervention (CTI) case management was originally designed to prevent recurrent homelessness among persons with severe mental illness by enhancing continuity of care during the “critical time” of transition between institutional care and community life. It has been adapted to meet the needs of those with nonpsychotic forms of mental illness. CTI uses the “stages of change” model and motivational interviewing to help clients develop their commitment to community-based recovery, stay with treatment, and maintain housing, employment, and other needed supports. Case managers meet with clients in the community, rather than an office setting, and actively attempt to keep clients engaged and prevent “drop-outs.”

The classic approach to CTI begins with the client’s discharge into the community and is divided into three phases, totaling nine months. The phases are characterized by decreasing frequency of services:

1. *Transition to Community*, in which the client and case manager formulate an individualized treatment plan, identifying community resources and service linkages most consistent with the client’s needs. During the transition to the community phase, as applicable, the case manager may need to pay particular attention to monitoring participation with pharmacotherapies and facilitate appointments with a psychiatrist.
2. *Try-Out*, in which the systems of community support are tested and adjusted and the case manager identifies any service gaps or areas where the patient requires more or less support; and
3. *Transfer of Care*, in which 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.

The creators of CTI liken it to passing a baton in a track relay race. The runner passing the baton runs alongside the runner receiving it until the first runner is sure that the second runner has a firm grasp on the baton. Similarly, the case manager “runs

alongside” the client until the person can “carry the baton” on his or her own and perform life tasks independently.

Successful implementation requires the presence of hired and trained case managers who have developed working relationships with key people able to link clients to community-based supports and services. The program will need to establish ways of tracking contacts with clients, assessing their progress, and making appropriate referrals to meet their needs. MISSION employs a treatment manual developed by CTI’s creators at Columbia University to guide its staff in implementing this aspect of the intervention (Felix, Herman, Sussner, Conover, and Bloom, 2001).

MISSION adds Peer Support Specialists to the CTI model, working in partnership with case managers. They offer the added benefit of their ability to connect on a peer level with clients, as well as their personal knowledge of challenges and opportunities in the community transition. Trained peer providers can “run alongside” the client offering coping strategies, empathy, and perhaps most importantly: hope. They can also improve access to self-help/mutual support services and community-based opportunities for social engagement, as well as encouraging the development of other life skills and natural supports.

Dual Recovery Therapy (DRT)

Dual Recovery Therapy (DRT) is an intervention that addresses co-occurring mental illnesses and substance abuse 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 and supportive psychotherapy/social skills training). Moreover, DRT is consistent with existing therapeutic models that manage both substance abuse and psychiatric conditions simultaneously (Bennet, Bellack, and Gearon, 2001; Drake, McFadden, Meuser, McHugo, and Bond, 1998; Minkoff, 1989; Shaner, 1997) and has been demonstrated in numerous studies to significantly improve outcomes for dually-diagnosed populations (Ziedonis and Trudeau, 1997; Ziedonis and Simsarian, 1997; Ziedonis and Stern, 2001). It includes two aspects that have been adopted by the MISSION program:

- Principles for successful treatment of persons who have co-occurring disorders, and
- A structured series of counselor-led group sessions that introduce clients to tools and methods that can enhance the recovery process (see Appendix B).



The MISSION program trains all staff in the principles of DRT to ensure consistency of approach and enhance synergy between the case managers and peer support specialists who are working with the same client.

While the DRT foundation is initially developed through the initial 13-week structured group sessions, the case managers and peers are familiar with the DRT approach and incorporate the DRT treatment philosophy and structured tools in the outpatient sessions as needed. Booster DRT sessions and the review of DRT worksheets exercises are also used as needed during the community phase. Each client receives a *Consumer Workbook* that contains all the DRT exercises, along with additional exercises and readings. See the chapters on peer support and case management for further details on implementation.

Peer Support

Peer support services – services provided by individuals who are role models for recovery – are emerging as an evidence-based practice for individuals diagnosed with mental illnesses and/or substance abuse disorders. In response to studies demonstrating substantial recovery rates from even the most serious of mental illnesses, the mental health field is increasingly recognizing “recovery” as an expected outcome of services when people have access in their communities to treatment and supports that are tailored to their needs. Recovery generally refers to the process in which people (even with the most serious mental illnesses) are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

With this shift in the paradigm of care, peer providers can help move mental health services towards a recovery orientation in several ways. They can point to stigma and bias within the care system that may not be apparent to providers. They can reinforce the need for full community integration rather than a simplistic focus on stabilization. They can help consumers work toward and achieve their goals, calling on a range of community providers to step up to the plate and help make recovery a reality.

Randomized, controlled trials of peer support are limited; however, when coupled with quasi-experimental studies, an increasing body of evidence suggests measurable benefits associated with mutual support, such as less inpatient hospital utilization (Galanter 1988; Rappaport, 1993), and improved

substance use and social functioning (Moos, Schaefer, Andrassy, et al 2001; Rappaport, Seidman, Toro, et al 1985; Carpinello, Knight, and Janis, 1991). The MISSION program employs the consumer-provider model of peer support. Consumer providers have been found to be successful at improving patient satisfaction with traditional mental health services, can increase patient access to needed services by assisting patients to navigate through fragmented service systems, and may be better able to empathize and be flexible, patient, and persistent with them (Chinman, Young, Hassell, Davidson, 2006).

“Peer Support Specialists” are full staff members of the MISSION program. Each has experienced significant recovery from challenges similar to those faced by MISSION clients (homelessness, unemployment, substance abuse, and mental illness) and has received training specific to the role of consumer provider. In addition to serving as role models, peer support specialists use their personal experience and consumer-provider training to advocate for clients and empower them to self-determine their recovery goals, share wellness and relapse prevention strategies, and provide practical supports to improve socialization and community life skills. While clients are in residential treatment, they attend weekly sessions led by peer support specialists (see Appendix A). The sessions reinforce DRT topics covered by the case managers but also encompass issues identified by the peer support specialists as part of the recovery process, including humility, courage, and willingness to change. After clients are discharged, the peer specialists continue to provide encouragement and practical support to help clients access needed community services and practice life skills. They often accompany clients to 12-step meetings and may help them with nitty-gritty tasks such as learning to use public transit or getting a driving license.

In addition to the relationship clients have with peer providers on staff, MISSION fosters and encourages participation in adjunctive self-help and mutual support services, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), consumer-run drop-in centers, and other consumer-operated services in which people encounter peers who are further along in recovery.

Vocational Support

Through the residential program, clients receive help in securing employment through vocational assessment and planning (weeks 1 and 2), job restoration and training (weeks 3 and 4), work adjustment (weeks 5 through 8), and employment maintenance and community integration (weeks 9+). MISSION case managers offer additional support as



clients enter the community, helping them resolve issues related to employment, access transportation needed to retain employment, or find new employment if they lose their original job placement. The MISSION staff also use the State Department of Labor as a resource and referral site to assist clients with their vocational needs. Some examples include helping clients to access training through Division of Vocational Rehabilitation and/or job placement assistance through “One Stop” Career Centers.

Service Components Essential to Replication

MISSION developers and staff believe all of these elements (CTI, DRT, Peer Support, and Vocational Support) work synergistically, thus making them more robust than if delivered alone. It is this synergistic approach that we believe has contributed to the achievement of the outcomes and benefits described in the next section. We therefore recommend that any replication of MISSION include all of these elements, even if partnering with other entities or providers is chosen as the means incorporate this comprehensive service delivery model. We see the collaborative services of the case managers and peers as the essential replication components of the MISSION service and as particularly helpful in improving access to internally or externally agency-offered service needs such as employment, housing, pharmacotherapy etc. The number of case management peer teams can be dictated by the needs of the agency implementing the MISSION

program, although the MISSION developers suggest funding at least two teams of four service delivery staff members (two peers and two case managers).

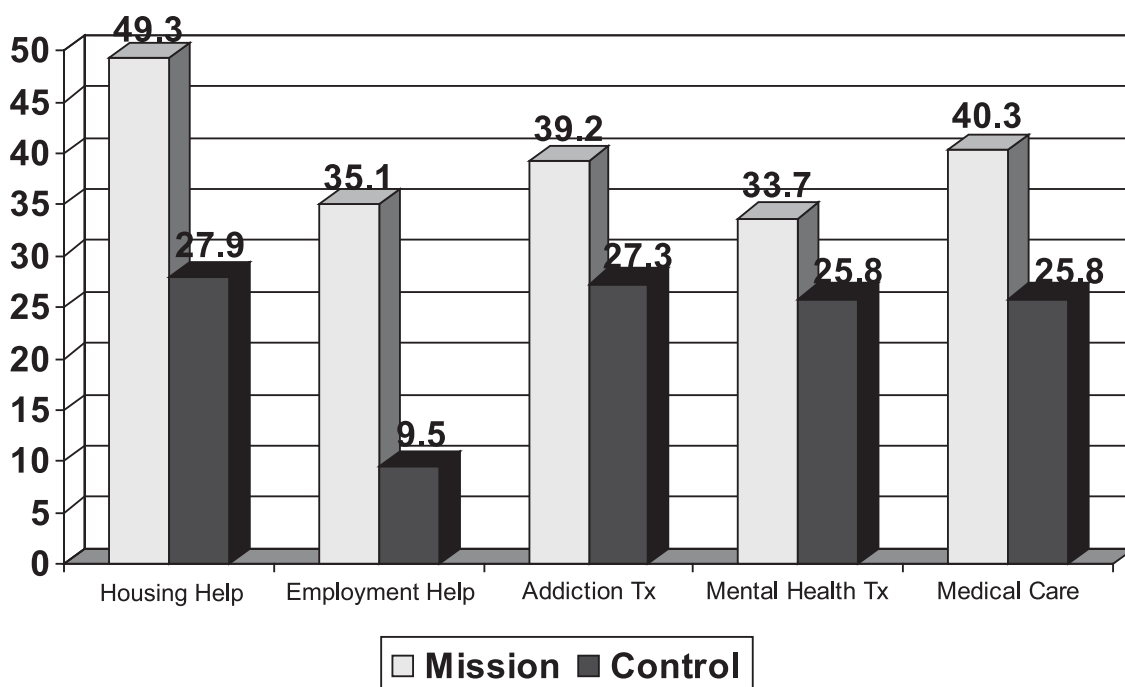
➤ D. Benefits and Outcomes Achieved

Preliminary quantitative data obtained from the twelve-month follow-up assessment confirm the progress MISSION patients have made since enrolling in the project. The following outcomes are associated with participation in MISSION services, as compared to baseline residential services:

- Better access to community resources;
- Reduced use of drugs and alcohol;
- Greater housing stability;
- Improved mental health status;
- More days employed;
- Higher wages;
- Decreased hospitalizations; and
- Decreased readmission into residential treatment.

As shown in Figure 1, comparisons of MISSION clients and a control group in the community reveal that MISSION clients were substantially more likely to have accessed needed services than control group members with respect to almost every service type measured.

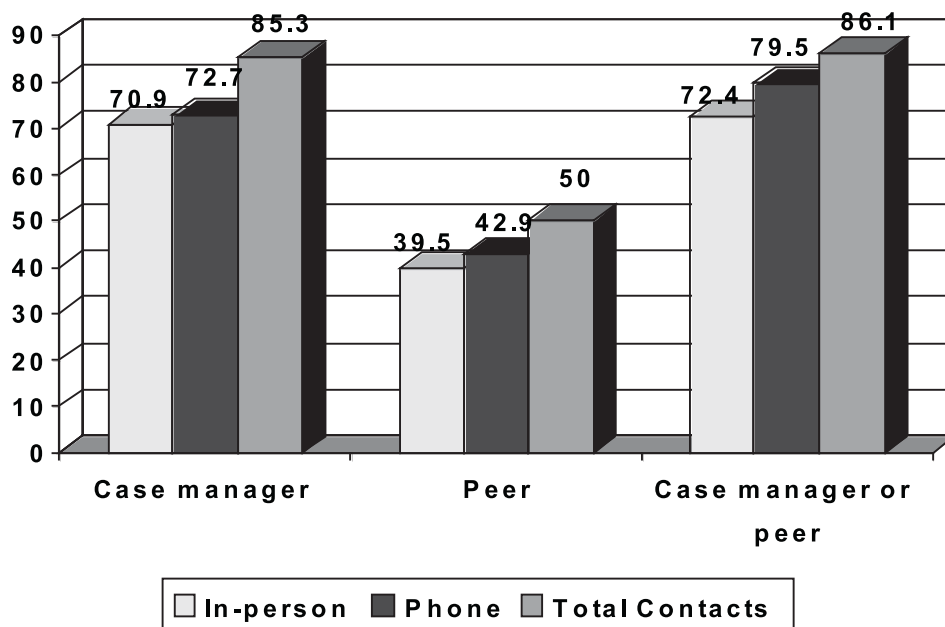
Figure 1. Proportion of Clients Receiving Key Community Services by Service Type



Unfortunately, the difficulties encountered in following up on people in our comparison group (a problem that highlights the benefits of the MISSION services) dilute our findings with respect to outcome because, at the time that this manual was written, there were simply fewer people in the comparison group to analyze to achieve statistically valid data. This issue will be resolved in our future analysis as our sample size continues to increase. However, preliminary data suggest not only that MISSION clients show benefits in certain key outcomes relative to the comparison group, but also that these benefits are enhanced as the client's contact with MISSION services increases.

Among MISSION clients, contact with case managers and peers remains exceptionally high throughout the 12 months. Of the 88 percent of MISSION clients completing a follow-up interview, 85 percent had contact with a MISSION case manager or peer in the last 30 days (see Figure 2). Because our case managers and peers remain so closely connected to their clients, even those who become homeless or experience relapse or intractable psychological problems, we have been able to achieve better 12-month response rates among homeless and lower functioning MISSION clients than were found among similarly low functioning clients in our comparison group.

Figure 2. Proportion of MISSION Clients Who Had One or More MISSION Clinical Contacts in the Last 30 Days at 12 Months Post-Baseline: by Type of Clinician and Type of Contact

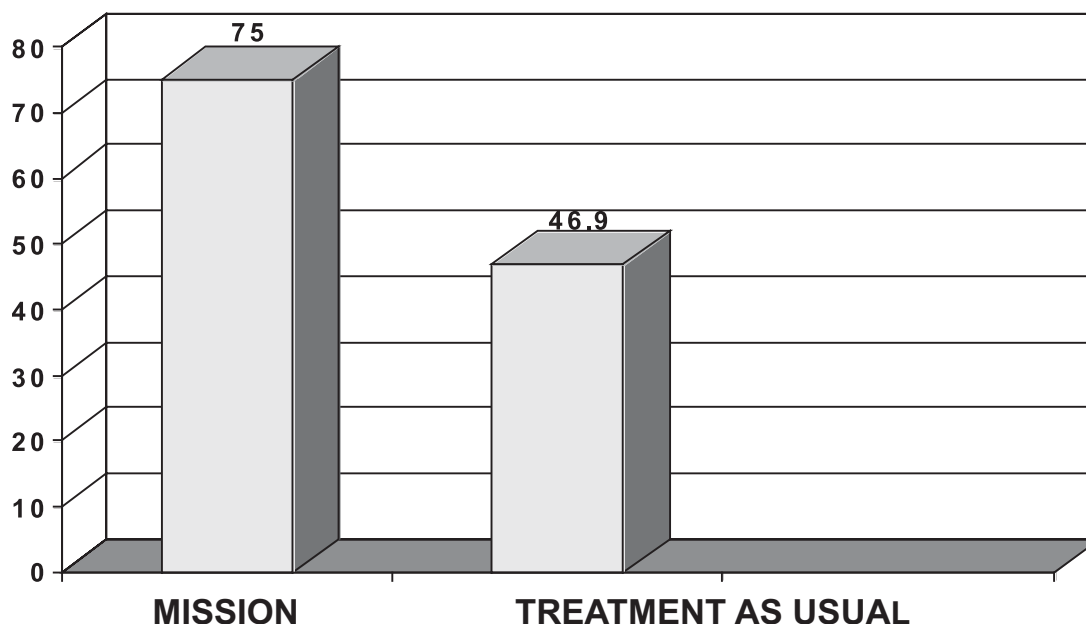


With respect to employment, MISSION clients are substantially more likely to be employed at 12 months than those in the comparison group (63.9% vs. 49.2%; $p=.053$). Moreover, MISSION services appear to be especially effective at enhancing employment rates among those having stable employment histories at admission, with 75.0% of all previously employed MISSION clients employed at follow-up

compared to 46.9% of similar control group clients ($p=.01$) (See Figure 3 page 21.) Within the MISSION group, there is a significant dose-response effect for employment, with clients having the highest contact with MISSION clinicians and peers being significantly more likely to be employed at 12 months than those having the lowest contact ($p=.045$).



Figure 3. Proportion Employed at 12 Months among those with Stable Employment at Admission



Preliminary data show no difference between MISSION and comparison group clients in rates of homelessness at 12 months, probably due to the response bias favoring homeless MISSION clients described above. There does, however, appear to be a dose-response effect within the MISSION group, with those having greater contact with MISSION service staff being substantially more likely than those with low contact to be housed at 12 months.

Overall, there is also a trend for MISSION clients to be less likely than comparison group clients to report one or more psychological symptoms at 12 months (40.4% of MISSION clients vs. 51.5% of controls; $p=.11$), with the difference between the groups being most pronounced with respect to symptoms relating to difficulty with concentration, comprehension, and memory ($p=.03$). Preliminary data show no significant differences between the groups with respect to days of alcohol or drug use at 12 months, however. Again, we attribute the lack of statistical significance to the smaller sample of people followed up in the treatment-as-usual comparison condition, which resulted in insufficient power to detect group differences.

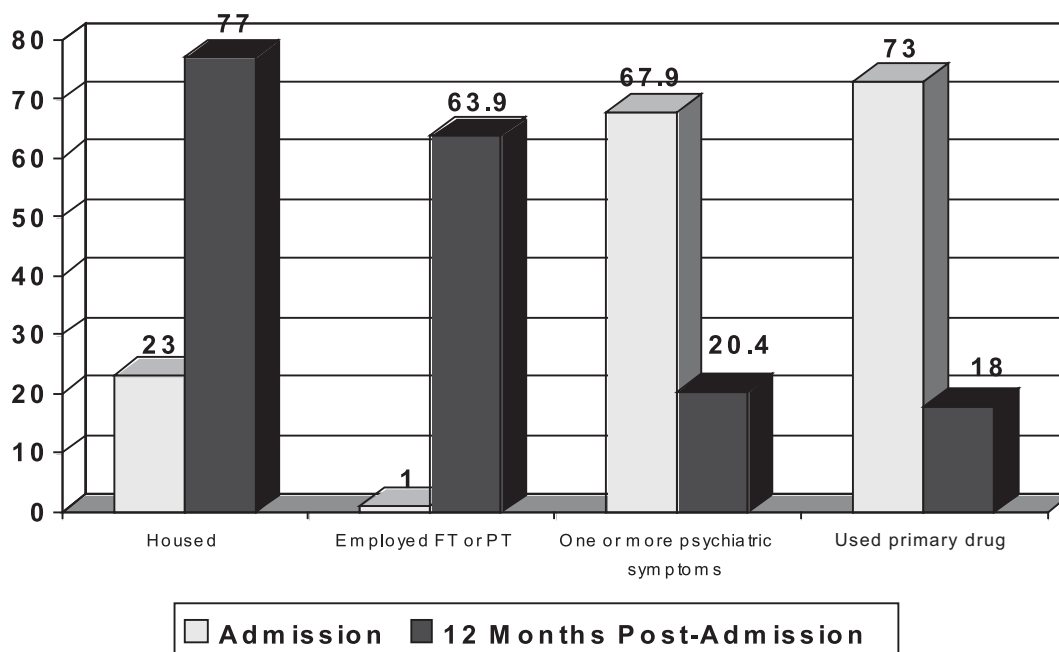
We are excited to report, however, that the comparison of follow-up data to baseline data reveals that MISSION clients also made great strides with respect to such outcomes as housing, criminal involvement, substance use, mental health status, and employment compared to their status at program admission (see Figure 4).

Significant changes were noted in the following areas:

- *Housing*: Increase from 23 percent with any form of housing at admission to 77 percent housed at twelve months.
- *Employment*: Increase from 1 percent of clients employed at admission to 64 percent employed full- or part-time at twelve months.
- *Psychiatric symptoms*: Decrease in the proportion reporting one or more psychiatric symptoms in the last 30 days from 68% to 20%. Decrease in the number of days in the past 30 on which symptoms were experienced from 25 to 6.
- *Substance abuse*: Decrease from 73 percent using their primary problem drug over the previous 30 days at admission to 18 percent at twelve months.



Figure 4. Changes in Past 30 Day Status of MISSION Clients from Admission to 12 Months Post-Admission



Subjectively, the twelve-month follow-up data suggest that MISSION participants have been highly satisfied with all key elements of the program. Ninety-one percent gave “high” satisfaction ratings of 8 or above on a 10 point scale to the overall program. With respect to individual program components, 91 percent gave high ratings to the individual case management meetings, 84 percent to the individual peer meetings, 87 percent to the peer groups, and 93 percent to the DRT groups. Focus groups also reflected this high degree of satisfaction, with many participants providing anecdotal accounts of ways in which MISSION case managers and peer support specialists facilitated reunions with family members, promoted enrollment and retention in outpatient substance abuse services, and assisted with housing, employment, and other needs critical to maintaining independence in the community.

➤ **E. Staffing and Supervision**

The original MISSION team consists of the following:

- **A part-time program director** (.5 FTE), who oversees the budget, personnel decisions, and other administrative

matters. This person has ultimate responsibility for making policy decisions and ensuring the program’s effectiveness.

- **A part-time clinical supervisor** (.25 FTE), to whom the case managers and peer support specialists report, who is responsible for ensuring that the clinical care provided is consistent with empirical data on successful use of CTI, DRT, peer support, and vocational support. The clinical supervisor should have some working knowledge of the American Society of Addiction Medicine (ASAM) Criteria and meet weekly with all clinical staff members, discussing cases and providing feedback regarding clinical decisions. Additionally, team members are encouraged to seek advice from the clinical supervisor, particularly when team members disagree as to the best course of action, in which case the clinical supervisor makes a determination.

It is important to underscore the need for both the part-time program director and clinical supervisor to work together (or for some other administrative support component to champion the program) in order to facilitate implementation and provide ongoing support to the MISSION staff. The need for sufficient administrative, clinical, and consumer buy-in across residential, MISSION,



and larger agency administrative structures should not be underestimated, and must be monitored and cultivated whenever possible for such a program to mature.

- **Case managers**, in a ratio of one case manager for every 25-30 clients, who work in permanent teams with peer support specialists and support clients in their transition to community living. Case managers should have the ability to forge strong working relationships with community agencies that can play a key role in client success, such as One-Stop employment centers, and be familiar with eligibility requirements for available services and supports. Case managers also document clinical issues, work cooperatively with the resident program staff, and collaborate with peer support specialists to help clients succeed.
- **Peer support specialists**, also in a ratio of one for every 25-30 clients, work in permanent teams with case managers serving the same client. They plan and deliver weekly peer support meetings in the residential treatment setting, model healthy living and recovery skills, and offer friendly support to clients in a variety of ways. For example, they may engage in recreational activities or attend 12-step meetings with them to help support their recovery.

Case managers and peer support specialists share a number of duties, such as participating in meetings with the residential treatment team; providing input into discharge plans; monitoring mental health and substance abuse symptoms and working with the clinical supervisor to address these symptoms; providing education and support on symptom management, relapse prevention, medication management, problem-solving, and other skills needed in the community; and providing practical assistance with transportation and other tasks.

The MISSION team has also involved consultants when necessary and benefits from ongoing consultation with experts familiar with the models used. For example, each month the team has a conference call regarding “high-risk” clients with an outside consultant, Dr. Alan Felix, who is one of the developers of CTI. Outside consultation by experienced consumer providers/trainers can be particularly useful in staff supervision and development of peer support specialists.

Staffing Considerations for Program Replication

Because the MISSION program was initiated through grant funds that required a thorough evaluation, a project

director was required to manage this effort and related funds. Programs that do not have similar reporting and evaluation requirements should easily be able to combine the tasks of the project manager and supervisor into one position. While the MISSION program had three case managers and three peer support specialists, other programs may require more or fewer to meet the needs of their client load.

While caseloads often vary depending on a number of factors, we generally try to have our case managers and peers carry a caseload of approximately 25-30 clients at any given time, which we believe is optimal based on the needs of our clients and the services available in our communities.

Sample MISSION program policies and procedures are provided as an attachment to this MISSION Treatment Manual to assist with implementation in other settings (see Appendix C). These were intended to serve as a general guide or starting point for programs interested in replication and not as a comprehensive set of documents “ready for use,” given that each system likely has unique requirements regarding policies and procedures. In addition, this manual includes sample job descriptions for a case manager and peer support specialist (see Appendix D).

We have learned many lessons in the process of setting up the peer support component of this project. First and foremost, we have learned that peers are incredibly valuable members of the treatment team. However, we believe that delays we experienced in fully benefiting from their valuable contributions can be avoided as the MISSION program is replicated. We believe that our process of hiring veteran consumers of the Residential Program who had little or no formal training in peer support unduly minimized and confused their unique and important role. We would, therefore, encourage those replicating the MISSION program to learn from our experiences. (See Appendix E, which is entitled “Peer Support: Lessons Learned and Issues to Consider.”)

► F. Orientation, Training, and Continuing Education

The MISSION program philosophy focuses on “recovery” and embraces the broader definition being adopted throughout the mental health field:

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in the community of



his or her choice while striving to achieve his or her full potential (SAMHSA, 2006).

Unfortunately, stigmatization of people with mental health disorders has persisted throughout history, and continues today. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger and/or avoidance, and can be found throughout our society to include employers, landlords, family members, and even people with mental illness and the professionals and healthcare systems who serve them. People who are homeless and have co-occurring disorders often suffer from discrimination and even increased violence. Stigma remains a significant barrier to an individual's recovery as well as to efforts of mental health systems to transform towards delivery of recovery-oriented services.

MISSION program replication will be most successful in organizations where mental health anti-stigma activities and recovery-oriented mental health system training have occurred and are ongoing. SAMHSA's Center for Mental Health Services (CMHS) Resource Center to Address Discrimination and Stigma (ADS Center) provides practical assistance and a wealth of resources for designing and implementing anti-stigma activities. (See the Resource section of this manual.) Likewise, program administrators, staff, consumers, family members, and community providers should be oriented to key facts provided in publications such as SAMHSA's *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring Substance Use Disorders* (SAMHSA, 2003).

For example:

- People who are homeless are people first. The fact that they have illnesses that may significantly disrupt their lives doesn't diminish their rights, their responsibilities, or their dreams.
- People with mental illnesses and/or co-occurring substance use disorders can and do recover.
- Fifty-five percent of individuals who remain in Alcoholics Anonymous for more than 90 days will be sober after one year, and 50 percent will be sober after five years.
- To help people with serious mental illnesses and/or co-occurring substance use disorders avoid becoming homeless or exit homelessness, communities and providers must understand who they are and why they are vulnerable.

Similarly, key recommendations of the President's New Freedom Commission's Report on Mental Health *Achieving the Promise: Transforming Mental Health Care in America* should be reviewed by administrators and staff seeking to replicate the

MISSION program (New Freedom Commission on Mental Health, 2003). In particular, given that a key component of the MISSION program includes peer support services, the New Freedom Commission's findings and recommendations associated with consumer-run services and consumer-providers are a first step towards supporting and valuing these services. The transformation of our nation's mental health care system was in its very infancy as the MISSION program began and will continue to be an ongoing effort for States and other mental health systems for years to come.

Trained consumer providers can help to move mental health services towards the recovery orientation sought by the President's New Freedom Commission. Their modeling of recovery and unique perspectives gives greater voice and empowerment to systems approaches that are consumer and family-centered. Incorporating consumer-providers such as MISSION's peer support specialists into traditional mental health systems also poses some unique challenges. As noted above, stigma and confusion regarding their unique role and qualifications are to be expected. Ongoing training and support for these staff are, therefore, essential. Likewise, training for supervisors and other professional staff members on the unique role of peer support specialists and the challenges they face is strongly recommended.

MISSION staff receive a general orientation to policies and procedures (included as Attachment C to this manual), such as those related to confidentiality, documentation requirements, crisis management, and reporting. They are also trained in the theory and application of all service components contained in the MISSION program (e.g., DRT, CTI, peer support, and vocational support), and the respective roles of all staff in the delivery of these key components, as well as other aspects of each position. MISSION has also arranged for training of the peer specialists through a number of organizations. We recommend using a training program that is designed specifically for peer support specialists working within traditional mental health systems. At a minimum, peer support specialist training should address

- 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 they 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,



forms of mental illnesses, co-occurring disorders, cultural competence, resume writing, and interviewing skills.

The availability of training and certification specific to the role of peer support specialists is expanding rapidly but was still quite limited at the time when this manual was written. If your organization is new to incorporating peer support specialists, it is recommended that you initially attempt to recruit at least one peer staff who has both training and experience (preferably certification) specific to the peer support specialist role. Doing so will likely minimize stigma and role confusion among all team members, and readily demonstrate the unique and valuable contribution of consumer providers. A fully trained and experienced peer provider can also serve as a mentor of 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, case management, and supervision sections of this manual for more detailed information regarding orientation, training, and continuing education for peer support specialists and case managers.

G. Logistical Requirements

MISSION case managers and peer support specialists spend a significant portion of their time meeting with clients in the community. This requires:

- *A means of transportation.* MISSION team members must have access to a car that can be used to meet with clients at places within a certain distance from the residential facility. Thus, while we suggest leasing a car for staff, it is also possible to have staff use their own transportation or public transportation and be reimbursed. Community outreach is an essential element of MISSION service delivery, but we recognize that agencies and settings have unique policies and liability issues that must be considered.
- *A means of communicating with clients and each other.* Case managers and peer support specialists on the MISSION team utilize cell phones and pagers.
- *A means of maintaining documentation and ready access to program resources.* Staff has access to computers.
- *Policies and procedures.* It is also essential to have clear policies and procedures governing transportation, reimbursement for travel expenses, and handling of emergencies involving clients in the community (see Appendix C). We hope these can serve as a resource to help you develop appropriate guidance for your system.

It is generally necessary for all staff to have an active driver's license. However, use of self-provided transportation may not be the preferred option if you live in an area with good public transportation. If this is the case, your staff can use public transportation for client visits and for escorting clients to community meetings and activities, thus affording clients an opportunity to learn transportation options and skills.

Considerations in Logistical Aspects of Program Replication

Safety is the primary consideration associated with logistical aspects of MISSION program replication. 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 and a pager. MISSION staff are encouraged to use their own judgment and wisdom to determine whether they feel unsafe in certain areas or neighborhoods where a client may reside. If this is the case, they are encouraged to do visits in teams of two or more when necessary. In circumstances in which staff feels unsafe and are worried about the safety of their clients, staff is always reminded that they can call 911. Staff is also encouraged to discuss safety issues regularly in supervision.

After-hours on-call schedules are done at the discretion of the institutional policies. While we believe that on-call mechanisms can be helpful, as the clients MISSION serves often have after-hour crises, an equitable arrangement should be made across staff with regard to coverage. Furthermore, it is critical to have a mechanism for an on-call clinical supervisor for consultation as well as a physician for any medical-related emergencies. For systems that are unable to support an on-call mechanism, MISSION staff is encouraged to discuss an emergency plan and review contact information for local Emergency Rooms with the client as part of the introduction to the program. Furthermore, staff is encouraged to leave information on how to contact these local agencies on their telephone answering machines.

H. Funding the Program

Because of in-kind contributions from the VA, actual MISSION costs do not reflect real costs for agencies interested in implementing the service. However, on the basis of actual costs and projected costs for services currently being provided in-kind, the cost of MISSION services per client per year averages approximately \$3,500. This cost is based on salaries and fringe



benefits for three case managers, three peer counselors, and one clinical supervisor (total \$339,786), local travel costs (\$6,000) and cell phone costs for all case managers and peers (\$9,000). It assumes that the program will serve 100 patients per year.

Possible Funding Sources to Consider in Replicating MISSION

For programs that are eligible for funding through Department of Veterans Affairs (DVA), programs like MISSION address a number of key priorities for which funding is likely to continue to be available. These overarching priorities include improved access to care, the translation of research into clinical practice, and a transformational shift towards recovery-oriented services. MISSION program replication specifically addresses each of these by incorporating Dual Recovery Therapy for co-occurring disorders, CTI community-based care coordination, the provision of peer support through the hiring of consumer-providers, and vocational support.

In addition to DVA funding that targets direct provision of services, MISSION program replication offers continuing opportunities for research on these approaches as well as on the dynamics of organizational systems change. Research-oriented MISSION program replication may be fundable through collaborative efforts with DVA's Mental Illness Research Education and Evaluation Centers (MIRECCs) and associated research grants.

Federal funding opportunities for treatment for the homeless are another option, though subject to change (see www.samhsa.gov/Grants/). Also, some foundations have social missions that would encompass treatment and aftercare for formerly homeless populations (see, for example, <http://foundationcenter.org/>). You may wish to consider networking with other community providers to apply for, share, or blend funding to ensure continuity of care.

Funding Peer Support

A limited but growing number of States use State and Federal Medicaid funding to pay for peer support services to Medicaid recipients who have mental illnesses. These states have chosen Medicaid's "rehabilitation option," which allows the state to receive matching federal funds for services that a health professional deems necessary to improve functioning associated with a health condition. The Department of Health and Human Services' Center for Medicare and Medicaid Services (CMS) has recently reaffirmed its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of peer support services. CMS has recognized peer support as an evidence-based practice. As additional States follow the lead of Georgia, Hawaii, and South Carolina, CMS has recently provided guidance to States regarding the supervision, care-coordination, training, and credentialing of Certified Peer Specialists (CPSs).

Obtaining federal matching funds for peer support under Medicaid does require each state to modify its Medicaid plan and receive approval from the Centers for Medicare and Medicaid Services (CMS). Additionally, the funding covers only services to Medicaid recipients. Adults whose primary diagnosis is substance abuse and who have no dependent children are unlikely to qualify for Medicaid, unless their other disabilities qualify them for coverage. Inquire within your State mental health system about the status of funding options for peer support and check SAMHSA's Web site for the latest development in peer support resources.

Obtaining funding for the peer support component outside of the Department of Veterans Affairs might present greater challenges than funding for other components of the program. Federal block grants are one option. Some states use Substance Abuse Prevention and Treatment (SAPT) block grant funds for the provision of peer support by trained peers. Many States have used Federal Mental Health Block Grant funding to support peer support for mental health consumers, but competition for these limited funds is often intense.



3. MISSION's Model of Care

This section provides a basic overview of the models of care incorporated in the MISSION program that will be of interest to all readers. The chapter reviews each of the components of Time-Limited Care Coordination and explains how the elements work together to support clients in sustaining recovery and reintegrating into the community. It also highlights the important role of vocational support in helping clients maintain stability. Information on how these models are actually implemented by the MISSION team will be found in the chapters on supervision, case management, and peer support that follow. Please see the Foreword for guidance on the sections that will address your specific areas of interest.

MISSION services are based on an intensive but time-limited model of care called Time-Limited Care Coordination (TLC), with the addition of vocational support. This section of the treatment manual discusses the TLC model, its adaptation to meet the needs of MISSION's clients, and the specific components that are included in MISSION.

➤ **Time Limited Care-coordination (TLC)**

TLC, the model that MISSION is based on, is a brief, 8-week intervention that integrates Critical Time Intervention (CTI) case management (Felix, Herman, Susser, Conover, and Bloom, 2001), Dual Recovery Therapy (DRT) (Ziedonis, Krejci & Epstein, 2005), and peer support to help people with co-occurring mental illnesses and substance abuse transition from acute psychiatry services to outpatient care. It combines education in self-care principles, an assertive clinical stance, and a focus on engaging clients in services and supports that will continue after case management ceases. The primary goal of the TLC approach is to facilitate rapid community transition and achievement of personal goals by helping the client engage in a comprehensive array of outpatient services. This service has been implemented in several VAs nationally because of the outstanding outcomes in a non-randomized trial (Smelson et al, 2006; Smelson et al, 2007) and the preliminary data from a randomized trial that includes a control condition matched for attention (Smelson et al, 2007). See Appendix F for representative data.

The MISSION program adapted the TLC approach to meet the needs of formerly homeless persons with less severe mental illnesses who are transitioning from residential treatment to community life. Like TLC, the MISSION program emphasizes care coordination, treatment engagement, and connecting clients

with services to facilitate community integration. In addition, MISSION recognizes the critical role of vocational support. We increased the length of services from 8 weeks in the original form of the TLC approach to a year because we believed it would take longer to address the unique and somewhat evolving psychosocial needs of recently homeless individuals with mental health and substance abuse problems. This decision was also based on the premise that the MISSION target population, unlike TLC clients with a severe mental illness, would generally be ineligible for VA or other entitlements, and thus would have fewer financial resources. Other agencies with different clients and resources may wish to make adjustments to the length of the model. We recommend calling the authors for feedback regarding increasing or decreasing the length of services.

➤ **Critical Elements of the MISSION Program**

As noted above, the MISSION program combines Dual Recovery Therapy (DRT), Critical Time Intervention case management (CTI), peer support, and vocational support to help people with co-occurring mental illnesses and substance abuse transition successfully from institutional care to community-based care. The chosen model meets the needs of our target population, our resources, and program staffing. Overall, the goal is to increase clients' participation in services by increasing their motivation to do so and by empowering individuals to manage their lives and sustain community living.

Each of the four elements is essential:

- *CTI case management* is designed to give clients a “running start” and a safety net by providing intensive services upon re-entry into the community, thus establishing firm linkages between clients and needed services.
- *DRT* helps to raise clients' awareness of the impact of substance use and other harmful behavior on their lives and offers tools, as well as group support, to aid in recovery.
- *Peer support* seeks 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.
- *Vocational support* helps clients find and maintain employment, which in turn contributes to general daily living stability and improved self-esteem.



While CTI and DRT are models of care, peer support and vocational support are strategies that enhance the effectiveness of these models. In MISSION, these four elements are blended, creating an integrated approach with a rich synergy that fosters and supports recovery and community independence.

Critical Time Intervention (CTI) Case Management

Critical Time Intervention (CTI) is an evidence-based, time-limited form of case management, for which a training manual is available (Felix et al., 2001). MISSION uses CTI to link clients with needed community services after discharge from residential treatment and to address common institutional

Clinical Principles of Critical Time Intervention

- Stages of Change
- Motivational Interviewing
- Harm Reduction
- Psychodynamic Approach

barriers to service access. CTI was designed to help homeless people with serious mental illnesses successfully make the

transition from institutional care to community living by providing services that decrease in intensity over the first nine months post-discharge (Susser, Betne, Valencia, Goldfinger, and Lehman, 1997). Because lack of support during this “critical time” can lead to recurrent homelessness, the approach emphasizes the need for a continuum of care and flexibility in meeting clients’ needs. The model recognizes that different clients require different levels of attention and services.

A randomized controlled study comparing CTI to treatment as usual (TAU) found that, 18 months post baseline, homeless individuals receiving CTI spent an average of 30 nights homeless, compared with 91 nights homeless for those receiving TAU (Susser, Betne, Valencia, Goldfinger, and Lehman, 1997). Besides reducing homelessness, CTI also has also been found to reduce the severity of psychiatric symptoms (Susser et al.) and to significantly reduce costs because it decreases the use of more intensive services while producing comparable outcomes.

CTI has been modified for the MISSION program with the help and ongoing consultation of Dr. Alan Felix. We are grateful for his ongoing supervision and assistance with modifications to meet the unique needs of individuals with a less severe mental illness who do have co-occurring mental health and substance abuse issues. The CTI approach is distinguished from that of traditional case management in several respects, as shown in the comparison of core intervention strategies in Table 2 below.

Table 2. 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)	No specific focus
Time-limited	Open ended
Focus on prevention of recurrent homelessness and continuity of care	Focus on comprehensive array of service needs
Phases of decreasing intensity	Unspecified phases/intensity



Areas of Intervention

CTI has five main areas of intervention:

1. *Psychiatric treatment and medication management.* The case manager's primary responsibility is to link clients to services rather than to serve as the client's therapist. The case manager assists 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.* The case manager identifies the client's method for budgeting and any potential problems that could result, helps the client establish a bank account, and assists with collecting any documentation needed to obtain entitlements. The case manager does not, however, handle or receive the client's money in any way. This can be done, when necessary, through the identification of representative payees to ensure that the rent and all essential bills are managed monthly, particularly early in the recovery process when there are often competing financial demands.
3. *Substance abuse treatment.* The case manager takes a more active role in substance abuse treatment than in psychiatric treatment. While the case manager actively works with the client's 12-step sponsor and outpatient treatment provider, the case manager also helps to monitor clients for signs of relapse and actively reduces substance use. In CTI, substance abuse treatment embraces the harm reduction philosophy, follows the stages of change model, and uses motivational interviewing techniques, each of which is described in detail in the CTI manual. As compared to CTI, DRT includes a slightly more comprehensive model of addictions and mental health treatment for persons with co-occurring disorders, including specific tools to increase the effectiveness of interventions. Thus, we focus on the DRT materials for the addiction and mental health treatment component of the MISSION services.
4. *Housing crisis management.* The case manager monitors situations that threaten clients' housing, such as threatened eviction, psychiatric decompensation, unsafe living conditions, and proximity to drug activity. The case manager can intervene when necessary with property management, help to identify alternate living arrangements, or link the client to community resources that can provide support. The case manager

can also play a key role in resolving housing-related conflicts, both teaching and modeling these skills for the client.

5. *Family interventions.* With the client's permission, the case manager will involve a client's family members in providing support for the client and responding to crises. Additionally, the case manager might provide emotional support to the family or engage in psychoeducation about mental illnesses, substance abuse, MISSION services, and positive and negative reinforcement of behaviors. Family therapy, if needed, is accomplished by referral.

Phases

CTI includes three phases, with frequency of contact between case manager and 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 (months 1-3 after residential care).* The case manager has weekly sessions with the client for three months. This phase of relatively intense support occurs in the first month of the MISSION program as clients are transitioning out of the residential facility and into the community. The case manager begins by reviewing the treatment plan developed in residential treatment and making any modifications needed based on any changes in the client's needs as a result of moving into the community. Particular attention is paid to areas that the case manager and client feel are critical to the community transition, with particular focus on the five core CTI domains described above. 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 assist with funds, the development of a realistic plan to pay rent, the identification of 12-step meetings, 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 to become acclimated to the community and to develop a support system that can be used as a foundation for community living.
2. *Try out (months 4-6).* In the fourth through sixth months after discharge, the case manager meets biweekly with the client. The case manager and client test and readjust the community-based support systems to work out any kinks, again with specific attention on the five CTI domains. The case manager makes an *in vivo* needs assessment, accompanying the client



in the community and identifying, first-hand, any holes in the system or areas in which the client needs more or less supports and services. With the decreased frequency of visits, it is important for the case manager to act increasingly as a liaison between the client and community-based services and less as a direct provider of supports. The therapy offered during this phase will focus on that link and the need to build these therapeutic relationships and community resources, as opposed to relying on the case manager.

3. *Transfer of care (months 7-9)*. Monthly visits in months seven through nine are used to fine-tune the connections established with the community-based resources. The case manager and key community providers may meet to review the transfer of care and identify any gaps in services. The case manager and client reflect upon the work that they have done together. The termination of CTI relationship should be viewed as another step in the journey of self-improvement.

Clinical Principles

As described in the CTI manual, the intervention requires a specific clinical approach, necessitated by the short-term and focused nature of the intervention. The case manager should take a flexible approach to assessing the client's strengths and needs and evaluating long-term needs (even though CTI is a time-limited intervention). Additionally, the case manager needs to be patient and work with clients "where they are" in recovery, rather than where the case manager wants them to be. Recognizing the client's strengths and helping the client to see and use them are essential to helping the client transition away from CTI care.

As described in greater detail in the CTI manual, the case manager's therapeutic stance should be:

- Active and focused;
- Supportive and empathic;
- Flexible but consistent;
- Fostering independence but available; and
- Responsive to treatment refusal.

Some of the counseling techniques described in the CTI manual include:

- 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; and
- Maintaining an awareness of the case manager's own feelings and actions.

It is important to underscore that the core therapeutic stance of the DRT approach is more similar than different from the CTI approach, making these interventions easy to blend. The minor differences in the two approaches include

- the specific focus on homelessness for CTI as compared to substance abuse and mental health for DRT,
- assertive outreach in CTI vs. the lack of assertive outreach in the DRT model, and
- the greater emphasis on psychodynamic principles in CTI as opposed to the cognitive-behavioral focus of the DRT intervention.

We view these distinctions as dovetailing rather than conflicting, making for a richer intervention when these features are combined.

Dual Recovery Therapy (DRT)

MISSION addresses co-occurring mental illnesses and substance abuse through Dual Recovery Therapy (DRT), a manualized program (Ziedonis, Krejci, and Epstein, 2005) that employs a comprehensive, biopsychosocial approach to the biological, emotional, social, and cognitive problems that characterize dually-diagnosed individuals. DRT is designed to help participants address mental health and substance abuse issues in an integrated fashion. The guiding premise of DRT is that clinicians must pay equal attention to both psychiatric and substance abuse symptoms and that successful treatment will address the interrelationship of the two problems.

The intervention, as provided by MISSION, includes structured weekly sessions delivered during residential treatment (see Appendix B). The group exercises are designed to help clients recognize the nature and interrelationships of their disorders and to choose supports and goals that will help them maintain healthy lives in recovery despite the presence of these disorders and the history that goes with them. Delivered by a case manager, the group sessions teach the individual skills that will support recovery in the community. These skills are reinforced by both peer support specialists and case managers while clients reside in the community.

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 and supportive psychotherapy/social skills training). Moreover, DRT is consistent with existing therapeutic models that manage both substance abuse and psychiatric conditions simultaneously (Bennet, Bellack, and Gearon, 2001; Drake, McFadden, Meuser, McHugo, and Bond, 1998; Minkoff, 1989; Shaner, 1997) and has been demonstrated in numerous studies to significantly improve outcomes for dually-diagnosed populations (Ziedonis and Simsarian, 1997; Ziedonis and Stern, 2001).

Some modifications have been made to the original formulation of DRT in order to offer highly structured DRT treatment sessions that clearly complement the skills being

developed through residential treatment and MISSION services. For example, in MISSION, the 20 sessions in the original intervention have been replaced with 13 sessions, corresponding to the typical length of the client’s stay in the residential facility and more closely reflecting the needs of homeless clients with co-occurring substance abuse and less serious mental illness. Dr. Doug Ziedonis, co-investigator on the MISSION project, originally developed DRT for people with serious mental illnesses through a series of NIDA behavioral therapy grants and received CSAT funding to modify the approach for patients with less severe mental health problems. The latter approach is consistent with the MISSION target population.

Table 3. Adaptations made to DRT in MISSION

	DRT in MISSION	Standard DRT
<i>Length</i>	13 sessions	20 sessions
<i>Subject matter</i>	Keyed to skill development provided in residence	Not keyed to external treatment
<i>Approach</i>	Structured and pragmatic with 13 sessions and handouts	Semistructured
<i>Target population</i>	People who are homeless and have co-occurring substance abuse and nonpsychotic mental illnesses	Previously used with people who have co-occurring substance abuse and serious mental illnesses

During residential treatment, DRT is delivered in a weekly group format by a MISSION case manager. As a result of this schedule, the intervention is “front-loaded” for the client’s first 13 weeks in the 12-month MISSION program. This schedule helps to give the individual the necessary recovery foundation and skills to remain abstinent when moving into the community. The MISSION program delivers up to four DRT groups each week to accommodate the clients’ alternating schedules.

Session Format

The format of the DRT sessions is the same throughout the 13 weeks. Each session focuses on a particular task (see Appendix B for the worksheets, including guidance for the facilitator). The therapist begins the group session by reviewing the goals and asking the participants to complete the worksheet keyed to that session. These worksheets, which are contained in a *Consumer*



Workbook given to each client, facilitate personal reflections that can then be shared to facilitate a group discussion of critical issues in dual recovery.

DRT includes two overall phases. Phase I involves four group sessions focusing on assessment and treatment engagement. Phase II involves nine group sessions devoted to skills training in the following areas:

1. Relapse prevention;
2. Regulating mood;
3. Regulating thoughts; and
4. Interpersonal relationships.

In the MISSION program, clients enter the program at different times and begin attending these sessions immediately, so each group may include clients who have attended several sessions or none at all.

Schedule for Phase I

Phase I emphasizes assessment and treatment engagement, focusing on the initial process of increasing commitment to treatment and eliminating the system barriers to access. Goals for this stage include enhancing motivation for change, developing credibility and trust between client and therapist, and working to increase the perceived benefits associated with change. Phase 1 exercises include:

1. *Onset of Problems.* Using a series of timelines, participants are asked to discuss when their psychiatric and substance abuse problems began and the factors that precipitated them. This discussion will help participants understand the dynamic relationship between psychiatric and substance abuse problems, i.e., how one set of problems can impact the other.
2. *Life Problem Areas Affected by the Individual's Co-occurring Disorder.* Participants complete a worksheet that lists problems in a number of major life domains and discuss the degree to which these problems have affected the functioning and quality of life. Answers will help the clinician and the participant to get a better sense of the types and degree of substance abuse and mental health services that the participant needs and also provide clues to his or her level of motivation for recovery.
3. *Motivation, Confidence, and Readiness for Change.* The participant completes a “readiness ruler” worksheet for each domain or life problem that was identified in the previous session, helping clients understand their stage

of readiness to make necessary changes to address each problem. Special attention is paid to helping the client prioritize life problem areas, which will be addressed throughout the DRT treatment and beyond.

4. *Developing a Personal Recovery Plan.* This session marks the end of the assessment and engagement phase and focuses on the review of treatment goals that were established with the participant's case manager. This session is intended to allow clients in the initial phases of the MISSION program learn from those clients in later phases of the program about challenges associated with different treatment goals. Participants farther along in the program will discuss how they coped with setbacks in achieving their goals. The DRT therapist will emphasize the importance of using substance abuse and mental health resources (e.g., individual counseling, psychiatric consultations, self-help group attendance) to meet treatment goals.

Schedule for Phase II

Phase II emphasizes skills building, employing effective behavior change strategies to help clients remain in treatment and achieve their identified treatment goals. These strategies can include abstinence, harm reduction, improved interpersonal functioning, and symptom reduction. Clients learn to set and accomplish goals, skillfully manage social situations, and identify feelings and triggers associated with relapse, thus avoiding high-risk situations. This model is particularly applicable to homeless substance abusers because of the many system and service-related barriers they routinely encounter. Further, the dual recovery staging process recognizes that individuals can have different levels of motivation for each specific mental health and substance abuse problem.

5. *Decisional Balance.* A “decisional balance worksheet” helps participants to identify the benefits and negative consequences of maintaining problematic behaviors. This is an exercise that is meant to provide the individual with a new and concrete method for weighing the cost and benefits of an issue.
6. *Communication Skills Development.* Participants learn to recognize effective and problematic communication styles and developing more effective communication skills. Attention is placed on the communication skills necessary to convey relevant information to mental health, substance abuse, and medical professionals. Participants discuss “elements of good communication” and “elements of poor communication.”
7. *12-Step Orientation and Recollections.* This session orients clients who have never attended 12-step meeting to



the structure, culture, rules, and language of 12-step interventions. Group participants who have experience in 12-step meetings are asked to reflect on their experiences. Emphasis is placed on engaging clients in 12-step meetings and improving attendance for those who have attended in the past, but who dropped out or attended inconsistently.

8. *Anger Management.* This session focuses on the appropriate management of anger and how the mismanagement of anger can impact recovery and relapse. The client learns to identify situations that trigger anger and strategies to manage the emotion.
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 a relapse. At VANJ, because relapse prevention is one of the core treatments in the residential facility, special emphasis is placed on the how the individual’s mental health or substance use problems can co-occur and lead to a relapse and the strategies that can be employed to prevent this.
10. *Interpersonal Relationships.* Using a worksheet on “relationship-related triggers,” clients learn how unhealthy relationships can contribute to a high risk of mental health and substance abuse relapses.
11. *Changing Unhealthy Thinking Patterns.* This session helps clients to understand how unhealthy thinking patterns can perpetuate emotional problems and result in continued substance use as a maladaptive coping mechanism. Basic cognitive behavioral principles are taught during this session, including the interplay among thoughts, behaviors, and emotions. Materials address “types of unhealthy thinking,” “managing unhealthy thoughts,” and the “automatic thought record.”
12. *Changing Irrational Beliefs.* Imposing rigid rules on oneself and others can have negative consequences, due to the high likelihood that rules will be broken. Using a worksheet and a list of irrational beliefs, participants identify rules that they impose on themselves and others and learn how to modify those beliefs to maintain flexibility in thinking. Special emphasis is placed on the rules associated with recovery from mental health and substance abuse problems.
13. *Activity Scheduling.* Participants will learn the importance of scheduling regular healthy activities in maintaining recovery, particularly while in transition from residential treatment to the community. A worksheet on “activity scheduling in early recovery” is included.

Aftercare

Although DRT is delivered primarily through the 13 sessions during residential treatment, DRT principles are reinforced outside of these sessions. Because each clinical staff member is trained to deliver DRT, outpatient sessions include the use of DRT principles and the ongoing use of the DRT worksheets when needed to reinforce skills and self-knowledge. “Booster” sessions that revisit DRT concepts and worksheets should be offered as needed when the individual is in the community-based component of MISSION.

In addition, both peer support specialists and case managers are trained to use the “Dual Recovery Status Exam” to track the client’s status in regard to both disorders. The exam includes the following:

- 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.

Peer Support

MISSION’s peer support component, described at length later in this manual (Chapter 6), 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 community life skills, and helping clients establish linkages to community services. MISSION employs three peer specialists (each with the same 25-30 client case load as case managers) who use their own recovery and employment success to inspire hope for recovery in current clients. Peer specialists work closely with case managers but also play an important role in socialization and recovery support. As role models and friends, they help clients take the concrete steps needed to achieve recovery from substance abuse. For example, they may help clients self-monitor for relapse triggers, accompany them to AA/NA meetings, help them avoid “people, places, and things” that promote substance use, show them how to use public transit, and assist with other supports as needed.



Peers who are providers can empathize and provide unique and special support to the clients they serve because they know what it is like to face mental illnesses, substance abuse, homelessness, and unemployment. They have experienced first-hand what it feels like to be on psychiatric medication, to be hospitalized, and to feel they have lost out on life. Because of these shared experiences, peer specialists tend to help clients set personally meaningful and realistic goals. As role models, they share their recovery stories and wellness strategies, offering mutual support and practical guidance to clients. Often, peer providers are able to develop a great sense of rapport and very trusting relationships with peers that other professionals might not be able to do.

Perhaps the most important contribution of MISSION's peer support component is the role peer support plays in offering inspiration: the hope that people can and do overcome the barriers and obstacles that confront them. Peers 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, peer providers enhance the client's voice in the formal treatment process, helping to ensure that professional services are individualized and person-centered. This liaison/coach role appears to enhance the likelihood that clients will complete and/or stay engaged in treatment as needed.

Other specific services offered include:

- Helping clients maintain stability and avoid hospitalization;
- Encouraging attendance at 12-step and other supportive meeting and groups;
- Furthering clients' healthy acceptance of their disorders;
- Helping clients rebuild relationships disrupted by substance abuse and mental illness;
- Enhancing clients' social and community living skills;
- Enhancing clients' activities of daily living (ADL) skills;
- Helping clients relieve stress or anxiety that could lead to relapse or loss of employment, housing, friends or supportive family relationships; and
- Looking out for signs of relapse or decompensation.

While clients are in residential treatment, they attend weekly peer support sessions led by the peer specialists. In these sessions, the peer specialists reinforce the principles taught in DRT sessions in a less formal atmosphere, helping to encourage

sharing and developing rapport between the peer specialists and the clients. (See Appendix A for a current list of peer-led group discussion topics, designed by the peers themselves to speak to client concerns and needs.). Peers also have a weekly "check-in" session to facilitate the use of the *Consumer Workbook* exercises and readings.

After clients are discharged, peer specialists hold individual and group meetings with them to address barriers to care, relapse prevention, and treatment compliance. Ideally, the majority of these meetings occur in the evenings and weekends when the client needs additional support to maintain sobriety. Peer specialists also offer transportation assistance in the community, including alternate routes to avoid drug zones and traveling with a client to appointments if needed. They may also arrange and participate in social activities suggested by the 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. Examples of activities might include bowling, movies, sporting events, museums or parks, picnics, or pot-luck dinners. Clients should be encouraged to recognize reasonable social and recreational activities as an important part of their personal budgeting; however, MISSION does solicit donations (i.e., funds, free tickets, etc.) to assist clients whose financial resources are still too limited to cover the costs of such activities.

Activities should be local and diverse to meet the unique interests and abilities of each client. Activities may be simple at first, such as starting off with shooting baskets, then playing full-court games; peer specialists may assist with facilitating the formation of a MISSION basketball team if there is interest. Peer specialists should attempt to maximize the use of activity funds by requesting group rates, scheduling activities during off-peak times, and requesting donations by phone, e-mail, or mail. When soliciting donations, booklets explaining the program and newsletters can be helpful in explaining the program to community organizations.

Vocational Support

Another core need for the clients served in the MISSION program is vocational support. The MISSION client initially receives vocational rehabilitation services through specialists associated with the residential treatment facility, who develop a vocational rehabilitation plan for each client. As part of aftercare, the MISSION case manager facilitates that plan and guides



the response to changes in employment status. For example, if the client loses his or her job, the case manager may assist in establishing or facilitating linkages with Department of Labor (DOL)-funded One-Stop Career Centers, whose employment specialists can assist in the job search. If clients are struggling to maintain employment, they help them understand and follow operating procedures of the employment site, maintain peer and supervisor relationships, and manage job-related stress.

The specific forms of vocational support offered by the case manager vary according to the client's needs. For example, for clients who are employed, the case manager discusses overall job satisfaction or dissatisfaction and relationships with supervisors and co-workers. Potential problem areas will be identified and potential solutions will be explored. The case manager may suggest role plays to practice healthy communication. The case manager also provides positive reinforcement for job successes and encouragement to deal with future challenges. As the client becomes ready, the case manager may discuss career advancement strategies.

If the client is not employed, the case manager may determine the methods that the client has been using to search for and obtain employment. The positive and negative results of each of these approaches are discussed. With both employed and unemployed clients, the case manager may focus on practical barriers to obtaining and keeping employment (e.g., transportation difficulties and inadequate attire). Because the lack of a valid driver's license is a common barrier to

employment among MISSION clients, the case manager and peer support specialist often help the client take whatever steps are needed to gain a license.

As the client approaches the end of MISSION's services, the case manager and client will discuss employment retention and growth. For example, they discuss how reliable the client has been regarding punctuality and absenteeism. The case manager can also help the client do the following:

- Develop an understanding that patience and asking questions are more important than short cuts, which could result in poor results;
- Improve problem-solving skills;
- Learn to feel proud of work accomplishments; and
- Learn to take constructive criticism and stay focused during conflicts.

Finally, it is essential for the case manager to link MISSION clients to community-based employment services, such as the local Disabled Veterans Outreach Program (DVOP) or DVR (Department of Vocational Rehabilitation) office and the One Stop Career Center. These linkages are used on an ongoing basis and as needed throughout 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 MISSION.



4. Clinical Supervision

This section explains how the clinical supervisor functions within the MISSION team. After an overview of the role of the clinical supervisor, the chapter provides details about how the supervisor fulfills key responsibilities related to diagnostic assessment; identification, prioritization, and management of high-risk cases; clinical coordination; ensuring fidelity to the model; individual supervision; and other responsibilities, such as monitoring adherence to required policies and procedures.

➤ A. Overview of the Role of the Clinical Supervisor

The clinical supervisor oversees the day-to-day activities of the project, including oversight of the MISSION program's clinical and peer support services and its interface with the residential program (for MISSION, the VA Domiciliary program) and any outside agencies or consultants who provide additional services or support to MISSION clients. He or she ensures coordination and communication between the clinical services staff and project management, as well as between the staff of the residential facility and the MISSION program. Qualified by strong clinical credentials and experience, it is the role of the supervisor to monitor and ensure quality care and fidelity to the model, to advise and support individual staff members, and to coordinate care through regular clinical team meetings.

As the primary supervisor for the clinical and peer support staff, the supervisor is responsible for recruiting qualified staff and for ensuring that program-specific training is comprehensive and timely. This individual guides weekly sessions to coordinate case management and help team members learn from each other's successes and mistakes. The supervisor helps to ensure effective coordination of care between the primary case managers and peer specialists assigned to each client. Should conflicts arise between case managers and peer support specialists regarding the clinical care of a client, the supervisor collaborates with staff to resolve the dispute. He or she also meets weekly with each individual case manager and peer specialist, providing clinical direction and ensuring that each team member complies with applicable policies and legal requirements.

The supervisor meets regularly with consultants and specialists (in the case of the MISSION program, usually within the VA) to ensure a smooth interface and transition between the residential and MISSION/aftercare teams. This includes

working closely with the medical and other service providers within the residence, facilitating input from the MISSION team as plans are made for the client's return to community life, and helping to ensure that critical information flows in both directions.

In addition to these responsibilities, the supervisor also has an eagle's-eye view of the program that helps to maintain fidelity to the model and to identify any overarching process issues that may call for adjustments in approach. To ensure all team members benefit from insights and emerging best practices, the supervisor disseminates good ideas and resources from team members and the field, helps identify appropriate opportunities for staff members to build their skills, and encourages on-target professional development.

➤ B. Diagnostic Assessment

When clients are admitted to the residential program, a MISSION case manager attends a team meeting to identify potential clients with a diagnosable mental disorder or who have been prescribed medication suggesting the presence of such a disorder. The case manager meets with potential participants to explain the program and do a brief eligibility screening. Those who express interest are referred to the supervisor for further assessment. The MISSION program has found it helpful to have this assessment done by someone who is not directly involved in giving care; this ensures that the client does not form an attachment that would interfere with the ability to assign the individual to any team member.

It is important to underscore that the initial screening process by the case manager is not in lieu of a formal diagnostic interview completed by the MISSION supervisor, which is seen as the cornerstone to commence comprehensive treatment. This is particularly important given that many of the clients self-identify as having an addiction problem, and it is only after a careful diagnostic interview that a co-occurring mental illness is uncovered.

The MISSION program was developed and studied through a grant from the Substance Abuse and Mental Health Service Administration (SAMHSA) through its Center for Substance Abuse Treatment (CSAT). This grant required a comprehensive evaluation to justify services. As part of this evaluation, we needed to be able to show data about our clients clearly and



demonstrate their eligibility. We have therefore approached screening in a way designed to yield reportable results we can use as part of this study.

The MISSION supervisor uses the Clinician version of the Structured Clinical Interview for DSM-IV Diagnosis (SCID) to confirm the client's diagnosis. This version of the test usually takes anywhere from 30-90 minutes to administer. While we have found the SCID to be helpful for both research and clinical purposes for diagnostic accuracy, it is time consuming. Programs with limited resources might consider doing a comprehensive assessment that includes questions regarding mental health, substance abuse, homelessness, employment, and other associated psychosocial problems instead of the SCID.

Regardless of the format selected for the diagnostic interview, findings are always discussed with the client and related to the problems and difficulties the prospective MISSION participant has reported. Thus, the assessment process lays the foundation for the therapeutic alliance with the MISSION team. Many of these participants are receiving information on their mental illness for the first time – for example, that they have a panic disorder rather than simply being anxious. The supervisor explains how the subject's abuse and mental disorder often interact, making recovery difficult, but that it is possible to learn how they interact and how to make choices that can lead to a healthier way of life.

The supervisor then describes how the MISSION program may help address these problems, providing motivation and hope that the program can support the client and lead to positive change. The supervisor verifies that the individual understands the services offered and the commitment and participation required of him or her. The participant also has the opportunity to ask questions.

C. Prioritization of Cases by Risk Level

Because clinicians in the MISSION program work with 25-30 clients at any given time, it is important to prioritize caseloads in terms of risk. To achieve this goal, the clinical director utilizes a modified version of the “zoning method” of case management to categorize clients in order of clinical need (Ryrie et al., 1997). On the basis of the clinical assessment described above and other factors, clients are classified as high, medium, or low-risk clients:

- Clients are classified as “high risk” if they are experiencing or are on the verge of a relapse (either psychiatric or substance abuse-related), have stopped medication or contact with the service, or have extensive unmet needs. Additional criteria identified by MISSION include a history of three or more psychiatric hospitalizations; a suicide attempt within the past year; a history of five or more convictions, three or more years of incarceration, or a history of homicide; or four or more prior episodes of inpatient/residential substance abuse treatment.
- Clients are classified as “medium risk” if they exhibit current symptoms of mental illness and/or active substance abuse but do not meet the criteria for high-risk clients.
- “Low-risk” clients are those who have not had significant mental health problems that impair daily functioning for at least one month and who have reported and exhibited sobriety from drugs of abuse for at least one month.

Clients who are in a “controlled environment” (e.g., prison/jail, residential substance abuse program, medical hospital) are assigned to a separate category because they are under the direct and regular care of another treatment or oversight team. Although these clients are usually considered low or medium risk because of the nature of the environment, clients may still be considered high risk due to continued evidence of the factors described above (e.g., psychiatric instability, recent substance use, extensive history of violence or legal problems, etc.). Despite the fact that these clients are under the supervision of other professionals, some clients, especially those voluntarily admitted to these other programs, may leave prematurely. In such cases, the MISSION team would need to coordinate their services with those of the other program to ensure a smooth transition across programs and levels of care.

For example, one MISSION client who was identified as high risk due to psychiatric instability and an extensive legal history had been referred to a residential Post-Traumatic Stress Syndrome (PTSD) program to address the history of trauma. The MISSION team was in consultation prior to and during the client's stay in the residential program to ensure that he successfully completed the treatment regimen. The MISSION staff also transported the client from the PTSD unit back to the residential facility to help maintain continuity in care. A lower degree of contact and clinical coordination might have been warranted if the client had been assigned originally to a lower risk category.

To ensure that cases in the highest risk categories are reviewed regularly in supervision sessions (described below), team members are asked to address cases in order of decreasing



risk, independent of the client's location or degree of contact with the program. In other words, medium or high-risk clients are still discussed in individual and group sessions with the supervisor even if the client has left the residence and has not responded to a clinician's outreach efforts for an extended period of time.

It is difficult to cover all the cases assigned to each pair of case managers and peer support specialists during the course of a single individual supervision session, but clinicians are required to discuss all of their high and medium-risk cases at each weekly clinical coordination session. All cases must be

reviewed at least once every two weeks during individual or group supervision. Over the course of treatment, changes in clinical status may result in reclassification.

D. Clinical Coordination and Supervision

Ensuring Fidelity to the Model

One critical role of the supervisor is ensuring fidelity to the intended program model. Poor fidelity to case management models and the incomplete implementation of clinical interventions have been associated with worse outcomes in case management programs (Vanderplasschen, Rapp, Wolf, and Broekaert, 2004). In order to maximize the benefits of comprehensive psychosocial programs, administrators and team leaders have been advised to monitor adherence to theoretical models and treatment protocols closely. In addition to extensive training and orientation, the use of treatment manuals, direct observation of interactions between staff and clients, and group and individual meetings for case review can play a critical role in maintaining fidelity to the core principles that guide clinical aspects of the intervention.

Though formal scales and checklists can be useful in surveying the overall fidelity of case management programs (SAMHSA, 2003), open and less-structured dialogue between the supervisor and the supervisee can serve the complementary purposes of checking adherence to expected practice guidelines and of honing the skills of service providers (Santacrose, Maccarelli, and Grey, 2004). Through coordination with case managers and peers, the supervisor monitors the use of the model, shows how it applies to individual cases, and suggests adjustments to meet client needs more effectively.

To ensure that fidelity is monitored in a systematic and consistent manner within the context of individual and group supervision, during all supervisory sessions (group and individual), cases are conceptualized in terms of core Dual Recovery Therapy and Critical Time Intervention case management concepts.

Tracking Fidelity

In addition, the MISSION Program utilizes two standardized instruments to assist clinical supervisors in tracking the fidelity of clinical practice to the MISSION model. One of

Key Elements of Clinical Approach Reinforced by Supervisors

1. Being client-centered.
2. Demonstrating respect and empathy.
3. Being aware of coping and personality styles.
4. Being flexible.
5. Being active.
6. Being aware of how mental health and substance use disorders interact.
7. Providing education.
8. Assessing and enhancing client motivation to address mental health and substance abuse issues.
9. Maintaining a focus on recovery.
10. Ensuring that treatment is recovery stage-appropriate.
11. Incorporating spirituality.
12. Recognizing the interpersonal context of change and involve significant others in treatment.
13. Providing gender and culturally competent services.
14. Being open to the complementary and alternative approaches that interest the client.
15. Focusing on problem solving and developing skills.



these instruments, the MISSION Services Delivery Record, is a computerized checklist created by MISSION project administrative staff on which case managers and peers 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 is 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.

A companion instrument to the Services Delivery Record is the MISSION Fidelity Index (see Appendix H). This instrument provides a broader overview of the fidelity of MISSION practices by documenting the extent, as well as the quality, of delivery of key MISSION service components. The Fidelity Index assesses such factors as the extent to which clinicians follow up on identified problem areas or assess and respond appropriately to changes in client status in the community. The Fidelity Index also assesses the quality of clinician record-keeping. Drawing on information gained from the Services Delivery Form as well as information from clinical records and individual supervisory sessions with case managers and peers, the clinical supervisor completes the MISSION Fidelity Index quarterly on a random selection of patients from each case manager's and peer's case load. The clinical supervisor uses the Fidelity Index as a tool to identify areas in which clinicians need improvement or additional support and provides feedback to clinicians on the results of the Fidelity Index assessment during individual clinical supervision sessions. If the clinical supervisor identifies areas in which clinicians are especially deficient, the supervisor institutes a remedial plan and performs more frequent oversight of the clinician's performance.

Ensuring Consistency with DRT Concepts

In addition to ensuring that clinical styles and approaches are consistent with DRT principles, MISSION clinical supervisors also ensure fidelity by monitoring the regular use of "dual recovery status exams" by peers and case managers. As described in the earlier chapter on "Models of Care" and in the section that follows this one on "Case Management," this series of questions is a template used to monitor the client's progress in achieving recovery from dual disorders. For each regularly scheduled session with the client, peers and case managers are asked to set the agenda for each session; check in with the client regarding any substances used since the last session; assess the client's motivational level to change substance use; track symptoms of depression or anxiety; explore compliance with medications, as well as psychotherapy and psychiatry appointments; check attendance at twelve-step or other

support groups; and discuss the other key topics of concern for the session, including employment and health issues.

As individual cases are discussed, the supervisor reinforces this basic tool by making sure that each item on the status exam is addressed in the discussion. For example, the supervisor might ask clinicians to review the agenda that was set for the session with the client, with particular emphasis on identifying the elements that the client raised as opposed to those that the clinician suggested. These case reviews can help the clinician determine whether the issues he or she deems a priority are consistent with what the client sees as most important. For instance, a client may suggest that the meeting focus on problems he is having with his living situation, while the clinician may want to understand a relapse that just occurred. As the discrepancy is explored, many explanations are possible. For example, the client may see the living situation as related to the relapse, may feel too much shame and fear about the relapse to feel ready to discuss it, or may have an urgent problem related to the living situation.

Clinical supervisors also confirm that staff members regularly track the frequency and intensity of mental health problems, with special emphasis placed on reinforcing the client's use of individualized wellness/relapse prevention strategies, as well as the linkage of clients to appropriate mental health services. To ensure that both disorders are continually monitored and critical questions do not go unasked, the supervisor asks about any areas of concern included in the DRT status exam that were not addressed by the case manager or peer support specialist during their presentations on their work with the client.

Ensuring Consistency with CTI Concepts

Fidelity to Critical Time Intervention (CTI) case management concepts is also addressed in clinical supervision. Clinicians are asked to address the needs of their clients in light of the CTI phase of the client. For instance, the work with clients in the "Transition to Community" phase (typically those who are preparing to leave residential services and those who were recently discharged) is to focus on the development and fine-tuning of the discharge/treatment plan that was developed during the last several weeks of the stay in the residential program. The plan may include psychiatric treatment and medication management; substance abuse treatment; money management; independent living skills training; securing and maintaining stable housing; and employment issues. Supervisors help to facilitate the treatment plan by prioritizing critical elements based on the immediate needs of the client and by checking on the status of linkages to community resources.



In the “Try-Out” phase of CTI, supervisors work with clinicians to test and adjust the systems of support that have been established in the community. For instance, rather than simply accepting that a client is living in a safe and secure residence, the supervisor requires that the case manager and peer specialist make at least one visit to the client’s home to determine if it adequately meets the client’s needs. For example, it may be apparent that other residents use or drink regularly, or that the environment is unsafe because of poor health standards. The clinical team helps the client assess whether the current environment is working to support recovery or is more likely to make it more difficult. Exceptions to the home visit requirement are made, however, if it would be unsafe to meet the client in his or her home due to psychiatric instability, severe drug use, or the presence of other residents with similar problems.

The “Transfer of Care” phase of CTI occurs during the final three months of the client’s participation in the MISSION program. During supervision, the network of support and treatment for the client is reviewed and adjustments are made to foster independence and to address any outstanding needs. The final phase of CTI also involves the full transfer of care coordination and support from the MISSION staff to community-based resources (e.g., psychotherapist, NA/AA sponsor, self-help groups, etc.). Because it is common for a strong bond to have developed between the MISSION team and the client, the clinical supervisor plays a critical role in managing the termination of care process. This can involve processing concerns regarding the client’s ability to function independently. Supervisors also help staff members to adhere to the declining frequency of contact in accordance with the MISSION service delivery structure. Though some crises may require more regular contact, supervisors reinforce the importance of disengagement, even when there are lingering doubts that the client will be fully successful in the community without continued connection to the MISSION program.

Supporting Clinicians in Changes of Phase. In applying the CTI model, the supervisor also plays a critical role in helping clinicians and peers respond appropriately to unexpected changes in the client’s phase of treatment. Clients often do not proceed through the phases of recovery smoothly; instead, they may relapse or decide to leave the residential facility prematurely, resulting in a setback. The supervisor helps the team reconceptualize the client and the relationship, realistically envision what can be accomplished in the remaining time for the intervention, and process their frustration and disappointment. Often, the team needs the supervisor to help members accept the need to end the intervention at the end of the 12-month period, a process that may be difficult for

clients who have not found stable sources of support within the community.

By working closely with team members in the final phase of treatment to establish and reinforce community linkages, the supervisor can help staff ensure that the client is as well prepared as possible to maintain recovery when MISSION services are at an end. Although extremely infrequent, if the client becomes symptomatic in terms of their mental health condition or sobriety, the MISSION staff member should review the case with the supervisor and make an appropriate referral to a more intensive level of care for stabilization. Again, this should be the exception rather than the rule, as a great deal of time is spent working with the client on the process of termination (consistent with the CTI approach).

Making Adjustments to the Models

The supervisor also views the application of the model with an eye to possible adaptations and “tweaks” to make it work better for the client population, staff members, and the service setting. Each component (DRT, peer support, CTI) is assessed both individually and as combined in the model. If necessary, the supervisor recommends and monitors changes that are consistent with the program’s overall goals. For example, a client with a serious, life-threatening medical problem once received ongoing support from the assigned case manager and peer support specialist beyond the normal length of program services.

The MISSION program recognizes substance abuse as a chronic condition; while it does not take relapses lightly, the MISSION program does not throw clients out of the program if a relapse occurs. The job of the MISSION team is to work with the client at each phase of recovery, understanding that recovery is often not a straight path. In the rare cases in which clients are unable to stop relapsing, regardless of the phase of recovery, the MISSION case manager, with the assistance of a peer, may help the client move into a more intensive level of care. If this occurs, the MISSION case manager and peer specialist continue to have visits with the client (at the discretion of the other program) and resume treatment after the intensive program is complete, possibly with a modified treatment plan.

However, no adjustments are made to the MISSION client’s one-year timetable of services. For those very unusual clients who relapse around the time services terminate, the case manager and peer support specialist help the client obtain intensive services, as they would at another time in treatment. The only difference is that the MISSION staff would not pick up the case again because of the unique contractual issues related to our grant. (However, your system may want to handle this



differently and decide to extend care for some prenegotiated period of time. If one considers this option, in our opinion, it may be important to discuss that period up front in order to prevent fostering dependency, since one of MISSION's primary goals is to help clients achieve independence so they can function well in the community.)

Clinical Care Coordination: Group and Individual Sessions

Process for Group Sessions

The supervisor conducts weekly sessions attended by both case managers and peer support specialists. These sessions provide an opportunity for learning through safe discussion of factors in successful interventions as well as mistakes. Group support in problem solving for current cases builds everyone's skills. The atmosphere must be open and nonjudgmental. Often, different staff members share insights on the same client from different perspectives. This sharing may result in less frequent meetings with a client who is feeling stifled and wants more independence, linking a client with a new resource, or devising a better strategy for case managers and peers to work together in supporting the same client.

Currently, the MISSION team discusses cases in the following sequence each session:

1. **New clients.** These are presented by the assigned case manager or peer (both of whom will have just met the client) in order to identify potential challenges and establish a tentative and informal treatment strategy.
2. **"Lost to contact" clients.** Such individuals can be high risk and particularly vulnerable to relapse and are therefore routinely discussed. In some instances, team members can assist each other in locating these clients. For example, a peer might remember a favorite hang-out for this individual, or a case manager might be about to meet with a close friend of the "lost" individual. It is always worthwhile to consider whether there are any actions the team can take to help an individual choose recovery. This is useful both from the standpoint of the individual's wellbeing and from that of the program itself, which may be held to account if (for example) an enrollee commits suicide or a serious crime, or if the client is murdered or injured during the period in which they are lost to contact.
3. **Other clients in order of risk.** Cases are discussed in order, beginning with the highest risk. The presenter may

be either the peer support specialist or the case manager on the assigned team. Often, other team members can comment helpfully on how to address current challenges.

Monitoring and Coordinating Interventions

Group sessions offer the supervisor an invaluable opportunity to keep interventions on course in any of the following ways:

Encourage flexibility in the interaction among team members. The supervisor can help case managers and peer support specialists work smoothly and respectfully together to support a client's recovery. A pair working together may need help resolving issues or honoring each other's viewpoint. Sometimes, a client has an attachment to team members other than those formally assigned; used properly, MISSION views this as helpful. For example, if a team member is ill or leaves the team, it is easier to reassign the client if she or he knows some of the other team members already. It is particularly likely for more than one peer to encounter various clients in an informal setting such as an AA meeting or a local recreation center. Team sessions also provide an opportunity to make sure relevant perceptions are shared and that no one is inadvertently undercutting another team member's work with the client through conflicting messages.

Consider and reconsider assignments. Group input can help the supervisor make effective assignments for new clients by providing information on any pre-existing relationships that may exist among certain team members and a client. When a particular assignment does not appear to be working or when alternate assignments must be made because of illness or staff departures, the supervisor can consider and make alternate assignments with group input. When a staff member must carry a higher load for a brief period (for example, due to prolonged absence of another staff member) the supervisor can help determine priorities and ensure that critical needs are met until a permanent solution can be put in place.

Encourage input from everyone. It is helpful to stress that "sitting back" in group sessions is not useful to the team; it is everyone's job to participate and share feedback. This makes the meeting more satisfying to everyone and encourages a habit of looking at the same problem from different angles, leading to new insights. It is especially important for the supervisor to encourage members of the team who are shyer or less confident to speak up. In case manager/peer teams where one member is overly deferential to the other, the supervisor can be helpful by modeling an attitude that honors the perspective of *both* team members and helps to incorporate their best insights in a sound strategy.



Identify clinically sound strategies to meet challenges. The supervisor bears the responsibility for ensuring that the strategies chosen are clinically sound. It is important to ensure that all team members have sufficient training to be comfortable with clinical vocabulary as well as clinical and peer support concepts and approaches relevant to the work. On occasion, the supervisor may need to intervene firmly to curtail a clinically inappropriate conceptualization or approach. In the case of questionable approaches by a peer support specialist, the supervisor may benefit from consulting with a consumer-provider expert or trainer prior to curtailing or modifying the approach, since the role played by peers in client recovery is complementary to that of the clinician, but distinctive.

Build skills and enhance effectiveness. Group sessions provide an important opportunity for members to learn from each other, growing in their skills. The supervisor can help ensure that key points “stick” by reinforcing lessons learned, acknowledging helpful insights and strategies that apply to many cases, and highlighting skillful work.

Process for Individual Sessions

Each case manager and peer support specialist has an opportunity to meet with the supervisor weekly. The length of the session may be from 30-60 minutes (as needed). These sessions serve a “restorative” function for staff and help them to manage the stress associated with working with challenging populations (Ryrie et al. 1997). Similar to group sessions, they also provide an opportunity to monitor and improve strategies for working with clients.

Individual sessions offer an opportunity to bring up issues the case manager or peer specialist may not have wanted to raise in a group session. For example, a female clinician might say, “My client told me he hates women,” or a male clinician might say, “My client thinks he’s worthless, and since he has done time for child abuse twice, I have to say part of me agrees with him.” The supervisor’s role is to listen, elicit the counselor’s own wisdom and experience, reframe the situation or challenge when helpful, and advise the supervisee on the most promising course to follow in each situation. The supervisor points out and celebrates small victories, respecting each counselor’s style but coaching each one on areas where he or she can become more effective.

Individual sessions provide a time to focus on areas of growth specific to each counselor. Some may need help structuring their work, while others need to unleash their creativity; some may feel invested in “saving” the client and need help remembering

not to work harder than the client. Some may have philosophical differences with a “harm reduction” approach, even when it is clearly the only viable alternative to the situation, and the supervisor may need to help them make this adjustment to ensure the client is as safe as possible. By building a strong working relationship with each counselor, the supervisor helps each of them reach his or her potential.

Supervisors new to incorporating consumer-providers as staff are strongly encouraged to receive prior training and/or study published guidance related to peer support supervision (see the Resources Section of this manual). Experienced peer support staff and/or a consultant may also be particularly useful in these individual sessions when the supervisor’s clinical/supervisory training predates the emerging practice of peer support through employment of consumer-providers.

Other Responsibilities of the Supervisor

Besides the supervisor’s roles in ensuring fidelity to the model and coordinating care, the supervisor also has administrative responsibilities. These will vary according to the program and the way in which this role has been conceptualized (i.e., whether or not it includes financial oversight). Roles played by the MISSION supervisor are highlighted below; however, programs replicating the intervention may need to assign a number of additional responsibilities appropriate to their design and context.

Ensuring Adherence to Policies, Procedures, and Laws

By ensuring team members are trained in legal and organizational requirements, sharing pertinent reference documents, and listening carefully to presentations on strategies used with clients, the supervisor can help ensure that counselors are working in accordance with applicable guidance and laws.

Coordinating between the Intervention Team and Residential Program

The MISSION program works closely with the residential program and views the relationship as a partnership. The MISSION supervisor plays a critical role in helping to ensure that the MISSION team has input into the discharge plan that case managers and peer support specialists will need to support and that team members receive a copy of the final plan. This role requires tact and an ability to forge strong, productive, outcome-focused relationships across program lines.



Facilitating Work with Other Agencies and Consultants

The supervisor may also seek assistance or guidance from experts in other fields when needed. For example, the MISSION team has periodic telephone consultations with an expert on the CTI model that focus on how best to handle difficult, high-risk cases. In addition, the supervisor may need to help develop solid working relationships or agreements with community agencies that provide services to clients. Such established relationships benefit the whole team and help ensure clients' needs are met during the critical period of community re-entry. For instance, the supervisor may need to contact the Director of a residential program for persons with post-traumatic stress disorder (PTSD) to which a MISSION client

has been transferred in order to educate him or her about the services offered as part of the MISSION program, to assuage any concerns that the MISSION staff would interfere with the clinical interventions conducted on the residential unit, and to foster effective communication to ensure a smooth transition back to the community after discharge.

General Supervisory Responsibilities

Typical supervisory duties associated with hiring, training, leave approval, performance appraisal, etc. are also required of the clinical supervisor. Given the emerging practice of employing peer support specialists, we've included some basic responses to frequently asked questions associated with employment of these staff in Appendix E.



5. Case Management

This section of the treatment manual explains the role of the case manager. It describes essential personal characteristics, explains how the case manager fits into the team and works with the residential staff, and illustrates the primary responsibilities of the position: (1) initiating relationships with clients in the residential facility; (2) conducting group sessions in Dual Recovery Therapy; (3) providing aftercare to ensure a successful transition from the facility into the community; and (4) developing relationships with community agencies. Because vocational support is integrated in the residential component of care and provided on an ongoing basis by the case manager, it is described throughout this section occurring across the phases of care.

A. Overview of the Role of the Case Manager

Case managers provide critical support to clients as they re-enter the community. During the period when clients are within the residential facility, they prepare for this crucial work by staying in touch with the client's progress through meetings led by the residential staff and by beginning to build a trusting relationship. During this period, one case manager introduces prospective clients to the program and makes a preliminary determination of eligibility; case managers also meet with the client at strategically chosen intervals. One case manager offers group discussions centered on a structured series of exercises for persons with co-occurring disorders – exercises that help the client address common issues, but also yield information that helps case managers work more effectively with their clients. Case managers also work with the residential staff (who have the lead during the period of residence) to contribute to plans for each client's treatment and aftercare.

As clients prepare for and adjust to community life, case managers work with them to prepare for the transition from residential care to the community and educate them about community resources, identify needs, and provide linkage to appropriate services, including education, employment assistance, and housing-related services. They conduct frequent community outreach following discharge to provide support, to promote compliance with medical, psychiatric, and substance abuse treatment regimens, and to encourage clients to become involved in community-based activities.

Through a series of meetings, which occur with decreasing frequency as clients become settled and self-sufficient, case managers continue to monitor clients for signs of psychiatric or substance abuse relapses and make referrals to appropriate treatment services when necessary. They also identify and address any barriers that may exist to full participation and attendance in community activities and treatment programs. For example, the case manager may provide life skills training, money management education, and assistance navigating the public transportation system. Case managers regularly document services rendered, entering case notes and other critical information in computer databases to help track client progress. Through participation in supervisor-led meetings that include both peer support specialists and clinical staff, they identify methods to improve outreach, program participation, and linkage to community resource.

It is important to underscore the need for the case manager to target the most troubling problems that he/she and the client can work on collaboratively, otherwise the case manager and client could run the risk of becoming overwhelmed. For instance, the case manager and client may initially focus on housing stability, employment, and money management even though the client has a long-term need to re-engage with his/her family. The latter issue can be discussed as a long-term goal as the other issues become less concerning. Prioritizing problems to focus on is always a team effort between the client, case manager, and peer (along with the residential team while the client is still in the residential facility).

Another key role of the case manager is providing linkages to vocational services and tracking the community-based vocational needs and services in which the client is engaged. Because a great deal of the vocational rehabilitation is delivered by the residential facility and through the State of New Jersey Department of Vocational Rehabilitation services, it is the case manager's job to assist in facilitating the vocational rehabilitation treatment plan, whenever necessary, and filling in any gaps as needed.

Essential Personal Characteristics

Case managers in the MISSION program share the same skill sets and personal traits as case managers in many other settings. For example, they must have the ability to engage clients, obtain their trust, and build and sustain a therapeutic alliance. Effective work with clients will require empathy, compassion,



patience, persistence, good listening and communication skills, dependability, and consistent and a nonjudgmental attitude. It also requires assertiveness, as much of the work requires community visits.

In addition, to help link clients to needed services, case managers need to be organized, personable individuals who can locate resources, work together to develop and maintain an accessible knowledge base of key resources, build relationships with agencies that can help clients succeed, and advocate for their clients when they need help accessing services and assistance for which they are eligible. Ability to work smoothly and respectfully as team members – with peer support specialists, other case managers, and the supervisor, as well as with residential staff – is also key. Case managers should have the judgment to make well-grounded decisions independently, but at the same time be open for assistance and guidance. This includes a willingness to build clinical skills, follow applicable policies and procedures, and work within laws and regulations. Finally, since recordkeeping is essential for effective long-term follow-up and for allowing others to take over cases in progress when necessary, case managers should be clear writers and possess strong organizational skills.

Training Needs

Training is seen as essential for personal growth and development, and MISSION staff are required to participate in MISSION-related training activities. Case managers receive ongoing internal training through group sessions and individual sessions led by the supervisor, as discussed in the preceding chapter. In addition, they receive:

- *Internal training*, to help them implement the program in accordance with the organization's expectations; and
- *Supplementary training* from outside sources, to help them build clinical skills and acquire the knowledge they need to help clients navigate and access community services. They may 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 case managers on a number of topics relevant to their job, including:

- Confidentiality policies;
- Research integrity;

- Documentation policies;
- Crisis management; and
- Expectations of the position.

They are also strongly encouraged to attend the mental health grand rounds within the institution.

Because of the research/evaluation component of the MISSION project as originally implemented, case managers also receive basic training in human subject protection, including applicable regulations, history, policies, procedures, and ethical practices.

Policies and procedures, as well as position descriptions, are included in the Appendix to this manual (Appendices C and D).

Third-Party Training

Like peer support specialists, case managers have participated in training offered by the CTI Project at the Mailman School of Public Health of Columbia University. Some of the topics covered in that training are:

- Assessment and Prevention of Suicidal Behavior;
- Counseling and Interviewing Skills;
- Motivational Interviewing;
- Harm Reduction;
- Drug Craving;
- Axis I and II Disorders;
- Trauma, PTSD, and the Treatment of Returning Veterans;
- 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; and
- Psychiatric Medications.

In addition, case managers retain their certification from the Red Cross in cardiopulmonary resuscitation. Finally, consistent with their own credentials and professional affiliations, case managers are encouraged to attend continuing education training events both within and outside our system. This is both supported and encouraged by the administration.



➤ **B. Working Effectively with Residential Facility Staff**

While MISSION's clients are receiving treatment at the residential facility, the facility staff take the lead in planning and implementing treatment. However, the MISSION case managers remain in close touch with the treatment providers, receiving information regularly on the client's progress and providing input to the treatment team. Each case manager attends briefings twice weekly at which his or her clients are discussed, with the residential staff in the lead. This coordination is essential for case managers to understand issues that have arisen for clients while in the facility so they inform their approach to aftercare. In fact, we are fortunate that the MISSION case managers are physically housed on the grounds of the VA and within the same complex as the residential facility. While not mandatory, this proximity serves to facilitate the close relationships between the MISSION and residential staff.

Case managers stress the importance of clear and open communications with residential staff. During the residential period, teamwork is critical, and the MISSION case managers make sure their communications with clients are consistent with the treatment plan and reflect their awareness of staff decisions and concerns. However, they do communicate with residential staff when they have observations that may be useful. For example:

Case Management in Action: Working with Residential Staff

- 1. The residential team is making plans to transition a client to the community. Aware that the client needs a job, the MISSION case manager hears of a place that may be hiring that might be suitable for the client. She tells the primary care provider in the residence, who encourages the client to interview with that employer.*
- 2. A client is due for a medical follow-up exam related to prescribed medication. The MISSION case manager notices a significant change in the client's interactions during an interview that could be a reaction to the medication or might indicate another problem. She communicates her observations to the primary provider and also to the staff member responsible for monitoring residents' health issues.*

➤ **C. Working Effectively with Project Team Members**

The MISSION approach requires case managers and peers to work together, with one peer and one case manager assigned to the same client. As shown in Table 4 below, some roles are specific to peers or case managers, while others are shared. For example, case managers take the lead on delivering dual recovery therapy, while peers support clients by attending AA or NA meetings.

For the team relationship to work effectively, it is critical that both members share information with each other about their meetings with the client. These communications help team members support each other's work and track evolving issues that may require special intervention. (Clients are informed at the outset of their participation that information is shared among team members.) A peer may tell a case manager that the client has been seeing drug-using friends at their old haunts, or a case manager may tell the peer that a client who has poor social skills has been shy and nervous about going to AA meetings and ask the peer to offer to attend with the client. Noticing that a client is showing early signs of depression, the case manager may remind the client that he or she felt really good when going to the recreation center regularly to work out and play basketball, then ask the peer to follow up and perhaps offer to arrange to meet the client at the recreation center. By working together smoothly, team members can enhance their effectiveness and ensure the client is receiving consistent messages and support.

Depending on the issues to be addressed and the client's preferences, case managers and peer support specialists may meet with the client at the same time, or they may meet at different times and share their observations, concerns, and responses with each other. Case managers have observed that each member of the team has a distinctive relationship with his or her clients that offers different benefits and a unique perspective on the client's recovery. It is important to underscore that case managers and peers are seen as equal members of the team, each of whom contributes a unique background and experiences to assist MISSION clients.

Weekly clinical coordination meetings, led by the supervisor, provide another opportunity for peers and case managers to share their perspectives and benefit from additional insights and suggestions offered by the other team members. In the event of a disagreement between assigned team members, the supervisor listens to both and provides guidance. The supervisor



also coordinates vacation schedules and manages interruptions due to illness, providing coverage to ensure that a client is not left unexpectedly without support.

Case managers must be thoroughly familiar with both the policies and requirements of the MISSION program and those of the residential facility, which govern recordkeeping, case

notes, security procedures for computer access and use, and many other areas. For example, when leaving the residence, in compliance with policy, case managers log themselves out and indicate where they are planning to go. This provides an important security precaution. Case managers also log themselves back in on their return and e-mail team members to inform them they are back in the office.

Table 4. Responsibilities of Peer Support Specialists and Case Managers

Primary Responsibility of Peer Support Specialist, with Input from the Case Manager	Primary Responsibility of Case Manager, with Input from the Peer Support Specialist	Shared Responsibilities
<ul style="list-style-type: none"> • Helping 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 mental health and substance abuse services (e.g., NA/AA, Double Trouble groups). • Accompany clients to clinical appointments, job interviews, recreational activities, and self-help group meetings. 	<ul style="list-style-type: none"> • Orientation/introduction, mid-program progress check, transition to community, and discharge plans. • Management of clinical crises. • Dual recovery progress check and appropriate interventions at each visit. • Vocational support as needed: interview skills training, linkage to education and training. • Linkage to professional clinical services. • Communication with clinical service providers. • Benefits and entitlements issues (e.g., Social Security Income [SSI] and Social Security Disability [SSD]). 	<ul style="list-style-type: none"> • Weekly team meetings with residential staff. • Discharge session from the residence. • Team visits to the community while peers support specialists are in training. • Linkage to needed community services, including vocational resources. • Assistance with safe and affordable housing. • Monitoring symptoms and responses to treatment. • Working with clinical supervisor to address deteriorating symptoms. • Psychoeducation and training in symptom management, coping skills, medication compliance, problem solving, and relapse prevention. • Transportation education and assistance. • Support for job stress and adjustment. • Support during clinical crises. • Assist clients with <i>Consumer Workbook</i> exercises, discuss the exercises and readings, and reinforce insights.



➤ **D. Developing Relationships with 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 case managers are seen as being in a unique position to foster these relationships.

In making connections within the community, they benefit from relationships with agencies already maintained by the residential facility. For example, the facility strives to place each client in employment and coordinates with a number of potential employers to accomplish this. The facility also has community contacts that help in securing housing. Often, needed contacts are found through “someone who knows someone,” so networking skills, and the “people skills” to go with them, are essential ingredients in success.

Second, case managers 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 MISSION’s case managers has experience in vocational rehabilitation and connections that facilitate employment; she also has an extensive background and years of experience in vocational counseling. Another case manager, a veteran, brings in-depth expertise in resources available to veterans. We encourage a team approach among the case managers so that each one can be a resource for the others based on their unique background, experiences, and professional training.

Third, case managers often build relationships “from scratch” through Internet searches or referrals from others in the field who know of a useful resource. Case managers 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 veterans 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. The team documents this shared knowledge and explains the process for applying for services or goods to clients.

➤ **E. Initiating Relationships with Clients in the Residence**

While in the residence – typically for fourteen weeks – interactions with MISSION clients are few, but sufficient to establish a relationship and provide essential background about the client. The following section reviews the process by which MISSION case managers lay the groundwork for the relationship they will need to provide effective aftercare.

Program Orientation and Introduction

As described in the previous chapter on supervision, a case manager screens the records of new admissions to the residential facility for persons eligible for admission to MISSION. The assigned case manager interviews prospective participants and explains how the program works, the benefits they could expect, and the expectations for participants. The case manager also verifies that they meet program criteria. Because of the reputation MISSION has been able to develop, prospective participants almost always accept the invitation. After signing required forms, participants are then referred to the supervisor for assessment. (See Chapter 4. Clinical Supervision.)

Following assessment, the supervisor introduces the participant to the person who will be the client’s case manager. The case manager receives contact information for the participant and schedules an introductory meeting, during which the case manager can begin to get to know the client. This initial meeting is an opportunity to learn about the client’s goals, barriers, strengths, hopes, and interests. The case manager also learns as much as possible about the prospective client’s triggers, coping skills, and available supports in the 45-minute session, and explains how the program can support and assist the client. Finally, the case manager expresses support and makes sure that the client understands the respective roles of the MISSION and the residential program during the first 14 weeks of treatment. The case manager files notes on this initial meeting. An example appears below.

Example of Case Manager Notes on MISSION Program Orientation Session

Individual Session: Orientation to the MISSION Program Date:

The veteran attended an orientation session with his MISSION Case Manager to learn the goals, structure, and schedule of the program. The veteran was given the



opportunity to ask questions about the project and these questions were answered to his satisfaction. The veteran's goals for his treatment in the Dom and after discharge were discussed. The veteran stated that his primary goals were to maintain his abstinence from drugs and to gain job-related experience during his Dom stay. After discharge, he hopes to get a part-time job while completing his GED. The veteran also agreed to continue his attendance at NA meetings, to continue his adherence to his psychiatric medication regimen, and to pursue 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 veteran reported feeling hopeful about his future and less depressed than when he was initially admitted to the Dom. Despite this improvement, his affect continues to be somewhat sad and constricted. His thought process was goal-directed and linear.

The MISSION case manager will contact the residential facility case manager to communicate information gathered during the orientation session to aid in the development of the treatment plan.

Weeks 1-13 of the Residential Program

As the client settles into the routine of the residential program, case managers keep tabs on the client's progress through team meetings with the residential staff. While individual case managers do not have formal contact with "their" client during this period, they may meet him or her in the hall or the client may drop by the office to say hello. The case managers are alert to the potential problem of "splitting" counselors by pitting one against the other, so they do not encourage complaints or become involved in disagreements or difficulties the client might be having with the primary caregiver. However, they empathize with the client, pay attention to whatever they might want to reveal about their experience in the residence, and encourage them to let staff in the residential facility know about their feelings. If something of significance is said during these informal and unscheduled meetings, the case manager may also call the primary provider in the residential facility or write a note in the MISSION client's Medical Record (in the case of the VA it is electronic charting system) and identify the counselor in the residential facility as a cosigner to ensure the information gets transmitted.

Case managers also stay in touch with the client through regular meetings to review progress led by the residential team.

In addition, peers offer regular sessions for informal discussion of topics of interest selected by the peers themselves. (See the following section on peer support.) A case manager also delivers regular structured sessions that address topics pertinent to Dual Recovery Therapy. These are described below and documented in Appendix B of this manual.

Dual Recovery Therapy

During the period of residence, one or more case managers hold regular group sessions for MISSION participants that are structured around recovery-oriented concepts of particular concern to persons who have dual mental and substance abuse disorders. Each session is summarized in Appendix B and listed in the text box above. Most sessions involve personalized, hands-on application of the concept to the individual's life, followed by a period of discussion and sharing. For example, in session 1, participants are introduced to the concept that personal timelines for episodes of substance abuse and symptoms of mental disorder may be related (e.g., the client may resort to substance abuse in an attempt to self-medicate).

DRT Topics*

- Onset of Problems (Timelines for Dual Disorders)
- Life Problem Areas
- Motivation, Confidence, and Readiness to Change
- Developing a Personal Treatment Plan
- Decisional Balance
- Anger Management
- Relationship-Related Triggers
- Changing Unhealthy Thinking Patterns
- Changing Irrational Beliefs
- Scheduling Activities in Early Recovery
- Developing Communication Skills
- 12-Step Orientation to Alcoholics/Narcotics Anonymous
- Relapse Prevention

* See Appendix B for a complete description of each session.



Group participants then fill out timelines that show periods in which they have experienced significant episodes involving each disorder and share their findings. Often, similar patterns are found among participants. Discoveries made about how the disorders interact with each other may help either the client or a care provider recognize a significant trigger and take action to prevent relapse.

The sense of community built into the DRT group also helps counter the crippling effects of shame and supports the change process. Further, it provides the opportunity to build substantive friendships that are not based on substance abuse.

Participants use the *Consumer Workbook* to follow activities and record their answers. Case managers not involved in leading the group sessions may benefit by reviewing the worksheets periodically, as they contain information of importance to the client's ability to maintain recovery.

Sometimes the group leader learns information in the discussion period that would be of clear and immediate concern to the primary caregiver and the MISSION case manager (for example, a roommate who is using, family pressures, events that are triggering a strong desire to use, or new symptoms). In such cases, the information is conveyed to the primary caregiver by telephone with a reinforcing note to maintain a written record for common reference.

Transitional Sessions and Discharge from Residential Program

During the month prior to discharge, case managers meet with clients four times (ideally, once each week, but again the model allows for flexibility depending on the needs of the client). These sessions are intended to form a solid bond as the client

Template for Notes on Individual Participation in DRT

Group: Dual Recovery Therapy for the MISSION Program

Date: 7/19/07

Agenda: **Relapse Prevention**

GROUP BEHAVIOR RATINGS:	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 veteran participated in the Dual Recovery Therapy group that is a component of the MISSION Program. Group members discussed **methods of relapse prevention.**



moves into the community, assure them of the case manager's support, and help the client make necessary preparations. They often address very concrete details: Does the client have a driver's license? Are business cards needed? Are there legal issues or obligations to resolve? Are plans for housing and employment working out? Who will provide medication and counseling? What 12-step programs are convenient? Is the client keeping up with mental and physical health appointments? In addition, the sessions explore the client's short-term and long-term goals and his or her feelings about the transition. For example:

- Where is the client working? How is it going?
- How are prescribed medications working? Are there significant side effects?
- What are the client's plans for transition?
- Where will he or she find support for recovery?
- How is the client feeling about the transition? What are major concerns or issues?

The case manager makes sure that he or she has the correct telephone numbers and addresses for client contact (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. The case manager should also devote a little time to discuss the *Consumer Workbook* readings that focus on transitioning to the community (this is discussed in more detail below).

These sessions provide a basis for MISSION input into the development of the client's discharge plan, though it remains the responsibility of the residential care provider. For high-risk cases, the MISSION case manager may meet with the primary care provider to ensure they are "on the same page" about how best to manage the critical transition back to the community and ensure that needed supports are in place. Rarely, the case manager may see an opportunity to provide support in locating housing, a job, or other resources needed for the transition at this stage; in this circumstance, assistance would be coordinated with the primary care provider.

In some cases, a MISSION participant may leave the residential program prematurely, usually because he or she has relapsed. It is important to underscore that while a relapse with substances is not a reason for termination from the MISSION program, by policy, it is a reason for immediate discharge from the residential facility. If this occurs, the MISSION case manager begins immediately to provide supportive assistance. While this is obviously not an ideal situation, some MISSION participants have successfully completed their transition to community life despite a precipitous early start.

F. Use of the Consumer Workbook

The *Consumer Workbook* is introduced in the residential period as a means of facilitating the transition to community life. During the initial orientation session, the MISSION client is given the *Consumer Workbook*, which provides additional information about the MISSION Program. It is divided in two parts. The first part contains Self-Guided Exercises; Dual Recovery Therapy: Tools and Readings; and Checklists. The second part offers readings on Sustaining Recovery and Community Living. This workbook can be distributed either by the case manager or the peer in the orientation session, but each will need to discuss his or her role as it relates to these materials. Whoever distributes the *Consumer Workbook* should provide a general overview of the book.

It is important that the peer and case manager carefully provide an overview of the materials in the *Consumer Workbook* and ensure that the materials are not seen as overwhelming, but rather as a critical resource that can be used throughout the year-long MISSION services and a set of tools for recovery. It is our experience that clients can initially become somewhat overwhelmed with the content of the workbook, particularly when considering that everything is new for the client: their commitment to recovery and sobriety; their surroundings, including the residential facility; the people that they are associated with; and the fact that they have just made a commitment to a 12-month intensive MISSION care coordination service. This is more likely to be the case if the workbook is presented in single-sided format so that it appears longer; a double-sided format (ideally spiral-bound) is both more usable and less intimidating.

While we encourage clients to complete the self-guided exercises containing in Part 1 independently, peers are seen as playing a critical role in these exercises; they check in with the client on a weekly basis to find out about progress and offer guidance and support. That is not to say that the case manager ignores the exercises; the case manager may also work with the client on significant issues raised by these exercises. However, the primary responsibility for facilitating the use of these particular exercises rests with the peer.

Part 1 also contains DRT exercises, which are used during the DRT group sessions while the MISSION client is in the residential facility. These sessions are led by a case manager. The client's written responses to DRT exercises can be a helpful resource and a reminder of the commitment the client made to achieving personal goals, the skills that help maintain recovery, and the essential concepts that will help the client maintain a recovery focus. For example, the case manager might refer back



to the client's "triggers" for use, personal goals, and plans for recreational activities, either as a reminder or as an opportunity for revisioning the path to recovery.

As participants transition to the community, the readings in the latter part of the workbook become particularly relevant, raising issues that may concern the client and suggesting opportunities for useful discussion. Case managers facilitate the use of readings related to the transition to the community, which should begin in the third month of treatment and correspond with the transitional care sessions. However, as is the case with the exercises described above, the peer can also provide some assistance in digesting these readings and helping the client work through fears and concerns. Because the case manager and peer work as a team, it is critical to have an ongoing dialogue about the client's progress regarding the readings in the *Consumer Workbook* and the issues that may be of concern to the client.

Please also note that Part 2 of the Consumer Workbook includes a brief explanation of the most common mental health conditions of those entering the MISSION program. This explanation is meant to serve as a resource for clients. In addition to the explanation of the mental health conditions, we have also provided a table with the most common medications used to treat those problems as well as the possible side effects that could occur from these medications. We point this information out for two reasons:

- Clients may want to talk about the materials in one of your sessions, and we want you to know it is present in the workbook.
- We have received feedback from our MISSION staff that these materials, particularly the table of medications and side effects, are a useful resource.

G. Providing Support in the Community

Effective aftercare to ensure that needed community supports are in place and functional lies at the heart of the MISSION program. The support provided by the case manager changes to match the client's status, usually evolving as the period of community living continues. The following describes some of the concerns that arise frequently in each phase of the transition.

Transition from Residential Care to the Community

To ensure continuity of care, the case manager schedules the first meeting in the community within a week after the last transitional session held in the residence. At each session, the meeting to follow is scheduled. For about six weeks to two months, sessions occur weekly. The case manager generally follows the client's lead on the desired frequency of meetings during the transition, however. As the client becomes more settled and stable, meetings occur less frequently.

During these early meetings, case managers explore key questions, such as: How are they handling the lack of structure and many choices to be made? Are they connecting with peers in recovery? How are they feeling now as opposed to when they were in the residence? What difficulties they are running into in making the adjustment? In addition to questions related to this specific phase of aftercare, case managers regularly use the dual recovery status exam to be sure that both the mental and substance use disorder are monitored carefully. This exam appears in the text box below.

When the client identifies a problem, the case managers asks what they are already doing to address it and explores further options with the client if needed. If necessary, the case

The Dual Recovery Status Exam

- **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.**



manager may establish or reinforce a linkage to a resource that can help solve the problem. The case manager schedules at least one meeting wherever the client is living to troubleshoot any hazards to health or wellbeing or to recovery (for example, proximity to people who are using).

During the early phase of care, problems may arise when the client is vulnerable and does not have well-established supports. These issues may require the case manager to intervene directly to prevent relapse, as in the examples described below. As the client's time in the community increases, he or she usually becomes more resilient, acquires additional resources and supports, and becomes increasingly likely to have the skills and confidence to overcome such obstacles.

Case Management in Action: Early Aftercare

Example 1. *At an early meeting, 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 same 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 at an outreach office for veterans to help the client 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 2. *The case manager inquires about how work is going for a client who is living in transitional housing. The client explains that she has been relying on public transportation to make it to work, but the buses are infrequent and she has been getting to work late. 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 vocational rehabilitation 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. Gradually, when she is ready, the client moves home – and she has managed to keep her job.*

Example 3. *A client is living at home with a friend and has not received the medications he needs to control severe pain because of a mix-up about the address. The 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, and ensures that the medication arrives before the client relapses.

Vocational Support

Vocational support is an important component of the case manager's job, spanning the entire period of work with the client. This includes providing ongoing monitoring and reinforcement of the client's employment-related goals on the treatment plan. The case manager assists with overcoming any barriers and helps to foster new links with employment resources in the community, including the use of State Department of Labor resources. The case manager also provides practical assistance with maintaining employment satisfaction and coping stress. Throughout the MISSION program, the case manager and client frequently discuss employment retention and growth. For example, they discuss how reliable the client has been regarding punctuality and absenteeism. The case manager can also help the client

- develop; and understanding that patience and asking questions are more important than short cuts, which could result in poor results;
- improve problem-solving skills;
- learn to feel proud of work accomplishments;
- understand that some skills take time to develop; and
- learn to take constructive criticism and stay focused during conflicts.

The case manager can explore topics such as:

- Methods to use in order to keep the job interesting and exciting, such as approaching a supervisor for additional responsibilities or assisting co-workers (while respecting boundaries);
- Time management and the development of a work ethic;
- The importance of establishing a viable work history by demonstrating longevity and dependability;
- What benefits to look for from a job, such as medical, vision, and dental insurance; holidays; vacation; or sick and personal leave (especially important considerations for people who might be satisfied initially with just having a job); and
- How to plan for retirement, including how to take advantage of opportunities offered by the employer.



In addition to job retention strategies, the case manager may also discuss career advancement strategies. While on the job, the client might become aware of promotion opportunities. If the client feels qualified, the case manager can discuss the option, encourage the client, and role-play various scenarios for approaching a supervisor about a promotion. The case manager should also support the client in lateral moves that might have long-term benefits. The case manager might discuss educational options that would help the client broaden his or her qualifications overall or move to another career where there are further opportunities for advancement.

Continuing Aftercare

As the client's transition to the community becomes more securely grounded, case managers 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 case manager plays a steadying role in helping the client to see the way forward. For example, the case manager may suggest a couples counselor, 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 case manager encourages the client and increases the likelihood the client will stay on course long enough to stabilize.

Case Management in Action: Continuing Aftercare

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 the client (who tends to act out and become inpatient) to stay calm, focus on the goal, and avoid antagonizing his ex-wife. The case manager reinforces the anger management tools the client learned in the residence and in the DRT group sessions. The case manager also helps the client get the information he needs to know about how to request visiting rights properly through the court system. The client is able to handle his frustration, keep focused on his goal, and attain visiting rights. He is now enjoying getting to know his children again and they have become a stabilizing and motivating factor in his recovery.

Ending Aftercare: Transfer of Care to Community Supports

As the clients' supports within the community stabilize, aftercare decreases in intensity and "tapers off." Meetings stretch from weekly to every other week. During the final two months of care, meetings may be as infrequent as once a month. Most case managers vary the timing 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 to foster client independence and reliance on the community supports. This will also assist with the termination, the process of which begins slowly as sessions become less frequent.

Maintaining some contact, however, is key: a client can sound on-course and confident but in fact be putting up a front 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 wellbeing. As the case manager continues to support and believe in the client's recovery, responding to setbacks without losing this faith, most clients become increasingly comfortable speaking truthfully about their experience.

MISSION case managers have the following advice to share about how to handle this final phase of the program:

- *Remember special events in the client's life when you can.* Wish luck on a new job, offer congratulations on a daughter's graduation. Find ways to let 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 the client's recovery.* It's important to make sure the client stays connected with support groups and peers in recovery. A client for whom things are just going too smoothly to be believed may in fact be on the verge of relapse.
- *Foster independence.* Where you once might have made a phone call on the client's behalf, you now may give the client the number and let the client make the call.
- *Recognize the possibility of late-stage relapse.* Some clients do need to re-enter residential care and start over.

Case managers may want to encourage clients to share good news and stay in touch, but they also want to be sure the client understands that once the program ends, you are no longer available as their care provider.



At the final meeting with the case manager, it is helpful to review the client's goals and accomplishments. The case manager also reviews next steps with the client and supports the client's plans to maintain recovery. This includes reviewing resources available at need and what they can offer. Examples of topics the case manager may go over with the client at this meeting include the following.

- Review the year. How has it gone for you? What have been the highlights and difficulties?
- What are your goals now as you move forward?
- 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?
- How long have you been clean and sober now?
- How are you doing with meetings? How is it going with your sponsor? What steps are you working on?
- Is your relapse plan current? Who would you contact if you were feeling at risk for a relapse?
- How is your health – mental, physical, and dental? How is health care working?
- How is money management going?
- Have legal problems been resolved?

- Do you have a driver's license? If not, what do you need to do?
- Have you been supporting your family? Have they been supporting you?
- Where are you living and how is that working out?
- How are your significant relationships going?
- How is employment working out?
- Are the activities you have chosen satisfying and fun for you?
- How has your mood been over the last few days?
- Do you have the name and contact information of a local Emergency Room should you require immediate attention?

The case manager may present a list of local resources and referrals for reference at the closing meeting, if the client has not received these before.

Often, case managers send a positive, personalized closing note that thanks the client and expresses good wishes. Depending on the institutional policy, one might even encourage clients to call and "check in" after three months. This offer helps some clients, who find it conveys the case manager's continuing interest in their welfare.



6. Peer Support

This section of the treatment manual explains the role of the peer support specialist. It describes essential personal characteristics, explains how the peer support specialist fits into the team, and illustrates the three important responsibilities of the position: (1) initiating relationships while the client lives in the residential facility; (2) facilitating peer-led group sessions in the residential facility; and (3) providing peer support to foster successful community integration to ensure a successful transition from the facility into the community.

➤ A. Overview of the Role of the Peer Support Specialist

Peer support specialists are important members of the MISSION team and seen as having equal status with case managers, but with a unique set of resources and skills to assist in helping the MISSION client. During the often lengthy and difficult process of rebuilding a life in the community, the formerly homeless client with co-occurring disorders can benefit greatly from the support of someone with similar experiences—someone who can offer advice and empathy as the client faces challenges along the way.

We do get paid, but this is something you'd have to be willing to do for free in order to do it for pay.

MISSION peer support specialist

Peer support specialists are full staff members of the MISSION program. Each has experienced recovery from challenges similar to those faced by MISSION clients (homelessness, unemployment, substance abuse and mental illness) and has received training specific to the role of consumer provider. In addition to serving as role models, peer support specialists use their personal experience and consumer-provider training to advocate for and empower clients to self-determine their recovery goals, share wellness and relapse prevention strategies, and provide practical supports to improve socialization and community life skills.

While clients are in residential treatment, they attend weekly sessions led by peer support specialists. The sessions reinforce DRT topics covered by the case managers and also highlight issues identified by the peer support specialists as part of the

recovery process, including humility, courage, and willingness to change. After clients are discharged, the peer specialists continue to provide encouragement and practical support in accessing needed community services, self-care, socialization and other life skills. They accompany clients to 12-step meetings and help them with nitty-gritty tasks such as learning to use public transit or getting a driving license.

Our peer support specialists also play a key role in facilitating the use of the *Consumer Workbook* and digesting the personal content that comes up through the Self-Guided Exercises. These exercises, developed by consumers, are seen as helpful tools to facilitate the recovery process.

Finally, in addition to the peer services provided through MISSION, all MISSION providers, including both peers and case managers, foster and encourage MISSION clients to continually expand their use of adjunctive self-help and mutual support services, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), consumer-run drop-in centers, and other consumer-operated services in which people encounter peers who are further along in recovery. These services are seen as essential to the recovery process and increasingly necessary as the client transitions from the MISSION program to the community support services.

The first and foremost qualification for becoming a peer support specialist in the MISSION program is that one must be able to consider himself or herself a peer of the program's current clients, and the clients must accept the peer support specialist as a peer. One critical component of the peer support specialist's job involves serving as a role model and providing advice and support based on personal experience. The success of the peer support services intervention relies, in part, on the clients' belief that peer support specialists truly understand what the clients are experiencing and can therefore provide practical support. Additionally, the inspiring example that peer support specialists set, as people maintaining recovery and working successfully, can strike a chord only if clients see the peer support specialists as people who have been in situations similar to those they have experienced themselves.

While peer support specialists actually may have the same category of diagnoses (substance abuse and non-serious mental illnesses) and experiences (homelessness, unemployment, and residential treatment) as current clients, the most critical factor is that they have a recovery experience that they can use to support others in their recovery journey. Among these criteria,



the MISSION peer support specialists believe that the most important issues that connect them to MISSION's clients are recovery from substance abuse, status as a veteran, and a history of homelessness. Further, the peer support specialists and clients share many experiences, such as having had and lost successful careers, estrangement from their families, loss of driving privileges, and owing fines or child support. Peer support specialists use their specialized training and personal experience, rather than clinical expertise, as a knowledge base for providing support. They speak in a language that the peer can understand rather than using clinical terms.

Essential Personal Characteristics

Of course, not everyone in recovery from similar diagnoses and life experiences would make an effective peer support specialist; a number of additional personal characteristics are important. They must be strong in their own recovery, have altruistic motivation, and be able to set limits in relationships. The importance of the peer support specialist being stable in his or her own recovery cannot be overemphasized, as the community support component of the job takes them into neighborhoods in which substance abuse may be prevalent, and they will be interacting with clients who themselves might have relapsed into substance abuse. Obviously, a peer support specialist who has relapsed with substances cannot do his or her job effectively and poses a risk to clients who themselves are susceptible to relapse.

Although peer support specialists generally gain tremendous satisfaction from what they do, the pressures of supporting others in their recovery and helping them overcome the challenges of successful community integration can be highly stressful. In addition, their unique role as nonprofessional members of the treatment team, and as individuals with a history of mental illness and addictions, may result in unusually stressful working conditions at times. It is, therefore, especially important that peer support specialists regularly reflect upon how work and other potential stressors are affecting their mental health or susceptibility to substance abuse relapse. As is the case with all health care professionals, whenever necessary, peer support specialists should discuss any interpersonal conflicts provoked by the work with their own care providers and others in their personal support network. They should also avail themselves to opportunities to network with other consumer-providers doing similar work. (See the Resource Section for suggestions.)

As is the case with all health care professionals, it is important to take care of oneself as well as one's clients. This includes behaviors such as getting enough sleep, eating healthy foods,

A Peer Support Specialist Should Be...

- Someone recognized as a peer by program participants
- Stable and confident in recovery
- Able to maintain recovery by self-monitoring, seeking support, healthy living, etc.
- Skilled at reducing personal stress
- Someone with “a heart for people”
- A team player
- Capable of managing boundaries and maintaining balance in relationships

using stress management approaches (such as meditation or spirituality practices), exercising, and taking time to do enjoyable things like going to movies, taking vacation, or socializing with friends. Taking care of oneself benefits the peer/client relationship. When the client sees that the peer support specialist is invested in his or her own life, the client's respect for the peer support specialist is increased.

In order to maintain healthy team relationships free from conflicts of interest, the peer support specialist should avoid engaging in therapeutic relationships with other team members or supervisors, regardless of how readily available and well-meaning these professional clinicians may be. It is important that the specialist be able to discuss stress, interpersonal issues, and relapse triggers with professionals who are independent of the program itself. Of course, it is entirely appropriate for peers specialists (like any other staff) to discuss issues pertinent to their employment with their supervisor, but the boundaries should be well maintained so there is no confusion about the nature of the discussion; it must be that of “employee-supervisor,” not “consumer-therapist.”

Another needed characteristic for peer support specialists is to “have a heart for people”—a sense of compassion for the struggles of others and a strong desire to help people as they struggle to maintain recovery and achieve a successful life in the community. Being genuinely caring is an important personal trait rather than a skill that can be learned.

Maintaining a friendly and egalitarian relationship while simultaneously trying to achieve specific outcomes with



MISSION's clients (sobriety, employment, etc.) requires a delicate balance from a number of perspectives.

- The peer support specialist must be able to develop a good rapport with clients and understand when to back off and when to be pushy when it comes to supporting people in their recovery and other goals. Their peer relationship with clients often leads clients to share important information more freely, without fear of misinterpretation or “over-reaction.” As a member of the MISSION team, the peer specialist is expected to help the client share any information with the rest of the team that is pertinent to the team's effort to support the client's treatment/recovery goals. Should the client refuse to share information with the team that is deemed vital to their safety, the peer specialist would be expected to inform the client that the peer must (and will) convey such information to the team anyway.
- The peer support specialist must never lose sight of the basic premise of peer support—that the employee and client are peers. Although clients are often full of praise for the peer support specialist's work, he or she should not allow clients to put the worker “on a pedestal.” The peer support specialist should never think that he or she has all the answers, but should instead be supporting the client's goals in connection with the treatment plan.
- Peer support specialists must recognize that although they are peers and likely to see clients outside of the context of their employment (such as at 12-step meetings, or in social settings), they are also employees who are not required to “be on the job” at all times. Being able to differentiate between one's role as an employee and that as private citizen is an important characteristic of a peer support specialist, and one essential to maintain a healthy balance between work and personal lives. Since most friendships outside of the work environment have the potential to influence behaviors within the work setting, peer specialists should avoid developing friendships outside of their work role with clients who are currently assigned to their team. In addition, it is essential that boundary issues applicable to the workplace (such as avoidance of financial transactions, intimate relationships, etc.) are always maintained during private interactions as well as in the context of their employment.

Many requirements of the peer support specialist position are similar to those for other positions, such as being willing to take advice and criticism during supervision meetings and respond to suggestions for change. Like all staff, the peer support specialist must be willing and able to work with others,

respecting the roles and responsibilities of each team member. Peers have a unique perspective and should be encouraged to share their knowledge and experience in ways that influence how the program interacts with clients and the specific services it provides.

Training Needs

MISSION peer support specialists receive training from a number of sources. Some of the day-to-day informal training is discussed in the Clinical Supervision section of this Treatment Manual. The formal training in which the peer support specialists participate includes internal training on program issues and operating procedures; certifications required by the New Jersey Veterans Administration and Robert Wood Johnson Medical School; and training for consumer-providers on mental health and co-occurring disorders provided by an outside agency. Additionally, peer support specialists 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 all employees, the MISSION program provides training to peer support specialists on a number of topics relevant to their job, including:

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

Because of the research/evaluation component of the MISSION project as originally implemented, they also received basic training in human subject protection, including applicable regulations, history, policies, procedures, and ethical practices.

Policies and procedures, as well as position descriptions, are included in the Appendix to this manual (see Appendices C and D).

Third-Party Training

MISSION peer support specialists have also participated in training offered by the CTI Project at the Mailman School of Public Health of Columbia University. This training is helpful



in ensuring that peers are able to work smoothly with case managers, with a common understanding of the foundations of this type of intervention for persons with co-occurring disorders. Some of the topics covered in that training are:

- Assessment and Prevention of Suicidal Behavior;
- Counseling and Interviewing Skills;
- Motivational Interviewing;
- Harm Reduction;
- Drug Craving;
- Axis I and II Disorders;
- Trauma, PTSD, and the Treatment of Returning Veterans;
- 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; and
- Psychiatric Medications.

The peer support specialists have also participated in extensive training program offered through consumer-run programs affiliated with the University of Medicine and Dentistry, the State, and other nonprofit agencies. Among the topics covered in the core training MISSION's peers received are the following:

Core Training Topics for Peer Support Specialists in MISSION

- 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)

Some MISSION peer specialists have also completed a six-day training on dual recovery focusing on co-occurring mental illnesses and substance abuse. Topics included:

- Biopsychosocial Assessment
- Differential Diagnosis
- Drugs of Abuse
- Addiction-Focused Counseling
- HIV Positive Resources/Information
- Family Counseling, and
- Addiction Recovery.

Because the peer support specialists have completed this training, after accumulating 2,000 work or volunteer hours in the mental health field, they will be certified by the Addictions Professionals Certification Board of New Jersey, Inc.

Additional Needs Identified

The MISSION peer support specialists have identified additional topics on which training would be helpful, including training on understanding and responding to the effects of trauma and training to help male counselors work well with female clients.

➤ B. Working Effectively with Project Team Members

Peer support specialists and case managers are paired into permanent teams and share primary responsibility for the clients assigned to each pair. Other members of the MISSION staff might provide back-up services; however, respecting the assignment of clients to particular teams is important to well-coordinated care. Peer support specialists sometimes have contact with clients assigned to another peer-case manager team; this may occur through a chance meeting in the residential treatment center or in the community, or a client may specifically seek out the peer support specialist.



Such contact is acceptable, but when a peer support specialist discusses issues of clinical significance (i.e., issues that relate to the client's mental health or substance abuse recovery) with a client assigned to another team, the peer support specialist must encourage the client to relay any relevant information to the peer specialist or case manager to whom the client is assigned, as this is often pivotal information that can facilitate their recovery.

Within individual teams, the peer support specialist and the case manager coordinate care in order to promote consistency in service delivery. Each team member, however, has areas of primary responsibility (see Table 5). The case manager is the lead author of service plans, but the plans should reflect the peer support specialist's input. On responsibilities for which one team member serves a primary or lead function, the other team member provides assistance and can serve in the primary or lead capacity in the absence of the primary team member. When conflicts arise between the peer support specialist and case manager regarding a client's care or the roles of team members, the team raises the issue with the clinical supervisor, who works with both team members to provide guidance and help resolve the conflict.

C. Initiating Relationships with Clients

Although MISSION is primarily conceived as a program that helps smooth the client's transition into the community once he or she leaves the residential facility (with residential staff assuming primary responsibility for oversight of care in the residence itself), it is important for the peer support specialist to establish a relationship with each client while the client is still in the residence. By building trust and camaraderie with the individual during this period, the treatment team is able to further treatment goals more effectively once the community transition begins.

Peers specialists get to know their clients both directly, through peer-led group discussions, and indirectly, through meetings of the treatment team. Along with the MISSION case managers, the peer support specialists attend weekly treatment team meetings held by the staff of the residential facility. By participating in these meetings, the MISSION team is able to learn more about some of the clinical issues that might affect their interactions with the clients. Additionally, this provides an opportunity to build relationships with the residential staff.

Maintaining proper boundaries between the services and staff of the residential facility and those of MISSION is important; however, the role of the peer support specialist is less likely than that of the MISSION case manager to be seen as conflicting with that of the residential case manager. Thus, the peer support specialists typically have more extensive contacts with the client in the residential facility than the case managers. Opportunities for client contact include:

- An initial meeting orienting the client to the MISSION program,
- Informal contacts,
- A transitional session near the end of the stay in the residential facility, and
- Weekly group sessions led by the peer support specialists.

The first three opportunities will be discussed immediately below, while the weekly group support sessions will be discussed in greater detail in the following section.

Initial Meeting with Client

MISSION's intake takes place after the residential treatment intake, with the clinical supervisor performing an evaluation to determine the client's suitability for MISSION's services. This is followed by a meeting in which the MISSION case manager explains the program to the client. After these meetings, the client then meets with the peer support specialist to whom he or she is assigned. Ideally, this meeting takes place right after the meeting with the case manager.

In this meeting, the peer support specialists take a relaxed and supportive stance. They make it clear to the client that the peer's role is one of support rather than providing clinical interventions. They offer to help clarify any aspects of MISSION that the client might not have understood after meeting with the clinical supervisor or case manager.

During this meeting, the peer support specialist stresses to the client that while the client is in the facility, the facility staff is responsible for treatment; neither the peer support specialist nor the MISSION case manager can be expected to act in conflict with their decisions, thereby "splitting" the team. On the other hand, the peer support specialists explain that their doors are always open for the clients to come by for emotional support, as the clients are making sometimes difficult changes to their lives. The peers have "been there."



Table 5. Responsibilities of Peer Support Specialists and Case Managers

Primary Responsibility of Peer Support Specialist, with Input from the Case Manager	Primary Responsibility of Case Manager, with Input from the Peer Support Specialist	Shared Responsibilities
<ul style="list-style-type: none"> • Helping 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 mental health and substance abuse services (e.g., NA/AA, Double Trouble groups). • Accompany clients to clinical appointments, job interviews, recreational activities, and self-help group meetings. 	<ul style="list-style-type: none"> • Orientation/introduction, mid-program progress check, transition to community, and discharge plans. • Management of clinical crises. • Dual recovery progress check and appropriate interventions at each visit. • Vocational support as needed: interview skills training, linkage to education and training. • Linkage to professional clinical services. • Communication with clinical service providers. • Benefits and entitlements issues (e.g., Social Security Income [SSI] and Social Security Disability [SSD]). 	<ul style="list-style-type: none"> • Weekly team meetings with residential staff. • Discharge session from the residence. • Team visits to the community while peers support specialists are in training. • Linkage to needed community services, including vocational resources. • Assistance with safe and affordable housing. • Monitoring symptoms and responses to treatment. • Working with clinical supervisor to address deteriorating symptoms. • Psychoeducation and training in symptom management, coping skills, medication compliance, problem solving, and relapse prevention. • Transportation education and assistance. • Support for job stress and adjustment. • Support during clinical crises. • Assist clients with <i>Consumer Workbook</i> exercises, discuss the exercises and readings, and reinforce insights.

In general, clients appear to be relatively comfortable with the informal nature of the relationship with the peer support specialist. Sometimes, however, establishing a rapport with a client will take some extra work. The MISSION peer support specialists (all men so far) have noticed that establishing a comfortable working relationship with female clients in

particular takes additional time; female clients may feel less comfortable confiding personal matters to male peers.

During the initial orientation session, the MISSION client is given the *Consumer Workbook*, which provides additional information about the MISSION Program. While this



information is usually given by the case manager in the orientation session, if distributed by the peer due to logistical reasons, it is critical for the peer to provide an effective introduction to the resource (see the section on the use of the Consumer Workbook below).

Informal Contacts in the Residence

Many clients take peer support specialists up on their “open door policy.” They often see the peers as having valuable insight based on their shared personal experiences. Peers and clients may also encounter each other informally while working out at the gym on site or simply chat in the halls. Peers may offer friendly advice or words of encouragement, based on their own experience. For example, a client might want to use money that he has been saving in his patient fund to take his girlfriend out to dinner, and the peer support specialist will talk to the client not only about the rule that clients must save a certain percentage of their funds toward housing after discharge, but also about why it is so important to save money toward housing. Having been through similar circumstances themselves, the peer support specialists have credibility with the clients. As noted above, they refer any clinical issues to the residential staff.

Peer Support Sessions in the Residential Facility

The peer support specialists each lead a weekly discussion group session of approximately 60-90 minutes for MISSION participants (see Appendix A). These group sessions are scheduled at different times and conducted by different peer specialists in order to accommodate the schedules of participants; however, each peer specialist covers the same selected topic for the week. Topics have been identified by the peer support specialists, working in conjunction with a small group of consumers, as having particular relevance to clients during their stay in the residential program and as they prepare themselves to return to the community. Each session lasts approximately 60 to 90 minutes.

These group discussions serve several purposes. From the standpoint of the MISSION program, the primary purpose is to establish a sense of camaraderie among the clients and the peer support specialists, so that during the aftercare phase of MISSION services, the client is already comfortable in seeking and accepting support and advice from the peer support

specialist. From the standpoint of the client, the weekly sessions offer them a forum to air their concerns, fears, questions, and hopes in a safe environment, knowing that they will not be judged and knowing that their peers (both peer support specialist and fellow clients) will support them. The meetings also offer a chance to begin working on some of the concepts with which the peer support specialists will assist during the aftercare phase.

Format

The design of the weekly sessions deliberately avoids excessive structure. Residents participate in a number of structured activities conducted by the staff of the residential facility each day, and the peer support specialists strive to present a more relaxed atmosphere. The basic structure of the meeting is:

1. A brief introduction to the day’s topic, why it was chosen, and why it is something important for clients to think about;
2. Personal insight or a story offered by the peer support specialist in order to further set up the topic;
3. Questions to spark discussion, if needed; and
4. A facilitated discussion on the topic.

To help ensure that the peer support sessions are a safe place for disclosure and a productive way of dealing with the issues that the residents want to address, the meetings follow a few basic ground rules that are common to most support groups, such as:

- Respecting confidentiality;
- Focusing on recovery rather than illness;
- Allowing others to speak without interrupting;
- Using respectful language toward other group members;
- Not allowing a single person to monopolize the conversation; and
- Not pressuring people to speak.

In the case of critical information conveyed in peer support groups, as discussed above, the peer specialist would generally engage the client in discussion outside of the peer support meeting to discuss the importance of making the team aware of the issue. Should the client refuse to share information with the treatment team that could be deemed vital to the client’s safety, the peer specialist would be expected to inform the client that they must (and will) convey such information to the team anyway.



Topics

The topics for the peer support sessions have evolved over the life of the MISSION program. Initially, topics mirrored the topics covered in each week's DRT session. However, the peer support specialists found that the clients were more interested in some topics than others and found it difficult to maintain attendance from week to week. Developing a new set of topics with input from clients helped the peer support specialists engage clients in more consistent participation. Detailed descriptions of the current sessions are included in Appendix A. Peers suggest, however, that periodically revisiting the content of organized peer support meetings has helped MISSION continue to meet clients' needs.

Transitional Sessions and Discharge from the Residential Program

The residential staff creates a discharge plan for each client who is reentering the community, and the MISSION team, including peer support specialists, have input into this plan. The peer support specialist's input is coordinated through the case manager assigned to the same client. This input reflects insights gained from informal contacts, observing the client's behavior in group sessions, and from information learned from weekly treatment team meetings. The peers often offer their personal insights and observations about the client and his or her needs. For example, the peer support specialist might feel that a particular transitional housing program might or might not be a good fit for a particular client, and would have an opportunity to explain the recommendation. The client and his/her residential team take these insights into account as they finalize the plan.

After the discharge plan is completed, the assigned MISSION case manager meets with the client to discuss the plan and the role that the case manager will play in supporting the plan. Soon afterward, the assigned peer support specialist meets with the client to identify ways in which the peer support specialist can help the client achieve the goals identified in the plan. This meeting is called the "transitional session."

For most clients, the peer support specialists primarily offer support in getting and keeping housing, sustaining recovery from substance abuse, maintaining mental health, and getting and keeping a job. Some clients might want support in other areas, such as reuniting with their children. The type of support that peers offer can be of either a practical or emotional variety; for example, they might offer to go to initial mental health appointments, bring them to AA or NA meetings, or tell them what to expect in a particular housing program.

F. Use of the Consumer Workbook

The *Consumer Workbook* is introduced in the residential period as a means of facilitating the transition to community life. It is divided in two parts. The first part contains Self-Guided Exercises; Dual Recovery Therapy: Tools and Readings; and Checklists. The second part offers readings on Sustaining Recovery and Community Living. This workbook can be distributed either by the case manager or the peer in the orientation session, but each of them will need to discuss his or her role as it relates to these materials. Whoever distributes the *Consumer Workbook* should provide a general overview of the book.

The overview is important to ensure that the workbook is not seen as overwhelming, but rather as a critical resource that can be used throughout the year-long MISSION services and a set of tools for recovery. It is our experience that clients can initially become somewhat overwhelmed with the content of the workbook, particularly when considering that everything is new for the client: their commitment to recovery and sobriety; their surroundings, including the residential facility; the people that they are associated with; and the fact that they have just made a commitment to a 12-month intensive MISSION care coordination service. This is more likely to be the case if the workbook is presented in single-sided format so that it appears longer; a double-sided format (ideally spiral-bound) is both more usable and less intimidating.

The peers also have a brief weekly check-in session with the MISSION client that centers around the facilitation of their progress with the *Consumer Workbook*. Because the clients in the MISSION Program are participating in DRT Groups and other services in the residential facility, this session serves to facilitate the use of and provide support with these materials. The amount of time spent is variable, depending in part on whether a client needs to work through an interpersonal issue related to the worksheets. Approximately 10 minutes a week is set aside for this purpose. Some clients may want to discuss the materials in the exercises or the transitioning to the community readings in more detail. This could be done in a longer session with the peer or, if appropriate, it could be brought into the peer group as an issue for everyone to discuss.

While we encourage clients to complete the self-guided exercises containing in Part 1 independently, peers are seen as playing a critical role in these exercises. That is not to say that the case manager ignores the exercises, and the case manager may also work with the client on significant issues raised by these exercises. However, the primary responsibility for facilitating the use of these particular exercises rests with the peer.



Part 1 also contains DRT exercises, which are used during the DRT group sessions while the MISSION client is in the residential facility. These sessions are led by a case manager. The client's written responses to DRT exercises can be a helpful resource and a reminder of the commitment the client made to achieving personal goals, the skills that help maintain recovery, and the essential concepts that will help the client maintain a recovery focus. It is equally helpful for peers as for case managers to be able to refer back to the client's "triggers" for use, personal goals, and plans for recreational activities, either as a reminder or as an opportunity for revisioning the path to recovery.

As participants transition to the community, the readings in the latter part of the workbook become particularly relevant, raising issues that may concern the client and suggesting opportunities for useful discussion. Case managers facilitate the use of readings related to the transition to the community, which should begin in the third month of treatment and correspond with the transitional care sessions. However, as is the case with the exercises described above, the peer can also provide some assistance in digesting these readings and helping the client work through fears and concerns. Because the case manager and peer work as a team, it is critical to have an ongoing dialogue about the client's progress regarding the readings in the *Consumer Workbook* and the issues that may be of concern to the client. The readings also provide an opportunity for peers to share their own stories about re-entry in the community and the issues that arose.

Please also note that Part 2 of the *Consumer Workbook* includes a brief explanation of the most common mental health conditions of those entering the MISSION program. This explanation is meant to serve as a resource for clients. In addition to the explanation of the mental health conditions, we have also provided a table with the most common medications used to treat those problems as well as the possible side effects that could occur from these medications. We point this information out for two reasons:

- Clients may want to talk about the materials in one of your sessions, and we want you to know it is present in the workbook.
- We have received feedback from our MISSION staff that these materials, particularly the table of medications and side effects, are a useful resource.

G. Providing Support in the Community

Having had the opportunity to form strong bonds with clients while they have resided in the residential program, the peer

support specialists play a crucial role in helping clients achieve the goals that they have set for themselves as they fully integrate into the community.

The aftercare phase of MISSION follows a model of decreasing frequency of contact, so 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. The peer support specialist works in close collaboration with the case manager. Both the peer and case manager have the mutual goal of ensuring that clients have the resources and skills they need to achieve their goals and continue to grow in their recovery.

Types of Support Provided by Peers

Besides the joint case manager and peer outreach visits, which we recommend whenever logistically possible, the types of individual support provided by the peer support specialists during the aftercare phase has significant overlap with the support provided by the case managers and includes such things as assistance with practical tasks and linking to resources. However, based on their personal experience and peer advocacy training, the peer support specialists are able to provide unique practical and emotional support. They also use specific tools and techniques, such as the "PICBA" tool for personal problem-solving (see the *Consumer Workbook*), to empower clients to become more involved in treatment decisions. Like case managers, they make ready use of the tools and narratives contained in the *Consumer Workbook* on an as-needed basis. Some of the other major areas of focus addressed uniquely by peer specialists are based on personal experience. The core areas described below are especially relevant.

Reducing fear

Achieving life goals requires overcoming fear of failure and fear of the unknown. Having been homeless and through residential treatment, MISSION's clients might doubt their own abilities 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, the peer support specialists 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 the Dom, and his peer support specialist had helped him find transitional housing. Now, Isaac was facing eviction from the transitional housing after he relapsed, and in a panic he called the same peer support specialist for help.

By facilitating access to resources, the peer support specialist was able to find Isaac a secure house located close to the VA Hospital, where the MISSION team could monitor and support him. In this housing, he was able to easily acquire his medications, get mental health counseling and treatment, and take care of other VA-related business. Throughout this process the peer support specialist 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 peer support specialists can provide practical support to clients is to accompany them to their first mental health appointments, when riding unfamiliar public transportation, or when they need to buy groceries or shop for clothes, until they are comfortable doing such tasks on their own. For example, a peer support specialist who has shopped for a child before might accompany a client who is trying to reunite with his family to help the client buy clothes for his son or daughter.

This support can be especially critical in times when the client stumbles on his or her recovery path. The peer support specialist can provide moral support when the client becomes homeless or begins using again by accompanying the client to a shelter, detoxification facility, or the hospital.

Promoting a healthy lifestyle

A healthy lifestyle includes eating well, getting enough sleep, and exercising regularly. Sleep, exercise, and nutrition all can 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 peer support specialist can help to promote healthy lifestyles.

Peer Support in Action: Example 2

“Ricardo” had completed the residential program and had gotten his own housing but relapsed and become homeless. Ricardo started living on the street, stopped eating and bathing, and could not hold down any job. The peer support specialist arranged a face-to-face meeting with him and talked to him about his weight loss, disheveled appearance, and inattention to personal hygiene. The peer support specialist asked Ricardo, “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. The peer support specialist helped Ricardo to 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 lifestyle, the peer support specialist helped link him to a detoxification program and then a bed at the Salvation Army. Because the Dom did not have any openings, the peer support specialist helped Ricardo find another long-term residential program. The peer support specialist helped Ricardo retrieve and use the tools he learned in the Dom about living a healthy lifestyle, such as the importance of hydration, eating healthy foods, avoiding unhealthy foods, monitoring caloric intake, and exercising. With ongoing peer support, Ricardo began reclaiming his recovery, aided by attending programs, taking classes, and seeing his family. He began feeling better about himself and his progress toward his goals.

Socializing

For clients who are transitioning back into the community, having social events in which to participate and friends with whom to spend time can have a positive impact upon recovery. Because the MISSION intervention lasts only a limited period of time, developing social relationships can become an important source of support after the intervention ends.

The peer support specialists primarily rely on AA and NA social events because these events tend to be larger and better established, offering the clients certainty that the event will be well-attended and thus worth their time. Events might include dances or other enjoyable activities.

At times, they have set up small, informal social events for clients. For example, a peer support specialist might get together with three or four clients to eat pizza and play pool.



Ideally, a small program budget would be available to support these activities. Donations from charitable organizations or advocacy groups may be solicited to assist in these endeavors as well. The frequency of such events in the MISSION program has been limited by the lack of a budget and limited solicitation of donations; as a result, peer support specialists and clients have usually paid for their own pizza and pool tables, each chipping in if another person did not have enough money. In the future, more aggressive solicitation of donations of money, food, or services could help open up more opportunities for these valuable social activities. However, please keep in mind that systems may have unique rules regarding soliciting donations and the policies of your system should be reviewed before initiating fundraising.

Especially as clients return to work, social events are more likely to be successful on evening or weekend hours. Ideally, the work schedules of peer support specialists 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 peers are most in need of natural support and opportunities for social connectedness. Although the peer support specialists in the MISSION program have a working schedule that mostly follows “normal business hours,” a mechanism allows them to use “comp time” to shift their working hours, when necessary. However, the peer support specialists 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 or activities, church, movies, or shopping).

Achieving goals

As someone who has had experiences similar to those of the clients, the peer support specialist often has excellent insight into what can be considered realistic goals for clients to set and achieve. People 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, the peer support specialist should help people set goals as high as the client wishes, with shorter-term objectives being developed.

While the peer specialists cannot provide medical or legal advice, they can check in with the clients to make sure that they are taking their prescribed medications each day or paying off fines.

Peer Support in Action: Example 3

“Earl” faced a financial barrier to getting his drivers’ license back. He had accumulated many fines over the years and could not pay them on the salary he earned at his current job. The peer support specialist working with him 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 well. Using the seven dollars a day the peer support specialist had spent on cigarettes, he was able to slowly pay off his fine and get his driver’s license back. He no longer smokes cigarettes. The peer support specialist’s sharing of his personal experiences showed Earl that it was not an insurmountable problem, and he also helped to motivate Earl to seek a better paying job with the VA. Through perseverance, Earl got that VA 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, the peer support specialist is a natural role model for providing support to the client who is considering returning to work, trying to find the right job, or adjusting to working life.

Many of the clients have extensive criminal records and limited work experience; therefore, they often have difficulty finding a job or have to start out working in undesirable positions. The role of the peer support specialist is to reinforce the work that the residential facility staff 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 with the VA when he relapsed. He asked for support from a peer support specialist who understood first-hand the impact of losing a good job. Other opportunities for Marcus were very limited, and the peer support specialist offered to help Marcus find a temporary job at a nursing home where the peer support specialist had worked. The pay for this job was much lower than for 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 the peer support specialist helped him to return to the Dom. Throughout the process, the peer support specialist helped Marcus keep hope, pointing out that the job in the nursing home was “a step down in wages, but a step up in humility.” The peer support specialist encouraged Marcus to learn from his experience, suggesting



that “perhaps he was being tested to prove himself in the little things, before he could go back to the bigger things.”

The peer support specialist 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 have to 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 best advantage.



About the Authors

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Dr. David Smelson is a Professor and Vice-Chair of Clinical Research in the Department of Psychiatry at the University of Massachusetts Medical School. He is also 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 the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment and Center for Mental Health Services, the National Institute of Health/National Institute of Drug Abuse, and the National Center for Complementary and Alternative Medicine, 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 these institutions for their ongoing support and assistance with these projects.

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Dr. Kline is Co-Director of Co-Occurring Disorders Research at the Department of Veterans Affairs, New Jersey Health Care System, 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. Since joining the VA, Dr. Kline has focused on the development and evaluation of innovative programs for dually diagnosed veterans.

Douglas Ziedonis

Dr. Ziedonis is Professor and Chair of the Department of Psychiatry at the University of Massachusetts Medical School and UMass Memorial Medical Center. Dr. Ziedonis 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, in particular tobacco dependence. He has served as an advisor to President Bush's New Freedom Commission on Mental Health and Substance Abuse (co-writing the section on co-occurring disorders) and advised 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 Co-Occurring Disorder Center for Excellence, Project Director for Co-Occurring Disorders Grants, and Site Visitor for the COCE Technical Assistance to non-COSIG sites. He served on the ASAM Patient Placement Criteria Co-occurring Disorder Workgroup that developed the Dual Diagnosis Capable/Enhanced concepts for the ASAM PPC. He has written over 100 book chapters and peer-reviewed publications and co-edited 3 books and 5 behavioral therapy manuals for co-occurring disorders. He also serves on the Editorial Board of *The American Journal of Drug and Alcohol Abuse*, *The Journal of Groups in Addiction & Recovery*, and *The Journal of Substance Abuse Treatment*.

Susan Hills

Dr. Hills is a seasoned writer, facilitator, and training developer who has developed handbooks, protocols, training programs, fact sheets, reports, and other documents related to substance abuse prevention and treatment, co-occurring disorders, and legal rights of persons with disabilities. As Senior Writer for Advocates for Human Potential (AHP), Dr. Hills served as lead writer for *Trends in Mental Health System Transformation: The States Respond 2005*, a publication of the Center for Mental Health Services (HHS), and for a similar forthcoming volume focusing on trends related to State Mental Health Planning and Advisory Councils: *Trends in State Mental Health Planning and Advisory Councils 2006: Fulfilling the Potential*. She provided technical assistance to the University of Medicine and Dentistry of New Jersey (UMDNJ) to enhance and prepare manuals on co-occurring disorders for publication in



several formats. Prior to joining AHP, Dr. Hills served as Associate Editor for Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons with Co-Occurring Disorders*. She also prepared draft chapters in nine other TIPs, including short-term therapy, group therapy, and motivational interviewing.

Christine Woods

Christine Woods is an independent consultant specializing in psychosocial rehabilitation program development and mental health systems transformation. As a national consultant for nearly 20 years with the Department of Veterans Affairs Central Office, she pioneered transformational development of VA residential rehabilitation programming and psychosocial recovery centers, including incorporating evidence-based approaches of supported employment and peer support. She has been widely recognized, including receipt of the President's Award from the United States Psychiatric Rehabilitation Association (USPRA), for championing VA's efforts to assess

the recovery-orientation of VA mental health services and for providing national leadership, strategic plans, policy, training, consultative site visits, and broad technical assistance towards the goal of recovery-oriented systems transformation.

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► **Models**

Dual Recovery Therapy (DRT)

For manuals and information, contact:

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Worcester MA 01655

Critical Time Intervention (CTI)

For manuals and information, contact:

Dr. Daniel Herman at (212) 342-0410 or
dbh14@columbia.edu

Individual Placement and Support

Implementation materials on Individual Placement and Support are available through the SAMHSA web site (www.mentalhealth.samhsa.gov) or by contacting Prof. Deborah Becker at (603) 448-0126 or deborah.becker@dartmouth.edu. See also: <http://www.modelprograms.samhsa.gov/pdfs/effective/individual-placement-and-support.pdf>

Ensure that clients register with local One-Stop Career Centers while still undergoing residential treatment. Find local One-Stops by calling your state's Department of Labor or calling (877) US2-JOBS.

Peer Support

Peer to Peer Resource Center: www.peersupport.org Offers training and certification for Peer Support Specialists, and training/consultation on incorporating Peer Support Specialists into the workforce.

META Services: www.metaservices.com/trainings.htm - Offers training and certification for Peer Support Specialists, and training/consultation on developing recovery-oriented services.

Positive Partnerships: How Consumers and Nonconsumers Can Work Together as Service Providers, National Research and Training

Center on Psychiatric Disability, Chicago, Illinois; Mardi L. Soloman, Jessica A. Jonikas, Judith A. Cok, Joseph Kerouac; contact Judith A. Cook, Ph.D., Director (312) 422-8180.

Consumers as Providers of Mental Health Services: A Literature Review & Summary of Strategies to Address Barriers, University of Kansas School of Social Welfare, January 1999; Linda Carlson, LMSW, Diane McDiarmid, LMSW. (Currently available on line if you enter "Consumers as Providers of Mental Health Services" in the search engine.)

► **Screening and Assessment Tools**

- Structured Clinical Interview for DSM-IV Diagnosis (SCID), available from Columbia University, (212) 543-5524 or scid4@columbia.edu
- Addiction Severity Index (ASI), available from the Treatment Research Institute, (800) 238-2433 or ASIHeline@tresearch.org
- Behavior and Symptom Identification Scale (BASIS-32), available from McLean Hospital, (617) 855-2424 or spereda@mcleanpo.mclean.org

► **Funding Options**

Medicaid

Some States (notably Georgia, Hawaii, and South Carolina) fund peer specialist services through the Medicaid rehabilitation option. Obviously, this is applicable only to clients eligible for Medicaid. An overview of the Medicaid rehabilitation option may be found at this site: http://www.tacinc.org/index/admin/index/_uploads/docs/CommunityLivingBriefsVol3Iss2a.pdf

Georgia's Medicaid guidelines: http://www.gacps.org/files/peer_supports_guidelines2_03.doc



General Planning

Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring Substance Use Disorders. DHHS Pub. No. SMA-04-3870, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003. Accessed 11/9/07 from this address: <http://mentalhealth.samhsa.gov/publications/allpubs/sma04-3870/default.asp>

➤ Consultation and Training Resources

Advocates for Human Potential (AHP) offers technical assistance, resources, and training in peer support, consumer-operated services, recovery-oriented mental health care, supportive housing, and supportive employment. See: www.ahpnet.com.

The Annapolis Coalition is a not-for-profit organization committed to improving the recruitment, retention, and training of the workforce for prevention and treatment of mental and substance use conditions. Offers technical assistance and training in a number of areas, including recovery-oriented care and bringing persons in recovery and family members into the workforce. See: www.annapoliscoalition.org

Center for Psychiatric Rehabilitation, Sargent College of Health and Rehabilitation Services, at Boston University,

maintains a Repository of Recovery Resources that describes and gives links to organizations that offer recovery-oriented training and/or training materials. See: www.bu.edu/cpr/repository/training-and-education.html

SAMHSA's Center for Mental Health Services has several Research, Training, and Technical Assistance Centers that offer a full array of technical assistance services. See: <http://mentalhealth.samhsa.gov/links/>

University of Pennsylvania Collaborative on Community Integration is a Rehabilitation Research and Training Center (RRTC) devoted to promoting community integration for individuals with psychiatric disabilities. It is conducted in partnership with The Clearinghouse at the Mental Health Association of Southeastern Pennsylvania and Horizon House, Inc. RRTC offers resources, training and technical assistance on all aspects of community integration, including housing, peer support, employment, self-advocacy, criminal justice, etc. See: www.upennrrtc.org

National Association of State Mental Health Program Directors, Centers for Mental Health Services: provides listing and links to research and training programs. See: www.nasmhpd.org/mental_health_resources.cfm#CMHS

Resource Center to Address Discrimination and Stigma (ADS Center), sponsored by SAMHSA's Center for Mental Health Services (CMHS), provides practical assistance and a wealth of resources for designing and implementing anti-stigma activities. See: www.stopstigma.samhsa.gov/



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Glossary of Acronyms and Terms

ASI: The Addiction Severity Index is an assessment used to determine a person's addiction severity as well as associated problems such as legal issues.

BASIS 32: Behavior and Symptom Identification Scale, thirty-two question version, is an assessment used to determine a person's mental health and medical problems.

CBT: Cognitive-Behavioral Therapy is a form of intervention that focuses on changing thought processes.

CSAT: The Center for Substance Abuse Treatment is a branch of the Substance Abuse and Mental Health Services Administration.

CMHS: The Center for Mental Health Services is a branch of the Substance Abuse and Mental Health Services Administration.

CTI: Critical Time Intervention is 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.

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 is the integrated mental health and substance abuse treatment model of care used in the MISSION program.

DSM-IV: The Diagnostic and Statistical manual for Mental Disorders-Fourth Edition is essentially a classification manual to quantify symptoms to diagnose a mental health condition.

MET: Motivational Enhancement Therapy is a component of both the DRT and CTI approaches. It includes both ways to identify the level of motivation for recovery and potential intervention strategies based on that level of motivation.

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

Peer Support: Social, emotional, and practical support offered between individuals with similar life experiences.

Peer Support Specialist: An individual in recovery from mental illness and/or addictions who has been trained to provide and foster development of peer support services, often referred to as a "consumer provider."

President's New Freedom Commission: A commission that was 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 is a DSM-IV diagnosis that relates 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.

P Value: A statistical value that is used to identify the significance of a study finding.

SAMHSA: The Substance Abuse and Mental Health Services Administration, which is a funding agency that support clinical research in addictions.

TLC: Time Limited Case management is a program that served as the foundation for MISSION.

VA: The Veterans Administration Hospital. Sometimes called the Department of Veterans Affairs or DVA.

Vocational Support: Case managers in MISSION offer linkages to vocational services as well as ongoing assistance with client employment retention such as managing conflicts on the job.



Appendix A. Topics for Peer-Led Group Sessions

The following sessions were designed based upon collaboration between the peer support specialists and MISSION clients. The goal is to focus on a different topic each week but impose a minimum of structure in order to promote free discussion and provide an alternative to the many structured activities in the residential facility.

Each session includes a brief description, a few learning goals, some suggestions on how to introduce the topic to the group, and some questions to spark discussion. Because the purpose of each session is to get the group participants talking to each other and sharing their experiences, the facilitator should feel free to use other introductory material or questions to get the group talking about the day's topic. Regardless of the session's individual goals, an overriding goal for every session is to increase the participants' willingness to seek support from and provide support to their peers.

Some of the session descriptions also include a short passage written by a veteran who participated in the group. If desired, the facilitator can read these passages as a way to spark discussion, asking group members 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 participants to pursue a course of action leading to recovery through their own choice.

Learning goals: Participants 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 that the participants understand that the assistance that people are offering them will be helpful only if they are willing. 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?
- How many people would 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: Participants will

- (1) understand that denial of one's illnesses and lack of respect for oneself inhibit 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 participants 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:

- Is there anyone who has not accepted the fact that they 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?
- Could someone explain something that they have accepted about themselves?
- Could someone explain how they have increased their respect for themselves?



Here's what one group participant 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 with humility 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, people should learn to recognize and be mindful of what they have to be thankful for.

Learning goals: Participants 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 participants know that acknowledging others (or a higher power) is normal, and the goal is not to be overwhelmed but help people become more comfortable with gratitude.

Questions to spark discussion:

- Has anyone experience gratitude in situations pertaining to their recovery?
- Has being grateful brought about change for anyone?
- What can anyone say about their gratitude for recovery?

4. Humility

Description: A discussion of the quality of humility and its benefits to a person in recovery.

Learning goals: Participants 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 that participants know 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?
- Would someone tell the group how they 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: Participants will

- (1) come to realize 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 situation.

How to introduce the topic: Make sure that participants know 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:

- Would someone share a situation that was frustrating to them?
- 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: Participants will

- (1) identify types of situations that are particularly painful for them;
- (2) learn to identify how they react with others 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 participants 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 anyone say that processing through a painful situation been beneficial to their recovery?
- Would anyone say that communication is an important factor in working through 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: Participants 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 participants know that honesty is something that is not always rewarded or recognized, but it is placed in high value. Participants 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 group 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 everyday, 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 the Domiciliary at Lyons VA, 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 thine 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: Participants will

- (1) come to realize situations in 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 affect them; and
- (4) learn strategies for being courageous even in chaotic and stressful situations.

How to introduce the topic: Make sure that participants 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:

- Are there times that anyone can share when they needed to call on their courage?
- Would anyone agree that it takes courage to stand up for yourself?
- Would courage be needed in your process of recovery?
- Would courage be needed in living with addiction and a mental health issue?

Here's what one group 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.

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: Participants will

- (1) come to realize 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 sure that participants know that impatience is normal, and the goal is not to eliminate impatience but to help people become more patient. Consider starting with an anecdote to which participants can relate—perhaps a common frustration in residential treatment (the Dom) or a desire for recovery to happen more quickly than it does.

Questions to spark discussion:

- How many people wish their 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 group 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: Participants 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 that participants know that medicine maintenance is part of life for people living with dual diagnosis, 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 anyone say that they have difficulty keeping up with their medication maintenance?
- 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. Participants should understand the importance of using the skills they have learned in the residential facility in order to keep what is good in their lives.

Learning goals: Participants will

- (1) come to realize 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 that participants know that wanting a good thing to last is normal, but making a good thing last requires work.

Questions to spark discussion:

- Would anyone care to share what good things in their life they're working to keep?
- Did anything good come easy for anyone?
- Would anyone say that keeping this good thing was difficult?
- Are there times when you have had to contribute more of yourself in order to maintain the good thing?
- Does anyone feel that it is really worth it to put in the effort of maintaining the good things in life?

Here's what one group 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 B. Leading Group Exercises in Dual Recovery Therapy**

The following section presents exercises as they appear in the *Consumer Workbook*, with the addition of a section called “Notes for the Group Leader.” Of course, each leader may want to make adaptations based on the particular group, time limits, and 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?

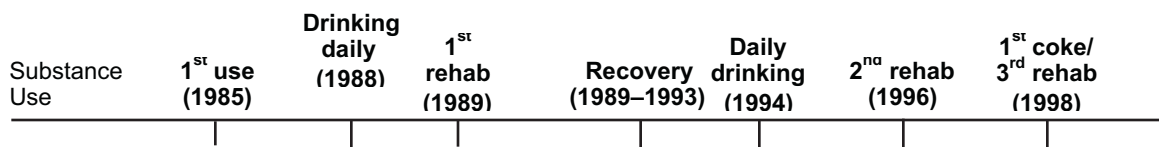
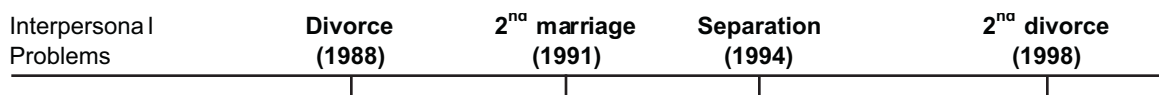
Once you have all three timelines, you can use them to explore what was happening at the same time in your life. What triggered what? Did you start using to control psychiatric symptoms? Did something in your personal life stress you out, causing symptoms to flare up? Once you can name these patterns, you can more easily make choices to put yourself in control.

Notes for the Group Leader

Explain to group members that there is usually a pattern to when symptoms begin and that symptoms for substance abuse and mental problems are often interrelated. After showing them how to fill out the timelines and going over the example, give participants time to fill out their own timelines. You can then invite each group member in turn to share his or her insights, leading to a discussion of common patterns and useful discoveries.



My Timelines Worksheet (sample)



My Timelines Worksheet

Psychiatric
Symptoms

Interpersonal
Problems

Substance Use



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 Group Leader

Explain that this exercise will help the consumer, 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 them 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.



Personal Life Problem Areas Worksheet (Sample)

LIFE AREAS	PROBLEMS
Substance Use	<i>Use cocaine every weekend for 2 days; must stop</i> <i>Drink heavily</i> <i>Wife objects to occasional marijuana</i>
Family	<i>Arguments with wife - frequent!</i> <i>Very angry with my wife</i> <i>Don't get along with Ben (15 year old son)</i>
Financial	<i>Last job was 5 months ago due to coke use - so money is very tight</i> <i>Wife is working but paying the bills is tough</i>
Psychological	<i>Angry a lot</i>
Social	<i>No problems</i>
Legal	<i>No problems</i>
Employment	<i>Unemployed - lacking for work</i>
Health	<i>No problems</i>
Spiritual/Religious	<i>Anger at higher power</i> <i>Lack of meaning in life</i>



Personal Life Problem Areas Worksheet

LIFE AREAS	PROBLEMS
Substance Use	
Family	
Financial	
Psychological	
Social	
Legal	
Employment	
Health	
Spiritual/Religious	



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 Group Leader

Explain to participants 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 following page or extra note paper so they can easily use the rules 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. Then, encourage sharing around some of the problems explored, the motivation participants find to address them, and implications for recovery.



Worksheet: Importance, Confidence, Readiness Ruler

Using the ruler below, please indicate with a line HOW IMPORTANT it is to you to make a change in this area. Marking #1 means it is not at all important to make a change, #5 means it is somewhat important and #10 means it is very important. Please feel free to use any of the numbers in between.

Not important Somewhat important Very important

↓ ↓ ↓

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Using the ruler below, please indicate with a line HOW CONFIDENT you feel about making a change in this area. Marking #1 means you are not at all confident to make a change, #5 means you feel somewhat confident and #10 means you feel very confident. Please feel free to use any of the numbers in between.

Not confident Somewhat confident Very confident

↓ ↓ ↓

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Using the ruler below, please indicate with a line HOW READY you feel to make a change in this area RIGHT NOW. Marking #1 means you feel not at all ready to make a change, #5 means you feel somewhat ready and #10 means you feel very ready. Please feel free to use any of the numbers in between.

Not ready Somewhat ready Very ready

↓ ↓ ↓

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----



4. Developing a Personal Recovery Plan

How to use it:

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.

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 Group Leader

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.



Example of a Recovery Plan

LIFE AREAS	PROBLEMS	RECOVERY PLAN (How will the problem be addressed?)
Substance Use	<p><i>Use cocaine every weekend for 2 days; must stop</i></p> <p><i>Drink heavily</i></p> <p><i>Wife objects to occasional marijuana</i></p>	<p><i>Stop using drugs and alcohol</i></p> <p><i>Attend NA/AA groups</i></p> <p><i>Learn new ways of coping with problems</i></p>
Family	<p><i>Arguments with wife - frequent!</i></p> <p><i>Very angry with my wife</i></p> <p><i>Don't get along with Ben (15 year old son)</i></p> <p><i>Mother ill with cancer</i></p>	<p><i>Enter couples counseling</i></p> <p><i>Improve communication skills</i></p> <p><i>Discuss feelings about mother's cancer in individual counseling sessions</i></p>
Financial	<p><i>Last job was 5 months ago due to coke use - so money is very tight</i></p> <p><i>Wife is working but paying the bills is tough</i></p>	<p><i>Learn money management skills</i></p>
Psychological Psychiatric	<p><i>Angry a lot</i></p> <p><i>Feels Depressed"</i></p>	<p><i>Work on developing anger management skills</i></p> <p><i>Get a psychiatric evaluation to find out if an antidepressant would help me feel better.</i></p>
Social	<p><i>No problems</i></p>	
Legal	<p><i>No problems</i></p>	
Employment	<p><i>Unemployed - lacking for work</i></p>	<p><i>Get a stable and satisfying job</i></p> <p><i>Enter Vocational rehabilitation</i></p>
Health	<p><i>No problems</i></p>	
Spiritual/Religious	<p><i>Anger at higher power</i></p> <p><i>Lack of meaning in life</i></p>	<p><i>Speak with pastor about anger at higher power</i></p> <p><i>Increase participation in meaningful activities and relationships</i></p>



Worksheet: Personal Recovery Plan

LIFE AREAS	PROBLEMS	RECOVERY PLAN (How will the problem be addressed?)
Substance Use		
Family		
Financial		
Psychological		
Social		
Legal		
Employment		
Health		
Spiritual/Religious		



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 Group Leader

This session marks the beginning of the skills building phase of DRT. Ask each person 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 group sharing.

Should I Stay the Same or Change my Behavior? (Sample)

Description of the Behavior: *Drinking*

	Maintaining My Current Behavior	Changing My Current Behavior
BENEFITS	<p><i>I can keep the same friends and enjoy hanging out with them.</i></p> <p><i>I like getting loose and letting it all go.</i></p>	<p><i>I could probably hold a job.</i></p> <p><i>I wouldn't lose my temper and hurt people.</i></p>
NEGATIVE CONSEQUENCE	<p><i>I keep getting fired.</i></p> <p><i>Sometimes I get into fights.</i></p> <p><i>I hit George pretty hard once and he's just a kid.</i></p>	<p><i>I couldn't hang out with the same friends in the same places, because I'd want to drink.</i></p> <p><i>I'd have to find some other way to relax and let go.</i></p>



Worksheet: Should I Stay the Same or Change my Behavior?

The Behavior:

	Maintaing My Current Behavior	Changing My Current Behavior
BENEFITS		
NEGATIVE CONSEQUENCE		



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 try 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 Group Leader

After group members 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 with their peers in the residence, so they can get useful feedback.



Elements of Good Communication

Be polite and considerate. Treat your partner with the same basic respect you show towards acquaintances!

Stop and think before commenting on things that bother you: Decide not to 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 lots of positive feelings* and to reward your partner rather than taking things for granted when they are going well.

Decide on *fun activities* together: (“I’ll do what you want today in exchange for you doing what I want over the weekend.”)

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.”

Avoid destructive criticism or complaining. Phrase change requests in a positive way. Avoid complaining just for the sake of complaining.

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”).

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 Group Leader

You will probably find this to be a lively session, since most people 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 recovering alcoholics and addicts 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 to alcoholics and addicts, 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 the 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 confused, 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 make 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 Group Leader

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 participants 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?



Anger Management Worksheet

Everyone reacts differently to different situations. What makes one person very angry may make another person only slightly annoyed. This is because our own experiences and personal interpretations of things greatly affect our emotional responses to them. Once you become aware of things that trigger you to become angry, you can begin to work on how you respond to them. Below is a checklist of things that often make people angry. Which ones do you have the most difficulty handling?

I am likely to get very angry when:

- I think that I am being treated unfairly
- People criticize me
- I remember times that others have mistreated me in the past
- I feel insulted
- People disobey or disagree with me
- I don't get credit for something I have done
- I feel embarrassed
- People lie to me
- People tell me what to do
- I feel that I have failed at something
- People are late or waste my time
- People ignore me
- I have to wait
- There is a lot of noise or confusion around me
- I see others being mistreated
- I feel helpless or out of control



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 Group Leader

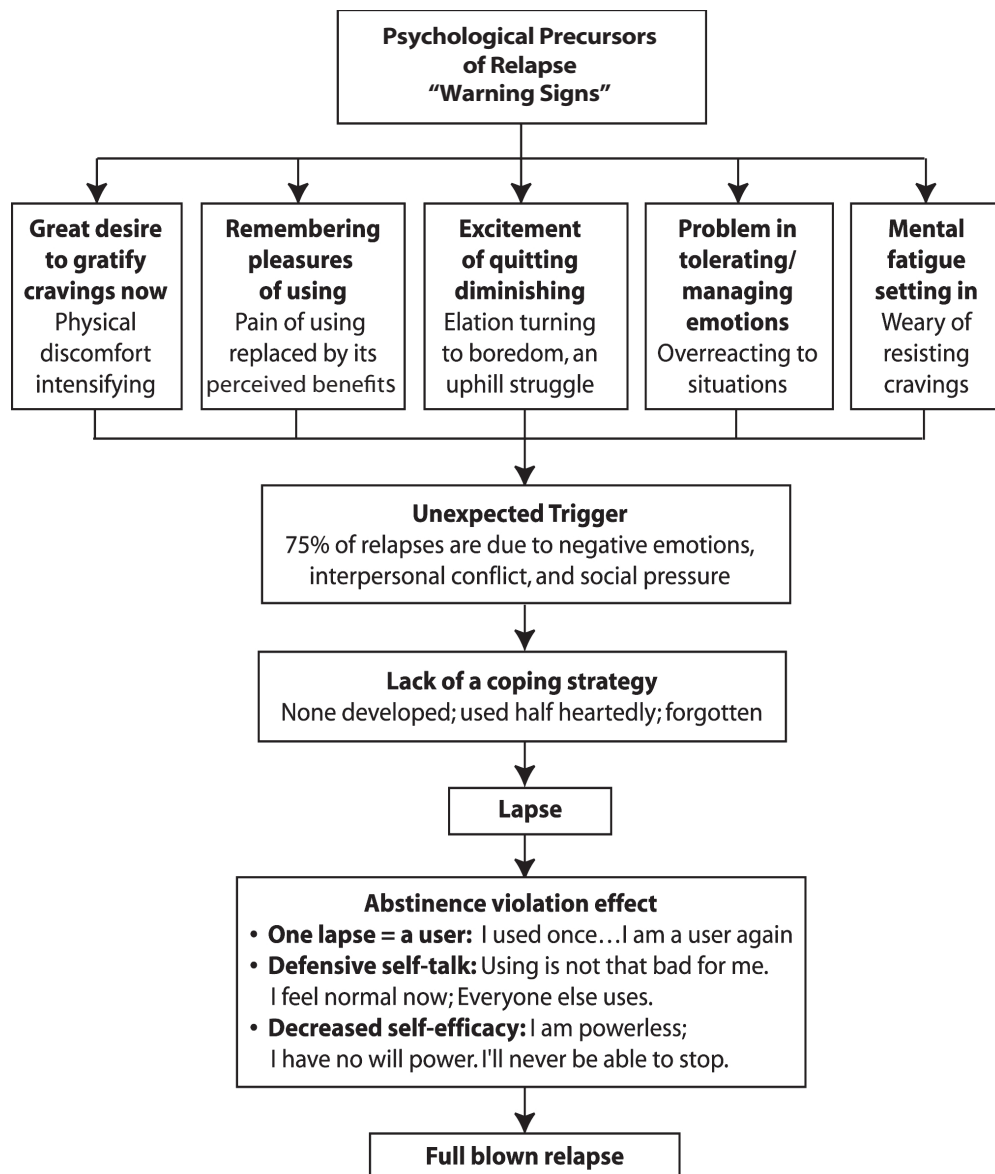
You will want to talk through the chart on relapse prevention that follows, eliciting examples of several of the boxes. (This should be easy.) After reviewing the coping strategies, ask them to share some of the others they have found effective, as well as their experience using the ones listed. Take time to fill out the worksheet on the “Change Plan” and encourage them 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 psychological or psychological withdrawal symptoms, depending on the substance of abuse. As physical discomfort begins to ease, warning signs are due more to psychological factors. The flowchart identifies major psychological warning signs.



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.
- Choose courage - be willing to make hard choices.



Dual Recovery Therapy Change Plan (Sample)

The changes I want to make are:

When I feel afraid of relapsing or something brings back memories of using really strongly, I don't want to give in. I want to have something else to do. I could call Jake or Alan or my sponsor. I could make plans to go to a 12-Step group that day. I could also read over my goals and what I want to achieve. It will also help if I will exercise every day at the gym.

The most important reasons for me to make these changes are:

*I want to share custody of my children.
I want to have a job and a home.
I want to respect myself.*

The steps I plan to take in changing are:

I will go to the 12-Step Group on First Street on Wednesdays and the one at the Y on Saturdays. I will take a route to and from work that doesn't take me by the old drinking spots.

The ways other people can help me to change are:

It will help if people tell me the positive changes they see.

I will know that my change plan is working if:

*My children really enjoy hanging out with me again.
I can keep a job.*

Some things that could interfere with my change plan are:

I could get a call from some of my drinking buddies. I would have to tell them I don't drink any more. That will be hard. I will role play that with Jed so I know what I want to say. I could also ask some other guys how they handled that.



Dual Recovery Therapy Change Plan (Worksheet)

The changes I want to make are:

The most important reasons for me to make these changes are:

The steps I plan to take in changing are:



The ways other people can help me to change are:

I will know that my change plan is working if:

Some things that could interfere with my change plan are:



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 Group Leader

Give participants time to finish the reading that comes just before the worksheet. Elicit some additional examples of "chain" reactions. Then ask participants to answer the first two questions and encourage them to share answers. As they do, brainstorm alternatives with the whole group.



Relationship-Related Triggers Worksheet (sample)

List some Relationship-Related Triggers that you can think of:

1. *My girlfriend Julie won't lend me money when I really need it.*
2. *My brother Bill keeps trying to get me to go back to school.*

What kinds of things do you think and feel when faced with these triggers?

1. *I get furious when I can't get money. Also frustrated and helpless and alone.*
2. *I get stressed out when I think about school. Maybe it would help me get a better job, but I wasn't a good student before. I don't want to be humiliated. I feel jealous of Bill, I guess - things always seemed so much easier for him.*

What might you typically have done then?

1. *I usually yell at Julie and leave the house.*
2. *I told Bill to just shut up and leave me alone.*

To Spouse, Family Member, or Friend:

Can you change anything about these triggers to make them less important?

1. *I shared this page with Julie and asked her why she doesn't want to lend me money when I need it. She told me couldn't lend me money and have me drink it away. But she says after I've been sober at least 6 months, she could help me out a little if I need it sometimes, just as long as I get a job and pay it back.*
2. *Bill agreed that he'd stop asking me to do this right now because I'm just not ready.*



Relationship-Related Triggers Worksheet

Spouses, friends, and family members may have strong emotions about your substance use: anger, frustration, desperation, and sadness. They may use a variety of methods to cope with it. Sometimes the ways they choose to cope “backfire” – that is, increase the chance that you will go use or use more.

Sometimes, situations that involve the spouses, friends, or family member serve as triggers for use, such as attending a social function together and facing an open bar.

REMEMBER:

- Spouses, friends, and family members are not to “blame” for these triggers!
- Ultimately, it is the personal responsibility of the substance abuser to control his or her use behavior, regardless of the trigger!

BUT:

- Is there anything the spouse, friend, or family member can do differently to eliminate or change certain triggers for the user?

EXAMPLE: Partner-related Chains

One of the children was suspended from school today for fighting with another child. The wife received the call from the school, had to pick up her son, and is angry at him for his attitude about the event, which seems to be “Good - I get a day off.” The husband walks in the door, and she starts to tell him what happened. His reaction is, “It’s no big deal, and it’s good that he stood up for himself.” She yells at him, “That is so typical of you. No wonder your son is in trouble - he’s just like you - no respect for rules or laws. If you hadn’t been using drugs for so long, maybe you’d finally realize that this is a bad situation.” He stares at her, feeling more and more edgy and angry as she continues to yell. Then he turns around, leaves the house, and goes over to his cousin’s, who always has some dope that he can cop.

In this example, the partner complaining about irresponsibility because of drug use is a *trigger* for further drug use. This is a *partner-related trigger*. After using, *short-term positive consequences* might include avoiding dealing with the household problems and not being bothered by his wife. *Long-term negative consequences* might include feeling depressed, guilty, and angry with himself for having no self-control over drug use and being lazy or for not dealing with family problems as they come up.



List some Relationship-Related Triggers that you can think of:

- 1 _____
- 2 _____
- 3 _____
- 4 _____

What kinds of things do you think and feel when faced with these triggers?

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

What might you typically have done then?

- 1 _____
- 2 _____
- 3 _____
- 4 _____

To Spouse, Family Member, or Friend:

Can we change anything about these triggers to make them less important?

- 1 _____
- 2 _____
- 3 _____
- 4 _____



11. Changing Unhealthy Thinking Patterns

How to use it:

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.

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 Group Leader

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 choices 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 to collect new examples and new ways of thinking.



Types of Unhealthy Thinking

- **ALL OR NOTHING THINKING:** You see situations in black or white terms--if your performance is not perfect, you see yourself as a total failure.
- **OVERGENERALIZATION:** You see one negative event as part of a never-ending pattern of defeat.
- **MENTAL FILTER:** You pick out one negative detail and dwell on it exclusively.
- **DISQUALIFYING THE POSITIVE:** You reject positive experiences by insisting that they “don’t count.”
- **JUMPING TO CONCLUSIONS:** You make negative interpretations even though there are no definite facts to support the conclusion. (This includes mind-reading and the “fortune teller error” in which you anticipate things will turn out badly and are absolutely certain that you are right.)
- **CATASTROPHIZING OR MINIMIZING:** You exaggerate the importance of things (such as your own mistakes or another’s accomplishments), and then either magnify your own faults or minimize your own strengths.
- **“SHOULD” STATEMENTS:** You have rigid categories of what you should and shouldn’t do, and you feel guilty if you don’t live up to your standard. You may also feel angry, resentful, and frustrated with others if they don’t live up to these same standards.
- **LABELING:** You attach labels to yourself or others because of errors (for example, “I’m a loser”).
- **“WHAT IF”:** You spend time and energy worrying thinking about possible events that might happen. “What if my wife is in an accident?” “What if I get sick and can’t work?” It is appropriate to plan for things that really might happen, but it is not helpful just to worry.

Common types of thinking errors that spouses of substance abusers use:

- **ALL OR NOTHING THINKING:** “My partner is being good, or he’s being bad.”
- **OVERGENERALIZATION:** “If he has one urge to use, or one bad day in which he uses, he’s hopeless (or unmotivated).”
- **“SHOULD” STATEMENTS:** “I should be able to control his drug use.”
- **PERSONALIZATION:** “His drug use problem is all my fault.”



Identifying “Stinking Thinking” Worksheet (Sample)

Experts believe that how we think about things affects the way we feel. Mental health professionals call this cognitive distortion; Twelve Step programs call it “stinking thinking.” Negative and self-defeating ways of thinking can make you depressed or anxious, and can set you up for relapse. It can also lead you to put impossible demands on your relationships. Below are some examples of stinking thinking – how many are typical of you? Write some examples from your own experience.

Black and white thinking: Does everything seem absolutely true or false? Right or wrong? Great or awful?

Example:

“I relapsed again; I am a total failure. I can’t do anything right.”

Examples from my experience:

Last time I was in treatment, just before I came here.

Projecting: Do you always predict the worse? If one bad thing happens, do you imagine the worst possible outcome? Or as they say in AA, do you “dwell in the wreckage of the future?”

Example: *“If I open my mouth everyone will think I’m stupid and they’ll hate me.”*

Examples from my experience: *In group yesterday, when I just couldn’t say what I wanted to say.*

I-can’t-take-it! Do you convince yourself you can’t tolerate frustration or discomfort? Do you think you are going to fall apart if you feel unhappy or anxious?

Example: *“I have to use when I get mad or I will just fall apart.”*

Examples from my experience: *When I went through my divorce. When I lost my job the last time.*

Emotional reasoning: Do you think that your moods always reflect reality? If you feel angry does it mean that others are wrong? As they say in AA, “how I feel is not the best indication of how I am doing.”

Example: *“I just know things aren’t going to work out...I can feel it.”*

Examples from my experience: *When I started going out with Joe and things seemed to be going so well.*



Identifying “Stinking Thinking” Worksheet

Experts believe that how we think about things affects the way we feel. Mental Health Professionals call this cognitive distortion; Twelve Step programs call it “stinking thinking”. Negative and self-defeating ways of thinking can make you depressed or anxious, and can set you up for relapse. It can also lead you to put impossible demands on your relationships. Below are some examples of stinking thinking – how many are typical of you? Write some examples from your own experience.

Black and white thinking: Does everything seem absolutely true or false? Right or wrong? Great or awful?

Example: I relapsed again; I am a total failure. I can't do anything right.

Examples from my experience:

Projecting: Do you always predict the worse? If one bad thing happens, do you imagine the worst possible outcome? Or as they say in AA, do you “dwell in the wreckage of the future?”

Example: “If I open my mouth everyone will think I'm stupid and they'll hate me.”

Examples from my experience:

I-can't-take-it! Do you convince yourself you can't tolerate frustration or discomfort? Do you think you are going to fall apart if you feel unhappy or anxious?

Example: “I have to use when I get mad or I will just fall apart.”

Examples from my experience:

Emotional reasoning: Do you think that your moods always reflect reality? If you feel angry does it mean that others are wrong? As they say in AA, “how I feel is not the best indication of how I am doing.”

Example: “I just know things aren't going to work out...I can feel it.”

Examples from my experience:



Combating “Stinking Thinking” (Sample)

Black and White Thinking

Example: “I relapsed again; I am a total failure. I can’t do anything right.”

Healthier response: “Relapse is serious, but it doesn’t mean I am a total failure.” OR

“I have a choice about whether I use drugs today.”

Projecting

Example: “If I open my mouth everyone will think I’m stupid and they’ll hate me.”

Healthier response: “Why do I care so much what other people think of me? I am here to help myself, not to keep them happy.” OR

“Everyone makes mistakes sometimes when they talk. People won’t hate me for it.” OR

“I don’t need to be so hard on myself. People probably aren’t judging me that harshly.”

I-can’t-take-it!

Example: “I have to use when I get mad or I will just fall apart.”

Healthier response: “I can deal with this. I am stronger than I think I am.” OR

“I may feel bad, but that doesn’t mean I have to use. I have a choice.” OR

“Relapsing will feel worse than getting mad.”



Emotional reasoning

Example: “I just know things aren’t going to work out...I can feel it.”

Healthier response: “Just because things feel bad doesn’t mean they are bad.” OR

“I can control my behavior, but not the results.” OR

“I need to live in today. Most things I worry about never happen.”



Combating “Stinking Thinking” Worksheet

Now that you have identified your “stinking thinking” and learned about healthier ways of thinking, it is time to practice. Take your examples from the “Identifying Stinking Thinking” worksheet, and come up with at least one healthier response. Remember, a healthy response should be realistic and reflect a balanced view of your problems. Then, go on to the next worksheet and see how you can put new ways of thinking into action.

Black and White Thinking

My example:

My healthier response:

Projecting

My example:

My healthier response:

I-can't-take-it!

My example:

My healthier response:

Emotional reasoning:

My example:

My healthier response:



Practicing New Ways of Thinking Worksheet (Sample)

Situation or Event	Automatic Thoughts	Emotion(s) Felt During the Situation or Event	Behavioral Response	Adaptive Thought	Potential Emotion Associated with the Adaptive Thought	Potential Behavioral Response
Describe the situation or event that was upsetting.	What were you thinking at the time of the event?	What emotion(s) did you feel at the time?	How did you react to the situation?	What are some other ways of thinking about the event?	What emotion(s) might be associated with this new way of thinking?	How would this new way of thinking and feeling affect how you might react to a similar event in the future?
<i>My date was rude to me and started flirting with other women.</i>	<i>I'm a loser, I'm fat, I'll never find someone who really loves me.</i>	<i>Rejected, sad, hopeless.</i>	<i>I wanted to take some drugs. I didn't. But I left the reception early and went home and cried.</i>	<i>He's just one guy. I will find someone else. Being in recovery will help.</i>	<i>Patience. More confidence.</i>	<i>I might be able to stay and have fun - and maybe meet someone new, who knows.</i>



Practicing New Ways of Thinking Worksheet

Situation or Event	Automatic Thoughts	Emotion(s) Felt During the Situation or Event	Behavioral Response	Adaptive Thought	Potential Emotion Associated with the Adaptive Thought	Potential Behavioral Response
Describe the situation or event that was upsetting.	What were you thinking at the time of the event?	What emotion(s) did you feel at the time?	How did you react to the situation?	What are some other ways of thinking about the event?	What emotion(s) might be associated with this new way of thinking?	How would this new way of thinking and feeling affect how you might react to a similar event in the future?



12. Changing Irrational Beliefs

What's it for?

To help notice and change things that we believe that 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 Group Leader

Ask participants to read through the examples of irrational thoughts and check those they find apply to them. Encourage them to share a few examples. 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 us, 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.



Personal Irrational Beliefs Worksheet (Sample)

Irrational Belief	Possible Modification of Belief
<i>If my father hadn't left, I'd be different today. He left because I wasn't a good enough kid. A kid that didn't have a father just doesn't have a chance. Nothing will make it right.</i>	<i>It was hard to lose my father so young, but it wasn't my fault. I have found other people to admire and help me, and I've really accomplished some things. It's up to me now.</i>



Personal Irrational Beliefs Worksheet

Irrational Belief	Possible Modification of Belief



13. Scheduling Activities in Early Recovery

How to use it:

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!

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 Group Leader

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 them to be as concrete and realistic as possible. It is easy to create a cotton-candy reality that just won't happen. Instead, participants need to think of choices that really appeal to them and activities they really would enjoy.



Scheduling Activities in Early Recovery Worksheet (Sample)

Many people in early recovery find they need help organizing their time. Drugs and alcohol gave their life structure and predictability. Staying clean and sober means developing a new lifestyle structured around more healthy activities. This worksheet is designed to help you begin to think about ways to organize your day.

What activities can I do every day to take care of my physical health?

Drink more water instead of always coffee. Run or work out.

What recovery-related activities can I do every day?

Write in my journal.

Listen to calm music or just be quiet and meditate 20 minutes.

What are some activities that I can do by myself?

Either of those above. I can also read more. I like books about history.

What are some activities I can do with others?

I can play basketball sometimes.

What are some activities that I will enjoy?

I like basketball. I used to play guitar, and I liked that a lot. I think my guitar is at my brother's house. Maybe I can pick it up and start playing when I have a place to live.

What are some activities that will make me feel good about myself?

Working out, basketball, running - all those things will make me feel better. I'd like it if I got to play guitar pretty well, too. And I guess if I can pass the auto-mechanics certification program eventually, that would make a huge difference. I bet I could do it. I'll look into it.



Scheduling Activities in Early Recovery Worksheet

Many people in early recovery find they need help organizing their time. Drugs and alcohol gave their life structure and predictability. Staying clean and sober means developing a new lifestyle structured around more healthy activities. This worksheet is designed to help you begin to think about ways to organize your day.

What activities can I do every day to take care of my physical health?

What recovery-related activities can I do every day?

What are some activities that I can do by myself?

What are some activities I can do with others?

What are some activities that I will enjoy?

What are some activities that will make me feel good about myself?



Appendix C. MISSION Sample Policies and Procedures

1. Inclusion Criteria

- Over 18 years old
 - Homeless and seeking treatment at the Dom
 - Presence of a substance abuse disorder and a mental health problem that is not severe and persistent (depression, anxiety, personality disorder, etc.)
 - The veteran received his or her medical, psychiatric, and substance abuse care within the VA Healthcare System.

2. Exclusion Criteria

- The veteran is not sufficiently medically, psychiatrically, or cognitively stable to participate in residential or outpatient treatment. If this is evident, the veteran could be re-evaluated for the study once he or she is stabilized.
- Confirmed diagnosis of schizophrenia, schizoaffective disorder, or bipolar 1 disorder
- Exclusive engagement in a methadone maintenance program
- Evidence of a serious suicide risk

3. Recruitment

- Each morning, a MISSION Case Manager will identify veterans who were admitted to the Dom the day before.
- A MISSION Case Manager will screen all newly admitted Dom residents via CPRS to exclude those veterans who are clearly ineligible for the MISSION program (e.g., admission into the MICA track of the Dom due to the presence of schizophrenia, schizoaffective disorder, or bipolar I disorder, repeated denial of substance use over the previous year with lab reports that support this claim, etc.).
- The MCM or another authorized staff member will meet with each newly admitted veteran who has not been previously found to be ineligible for MISSION services.
 - During the in-person screening, the MISSION staff member will ask the veteran questions to determine if it is likely that the veteran has a substance abuse problem and a mental health problem that is not severe and persistent.

- If the veteran is likely to meet criteria, the MISSION staff member will conduct a Structured Clinical Interview for DSM-IV diagnosis (SCID) to determine the veteran's psychiatric diagnosis and eligibility for the MISSION program.
 - The SCID can be administered after the informed consent and assessment procedures described below.
- After MISSION eligibility has been confirmed through the SCID or supported through the initial screening process, the staff member will explain the MISSION program and the associated study.
- If the veteran agrees to participate, the staff member obtains informed consent after verbally explaining the purpose and procedures of the program and study, confidentiality and its limits, the amount of compensation provided for participation in the study, and the voluntary nature of the program and study. The veteran will be asked to read the consent forms for both the VA and UMDNJ and sign them and the HIPAA form.
- The staff member will sign the consent and Decision Making Capacity forms and obtain witness signatures for the consent forms.
- The staff member will then proceed with the locator form and the questionnaire.
- The veteran will be given canteen books as compensation for their time after they have completed all baseline assessments and procedures including the SCID.
- Once the subject completes all of the baseline procedures, the MISSION Psychologist will assign the veteran to a MISSION case manager (MCM) and Peer Support Specialist (PSS).
- The MCM and PSS will arrange to meet with the veteran individually for 45 minutes within one week to orient him or her to the MISSION program and their respective roles in the project.

4. MISSION Services During Dom Residence

- MISSION participants will attend one Dual Recovery Therapy (DRT) session per week that a MCM will conduct.
 - Veterans who are not working will attend a group during the day (Mondays or Tuesdays from 12:15 to 1).
 - Those veterans who are working, or who have a regular appointment that conflicts with the daytime DRT meeting, will attend the evening DRT meeting from 5 to 5:45 PM on Tuesdays.



- MISSION participants will attend one Peer Support session per week that a PSS will conduct.
 - Peer Support sessions will occur on Saturdays from 9 to 10 and Fridays from 3 to 4.
 - An effort will be made to schedule veterans with a regular session time.
- MISSION participants will meet with their MCMs during the first week after they are recruited into the program. In addition to an orientation to the program, problem areas and needs will be discussed.
 - The MCM will contact the Dom Primary Care Provider (DPCP) to inform them of these problem areas.
 - The DPCP will incorporate these problems/needs into the treatment plan.
- Approximately one month prior to discharge from the Dom (around the beginning of the third month), the MCM will meet with the veteran to begin planning for his or her discharge from the Dom.
 - The sessions will cover the domains included in the Critical Time Intervention Case Management (CTI) manual and others as needed:
 - Psychiatric Treatment and Medication Management
 - Substance Abuse Treatment
 - Housing
 - Life Skills
 - Family/Relationships
 - Employment
 - Education
 - Medical Treatment
 - Money Management
 - Social/Recreational Activities
 - Religious/Spiritual Issues
 - Cultural Issues
 - The MCM will inform the DPCP of the domains of interest/importance to the veteran.
 - The Dom Case Manager will incorporate these domains into the discharge plan.
 - The MCM will meet with the veteran once per week until they are discharged from the Dom.

- Approximately two weeks prior to being discharged from the Dom, MISSION participants will meet with their PSS to discuss their thoughts and feelings about the pending discharge.
 - The PSS will meet with the MCM working with the veteran to inform him or her about any clinically relevant material that arose during the discharge sessions.

5. MISSION Services Following Discharge from the Dom

- During the first two months after discharge, the MCM will meet with the veteran either at his/her home or at another convenient location on a weekly basis.
 - Phone contacts can replace in-person visits on an as-needed basis, but they should not characterize the majority of contacts in any given month of the program.
 - Group sessions can also be held if a number of veterans on an individual MCM's caseload reside in close proximity to one another, but only veterans who are amenable to this modality should be included. In addition, group sessions should not characterize the majority of contacts in any given month of the program.
- The frequency of contacts will decline to bi-weekly in the third through seventh month post-Dom.
- The MCM will meet with the veteran once per month in the last two months of the program.
- The last session will serve as a transitional session that will also reinforce concepts learned and established throughout the veteran's participation in the program.
- Peer support sessions will be held every two weeks during the first month after discharge, biweekly in months 2 through 7, and monthly in months 8 and 9.
 - Phone contacts can replace in-person visits on an as-needed basis, but they should not characterize the majority of contacts in any given month of the program.
 - Group interactions should be held regularly and can involve recreational activities and AA/NA meetings.

6. Charting Procedures

The staff member who obtains informed consent should write a "Research Patient" note in CPRS that includes the following elements:

- IRB Number
- Name of the protocol
- Name of the PI



- How to contact the PI in an emergency and under what conditions.
- Major elements of the MISSION Program.
- Name of the individual who obtained informed consent and the date on which it was obtained.
- Confirmation that the veteran received information about the study and that the risks and benefits were discussed.
- Confirmation that the subject was given the opportunity to ask questions and that his/her questions were answered to his/her satisfaction.
- Confirmation that the veteran expressed understanding of the study and the consent procedure.
- Confirmation that that the subject will receive a copy of the consent form.
- Confirmation that a copy of the signed consent form will be placed in the subject's unit chart.
- Confirmation that a copy of the signed consent form will be placed in the locked files of the Principal Investigator.

- Where you are going (use an address or be specific as possible)
- When you will be leaving
- When you are expecting to be back in Lyons
- The cell number of the phone you will be using
- The license number of the car you will be using. If you don't know the license number before you leave, leave a message with Laura with the license number, and make, model and color of the car you will be using before you head out for the visit.

After you have returned, please send another email to your supervisor indicating that you have returned from your field visits.

b. Procedures for using the government car:

The vehicle (white Chevy License Plate # ?) is to be used whenever possible to travel to field visits. The government vehicle cannot be taken out overnight for any reason.

The MCM should place a note in a participant's chart after the orientation/treatment planning session has been completed.

- The note should be placed in CPRS after the MCM speaks with the DPCP.
- The note should include the following:
 - The objective purpose/facts/events of the session.
 - The subject's subjective reports of his mood, goals, barriers, concerns and any other clinically relevant material.
 - A brief mental status exam (e.g., affect, thought process, speech, appearance, and any other relevant elements of the exam).
 - The MCM's assessment/clinical impression.
 - The plan for the veteran's future treatment/appointments/tasks, etc.

1. Fill out a trip ticket with the following information via VISTA to request use of the government vehicle

- Name of driver
- Extension of driver
- Date of departure
- Location of departure
- 1st destination
- How long at destination #1
- 2nd destination – if applicable
- Departure time from 2nd destination – if applicable
- Estimate time of arrival back at site of origin

2. Print a copy of the trip ticket when you are finished entering all the information.

3. Call trip ticket # into the transportation office (Ext.) and fax the trip ticket to the transportation office.

4. Upon return to the office, record odometer reading of car, the total trip hours, and if there were any passengers in the government car on the trip ticket paperwork, and fax this information to the transportation office.

7. Local Travel

a. Procedures for notification of local travel:

As standard procedure for any visit with a veteran in the community or elsewhere (e.g., inpatient unit), please send ___ an e-mail letting us know the following pieces of information BEFORE you leave:

- Who you will be visiting (first and last initial and last 4 of his/her social)

c. MISSION distance policy

The following are guidelines related to the distance from the Dom of the locations to where MISSION participants will be discharged to be eligible for the study and how far MISSION



Case Managers and Peer Support Specialists can travel for regular visits to participants.

- MISSION Case Managers and Peer Support Specialists can arrange for regular field visits with program participants if they live within 32 miles or 1¼ hours driving time from the Lyons campus. The outer reaches of this area extend to Jersey City in the east, Freehold in the southeast, Trenton in the southwest, Phillipsburg in the west, Newton in the northwest, and Paterson in the northeast. At the time of recruitment for the MISSION Program, veterans should be asked if they have set plans for where they will live after their discharge from the Dom.
- If they are sure that they will be discharged outside of this area, but within the State of New Jersey, or in surrounding

states within 2 ½ hours driving time, they should be told that MISSION Case Managers and Peer Support Specialists will only be able to visit them in-person once every three months. Regular contact, however, will be maintained via phone. If they are between 1 ¼ and 2 hours drive time, they will be visited once per month.

- If they are sure that they will be discharged outside of the State of New Jersey and outside of the 2 ½ hour driving time area, they should be informed that they can participate in the MISSION Program, but all contacts will be made via phone or videoconference if the veteran lives near a VA facility with this capability.

Please do not hesitate to ask any questions.



➤ **Appendix D. Position Descriptions**

Generic Case Manager Position Description

Major Duties and Responsibilities

Case management and community outreach with homeless veterans with substance abuse and mental health problems in the MISSION Program (Maintaining Independence and Sobriety Through Systems Integration Outreach and Networking). This will consist of meetings with veterans 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 support to help veterans maintain employment and find new employment/educational opportunities.

Factor 1. 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 with case management and vocational support.

Factor 2. Supervisory Controls

- The incumbent works under the supervision of the Associate Director. The incumbent is required to function independently, but he/or she must provide regular updates and status reports regarding contact with veterans in the MISSION Program.

Factor 3. 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 Associate Director of Dual Diagnosis Research. Incumbent uses these guides as a base, but functions flexibly depending on the needs of the problem or situation.

Factor 4. Complexity

- Working with homeless veterans with mental health and substance abuse problems requires a sensitive individual who has theoretical knowledge and experience to provide case management, outreach and vocational support. On occasion, he or she may also have to quickly assess a situation and contact a credentialed individual on the VA staff to do an evaluation.

Factor 5: Scope and Effect

- The objective of this position is to provide case management, outreach and vocational support to homeless veterans with mental health and substance abuse problems for the MISSION Program under the direction of the Director of ___. These tasks will contribute to the overall effectiveness of the ___ program.

Factor 6. Personal Contacts

- The incumbent will have direct contact with homeless veterans with mental health and substance abuse problems. He/she may also contact the family members/friends/clinicians/employer of veterans (with the permission of the veteran). He/she will also have direct contact with the staff of the MISSION program and the Dom.

Factor 7. Purpose of Contacts

- The incumbent will contact veterans to help them maintain residence and employment in the community. He/she will contact the family members/friends/clinicians/employer of veterans to promote the tenure of the veteran in the community and in their job. The incumbent will contact the Dom staff to promote the smooth integration of MISSION and Dom services.

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 veterans in the MISSION Program.

Factor 9. Work Environment

- The incumbent will have a workspace in room ___ on the __ campus. However, he/she will spend the majority of her time in the community meeting with veterans and members of various community agencies and organizations.

Peer Support Specialist

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 veterans with co-occurring nonpsychotic psychiatric and substance use disorders. Under supervision of the MISSION Clinical Supervisor, the Peer Support Specialist functions as a role model to peers; exhibits



competency in personal recovery and use of coping skills; and serves as a consumer advocate, providing consumer information and peer support for veteran 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 *Consumer Workbook*, tapes, pamphlets, and other written materials are utilized by the Peer Support Specialist in the provision of services.

Using a formal goal setting process, the PSS will:

- Assist veterans in articulating personal goals for recovery through the use of one-to-one and group sessions. During these sessions the Peer Specialist will support veterans in identifying and creating goals and developing recovery plans with the skills, strengths, supports, and resources to aid them in achieving those goals.
- Assist veterans in working with their case manager to determine the steps he/she needs to take in order to achieve these goals and self-directed recovery.
- Assist veterans in setting up and sustaining self-help (mutual support) groups, as well as means of locating and joining existing groups.
- Utilize tools such as the MISSION *Consumer Workbook* and Wellness Recovery Action Plan (WRAP) to assist veterans in creating their own individual wellness and recovery plans.
- Independently or with periodic assistance from the case manager or other providers, utilizes and teaches problem solving techniques with individuals and groups. Leads discussions where veterans will share common problems in daily living and methods they have employed to manage and cope with these problems. As people who have used mental health services, the Peer Support Specialists will share their own experiences and the skills, strengths, supports and resources they use and/or have used. As much as is helpful, the Peer Support Specialists will share their own recovery stories and, as facilitators of these sessions, demonstrate how they have directed their own recovery.
- Use ongoing individual and group sessions to teach veterans how to identify and combat negative self-talk and how to identify and overcome fears by providing a forum which allows group members and Peer Support Specialist to share their experiences. By using identified literature, tapes, etc. veterans will gain hope, learn to identify their strengths, and combat negative self-talk.
- Support veterans' vocational choices and assist them in choosing a job that matches their strengths, overcoming

job-related anxiety by reviewing job applications, and providing interview and job survival tips.

- Assist veterans in building social skills in the community that will enhance job acquisition and tenure, as well as improved quality of life.

Utilizing their recovery experience, the PSSs will:

- Teach and role model the value of every individual's recovery experience.
- Assist the veteran in obtaining decent and affordable housing of his/her choice in the most integrated, independent, and least intrusive or restrictive environment by taking them out to view housing, either driving them or riding with them on public transportation. The Peer Specialist models effective coping techniques and self-help strategies.
- Serve as a recovery agent by providing and advocating for any effective recovery-based services that will aid the veteran in daily living.
- Assist in obtaining services that suit that individual's recovery needs by providing names of staff, community resources, and groups that may be useful. Inform veterans about community and natural supports and how to use these in the recovery process. Community resources may include but not limited to: social security office, Department of Family and Children Services, local YMCA, public library, restaurants, veterans' service organizations, apartment complexes and other types of housing, etc.
- Assist veterans in developing empowerment skills and combating stigma through self-advocacy. This will be accomplished through regular meetings, including both individual and group sessions. Through the use of role playing/modeling techniques the Peer Specialist provides opportunities for others to show/demonstrate how they have handled similar problems, how to present themselves in certain situations, or how to handle problems that may arise in interactions with others.

Together with the MISSION Case Manager, the Peer Support Specialist works with the veterans and other treatment team staff to develop a treatment/recovery plan based on each veteran's identified goals. Treatment/Recovery Plans will be reviewed and signed by the Coordinator/Team Leader and other participating treatment team staff.

The PSS will document the following on the client's treatment/recovery plan:



- identified person-centered strengths, needs, abilities, and recovery goals,
- interventions to assist the veteran with reaching their goals for recovery, and
- progress made toward goals.

The PSS will maintain a working knowledge of current trends and developments in the mental health field by reading books, journals, and other relevant materials. He/she will continue to share recovery materials with others at continuing education seminars and other venues to be developed to support recovery-oriented services. The Peer Specialist will attend continuing education seminars and other in-service training when offered.

Factor 1: Knowledge Required by the Position

- Knowledge of the recovery process and the ability to facilitate recovery using established standardized mental health and peer support processes.
- Knowledge and skill to teach and engage in basic problem solving strategies to support individual veterans in self-directed recovery.
- Knowledge of the signs and symptoms of mental illness (i.e. auditory and visual hallucinations, aggressive talk and behavior, thoughts of self-harm or harm towards others, isolation) and the ability to assist the veteran to address symptoms using strategies such as positive self-talk or to seek additional professional services.
- Knowledge of relapse prevention strategies and signs of substance abuse relapse to assist veterans in maintaining their sobriety goals.
- Knowledge and skill sufficient to use community resources necessary for independent living and ability to teach those skills to other individuals with histories of mental illness, substance abuse, and homelessness. Community resources may include but are not limited to: the Social Security office, Department of Family and Children's Services, local YMCA, public library, restaurants, veterans' service organizations, housing providers, etc. The Peer Specialist may accompany veterans to community resources to assist them in accessing these resources.
- Knowledge of how to establish and sustain self-help (mutual support) and educational groups by soliciting input from the mental health consumers on their strengths and interests.

g. A valid driver's license is required as some driving and/or transportation may be required to take veterans to medical appointments, job sites, social activities and other community resources.

Factor 2. Supervisory Controls

The Peer Support Specialist is administratively assigned to the MISSION program and will receive supervision from the MISSION Clinical Supervisor. The supervisor provides weekly supervision and generally helps to guide and prioritize unique situations encountered. The incumbent is expected to handle routine duties independently and is expected to establish common priorities for his/her assignments. Some group 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 VA and 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. Incumbent will use judgment in determining the appropriate guide or instruction to fit the circumstances and in determining what information is required. In situations where the guidelines are not applicable, do not exist, or are unclear the PSS refers the problem to the Clinical Supervisor.

Factor 4. Complexity

The work involves providing support services for the veteran client and helping them 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 case manager/treatment team and reviewed with the supervisor. Decisions regarding what needs to be done involve choices that require a simple analysis such as organizing facts in narrative or logical order and comparing them to past solutions in similar cases or to applicable criteria. Actions to be taken or responses to be made, such as advice to the veteran, differ depending on the facts of the situation.



Factor 5. Scope and Effect

The PSS assists and guides veterans toward the identification and achievement of specific goals defined by the veteran 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 veterans, family members and significant others, treatment team members and other VA 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 veteran. Contacts with veterans 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. Typically, the employee will sit to do the work. However, there may be some walking, standing, bending, carrying of light items such as books and papers, accessing transportation, and driving a government car or van.

Factor 9. Work Environment

Work will be performed in a wide range of settings, including the medical center; in client, group or family homes; in community-based outpatient settings or community agencies; or in transport vehicles (public or government). Work areas are often noisy, irregular, and unpredictable and can be stressful at times. Clients demonstrate varying levels of recovery and symptoms.

Other Significant Requirements:***Customer Service***

Meets the needs of customers while supporting the Medical Center and Service missions. 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, VA statutes and policy, and VHS&RA 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., as set out in the computer access agreement that the employee signs.

Age-Related Competency Statement

Provides care and/or services appropriate to the age of the patients being served. Assesses data reflective of the patient's status and interprets the information needed to identify each patient'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.

Computer Knowledge - VistA

Uses the Veterans Health Information & Technology Architecture (VistA) to access information in the Medical Center Computer System.



Appendix E. Peer Support: Lessons Learned and Issues to Consider

As stated in Chapter 2 of this manual, Replicating the MISSION Program: Guidance for Administrators, we have learned many lessons in the process of setting up the peer support component of this project. 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, just a starting point.

First and foremost, we have learned that peers are incredibly valuable members of the treatment team. However, we believe that delays in fully benefiting from their valuable contributions can be avoided as the MISSION program is replicated. We believe that our process of hiring veteran consumers of the VANJ Residential Program, with little or no formal training in peer support, unduly minimized and confused their unique and important role. We would, therefore, encourage those replicating the MISSION program to learn from our experiences. This Appendix offers a brief overview of our learning process and addresses some of the most frequently asked questions regarding the incorporation of Peer Support Specialists into mental health care systems.

The role of MISSION's Peer Support Specialists 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 affecting the applicant pool, the program's relationship with the VA New Jersey Health Care System, 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 veterans who had completed VA's residential treatment program over consumers who were already trained and experienced consumer-providers. While the value of this additional layer of shared experience with clients of the MISSION program appears to have some obvious benefit, we have now learned that it also significantly limited the applicant pool, resulting in the need for extensive on-the-job peer support training. It also meant that until training was completed, some peer specialist activities were significantly curtailed. This has presented significant challenges associated with understanding the role of peer specialists, their acceptance as full-time members, and the achievement of their full potential.

The system in which MISSION was operating was just beginning to embrace the role of peers as equal team members. Thus, the peer specialist initially did not have access to patient records, which necessitated that the case manager be the conduit for all information collected by the peer support specialist and required that the case manager be counted upon to relay any relevant medical record information to the peer support specialist. The delay in access to the record system impeded the peer support specialist'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 VA-New Jersey 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.

These issues are being resolved as the MISSION program matures and the VA system begins to develop national system-wide infrastructure for peer support services. A more formalized MISSION on-the-job training program (to include “shadowing assignments”) has been implemented, and existing MISSION peer specialists have completed their on-the-job training. In addition, interested veterans completing the VA residential program are now encouraged to pursue their own peer support training and experience (see the Resources Section for a sampling of venues), which will expand the applicant pool as vacancies occur. MISSION-specific on-the-job training would still be necessary, but the recent measures taken will substantially reduce the time associated with peer specialists being limited in the full performance of their duties. In the future, recruitment of trained veterans who have received their residential care at other facilities, and/or trained nonveterans who otherwise share recovery experiences associated with mental illness, addictions, and homelessness, will be pursued in MISSION to ensure that the role of Peer Support Specialists will not be marginalized in the future.

These experiences are shared as a means of conveying “lessons learned” from which others replicating MISSION may benefit. As stated above, the employment of Peer Support Specialists 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 nearly 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 peer specialists 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 Peer Specialists?

- **Is a certain type of mental illness required, or not?**
- **Should the Peer Specialists be free of substance use? For how long?**
- **Should the Peer Specialists 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 peer specialists should be based on the knowledge, skills, abilities, and personal characteristic required to perform the duties of the position. Position descriptions and recruitment announcements should describe the population served and the expectation that the peer specialist 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 experience have afforded them the knowledge and skills necessary to successfully perform the duties of a peer support specialist. (Examples of key knowledge, skills, and abilities and some suggested interview questions identified for the MISSION Peer Specialist 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 peer specialists 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 peer specialist’s supervisor also be that person’s mental health services provider.***

Peer specialist 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 peer specialists than for other service providers? Does everything that gets stated to a Peer Specialist by a client automatically get transmitted to the rest of the team?

Peer specialists are members of a treatment team, and 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 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 peer specialist would be expected to inform the client that they must (and will) convey such information to the team anyway.

3) *Fraternization.* Can Peer Specialists spend time with their patients after hours? What are the boundaries of patients and Peer Specialists giving money to each other? Can a Peer Specialist buy a client a cup of coffee or not?

Peer specialists 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 peer specialists. The fact that peer providers 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. Peer specialists are, however, likely to have more social contact with clients than traditional healthcare providers, and as 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 peer specialists to discuss these situations with their supervisor as they may arise, to include assistance with discussing healthy boundaries with clients. Like all employees (and perhaps even more so), it is important that peers 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 peer specialist and a new client coming into the program, the peer specialist (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 peer provider/client relationship and goals of the program.

4) *Supervision/performance appraisal.* How does a supervisor appraise performance of a Peer Support Specialist?

Performance standards for peer specialists should be developed based on the work of the position, as with any other staff member. In the case of MISSION peer specialists, the supervisor's appraisal should focus on the peer specialist'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 Peer Specialists is what will happen when the Peer Specialist relapses. Should special sick leave policies be in place for them?

The sick leave policy should be no different for peer support specialists 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 peer specialist, 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 (ADA). As such, they should be advised that they may 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 are peer specialists required to disclose their 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 peer support specialist requires peer support specialists to do so. Their training as a peer support specialist should comprehensively address how to utilize their own experiences effectively, so as to connect with, empathize with, and support clients. Peer specialist 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 peer specialist feel compelled to disclose aspects of their personal experiences that they would be uncomfortable sharing.



Knowledge, Skills, and Abilities considered essential for the MISSION Peer Support Specialist 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, role-modeling techniques, to include role-modeling personal experiences to assist others 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 MISSION Peer Support Specialist 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 set 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 the VA Healthcare System_____

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.



1. Methods

An interim analysis was completed with the first 55 individuals who completed our federally funded follow-up study. Subjects include 55 seriously mentally ill, substance abusing individuals randomized to TLC or treatment as usual (TAU-A). Preliminary data include treatment engagement, attendance, community adjustment, and subsequent re-hospitalizations.

This study used a rigorously randomized controlled trial that carefully matched for equal attention. Thus, the control condition includes treatment as usual in acute psychiatry and outpatient care along with matched attention, but does not include dual recovery therapy, case management, and peer support interventions approaches.

2. Results (TLC vs. TAU)

Hospitalization Data

- Six Months Pretreatment Hospitalization (34.4% vs.. 26.1%)
- Eight Weeks Post-treatment Hospitalization Days (12.5% vs.. 21.7%)
- Six Month Post-treatment Hospitalization Days (28.1% vs. 39.1%)

Service Utilization Data

- Show rate to initial outpatient assessment (77.4% vs.. 50.0% *)
- Mean # of Inpatient Sessions Attended (4.3 vs.. 1.7**)
- Mean # of Outpatient Sessions Attended (6.9 vs.. 2.1 **)
- Proportion refilling prescriptions (70.8 vs. 57.9)

Social/Clinical Improvement at 6 Months Follow-up

- In Permanent Housing (69.2% vs. 50.0%)
- Seriously Bothered by Psychiatric Symptoms (46.2% vs..= 75.0%)
- No Alcohol Use 30 Days Post Assessment (46.2% vs. 37.5%)
- No Illicit Drug Use 30 Days Post Assessment (76.9% vs.75.0%)

(* = $p<.05$; **= $p<.01$)



➤ Appendix G. Sample Notes

1. Individual Session: Orientation to the MISSION Program

Date:

The veteran attended an orientation session with his MISSION Case Manager to learn the goals, structure, and schedule of the program. The veteran was given the opportunity to ask questions about the project and these questions were answered to his satisfaction. The veteran's goals for his treatment in the Dom and after discharge were discussed. The veteran stated that his primary goals were to maintain his abstinence from drugs and to gain job-related experience during his Dom stay. After discharge, he hopes to get a part-time job while completing his GED. The veteran also agreed to continue his attendance at NA meetings, to continue his adherence to his psychiatric medication regimen, and to pursue 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 veteran reported feeling hopeful about his future and less depressed than when he was initially admitted to the Dom. Despite this improvement, his affect continues to be somewhat sad and constricted. His thought process was goal-directed and linear.

The MISSION Case Manager will contact the Dom Case Manager to communicate information gathered during the orientation session to aid in the development of the treatment plan. The veteran's next DRT session is scheduled for 9/20/05 and his next peer support session is scheduled for 9/24/05. The MISSION Case Manager will meet with the veteran once per week approximately one month prior to his expected discharge from the Dom in order to promote a successful transition to the community. The MISSION Case Manager will convey information gathered in these sessions to the Dom Case Manager to aid in the development of the discharge plan.

2. Notes on Participation in DRT Sessions

Group: Dual Recovery Therapy for the MISSION Program

Date: 9/19/07

Agenda: Relapse Prevention

GROUP BEHAVIOR RATINGS:	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 veteran participated in the Dual Recovery Therapy group that is a component of the MISSION Program. Group members discussed **methods of relapse prevention.**



3. Preparation for Community Transition

Individual Session: Preparation for Community Transition

Date:

The veteran and MISSION Case Manager discussed the veteran's pending transition to the community following his discharge from the Dom. The veteran's progress towards meeting the goals he set at the onset of his admission to the Dom were discussed. The veteran reported success in maintaining his sobriety and in obtaining job-related experience. The veteran reported some difficulty coping with stress-related triggers. The veteran's goals in the community were discussed. He stated that his short term goals were to renew contact with his children, to set up an appointment with an outpatient therapist, to regularly engage in healthy recreational activities, and to begin regular attendance at NA meetings. His long term goals include moving into his own apartment, to begin training to become an auto mechanic, and to maintain abstinence from drugs and alcohol.

The veteran reported feeling excited, but somewhat nervous about his transition to the community. His affect was full-range and appropriate. His thought process was goal-directed and linear.

The MISSION Case Manager will contact the Dom Case Manager to communicate information gathered during the transition preparation session to aid in the development of the discharge plan. The veteran's next DRT session is scheduled for 9/20/05 and his next peer support session is scheduled for 9/24/05. The MISSION Case Manager will meet with the veteran on 9/26/05 to continue the transition preparation process.

4. MISSION Discharge Summary

TITLE: Discharge Summary

MISSION Case Manager:

DATE OF ADMISSION: 6/25/05

DATE OF DISCHARGE: 7/1/05

TYPE OF DISCHARGE: regular

DIAGNOSIS UPON ADMISSION TO THE MISSION PROGRAM:

Axis I: Post Traumatic Stress Disorder, cocaine abuse, alcohol abuse, depression.

Axis II: Deferred

Axis III: Hypertension, healed fractured heels

Axis IV: fiduciary not paying his bills on time

Axis V: GAF - 50

SIGNIFICANT FINDINGS:

HPI (History of Present Illness): The patient is a 48 year old African American male with a past psychiatric history significant for Post Traumatic Stress Disorder, cocaine and alcohol abuse who came to the Dom due to homelessness and regular use of cocaine. Upon admission he stated that he had lost his home and his family due to his drug use. He said that his addiction led to regular criminal behavior for which he expressed considerable guilt.

Past Psychiatric History:

Post Traumatic Stress Disorder since Vietnam War.

Patient states he's had constant suicidal thoughts since the 1980's but states that he does not have any intention of hurting himself. He has a history of jumping out a 2 story building following an intense flashback and was hospitalized for trauma and psychiatry at EO General Hospital. Patient has been having flashbacks from the Vietnam War since he was discharged. These flashbacks consist of images of Vietcong soldiers chasing him.

Patient has history of cocaine and alcohol abuse. Patient stated using heroin in Vietnam and continued until he returned to the United States. He then started using cocaine and alcohol. He has been to SATP twice. He states he was clean for 10 years until his injury after jumping from the 2 story building. He was then treated and clean until prior to admission in April. He states that since that discharge he has been clean once again. And only used on the day prior to admission, as written above. The patient was last discharged from EOVA with a referral to the outpatient PTSD program. He failed to follow-up with this appointment. Patient has been treated in the past with Paxil and Buspar. The patient reported little benefit from treatment with these medications.



Past Medical History:

- Hypertension
- Healed broken heels (After jumping off a 2 story building)

Family History:

None. There is no family history of depression, suicide, or any other psychiatric problems.

Social History:

Patient obtained his GED and attended a 1/2 year of junior college. Been married three times with last divorce in 1995. Last time patient worked was in 1992 as a cab driver, a position he held for 15 years. Patient states that he was in jail for 50 days after being accused by his tenant of breaking and entering his apartment which he was renting out to the tenant. The police saw cocaine in the apartment when they came to investigate and arrested him for possession. He served 50 days in jail and upon his hearing, neither the tenant or the police officers showed up and thus he was released in December. The patient is not on parole and does not have any other legal issues pending.

Military History:

Was in the Army as an infantryman from 1965-1971 and was in the Army National Guard from 1975-1989. Served in Vietnam. Patient was discharged honorably.

MSE (Mental Status Exam) at Last Contact:

- Appearance: Fairly groomed, dressed in his own clothing, coherent, calm, cooperative, with fair eye contact, no psychomotor abnormality.
- Mood: Euthymic (normal mood)
- Affect: Guarded
- Speech: Normal volume, fluent, non-pressured, normal rate and rhythm
- Thought Process: Linear
- Thought Content: Denies SI (suicidal ideation) and HI (homicidal ideation), no delusions/paranoia elicited
- Perceptions: Denied AH/VH (auditory and visual hallucinations)
- Insight/Judgment: Intact
- Impulse control: Intact

- AAO (Alert and Oriented) to time, place, and person.
- Axis I: Post Traumatic Stress Disorder, cocaine abuse, alcohol abuse, depression.
- Axis II: Deferred
- Axis III: Hypertension, healed fractured heels
- Axis IV: Fiduciary not paying his bills on time
- Axis V: GAF - 40

COURSE OF MISSION PARTICIPATION (Services Rendered):

While in the Domiciliary, the veteran participated in weekly Dual Recovery Therapy groups and weekly peer support groups. Upon his regular discharge from the Dom, he participated in case management sessions weekly for two months, bi-weekly for six months, and monthly in final two months of the program. He also participated in peer support sessions bi-weekly for seven months and monthly in the final two months of the program. During his participation in the MISSION Program, the veteran was linked to the outpatient substance abuse treatment program on the EO campus of the VA. He was also referred to a local NA group where he developed a relationship with a sponsor. He was also referred to an outpatient therapist with whom he meets on a weekly basis. The veteran was referred to an outpatient physician for treatment of his hypertension that is currently under control. The veteran was also given vocational assistance in managing the stressful relationships on his current job. In addition, the veteran was educated about recreational planning that resulted in his regular participation in a bowling league.

PATIENT'S CONDITION AT DISCHARGE:

The patient reported significant improvement in his mood and his ability to live independently since he entered the Dom. He was hopeful about the future and proud of his recent accomplishments.

DISCHARGE INSTRUCTIONS (follow-up appointment(s), scheduled activities level, referrals):

FOLLOW-UP VISIT:

The patient's next outpatient mental health visit is scheduled for ___with Dr. ___ at ____ . He has agreed to continue his participation in NA meetings three times per week. His next medical appointment will occur on ____ with Dr.____. The veteran was given a referral to the smoking cessation program at the EO VA.

THE DISCHARGE INSTRUCTIONS WERE DEVELOPED IN COLLABORATION WITH THE CLIENT. ALL OF HIS QUESTIONS WERE ANSWERED AND EXPRESSED A CLEAR UNDERSTANDING OF THE PLAN.



Appendix H. MISSION Fidelity Index

1. Comprehensive Assessment

- | | | |
|--|-----|----|
| a) Did the client get a comprehensive orientation to the MISSION program? | Yes | No |
| b) Did the MISSION case manager participate in developing a comprehensive aftercare discharge plan from residential treatment? | Yes | No |
| c) Did the client sign the treatment plan? | Yes | No |

2. Co-Occurring Disorders Treatment

- | | | |
|---|-----|----|
| a) Did the client attend at least 8 DRT co-occurring treatment groups while in residential treatment? | Yes | No |
|---|-----|----|

3. Case Management - Case Managers

- | | | |
|--|-----|----|
| a) Did the case manager complete at least 1 transitional discharge session with the client during the last month of residential treatment? | Yes | No |
| b) During the client's first two months in the community, did the case manager see the client at least weekly? | Yes | No |
| c) During the next five months, did they meet bi-weekly? | Yes | No |
| d) During the remaining 2 months, did they meet monthly? | Yes | No |
| e) Did the case manager conduct a comprehensive MISSION discharge session with the client? | Yes | No |
| f) Were dual recovery issues addressed at least monthly in the community? | Yes | No |



4. Record-keeping

- | | | |
|---|-----|----|
| a) Do the notes reflect follow-up with problem areas identified during the intake assessment? | Yes | No |
| b) Do the notes reflect a clear picture of the intervention(s) delivered during each treatment contact? | Yes | No |
| c) Do the notes reflect that the case manager discussed the client's awareness and understanding of his/her mental health symptoms with the client? | Yes | No |
| d) Do the notes reflect that the client was asked about medication compliance? | Yes | No |

5. Housing Placement and Daily Living

- | | | |
|---|-----|----|
| a) Was housing addressed in the orientation and transitional sessions prior to the client entering the community? | Yes | No |
| b) Was there an assessment of the client's adjustment to housing and other aspects of community living after leaving residential treatment? | Yes | No |
| c) If problems in adjustment were noted, were they addressed? | Yes | No |
| d) Was the client taught money management? | Yes | No |
| e) Was the client given assistance with transportation? | Yes | No |

6. Vocational Services / Job Placement

- | | | |
|---|-----|----|
| a) Did the case manager review the client's vocational plan developed during residential treatment? | Yes | No |
| b) Was the client linked to vocational placement assistance in the community if needed? | Yes | No |
| c) Did the client receive ongoing employment support once they started working? | Yes | No |
| e) Did the client obtain help in obtaining a drivers license, if help was needed? | Yes | No |



7. Support Network Building - 12 Step; work; church; other networks - cultural, etc

- a) Did the client participate in AA/NA or other self-help/recovery oriented programs in the community? Yes No
- b) Did the client engage in other community activities to build his/her social network? Yes No
- c) Did the client meet with a Peer Counselor prior to residential discharge? Yes No
- d) Did the client meet with a Peer Counselor following residential discharge? Yes No
- e) Did the client remain active in meeting with a peer counselor in the community
- Weekly? Yes No
- Monthly? Yes No
- Quarterly? Yes No

8. Medical Services - Nutrition / dietary linkage / dental / general health

- a) Did the client get connected to a primary care provider before being discharged from residential treatment? Yes No
- b) Did they receive a follow-up appointment post-residential treatment? Yes No
- c) Did they attend the follow-up appointment post-residential treatment? Yes No

