1-1-2011

MISSION-VET Treatment Manual

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

VETERANS EDITION

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Veterans Health Administration
Research & Development
Improving Veterans' Lives — www.research.va.gov

Department of Veterans Affairs
Patient Care Services

HSR&D
Health Services Research & Development Service

VA National Center on Homelessness Among Veterans

This Treatment Manual was supported by grants from the United States Department of Veterans Affairs, Office of Research and Development, Health Services Research and Development and The National Center on Homelessness Among Veterans

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Acknowledgements

This Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking (MISSION) Treatment Manual: Veteran's Edition (MISSION-VET) is a publication supported by grants from the United States Department of Veterans Affairs [VA], Office of Research and Development [ORD], Health Services Research and Development [HSR&D], and National Center on Homelessness Among Veterans. The original MISSION treatment studies and manual fidelity projects were supported by Grant # IIR 120-145 from VA HSR&D and Grant # TI16576 funded by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), United States Department of Health and Human Services (HHS).

With appreciation, we acknowledge the valuable feedback we received on the first edition of the MISSION Treatment Manual (Smelson, et al, 2007) and MISSION Consumer Workbook (Smelson, et al, 2007) from Pat Corrigan, Moe Armstrong, Miklos Losonczy, Sarah Guzofski, Manny Guantez, and Chris Barton. We also wish to thank our original MISSION team which included Bradley Sussner, Mark Benson, Chandra Mustafa, Louise Romalis, Mike Somers, Stephen White, Hamilton Cook, and Ray Gaines.

We are also grateful to Kathleen Browne (Healthcare for Homeless Veterans Services), Philip E. Thomas, (VISN 11 Network Homeless Coordinator), Richard De Blasio, (VISN 19 Network Homeless Coordinator), Jesse K. Vazzano, (VISN 5 Network Homeless Coordinator), Shara Katsos (Bedford VAMC Chief of Social Work), Kenneth Link and Cheryl Coviello (both from the Bedford VAMC HUD-VASH program), Robert Hallett (VA National Coordinator, Healthcare for Homeless Veterans), Teresa Pittman (HUD-VASH Program Analyst), Roger Casey (VA National Director, Homeless Providers Grant and Per Diem Program), Daniel O'Brien-Mazza (VA National Director, Peer Support Services), Gerald Carmichael (VISN 1 Network Homeless Coordinator), Julie Irwin (VISN 3 Homeless Care Line Manager), Debra Pinals (Assistant Commissioner of Forensic Mental Health Services, Massachusetts Department of Mental Health) and John O'Brien (United States Interagency Council on Homelessness) for their much appreciated feedback on this MISSION-VET Treatment Manual.

We have drawn from the groundbreaking work of Douglas M. Ziedonis, M.D., M.P.H., Chair of the Department of Psychiatry at the University of Massachusetts Medical School, whose Dual Recovery Therapy (DRT) principles and exercises have been adapted for use in the MISSION-VET program. We have also benefited from the critical contributions of Ezra Susser, M.D., Alan Felix, M.D., and the other members of the Critical Time Intervention (CTI) development team.

Additionally, we wish to thank the leadership of VISN 1 and the Edith Nourse Rogers Memorial VA Medical Center for their commitment to improving the lives of homeless Veterans. We also wish to acknowledge the support, advice, and guidance we received from VA's Office of Research and Development, Health Services Research and Development Service, and National Center on Homelessness Among Veterans.

Finally, we hope that you find this manual to be a useful resource as you provide day-to-day support to our Veterans. For questions regarding the use of the MISSION-VET manual or any questions related to the MISSION-VET program itself, please contact

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The following institutions are affiliated with and participated in the writing of the MISSION-VET Treatment Manual: VA Edition:

United States Department of Veterans Affairs (VA)

- National Center on Homelessness Among Veterans
- Office of Research and Development (ORD),
- Health Services Research and Development Service (HSR&D)
- Edith Nourse Rogers Memorial Veterans Hospital (Bedford, VA)
- Center for Health Quality, Outcomes and Economic Research (CHQOER)
- VA New England Healthcare System (VISN 1)
- VA Healthcare VISN 4

University of Massachusetts Medical School

- Department of Psychiatry
- Commonwealth Medicine

Dedication:

We dedicate this Treatment Manual to VA and community service providers who offer real hope and tangible Support to Veterans whose battles do not end when their military service does. We hope that this Treatment Manual provides a roadmap that helps facilitate the journey of recovery.

Foreword

The original Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION) integrated treatment approach provided case management, psychoeducational treatment, and vocational support to homeless and formerly homeless Veterans with co-occurring psychiatric and substance use disorders (COD) as they worked to achieve recovery from homelessness, substance abuse, mental illness, and unemployment while transitioning to independent living in the community. The MISSION-VET program, like the MISSION program that preceded it, provides support when these Veterans need it most – at the beginning of the transition period.

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

The MISSION-VET treatment approach is rooted in the theoretical framework of the Health Belief Model (HBM) and structured upon the principles and phases of the Critical Time Intervention (CTI) case management. To better meet the needs of homeless and formerly homeless Veterans with COD, MISSION-VET has systematically blended the following:

- Time-limited case management services using the Critical Time Intervention model
- Psychoeducational co-occurring disorders treatment using Dual Recovery Therapy
- Peer support delivered by fellow Veterans
- Vocational and Educational support through linkages to VA and community-based programs
- Support for trauma-related symptoms by training MISSION-VET treatment staff to identify and monitor symptoms that may be related to trauma, and to provide referrals to specialists when needed.

With support from VA ORD, HSR&D, and The National Center on Homelessness Among Veterans, this treatment manual is designed to enable VA and community-based service providers who work with homeless and formerly homeless Veterans to effectively implement the MISSION-VET treatment approach in their own treatment settings using their own resources.

Overview of Manual Contents

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

I. ***Replicating the MISSION-VET Program: Guidance for Program Managers and Administrators***. This chapter provides information of particular interest to both VA and community-based program managers and administrators who are considering implementing the MISSION-VET program in their treatment settings. This chapter discusses MISSION-VET's target audience; treatment settings; service components; previous outcomes; staff training needs; and other logistical, staffing, and supervision requirements necessary for successful implementation. It is important to underscore that this chapter was intentionally developed to succinctly present key information from the manual as a whole that is essential for a sufficient, yet abridged, understanding of MISSION-VET.

II. ***Homelessness Among Veterans.*** This chapter describes the problem of homelessness among Veterans, discusses *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*, and offers an overview of existing VA homeless programs and services.

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

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

V. ***Peer Support.*** This chapter explains the unique position of Peer Support Specialists (PSSs). Following an overview of their role within the MISSION-VET treatment program, the chapter

explains how PSSs work with MISSION-VET CMs to carry out individual and shared responsibilities. The chapter also highlights how the MISSION-VET PSS serves as a role model and as a source of encouragement and support to Veterans receiving MISSION-VET services. Case examples are included to illustrate how PSSs facilitate discussions on topics of particular concern to Veterans, support Veterans in the community, and help Veterans address problems and challenges that arise during community transition and adjustment.

VI. ***Vocational and Educational Supports for Veterans.*** This chapter discusses the role and provision of vocational and educational supports offered within the MISSION-VET treatment approach. MISSION-VET CMs and PSSs are given a concise review of the critical components of existing vocational and educational supports developed to help Veterans meet their employment and educational goals. Suggestions for linking Veterans to these, as well as other community-based vocational and continuing education programs, are provided.

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

VIII. ***Core Competencies for Clinical Supervisors.*** This chapter will guide clinical supervisors who oversee and support the work of MISSION-VET CMs and PSSs. It includes an overview of the supervisor's role and provides guidance on how to successfully address key responsibilities. Specifically, it addresses how to forge an effective supervisory alliance with MISSION-VET CMs and PSSs, respond appropriately to each team member's learning needs and styles, negotiate an agreement with team members about the nature and tasks of supervision, ensure fidelity to the MISSION-VET treatment approach, provide clinical direction to CM/PSS teams when emergency situations arise, monitor and help manage the team's stress and the potential for burnout, and attend to issues related to diversity.

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

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

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

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

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

Appendix D: MISSION-VET 2-, 6-, and 12-month Service Delivery Schedules. Sample service delivery schedules have been included to serve as a guide for implementation of the MISSION-VET model.

Appendix E: Leading Exercises in Dual Recovery Therapy. Facilitated by the MISSION-VET Case Manager, these psychoeducational co-occurring disorder treatment sessions are essential to the MISSION-VET approach. These structured sessions can be delivered in an individual or group format. Guidance for delivering booster DRT sessions is also provided to help CM's monitor "their" Veteran's recovery from both mental health and substance use disorders.

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

Appendix G: Case Management Considerations. As the Case Manager role is critical to successful implementation of the MISSION-VET treatment approach, this section contains additional information to supplement the material presented in Chapter IV.

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

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

Appendix J: Supported Employment and Supported Education Resources. This appendix includes several resources that will assist MISSION-VET team members in exploring and accessing vocational and educational supports for "their" Veterans. Selected tools that will assist MISSION-VET team members in assessing service needs are provided. References for more in-depth resources have also been included.

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

Appendix L: MISSION-VET Fidelity Index. This fidelity index has been developed to assist clinical supervisors monitor fidelity to the MISSION-VET treatment approach.

How to Use This Manual

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

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

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

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

III. The MISSION-VET Model of Care

Your own role as a supervisor described in detail in

VIII. Clinical Supervision

Descriptions of your supervisee's roles can be found in

IV. Case Management
V. Peer Support

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

I. Replicating the MISSION-VET Program: Guidance for Program Manaagers and Administrators
IV. Case Management
V. Peer Support
VI. Vocational and Educational Supports for Veterans
VII. Trauma-Informed Care

Veterans: A separate *MISSION-VET Consumer Workbook* (Smelson et al, 2010) has been developed specifically for Veterans who receive services through the MISSION-VET program. The *MISSION-VET Consumer Workbook* should be given to each Veteran as he or she enrolls in the MISSION-VET treatment program. The Workbook is divided into two parts: Part 1, which includes exercises and checklists designed to help strengthen and solidify the recovery tools learned during DRT psychoeducational co-occurring disorders treatment sessions; and Part 2, which is intended to help Veterans prepare for the transition back to the community. Additionally, the reading material in the Workbook is intended to help Veterans during their adjustment to the community and empower them to succeed in their recovery.

What is MISSION-VET?

Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking: Veterans Edition (MISSION-VET) is a program developed specifically to meet the needs of Veterans who have experienced homelessness and whose ability to return to independent community living is further complicated by mental illness and substance abuse. The MISSION-VET program is one of many designed to meet the objectives of *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* (U.S. Interagency Council on Homelessness, 2010). Given the high rate of substance abuse and mental illness among homeless and formerly homeless Veterans, and as mental illness and substance abuse have been recognized as important contributing factors to chronic homelessness, the MISSION-VET treatment approach serves the needs of a population that must be addressed to fulfill the commitment made by the United States Department of Veterans Affairs (VA) to end homelessness among Veterans by 2015. The primary goal of the MISSION-VET treatment model is to facilitate rapid community engagement and achievement of personal goals by helping Veterans engage in a comprehensive array of outpatient mental health and substance abuse treatment services as well as vocational and educational rehabilitation programs.

MISSION-VET, which is built on the theoretical framework of the Health Belief Model (Becker, 1974), uses Critical Time Intervention (CTI) case management (Susser, et al., 1997) and Dual Recovery Therapy (Ziedonis & Trudeau, 1997) to support homeless and formerly homeless Veterans during the critical period when they are seeking to maintain recovery from co-occurring psychiatric and substance use disorders and adjust to living independently in the community. Each Veteran in the program is assigned to a team consisting of one Case Manager and one Peer Support Specialist. Together they provide the Veteran with foundational support through psychoeducational exercises and the facilitation of service linkages in the community, including outpatient mental health and substance abuse treatment programs, primary and specialty medical care, vocational and educational rehabilitation services, and trauma-informed treatment providers. With the support and guidance of an experienced Clinical Supervisor, the MISSION-VET team helps the Veteran resolve problems that arise, teaches and reinforces skills needed to meet personal goals, and celebrates the Veteran's achievements.

MISSION-VET services can be delivered over two, six, or twelve month service delivery schedules. Services can also be initiated in a range of settings, including within inpatient and residential treatment programs, or once the Veteran has received a housing placement (for example, stable and permanent housing arrangements made available through the joint Department of Housing and Urban Development and the Department of Veterans Affairs Supportive Housing (HUD-VASH) program). Consistent with the CTI model, services provided by MISSION-VET Case Managers and Peer Support Specialists taper off as the Veteran becomes more confident in his or her ability to access and use essential supports and to function independently in the community, free from drugs and/or alcohol.

MISSION-VET primarily focuses on the delivery of case management to meet the unique needs of homeless and formerly homeless Veterans with co-occurring disorders. It includes treatment for mental health and substance abuse, vocational and educational support, and incorporates trauma-informed care considerations.

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

2. Case managers are trained to deliver 13 structured psychoeducational Dual Recovery Therapy (**DRT)** sessions, which can be delivered in either a group or individual format. Discussion and exercises help raise Veterans' awareness of the impact of substance abuse, mental illness, and other harmful behavior on their lives, and offer tools to aid in recovery.

3. **Peer support** is provided alongside case management to help Veterans maintain sobriety and mental health, follow healthy lifestyles, and participate in needed support–thus bolstering the effectiveness of the other interventions. Peer Support Specialists offer inspiration, the understanding of one who has "been there," and assistance in adjusting to new routines such as attending 12-Step programs.

4. **Vocational/Educational supports** are offered by the MISSION-VET team to help Veterans find and maintain employment and to achieve educational goals, contributing to daily living stability and improved self-esteem.

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

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

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

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Emily Muñoz

This chapter provides information that will interest administrators and program managers who are considering replicating the MISSION-VET program in their own treatment settings. It provides an explanation of how the Mission-Vet program has been adapted from the previous mission program, and summarizes the MISSION-VET program and the key elements to be addressed when the program is adapted and implemented, including target population; treatment setting; the service components included in the program; staffing, education and training requirements; and other strategic considerations. More detailed information on the models of care that inform the MISSION-VET intervention and on the roles of staff that are crucial to its success are found in later chapters.

A. Introducing MISSION-VET: History and Background

Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking: Veterans Edition (MISSION-VET) is a flexible, time-limited, and integrated treatment intervention rooted in the Health Belief Model (Becker, 1974). Originally known as Time-Limited Care (TLC) coordination (Smelson et al., 2005; Smelson et al., 2007; Smelson et al., 2010), the program has been used successfully by U.S. Department of Veterans Affairs (VA) programs nationwide and recognized by the VA's Office of Mental Health Services as a promising best practice.

TLC, which has become the MISSION-VET 2-month curriculum, was originally developed in 1999 in the VA New Jersey Health Care System (VANJ) and studied in a randomized controlled trial through VA Merit # IIR-020-145. TLC integrated elements of Critical Time Intervention (CTI) case management, Dual Recovery Therapy (DRT), and Peer Support to meet the multi-faceted needs of Veterans who were suffering from co-occurring serious mental illness (SMI) and substance use disorders transitioning from acute psychiatric to outpatient care. Together, CTI and DRT formed the core treatment components of the TLC model, and Peer Support Specialists encouraged community treatment engagement among Veterans. TLC Case Managers and Peer Support facilitated the transition from inpatient to outpatient care, providing more support than the traditional service model during a critical time.

In 2004, TLC was expanded from a 2- to 12-month model in order to provide Veterans with longer support given their expanding service needs. This 12-month service delivery schedule, MISSION, offered longer community support and service linkages for homeless Veterans with non-psychotic mental health and substance abuse problems. The decision to lengthen the period during which the transitioning Veteran received support was based on the concern that the target population would likely not be eligible for the many VA and community programs geared towards the treatment of Veterans without a Serious Mental Illness (SMI) and would, therefore, likely need longer community-based supports to establish housing stability, maintain sobriety, and achieve community independence. Furthermore, the target population of the MISSION program was often not eligible for entitlements such as VA disability and Social Security disability.

A study of the 12-month curriculum was supported by grant #TI16576, funded by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The study was performed in the VANJ and targeted Veterans in the 14-week Domiciliary (DOM) program.

The following guide outlines the adaptations of MISSION services as they have been implemented and reported in the literature over the past 11 years:

Figure 1: Names and Characteristics of MISSION Programs

TLC (1999)	***Components:*** Critical Time Intervention (CTI), Dual Recovery Therapy (DRT), and Peer Support. ***Treatment Length:*** 2 months ***Target Population:*** Veterans with Serious Mental Illness (SMI) and co-occurring substance use disorder ***Setting:*** Acute psychiatry/inpatient treatment program
MISSION 12-month (or MISSION NJ) (2004)	***Components:*** CTI, DRT, Peer Support, and Vocational Support. ***Treatment Length:*** 12 months ***Target Population:*** Homeless Veterans with non-psychotic mental illness and co-occurring substance use disorder ***Setting:*** Residential treatment program
MISSION-VET (2010)	***Components:*** CTI, DRT, Peer Support, Vocational/Educational Supports, and Trauma-Informed Care Considerations ***Treatment Length:*** 2 months, 6 months, or 12 months ***Target Population: :*** Homeless and formerly homeless Veterans with mental illness (either SMIs or non-psychotic mental illness) and co-occurring substance use disorder ***Setting****:* Inpatient treatment program, residential treatment program, or community-based outpatient setting once placed in housing (HUD-VASH)

The MISSION approach has been shown to improve outcomes related to substance use, psychological functioning, and housing/employment retention (see Appendix A). Research further suggests that MISSION increases treatment retention and participation in outpatient services, while also improving behavioral health outcomes in other domains. Those interested in learning more about the findings from these treatment studies than is provided in Appendix A are encouraged to review the following publications: Smelson et al., 2005; Smelson et al., 2007; Smelson et al., 2010).

The MISSION-VET program presented in this manual has been enhanced to be more Veteran-centric in response to the VA's goal of ending Veteran homelessness by 2015. Chapters and resources added to this manual that were not found in the previous MISSION Treatment Manual include a review of homeless programs and resources within the VA, a chapter on trauma-informed care, expanded information on vocational support, including information on educational supports. We have developed additional resources, included as appendices, which Case Managers and Peer Support Specialists will find useful when implementing the MISSION-VET model.

B. Target Population and the MISSION-VET Team

Veterans are eligible for MISSION-VET services if they are homeless and transitioning from inpatient or residential treatment to community living and outpatient care; or if they are formerly homelessness living in the community, and in need of additional support in adjusting to independent community living. Additionally, in order to be eligible for MISSION-VET treatment services, Veterans must also meet the following criteria:

- Homeless or at-risk for homelessness
- Diagnosed with both a substance use disorder and mental illness
- Willing to take part in the program and receive services
- Able and willing to live in the community

The MISSION-VET team consists of a Program Director, Clinical Supervisor, Case Managers (CM), and Peer Support

Specialists (PSS). The heart of the intervention is the support provided by CM /PSS treatment teams, who work together to help Veterans make the critical transition from homelessness to community living.

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

C. The Population's Need for Services

Homelessness remains a persistent public health concern and a national tragedy. According to data from the 2009 Annual Homeless Assessment Report to Congress (AHAR), there were 643,067 individuals living across our country that were literally homeless on a single night in January. Sixty-three percent of those counted were sleeping in emergency shelters or transitional housing. Thirty-seven percent were unsheltered, sleeping on the streets, in cars, in abandoned buildings, or other places not meant for human habitation (AHAR, 2009). The VA estimates that approximately 12% of the homeless population identified in the AHAR are Veterans. VA's 2010 Community Homeless Assessment, Local Education and Networking Group (CHALENG) report, which provides a yearly estimate of homelessness among Veterans, estimates that there are approximately 107,000 Veterans who are homeless at any single point in time (CHALENG, 2009).

The VA notes that the majority of Veterans who are homeless served in the Vietnam and post-Vietnam era. However, a growing number of Veterans who served in Iraq and Afghanistan are now being identified as persons who are homeless and living in community shelters, on the streets of our cities, or in our rural communities. Furthermore, mental illness and substance abuse have been recognized as important contributing factors to chronic homelessness, especially when these conditions co-occur (North et al., 1996). Nationally, approximately 45% of homeless Veterans suffer from a mental illness and (with considerable overlap) slightly more than 70% suffer from alcohol or drug problems (VA, 2010).

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

D. Settings for Service Delivery

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

Major Goals of MSSION-VET

1. Provide Veterans with direct support services to help them maintain housing, address mental health and substance abuse problems, and attain their employment and education goals.
2. Help Veterans engage in treatment, become integrated members of their communities, and maintain lives in recovery.
3. Coordinate care for Veterans across providers within and outside the VA.

MISSION-VET in Inpatient/Residential Settings

When MISSION-VET is delivered in conjunction with inpatient/residential treatment, the MISSION-VET CM/PSS team begins to interact with "their" Veterans while they are in the residence and build a foundation that will enable them to provide longer-term support as Veterans re-enter the community. The focus here is on transitional support, using interactions with the inpatient/residential staff to get to know the Veteran, and using discharge planning to provide a roadmap for treatment once in the community. During the inpatient/residential phase of treatment, staff from the inpatient/residential program have the central role in treatment planning, and the MISSION-VET team coordinates its work with them. By respecting the role of inpatient/residential staff as primary caregivers, the MISSION-VET team is able to provide enhanced services, develop functional working relationships with both treatment facility staff and the Veteran, and monitor progress of the Veteran throughout inpatient/residential treatment as detailed in the "*Role of MISSION-VET Staff"* table. Once the Veteran leaves the inpatient/residential setting, the MISSON-VET CM/

PS Sworks with the Veteran to help him/her achieve recovery goals and resolve challenges that arise along the way, preventing a return to homelessness.

Role of MISSION-VET Staff While Veteran is in Inpatient/Residential Treatment

- Participates in the development of the treatment plan
- Participates with residential staff in weekly team meetings
- Contributes to the development of the housing plan
- Participates in the development of the discharge plan
- Delivers group sessions on Dual Recovery Therapy (Case Managers) and issues related to the transition to community life (Peer Support Specialists)
- Plays a key role in helping to facilitate the discharge plan

Given the flexibility of the MISSION-VET approach, administrators and program managers should feel comfortable setting up MISSION-VET in any VA or non-VA inpatient or residential setting, regardless of treatment length. While the 12-month MISSION model was developed in conjunction with a 14-week residential program, the approach can be modified by adjusting the timeline of contact in the inpatient/residential treatment phase. For example, sessions related to community transition can be delivered as the Veteran's discharge from inpatient/residential is approaching. Ideally, the Veteran could complete the 13 DRT sessions while still in inpatient/residential care, since these psychoeducational sessions offer skills for community living.

MISSION-VET in Community Settings

A transition from inpatient/residential care to the community is not a necessary requirement for implementing the MISSION-VET program. MISSION-VET may begin when a Veteran who has been homeless receives a housing placement and begins to adjust to a new life in the community. It is particularly well suited for use in the Housing and Urban Development and Veterans Affairs Supportive Housing initiative (HUD-VASH), through which previously homeless Veterans receive housing and supportive services, including case management and treatment. When used to support Veterans in the HUD-VASH program, MISSION-VET services are initiated at the time the Veteran enrolls in HUD-VASH.

The primary difference between implementation of MISSION-VET in inpatient/residential and community settings is the loss of a stabilization phase in a controlled environment, which may require the MISSION-VET CM/PSS team to offer more services and be even more proactive at the outset. Nevertheless, the goals of MISSION-VET remain consistent: engagement in mental health and substance abuse treatment, housing stability, and improved income/employment.

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

Role of MISSION-VET Staff in Community Care Settings

1. Facilitates execution of the treatment plan
2. Participates with HUD-VASH case managers and other care providers in weekly team meetings
3. Contributes to the development of the housing maintenance plan
4. Provides linkages to outpatient substance abuse, mental health, and medical treatment services
5. Plays a key role in coordinating both VA and non-VA services
6. Supports and inspires Veterans by helping them pursue and achieve their goals as community members

E. Service Components

The MISSION-VET model includes five essential components, each of which will be discussed in the section below. These include **Critical Time Intervention (CTI)**, the foundation of MISSION-VET's services; **Dual Recovery Therapy (DRT)**, to address co-occurring mental health and substance use disorders (COD); **Peer Support**, which models and supports life in recovery; **Vocational and Educational Support,** which helps Veterans reclaim productive lives and achieve personal goals; and **Trauma-Informed Care Considerations,** which include the implications of trauma for effective treatment (Fallot & Harris, 2001) and ensures that Veterans who need specialized treatment for trauma-related symptoms are referred to qualified resources able to provide that support. If onset of trauma-related symptoms occurs acutely, Veterans return to the MISSION-VET program once these symptoms have been stabilized.

Essential Components of the MISSION-VET Model

1. **CTI** case management is used as the foundation of MISSION-VET's service components. CTI is designed to give Veterans a "running start" then provides a "safety net" of intensive services upon re-entry into the community, thus establishing firm linkages between Veterans and needed services.
2. **DRT** helps educate Veterans on the impacts of substance use, mental illnesses, and harmful behavior, offering exercises and tools to aid in recovery.
3. **Peer support** helps Veterans engage in sobriety and mental health stability services with a "battle buddy" approach. The personal relationship and support provided by someone who "has been there" also bolsters the effectiveness of the other interventions.
4. **Vocational and Educational Support** helps Veterans find and maintain employment. This contributes to stability in daily living and improved self-esteem. MISSION-VET includes educational supports to help Veterans understand and utilize benefits such as the Post-9/11 GI Bill, navigate enrollment and registration processes, and further and sustain their educational goals.
5. **Trauma-Informed Care Considerations**: MISSION-VET Case Managers and Peer Support Specialists are trained to screen for and identify trauma-related symptoms and, in cases of acute symptoms, make referrals to treatment providers who are better trained to treat Post-Traumatic Stress Disorder (PTSD) and other trauma-related disorders. They are also trained to provide ongoing support for Veterans while Veterans are receiving treatment from a specialized PTSD program and to serve Veterans who are not acutely symptomatic and do not require specialized PTSD services.

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

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

Within MISSION-VET, CTI has been adapted to meet the needs of homeless or formerly homeless Veterans with COD. The classic approach to CTI begins with the Veteran's discharge into the community and is divided into three phases. The phases are characterized by a decreasing frequency in services.

Three Phases of CTI

1. Transition to Community: The Veteran and MISSION-VET Case Manager formulate an individualized treatment plan and identify community resources and service linkages most consistent with the Veteran's needs. During this phase, the Case Manager may need to pay particular attention to monitoring medication compliance and facilitating appointments with mental health and other medical service providers.
2. Try-Out: Systems of community support are tested and adjusted and the MISSION-VET Case Manager and Peer Support Specialist identify any service gaps or areas where the Veteran requires more or less support.
3. Transfer of Care: Long-term, community-based linkages are established and fine-tuned to assure that transfer of care issues are resolved and long-term goals are finalized.

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

CTI uses the "Stages of Change" (Prochaska & DiClemente, 1983) model and Motivational Interviewing (Miller & Rollnick, 2002), to help Veterans develop a commitment to community-based recovery, remain engaged in treatment, maintain housing, sustain employment, and find other needed supports. The use of CTI within MISSION-VET has been developed in collaboration with Dr. Alan Felix from the original CTI development team at Columbia University. Successful implementation requires the presence of trained MISSION-VET CMs who have developed working relationships with key people able to link Veterans to community-based supports and services. Programs implementing the model need to establish ways of tracking each contact between staff and Veterans, assessing their progress and making the appropriate referrals to meet their needs.

Outcomes Achieved with the CTI Approach

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

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

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

Dual Recovery Therapy (DRT) as used in MISSION-VET

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

Dual Recovery Therapy (DRT) (Ziedonis & Trudeau, 1997) is an intervention that addresses COD in an integrated manner. DRT blends and modifies traditional addiction treatment therapies (relapse prevention, motivational enhancement therapy, 12-step facilitation) with traditional mental health approaches (cognitive-behavioral therapy, supportive psychotherapy/social skills training). DRT is consistent with existing therapeutic models that manage both substance abuse and psychiatric conditions simultaneously (Bennett, et al., 2001; Drake, et al., 1998; Minkoff, 1989; Shaner, 1997). Numerous studies have demonstrated improvements for populations with COD who received DRT (Ziedonis & Trudeau, 1997; Ziedonis & Simsarian, 1997; Ziedonis & Stern, 2001). DRT includes two aspects that have been adopted by the MISSION-VET program:

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

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

DRT is delivered by the MISSION-VET CM through 13 weeks of structured psychoeducational sessions.

Topics Addressed in DRT Sessions

1. Onset of Problems (History of lifetime substance use and psychological symptoms)
2. Life Problem Areas Affected by the Individual's Co-occurring Disorder
3. Motivation, Confidence, and Readiness for Change
4. Developing a Personal Recovery Plan
5. Decisional Balance
6. Communication Skills Development
7. 12-Step Orientation and Recollections
8. Anger Management
9. Relapse Prevention
10. Interpersonal Relationships
11. Changing Unhealthy Thinking Patterns
12. Changing Irrational Beliefs
13. Activity Scheduling

Additionally, booster DRT sessions and ongoing review of DRT worksheets and exercises should be used as needed after completion of the 13 DRT psychoeducational treatment

sessions. When a Veteran enrolls in the MISSION-VET program, he or she receives a *MISSION-VET Consumer Workbook* that contains all of the original DRT exercises, along with additional exercises and readings. All MISSION-VET CMs and PSSs receive training in the principles of DRT to ensure consistency of the approach. See Chapter IV on Case Management and Chapter V on Peer Support for further details on implementing DRT sessions within the MISSION-VET program.

Peer Support

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

Peer support services, services provided by Veterans who are role models for recovery, are emerging as an evidence-based practice for individuals with COD (Chinman, et al., 2010; Fisk, et al., 2000; Klein, et al., 1998; Roman & Johnson, 2002) as well as for individuals who are homeless (Besio & Mahler, 1993; Van Tosh, 1993). As part of the VA's major initiative to create "a system of care that is recovery-oriented, high quality, and maximizes the delivery of evidence-based practices," Peer Support Specialists (called Peer Support Technicians in VA) are now used as a part of many treatment teams within the Mental Health Service of the VA (Chinman et al., 2008). This development was first called for as a specific recommendation of the VA's Mental Health Strategic Plan ("Hire Veterans as Peer/Mental Health Para-Professionals," Mental Health Strategic Plan Workgroup, 2004). The role of Peer Support Specialists or Technicians was further codified in 2008 in the VA's *Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics* (Office of Mental Health, 2008), which lists the mental health services all VA facilities must provide. That document states that "all Veterans with serious mental illnesses must have access to Peer Support" (pg. 28).

As part of this shift in the paradigm of care, peer providers help to move mental health services towards a sharper focus on recovery as defined by the Veteran–by identifying and eliminating subtle forms of stigma and bias within the health care system that can negatively impact treatment engagement if left unaddressed. Within the MISSION-VET treatment program, PSSs can play an important role in helping the Veteran to become a more fully integrated member in his or her community. PSS's can help Veterans work toward and achieve their goals and, in collaboration with the MISSION-VET CM, call on a range of community providers to step up to the plate and help make recovery a reality.

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

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

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

Topics Addressed in Peer-led Sessions

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

Vocational and Educational Supports

Besides the stigma accompanying diagnoses of mental illness and substance abuse and any functional limitations that they may impose, Veterans with COD may face other barriers to achieving their employment and educational goals. Veterans with prior criminal justice involvement or gaps in employment may be less likely to be selected for a job. Furthermore, Veterans receiving MISSION-VET services have limited resources. Often, these Veterans are unprepared for job competition and even job application, and may need training in skills such as looking for a job, preparing and sending out resumes, and interviewing with potential employers. Even if a job is obtained, job tenure for Veterans with COD is especially low. Additionally, there may be difficulties interacting with co-workers or supervisors, handling relapses, or coping with symptoms like poor concentration, anger, and/or drug use cravings. When possible, MISSION-VET staff link Veterans to vocational rehabilitation programs such as VetSuccess, Compensated Work Therapy, and Supported Employment. After the Veteran is able to maintain employment independently, these services are phased out.

MISSION-VET CMs and PSSs use the following Supported Employment principles to help facilitate the Veteran's full- or part-time employment, negotiate workplace accommodations, and build continued employment eligibility.

Supported Employment Principles Used in MISSION-VET

1. Zero exclusion
2. Integration of vocational and treatment services
3. Competitive employment
4. Benefits planning
5. Rapid job search
6. Follow-along supports
7. Veteran preferences

(Adapted from Swanson, Becker, Drake, & Merrens, (2008) Supported Employment, A Practical Guide for Practitioners and Supervisors, published by the Dartmouth Psychiatric Research Center, Lebanon, NH)

MISSION-VET CMs and PSSs also provide linkages to other key vocational resources. Some examples include helping Veterans to access training through the Department of Labor, Division of Vocational Rehabilitation, and/or job placement assistance through "One Stop" Career Centers. For more in-depth information on Vocational Supports, please refer to Chapter VI. *Vocational and Educational Supports for Veterans.*

As described in the following table, homeless and formerly homeless Veterans with COD may also face formidable barriers to achieving their educational goals., including:

Barriers to Achieving Educational Goals

- Lack of knowledge or difficulty in accessing GI Bill benefits
- Lack of knowledge about which educational programs would meet their needs
- Difficulty negotiating the admission and enrollment process
- Feeling isolated or stigmatized on campus
- Difficulty keeping up with course demands

Supported education is a service that provides individualized and practical assistance to help students (in this case, Veterans) with mental illness achieve their educational goals. Supported Education is considered an "emerging" evidence-based practice for people with mental illness by SAMHSA. The principles of Supported Education can be used by MISSION-VET CMs and PSSs as described in the following table.

Supported Education Principles Used in MISSION-VET

1. Accessing GI Bill benefits
2. Interface with campus system including Administration and Faculty
3. Acquire support on campus through Veterans service offices
4. Determining educational goals
5. Ongoing monitoring and support

Trauma-Informed Care Considerations

MISSION-VET is not a specific trauma or PTSD intervention. However, as many homeless Veterans have experienced trauma, trauma-informed care considerations have been incorporated into the overall MISSION-VET treatment model. MISSION-VET CMs and PSSs receive training on how to screen Veterans for trauma and how to coordinate care with specialized trauma clinicians, when needed, until trauma-related symptoms stabilize. MISSION-VET CMs and PSSs can provide support to Veterans with elevated trauma symptoms; however, they are not expected to serve as primary providers of care for trauma-related disorders.

Goals of Trauma-Informed Care as Incorporated in MISSION-VET

- Establish strong rapport with the Veteran in an attempt to make him/her feel comfortable in raising any trauma-related concerns.
- Document any trauma-related issues and review with Clinical Supervisor.
- Develop a plan for increased safety when necessary (identifying triggers, reinforcing recovery thinking, supporting the use of techniques to address trauma symptoms, and creating meaning).
- Provide referrals and coordinate services to specialized clinicians as needed.

F. Replicating MISSION-VET: Essential Services and Staffing

By blending the delivery of previously tested components of the MISSION-VET model (CTI, DRT, Peer Support, and Vocational/Educational Supports) with Trauma-Informed care considerations, the authors strongly believe that the MISSION-VET approach can more comprehensively address the multi-dimensional service needs of homeless and formerly homeless Veterans with COD. The effectiveness of the original MISSION-NJ model was indicated in the outcomes of our original 12-month MISSION program study (Smelson et al., 2010). Therefore, we recommend that any replication or adaptation of the model include all of these elements, even if accomplished through partnerships with outside providers.

The collaborative efforts of MISSION-VET CMs and PSSs are seen as the essential conduit of service access and delivery. While caseloads often vary, depending on a variety of factors, the authors generally recommend a caseload of approximately 25-30 Veterans at any given time. The number of CM/PSS teams should be dictated by the needs of the agency implementing the MISSION-VET program.

G. Orientation, Training, and Continuing Education

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

It is also important to consider additional training for the MISSION-VET PSS role. The authors recommend using a training program that is designed specifically for PSSs working within traditional mental health systems.

Subjects to Address in Training for Peer Support Specialists

- The meaning and role of peer support
- Skills needed to create and facilitate a variety of group activities that support and strengthen recovery
- The recovery process and how Peer Support Specialists can use their own recovery story to help others
- Self-care, including how to manage conflict and stress in the workplace
- 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 interview skills

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

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

H. Logistical Requirements

There are several logistical requirements to consider as you implement the MISSION-VET program. It is essential to

have clear policies and procedures governing transportation, reimbursement for travel expenses, and handling of emergencies involving Veterans in the community. The following overview serves as a resource to help you develop appropriate guidance for your system.

Key Logistical Requirements for MISSION-VET

Transportation

- MISSION-VET Case Managers and Peer Support Specialists spend a significant portion of their time meeting with Veterans in the community, which requires constant access to reliable transportation. Community outreach is an essential element of MISSION-VET service delivery, but each agency and setting has unique policies and liability issues that must be taken into consideration.
- It is generally necessary for all MISSION-VET staff to have a valid driver's license. Ideally, team members should have access to a vehicle that can be used to meet Veterans in the community. If this is not possible, staff can also be asked to use their own transportation or public transportation, with proper reimbursement for these expenses.

Communication

- MISSION-VET Case Managers and Peer Support Specialists must have a reliable way to communicate with "their" Veterans as well as with each other. Case Managers and Peer Support Specialists on the MISSION-VET team utilize cell phones and e-mail communication regularly.
- All MISSION-VET staff must have access to computers to maintain documentation and access program files and resources.

Safety

- Safety is the primary consideration associated with logistical aspects of the MISSION-VET program. As with any program requiring staff to work alone in the community, they must have a means of calling for immediate assistance if needed. This includes traveling with a cell phone at all times.
- MISSION-VET staff are encouraged to use their own judgment to determine whether they feel unsafe in certain areas or neighborhoods and are encouraged to conduct visits in teams when necessary.
- In circumstances in which team members feel unsafe and are worried about the safety of their Veterans, staff are reminded that they can always call 911.
- Regular discussion of safety issues in supervision is also recommended.

Emergencies

- After-hours, on-call schedule policies vary by institution. While the authors believe that on-call mechanisms can be helpful, as the Veterans served often have after-hour crises, an equitable arrangement should be made across staff with regard to coverage.
- It is critical to have a mechanism for immediate consultation between MISSION-VET Case Managers or Peer Support Specialists with their Clinical Supervisor when needed, as well as access to a physician for any medical emergencies. For systems that are unable to support an on-call mechanism, MISSION-VET staff are encouraged to discuss an emergency plan and review contact information for local Emergency Rooms with the Veteran as part of the introduction to the program. Staff are further encouraged to leave information on how to contact these local agencies for emergency assistance on their telephone answering machines.

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NOTES

II. Homelessness Among Veterans

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MISSION-VET staff will want to ground their work in a thorough understanding of the problem of homelessness among Veterans, as well as the programs and initiatives designed to address this national challenge. This chapter includes a description of the Department of Veterans Affairs (VA) plan to end homelessness among Veterans as well as Opening Doors: Federal Strategic Plan to Prevent and End Homelessness. It provides an overview of the problem of homelessness among Veterans and describes some of the key programs that are designed to assist these Veterans. Since the MISSION-VET program relies on linkages with other programs serving the same population, it is particularly important for all MISSION-VET staff to be familiar with their goals and eligibility requirements.

A. The Federal Plan to Prevent and End Homelessness

In 2009, VA took decisive action toward its goal of ending homelessness among our nation's Veterans. To achieve this goal, the VA, under the leadership of Secretary Eric Shinseki, developed a comprehensive plan to end homelessness among Veterans that will assist every eligible homeless Veteran and Veterans who are at risk for homelessness. The plan helps Veterans acquire safe housing and provides access to primary care and specialty mental health care, substance use disorder treatment, support services, and homelessness prevention services. It also provides direction for Veterans who wish to return to employment and obtain needed benefits assistance. These services are provided to prevent Veterans and their families from entering homelessness, and to help those who have become homeless return to fulfilling lives in their communities as safely and quickly as possible.

In June 2010, the United States Interagency Council on Homelessness, announced *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness.* This plan outlines an interagency collaboration that aligns mainstream housing, health, education, and human services to end current homelessness and prevent Americans from experiencing homelessness in the future. Developed through the leadership of the United States Interagency Council on Homelessness (Secretary Shaun Donovan, U.S. Department of Housing and Urban Development; Secretary Kathleen Sebelius, U.S. Department of Health and Human Services; Secretary Eric Shinseki, U.S. Department of Veterans Affairs; and Secretary Hilda Solis, U.S. Department of Labor), the plan is based on the firm tenets that "no one should ever experience homelessness" and "no one should ever be without a safe, stable place to call home." It states four key goals.

Four Key Goals of *Opening Doors, Federal Strategic Plan to end Homelessness*

1. Finish the job of ending chronic homelessness in five years.
2. Prevent and end homelessness among Veterans in five years.
3. Prevent and end homelessness for families, youth, and children in ten years.
4. Set a path to ending all types of homelessness.

As of March 2011, there are more than 640,000 men, women, and children, including 75,609 Veterans who are homeless in America on any given night (2009 Veteran AHAR). As a firm believer that no Veteran should ever live on the streets, President Obama charged the VA with ending homelessness among Veterans by 2015, and this mandate has led to a major expansion of the joint HUD-VA Supportive Housing (HUD-VASH) program; the development of new VA initiatives to increase access to VA and community housing, employment, medical, mental health, and substance abuse treatment programs; and an increased emphasis on delivering prevention services that target Veterans at risk for homelessness.

In early 2011, through ongoing collaboration, the VA and HUD published the first-ever authoritative and comprehensive analysis of the specific nature of Veteran homelessness, titled "Veteran Homelessness: A Supplemental Report to the 2009 Annual Homeless Assessment Report to Congress." According to this report, 75,609 Veterans were homeless on a given night in 2009; a one-year estimate of sheltered homeless Veterans documented that 136,334 Veterans spent at least one night in an emergency shelter or transitional housing between October 2008 and September 2009 (2009 Veteran AHAR). Of the nearly 76,000 homeless Veterans on any given night in 2009, 57 percent were staying in an emergency shelter or transitional

housing program, while the remaining 43 percent were living on the street, in an abandoned building, or another place not meant for habitation. To read this report in its entirety, and for additional information on the state of Veteran homelessness, please download the full report at http://www.hudhre.info/documents/2009AHARVeteransReport.pdf

In light of a renewed national commitment to end homelessness among Veterans, new models of clinical intervention, particularly those that focus on transitioning Veterans to the community, are of increasing interest to VA. Successful implementation of MISSION-VET requires close cooperation with Veterans Administration Medical Centers (VAMCs), state and local governments, Veteran Services Organizations (VSOs), community programs, and health care providers to meet the unique service needs of homeless and formerly homeless Veterans who have co-occurring psychiatric and substance use disorders (COD).

The need for affordable housing is well documented, and VA housing initiatives continue to expand to address this need. Previous research has demonstrated that stable housing is instrumental in the effective delivery of health care and other social services to facilitate recovery. It is, in effect, the foundation upon which people rebuild their lives after experiencing homelessness. Permanent supportive housing – housing in which tenants receive treatment and other supports – has been shown repeatedly to be a critical adjunct in helping chronically homeless persons retain housing (www.csh.org).

B. Background on Homelessness

Homelessness remains a persistent public health concern and a national tragedy. According to data from The 2009 Annual Homeless Assessment Report to Congress, 643,067 individuals were literally homeless on a single night in January 2009; 63 percent were sleeping in emergency shelters or transitional housing, and the remaining 37 percent were unsheltered, or sleeping on the streets, in their cars, in abandoned buildings, or other places not meant for human habitation (AHAR, 2010). Homelessness exacts a grave toll on the individual and, now more than ever, on families, including low quality of life, risk of assault, and healthcare concerns that can contribute to early death. Although healthcare needs are high among homeless individuals, their access to health services is variable, with frequent reports of limited ability to access needed care, problems with treatment–thus contributing to a visous downword spiral that often results in further compliance, high reliance on emergency medical services, and frequent use of very costly inpatient hospital care including mental health and medical detoxification services. The daily struggles for food and shelter often take priority over treatment–thus, contributing to a vicous downward spiral that often results in further disengagement and isolation.

C. Overview of Homelessness Among America's Veteran Population

Recognizing the importance of treating homelessness among our nation's Veterans, VA began to provide specialized treatment services to homeless Veterans in 1987. These services were intended to complement all of the existing medical and mental health services routinely offered to eligible Veterans through the Veterans Healthcare Administration (VHA). Given the disproportionately high rate of homelessness among Veterans, these programs have grown dramatically. Each year VHA serves over 165,000 Veterans who are homeless or who are at risk for homelessness–making the VA the largest single provider of homeless services in the country.

Despite the wide array of homeless services offered, homelessness among Veterans remains an urgent issue in the United States. In order to better serve these Veterans, and in response to President Obama's mandate to end homelessness among Veterans, Secretary Shinseki has taken the lead in developing housing interventions and support strategies to eliminate existing homelessness and prevent future homelessness among Veterans. However, several challenges lie in the way of accomplishing this goal. The most common challenges include the high rate of mental health issues among homeless Veterans, including substance abuse, mood disorder, PTSD, and schizophrenia (Mares & Rosenheck, 2006).

Substance abuse is one of the most common co-morbidities among individuals with severe mental illness (SMI), including those who are homeless (Brunette, et al., 2004; Adams, et al., 2007). Approximately half of all individuals with SMI, such as schizophrenia and bipolar disorder, have lifetime substance use disorders; of those, 30% also meet the diagnostic criteria for a current substance use disorder (Regier, et al., 1990; Essock, et al., 2006). The most commonly used substances include nicotine, alcohol, marijuana, cocaine, and heroin. Furthermore, many Veterans are polysubstance users, meaning that they use cocaine and/or other drugs, drink alcohol, and smoke cigarettes concurrently. Recent data from the HUD-VASH program illustrate that over 60% of Veterans who apply to the program suffer from alcohol abuse or dependence, and that over two-thirds will have at least one psychiatric diagnosis (O'Connell, et al., 2010).

These co-occuring disorders, or COD, result in increased symptom severity, treatment dropout, increased affective instability, poor community integration, and more frequent use of costly services like emergency rooms and inpatient units (Nunes & Quitkin, 1997; Rounsaville, et al., 1987; Kranzler, et al., 1996). Furthermore, studies of labor participation suggest that both alcohol and illicit drug use worsen work performance and job retention, with COD having an even greater negative impact than either the presence of substance abuse or mental illness alone (French & Zarkin, 1992; McCarty, 1990; Mullahy & Sindelar, 1995).

The MISSION-VET treatment approach was developed specifically to target the unique housing stabilization, addiction, mental health, treatment engagement, vocational, and care coordination needs of homeless and formerly homeless Veterans with COD by systematically combining evidence-based treatment approaches into a comprehensive system of care and delivery platform. The MISSION-VET approach is assertive and community-based. In addition, the goals of the MISSION-VET program naturally dovetail with the key goals of the Federal Strategic Plan to Prevent and End Homelessness among Veterans by 2015. In line with the Federal Strategic Plan, MISSION-VET is an integrated, multifaceted, cooperative approach that draws on community partners as well as existing VA homeless programs and resources. For example, MISSION-VET services can begin either in an inpatient/residential setting, and then follow the Veteran through his or her transition to independent community living, or MISSION-VET service delivery can be initiated as Veterans enroll into the HUD-VASH program.

The overall flexibility found in the MISSION-VET treatment approach also assures that Veterans are receiving care aligned with the Federal Strategic Plan to End Homelessness among Veterans by 2015. VA's philosophy of "no wrong door" means that all Veterans seeking to remove themselves from homelessness or prevent themselves from becoming homeless must have access to essential VA and community programs and that providers must not deny them assistance. The Federal Strategic Plan is built upon six strategic pillars: Prevention; Outreach/Education; Treatment; Housing/Supportive Services; Income/Employment Benefits; and Community Partnerships.

In addition to safe, stable, and affordable housing, VA's Plan to Eliminate Homelessness states that programming must include mental health stabilization, substance abuse treatment, enhancement of independent living skills, vocational rehabilitation and employment services, and assistance with permanent housing searches and placement. To meet these objectives, MISSION-VET utilizes Case Manager (CM)/Peer Support Specialist (PSS) treatment teams to provide direct services and linkages to essential VA and community programs. Veterans enrolled in MISSION-VET receive a comprehensive array of treatment and rehabilitative services. MISSION-VET CMs and PSSs promote the Veteran's adherence to mental health, substance abuse, and medical treatment regimens through psychoeducational sessions and regular meetings with the Veteran. Additionally, MISSION-VET CMs and PSSs closely monitor fluctuations in the Veteran's substance use and mental health status which may impede housing stability. Veterans in MISSION-VET are also linked to VA and community vocational and educational rehabilitation programs to help Veterans achieve their employment and educational goals. Furthermore, MISSION-VET CMs and PSSs facilitate important connections to key community programs such as community mental health centers, outpatient substance abuse treatment programs, medical treatment centers, and 12-step groups. All of these services are provided to meet the multi-faceted needs of homeless Veterans and Veterans at risk for homelessness and to address some of the underlying root causes of homelessness. The following table illustrates how MISSION-VET services are in line with VA's Five-Year Plan to End Homelessness among Veteransby 2015.

MISSION-VET Services in Line with VA's Plan to End Homelessness among Veterans by 2015

- **PREVENTION:** Ensures that programs are available for Veterans and their families who are at risk for homelessness, and their families, that can help them maintain their housing, and that assist Veterans who have fallen into homelessness rapidly exit and become connected to housing and treatment.
- **OUTREACH & EDUCATION:** Increases access to Veterans in need of services through linkages to community programs, the VA National Homeless Call Center, and the homeless registry.
- **TREATMENT:** Ensures that Veterans are assessed for medical, dental, psychosocial, family, legal, and vocational issues and provided with comprehensive treatment for mental health and substance abuse problems.
- **HOUSING AND SUPPORTIVE SERVICES:** Ensures that Veterans are provided with transitional and permanent housing and with supportive services that include both VA and community-based treatment.
- **INCOME/EMPLOYMENT BENEFITS:** Ensures that Veterans are linked to services that will help eliminate barriers to, and promote successful attainment of, vocational and educational goals, and provide access to entitlement and short-term financial assistance.
- **COMMUNITY PARTNERSHIPS:** Ensure that Veterans are offered support in establishing connections with essential community programs that they can continue to use for services as they transition from homelessness to independent community living.

D. Existing Homeless Programs and Resources

Other homeless programs and resources currently exist that are also aligned with the six pillars described in the table. This section provides descriptions of some key VA homeless treatment programs and resources that might be helpful for various care providers. It is, however, not meant to be exhaustive. A list of available VA homeless services can be found at *www.va.gov/homeless.*

HUD-VASH

HUD-VASH is a joint program between the U.S. Departments of Housing and Urban Development (HUD) and Veterans Affairs (VA) designed to address the needs of the most vulnerable homeless Veterans. In general, the program

- assists Veterans to locate and secure safe, stable, permanent housing;
- assists the Veteran with accessing treatment and benefit services;
- helps the Veteran follow and adhere to landlord and public housing authority (PHA) procedures;
- provides planning assistance for the Veteran's move into the community; and
- ensures perpetual access to the housing voucher, case management, treatment services, and access to employment opportunities provided the Veteran continues to meet program criteria.

The primary goal of HUD-VASH is to move Veterans and their families out of homelessness. As such, it is unique among VA treatment interventions, offering placement not only to Veterans, but also to all family members in the Veteran's household. A unique feature of HUD-VASH is that the Veteran can reside with his or her family member while they are engaged in treatment. As a result, over 5000 Veterans are currently living or planning to live with dependent family members through the program.

Since HUD-VASH was developed for homeless Veterans, eligible families must include the Veteran in the household. However, any member of the household with a Lifetime Sexual Offender Registry status is not eligible to live in the housing unit. HUD-VASH does not require a set period of sobriety in order for a Veteran to be considered eligible for the program, nor does noncompliance with HUD-VASH necessarily lead to loss of the housing voucher. Rather, ongoing case management provides critical continuity of care and an opportunity to continue to assist the Veteran in his or her recovery from substance abuse and/or mental illness.

Veterans must meet the criteria in the table to be eligible for HUD-VASH.

HUD-VASH Eligibility Criteria

1. Eligible for VA Health Care services
2. Meet the definition of homelessness according to the McKinney-Vento Act
3. Require case management support services to obtain and sustain permanent housing
4. Able to complete the daily activities required of independent living
5. Does not require a set period of sobriety in order for a Veteran to be considered eligible for the program

Eligibility for HUD-VASH is determined on a case-by-case basis by the designated HUD-VASH Case Manager from the participating VAMC. HUD-VASH Case Managers determine clinical eligibility by screening and assessing mental illness, substance use, and other psychosocial factors, such as whether or not the Veteran is responsible for children and/or other family members. Concurrently, the local Public Housing Authority (PHA) determines legal eligibility (including income and criminal behavior) of each Veteran who wishes to enroll in the program. Since there is no minimum period of sobriety for eligibility, treatment services are often critical to housing maintenance among participating Veterans.

Veterans who would like to be evaluated for the program should contact the HUD-VASH program coordinator at their local VAMC directly or obtain a referral from a case manager or clinician in another VA or community homeless program. Additional information regarding HUD-VASH can be found at *http://www.va.gov/HOMELESS/HUD-VASH.asp*

Health Care for Homeless Veterans Program (HCHV)

HCHV provides outreach, case management, and community-based residential treatment. HCHV staff actively seek out those homeless Veterans that are most vulnerable and diagnosed with a chronic mental illness in an attempt to engage these Veterans in services. Veterans that may be most at-risk are offered community-based residential care through contract arrangements with local providers. Case management is provided to Veterans on an on-going basis in the community, in contracted residential treatment, or after more stable housing is obtained. HCHV staff facilitate linkages with VA medical care, VA and non-VA benefits, and vocational development and training programs and services. Most VAMCs have HCHV programs. At many sites, these HCHV programs serve as the umbrella for the medical center's other homeless Veteran programs. For more information, please visit *http://www.va.gov/HOMELESS/HCHV.asp*

National Call Center for Homeless Veterans

The VA's National Call Center for Homeless Veterans hotline was established to ensure that homeless Veterans or Veterans at risk for homelessness have free, 24/7 access to trained counselors. The hotline is available for homeless Veterans and their families; VAMCs; federal, state and local partners; community agencies; service providers; and others in the community. To be connected with a trained VA staff member, call **1-877-4AID VET (877-424-3838).**

CHALENG

The Community Homelessness Assessment, Local Education, and Networking Groups (CHALENG) for Veterans is a nationwide initiative in which VAMCs and regional office directors work with other federal, state, and local agencies and nonprofit organizations to assess the needs of homeless Veterans, develop action plans to meet identified needs, and develop directories that contain local community resources for homeless Veterans. In 2009, 16,512 people participated in Project CHALENG meetings, which bring together homeless and formerly homeless Veterans, providers, advocates, local officials, and other concerned citizens to identify the needs of homeless Veterans and then work to meet those needs through planning and cooperative action.

For more information, please visit: *http://www.va.gov/HOMELESS/chaleng.asp*

Grant and Per Diem Program (GPD)

VA's Homeless Providers Grant and Per Diem (GPD) Program was authorized in 1992 by Public Law 102-590 and permanently authorized by Public Law 109-46 in 2006. The law authorizes VA to assist public or non-profit private organizations in establishing new or expanding existing programs by awarding capital grants and per diem grants through a competitive process. The purpose is to promote the development and provision of supportive housing and/or supportive services, which help homeless Veterans achieve residential stability, increase their vocational skill levels and/or income, and achieve greater self-sufficiency. GPD-funded projects offer communities a way to help homeless Veterans with housing and services while assisting VAMCs by augmenting, or, in some cases, supplementing care. The GPD Program, an essential and critical part of Veterans Health Administration (VHA), is vital for providing safe transitional housing and supportive services for homeless Veterans.

For more information, including sample applications, please visit the GPD website: *http://www.va.gov/HOMELESS/GPD.asp*

Health Care for Re-entry Veterans (HCRV)

The Health Care for Re-entry Veterans (HCRV) program is designed to address the community re-entry needs of incarcerated Veterans. HCRV's goals are to prevent homelessness; reduce the impact of medical, psychiatric, and substance abuse problems upon community re-adjustment; and decrease the likelihood of re-incarceration for those leaving prison. To support this, VA staff across the United States have developed state-specific resource guides that identify steps Veterans can take prior to their release.

HCRV services include

- Outreach and pre-release assessment services for Veterans in prison;
- Referrals and linkages to medical, psychiatric, and social services, including employment services upon release; and
- Short-term case management assistance upon release.

For more information on the Health Care for Re-entry Veterans Program, please visit: *http://www.va.gov/HOMELESS/Reentry.asp*

Domiciliary Care for Homeless Veterans (DCHV)

The Domiciliary Care for Homeless Veterans (DCHV) program provides residential biopsychosocial treatment and rehabilitation services to homeless Veterans. The DCHV provides residential rehabilitative and clinical care to homeless Veterans who have a wide range of problems, illnesses, or rehabilitative care needs (medical, psychiatric, substance use, homelessness, vocational, educational, or social). DCHV provides a 24-hour therapeutic setting utilizing a milieu of peer and professional support. The programs provide a strong emphasis on psychosocial rehabilitation and recovery services that instill personal responsibility to achieve optimal levels of independence upon discharge to independent or supportive community living.

The average stay is four months, during which domiciliary staff provides outreach, referrals, vocational counseling and rehabilitation, and post-discharge community support services. The DCHV program houses approximately 5,000 homeless Veterans with health problems each year.

Mental Health Residential Rehabilitation and Treatment Programs (MH RRTPs)

The MH RRTPs provide state-of-the-art, high-quality, residential rehabilitation and treatment services for Veterans with multiple and severe medical conditions, mental illness, addiction, or psychosocial deficits. The MH RRTP identifies and addresses goals of rehabilitation, recovery, health maintenance,

improved quality of life, and community integration in addition to specific treatment of medical conditions, mental illnesses, addictive disorders, and homelessness. The residential component emphasizes incorporation of clinical treatment gains into a lifestyle of self-care and personal responsibility.

VA Prevention and Supportive Services for Veteran Families Program (SSVF)

Public Law 110-387 authorized VA to develop the new Supportive Services for Veteran Families (SSVF) program. In 2011 under the SSVF Program, VA will award grants to private non-profit organizations and consumer cooperatives who will provide supportive services to very low-income Veteran families residing in or transitioning to permanent housing, after exiting permanent housing, or are seeking other housing responsive to low-income Veteran family needs and preferences. The new SSVF Program is within the continum of VA's homeless services.

Homeless Veteran Supported Employment Program (HVSEP)

The goal of the Homeless Veteran Supported Employment Program (HVSEP) is to provide employment services for homeless Veterans, and Veterans at-risk of homelessness, utilizing the model of Compensated Work Therapy (CWT)/ Community Based Supported Employment (SE). CWT is a clinical program that provides work restoration and vocational services integrated into treatment, as part of VHA's comprehensive efforts to increase community integration and the economic wellbeing of its participants. Vocational and employment services to homeless Veterans will be based on rapid engagement, customized job development, and competitive community placement, with on-going supports for maintaining employment.

Medical centers will be funded to hire 400 new Homeless Vocational Rehabilitation Specialists (HVRS), at the GS-1715-5, 7, or 9 levels, utilizing the Schedule A Non-Competitive Appointing authority (5.C.F.R. 213.3102u). For these positions, medical centers will be required to recruit and hire Veterans who are homeless, formerly homeless, or at-risk of homelessness.

For additional information on CWT and SE please refer to Chapter VI Vocational and Educational Supports for Veterans.

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NOTES

III. The MISSION-VET Model of Care

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

A. Critical Elements of the MISSION-VET Program

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

The primary goal of the MISSION-VET treatment model is to facilitate rapid community transition and achievement of personal goals by helping participating Veterans engage in a comprehensive array of outpatient services. The MISSION-VET model uses Case Managers (CM) and Peer Support Specialists (PSS) who link participating Veterans to community resources such as outpatient mental health and substance abuse treatment programs, primary and specialty medical care, vocational/educational rehabilitation services, and providers trained to deliver trauma-informed treatment services. Overall, the goal is to increase Veterans' participation in these services by increasing their motivation to do so and by empowering each Veteran receiving MISSION-VET services to manage their own lives and sustain satisfying lives in their communities.

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

1. CTI case management is used within MISSION-VET as the core treatment intervention. CTI is designed to give Veterans a "running start" and "safety net" by providing intensive services upon re-entry into the community, thus establishing firm linkages between Veterans and needed services.
2. DRT involves MISSION-VET Case Managers delivering 13 structured psychoeducational sessions to help raise Veterans' awareness of the impact of substance use, mental illness, and harmful behaviors on their lives. It offers tools to aid in recovery and encourages Veterans to reflect on their goals and choices.
3. MISSION-VET Peer Support Specialists work alongside Case Managers and seek to help Veterans maintain their sobriety and mental health, follow healthy lifestyles, and participate in needed supports, thus bolstering the effectiveness of the other interventions.
4. MISSION-VET Case Managers and Peer Supports Specialists help Veterans find and maintain employment, which in turn contributes to general daily living stability and improved self-esteem. They also assist them with achieving educational goals.
5. MISSION-VET Case Managers and Peer Support Specialists are trained to screen for trauma-related symptoms and, when appropriate, refer Veterans to clinicians better equipped and trained to treat PTSD and other trauma-related disorders.

B. Critical Time Intervention (CTI) Case Management

Critical Time Intervention (CTI) case management is an evidence-based, time-limited form of case management that provides the foundation of the MISSION-VET treatment approach. CTI is used to link Veterans with needed

community services and to address common institutional barriers to service access. CTI was originally designed to help homeless people with serious mental illnesses (SMI) successfully make the transition from institutional care to community living by providing services that decrease in intensity over the first nine months following discharge (Susser, et al., 1997). MISSION-VET adapts the original design of CTI slightly to also provide support to Veterans who have recently transitioned to the community (such as Veterans recently enrolled in the HUD-VASH program) in addition to Veterans transitioning to the community from inpatient/residential treatment settings. Because lack of support during this "critical time" can lead to recurrent homelessness, MISSION-VET emphasizes the need for a continuum of care and flexibility in meeting Veterans' needs, recognizing that different Veterans require different levels of attention and services.The first randomized trial (Susser et al., 1997) of CTI case management examined outcomes among 96 individuals transitioning from a homeless shelter to community living who received either a 9-month CTI intervention or Usual Services and found that those individuals who received CTI experienced fewer days of homelessness, greater continuity of care, and increased use of community supports as compared to individuals who received Usual Services only. In addition to reducing homelessness, CTI has been shown to reduce the severity of psychiatric symptoms, alcohol and drug use, and significantly reduce treatment costs because it decreases the use of more intensive services while producing comparable outcomes (Jones et al., 2003; Kasprow & Rosenheck, 2007).

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

Comparison of CTI to Traditional Case Management

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

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

Areas of Intervention

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

1. ***Psychiatric treatment and medication management.*** The primary responsibility of the MISSION-VET CM/PSS team is to link Veterans to services rather than to serve as the Veteran's therapist. The MISSION-VET CM and PSS assist in areas such as accompanying Veterans to initial treatment visits and overseeing their participation in follow-up visits, monitoring medication compliance, or helping Veterans with service-connected psychiatric disabilities receive the additional health benefits to which they are entitled.
2. ***Money management.*** The MISSION-VET CM and PSS help the Veteran establish a bank account and create a budget. The team also assists with collecting any documentation needed to obtain entitlements. Neither the MISSION-VET CM or PSS, however, handles or receives the Veteran's money. This can be done, when necessary, through the identification of representative payees to ensure that rent and all other essential bills are managed monthly, particularly early in the recovery process when there are often competing financial demands.
3. ***Substance abuse treatment.*** The MISSION-VET team takes a more active role in substance abuse treatment than in psychiatric treatment. While the MISSION-VET CM works with the Veteran's 12-step sponsor and outpatient

treatment provider, both the MISSION-VET CM and PSS monitor the Veteran for signs of relapse and support the Veteran in actively reducing or eliminating substance use. As compared to CTI, the program's use of Dual Recovery Therapy (DRT) offers a more integrated and intensively structured model of addictions and mental health treatment, including specific tools to increase the effectiveness of interventions (See Appendix E for more information on the DRT exercises).

4. ***Housing crisis management.*** The MISSION-VET CM/PSS team monitors situations that threaten the Veteran's housing, such as potential eviction, psychiatric decompensation, unsafe living conditions, and proximity to drug activity. MISSION-VET team members can intervene if necessary to identify alternate living arrangements or link the Veteran to community resources that can provide support. Either team member can also play a key role in resolving housing-related conflicts, both by teaching and modeling interpersonal skills and communication strategies for the Veteran.
5. ***Family interventions.*** With the Veteran's permission, the MISSION-VET CM/PSS team may involve the Veteran's family members in providing support and responding to crises. Additionally, the CM might provide emotional support to the family or engage in psychoeducation about mental illness, substance abuse, and MISSION-VET services. Family therapy, if needed, is accomplished by referral.

Phases

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

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

   Within this phase, particular attention is paid to areas that the MISSION-VET team and Veteran feel are critical to community transition, with particular focus on the five core CTI domains previously described. Interactions might include the identification of a community-based psychiatrist, ongoing dialogue about the importance of medication compliance, the selection of a representative payee to assist with funds, the development of a realistic plan to pay rent, the identification of 12-step meetings in the community, the development of a crisis plan, and assistance in reconnecting with family and friends. The overall goal of this phase is to help the Veteran adjust to community living and to develop a support system that can be used as a foundation for community living.
2. **Try-Out**. The services offered during the *Try-Out* phase focus on establishing the link between the Veteran and community resources. During this phase, the MISSION-VET CM meets with the Veteran on a bi-weekly basis, testing and readjusting the community-based support systems in order to fill any gaps in care, again with specific attention to the five CTI domains. The MISSION-VET CM makes an in vivo needs assessment, and if necessary the MISSION-VET PSS accompanies the Veteran to counseling, medical, and other appointments in the community, identifying, first-hand, any holes in his/her support system and service plan. If holes are identified, the MISSION-VET CM/PSS team works to address and resolve those issues. As the frequency of visits decreases, MISSION-VET team members act increasingly as a liaison between the Veteran and community-based services and less as a direct provider of supports.

   It is essential that relationships are established between the Veteran and staff from resources in the community that will be valuable to his/her ongoing recovery. Examples of resources include community mental health clinics, substance abuse treatment programs, vocational/educational training programs, and Veteran's Service Organizations (VSOs). The linkages provided during this time mark the true start of the transition from services primarily being offered through the MISSION-VET team to being offered by treatment providers and other resources in the community.
3. **Transfer of care**. Visits in phase 3 are used to fine-tune the connections established with community-based resources. The MISSION-VET CM/PSS team and key community providers may meet to review the transfer of care and identify any existing gaps in services. The MISSION-VET CM/PSS team and Veteran reflect upon the work that they have done together. The termination of MISSION-VET should be viewed as another step in the journey of recovery.

Clinical Principles

The CTI intervention requires a specific clinical approach, necessitated by the short term and focused nature of the intervention. The MISSION-VET CM/PSS team should take a flexible approach to assessing the Veteran's strengths and needs, including evaluating the Veteran's long-term needs (even

though CTI is a time-limited intervention). Additionally, the MISSION-VET CM/PSS team will need to be patient and work with Veterans "where they are" in recovery. Helping Veterans to recognize and use their strengths is essential to help the Veteran transition from reliance on MISSION-VET services.

MISSION-VET CMs and PSSs will want to use the CTI manual (Felix et al., 2001) as a source of in-depth information on clinical concepts and techniques that will help them assist Veterans in becoming self-sufficient and independent in their communities. The *"Clinical Concepts of Critical Time Intervention"* table describes some of the most important concepts and techniques that MISSION-VET staff will need to employ when working with Veterans during their time in the MISSION-VET program.

Clinical Concepts and Techniques Used in CTI

- **Stages of Change** is a framework that recognizes people may be at different stages of thinking about any particular change and that, depending on where they are, people working to help them change must adapt their approach.
- **Motivational Interviewing** is a technique that reinforces motivation for recovery across problem areas in which change is needed for healthy living. Instead of advising and directing the Veteran, the person uses a "guiding" style that helps the Veteran hear his/her *own* reasons and desire for change. Treatment Improvement Protocol 35, *Enhancing Motivation to Change*, a free resource developed through the Substance Abuse and Mental Health Services Administration, addresses both motivational interviewing and the stages of change. It may be downloaded at this address: *http://www.kap.samhsa.gov/products/manuals/tips/numerical.htm*
- **Harm Reduction** is a therapeutic approach that recognizes people may be doing the best they can in recovery, even when their choices are flawed, and that punishment for engaging in problematic behaviors is not the best response. Rather, this approach encourages discussion of the negative consequences associated with problematic behaviors, focuses on reducing harmful behaviors and their impact, and promotes adaptive coping strategies. See, for example: *http://www.peele.net/lib/smart.html*
- **Attachment and Engagement** strategies create an environment in which the person feels comfortable and safe to explore problem areas and develop insights that will help break the cycle of engaging in problematic behaviors.

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

CTI Counseling Techniques

- Observing nonverbal behavior
- Identifying discrepancies between verbal and nonverbal behavior
- Reflecting the Veteran's feelings
- Clarifying the Veteran's statements
- Staying aware of the Veteran's history and cultural background
- Maintaining an awareness of the care provider's own feelings and actions

C. Dual Recovery Therapy (DRT)

MISSION-VET addresses co-occurring mental illnesses and substance abuse (COD) through the use of Dual Recovery Therapy (DRT) (Ziedonis & Trudeau, 1997). DRT is consistent with existing therapeutic models that manage both substance abuse and psychiatric conditions simultaneously (Bennet, et al., 2001; Drake, et al., 1998; Minkoff, 1989; Shaner, 1997) and has been demonstrated to significantly improve outcomes for populations diagnosed with COD (Ziedonis & Simsarian, 1997; Ziedonis & Stern, 2001). DRT is a psychoeducational approach that uses structured exercises developed around addiction treatment therapies (Relapse Prevention, Motivational Enhancement Therapy, and 12-Step Facilitation) and mental health approaches (Cognitive-Behavioral Therapy and Social Skills Training). The guiding premise of the DRT approach is that equal attention must be paid to both psychological and substance abuse symptoms and that successful treatment will address the interrelationship of the two problems.

DRT structured weekly sessions begin immediately after the Veteran enrolls in the MISSION-VET program (see Appendix E for more information on DRT sessions and exercises). DRT sessions are designed to help Veterans recognize the nature and interrelationships of their COD and to choose supports and goals that will help them maintain healthy lives in recovery despite the presence of these disorders and the often complicated history that goes along with them. Therapeutic techniques that facilitate the delivery of the 13 structured psychoeducational sessions are also included and described at length later in this manual (see Appendix E). Delivered by a

MISSION-VET CM, DRT sessions teach Veterans skills that will support them in their recovery from both psychiatric and substance use disorders and adjustment to community living. Specifically, the topics covered in the DRT sessions will help the Veteran to:

- develop skills for recovery from drugs, alcohol, and mental health issues which in turn prevents housing instability and loss;
- develop an understanding of the relationship between the Veteran's mental health and substance abuse problems and how the two are interrelated; and
- understand that both mental health and substance abuse issues need to be monitored together and that level of motivation to change can be different for each problem area.

At the onset of enrollment, DRT is delivered weekly by a MISSION-VET CM. It is intentionally delivered at the onset of enrollment in order to provide Veterans with needed skills for recovery. These sessions can be delivered in an individual or group format, but should be delivered at least once weekly. Group formats are a little more complicated logistically as Veterans enter the DRT groups at different times depending on their enrollment into the MISSION-VET program. Consequently, each group may include Veterans who have attended several DRT sessions or none at all. DRT sessions can also be delivered more frequently if the MISSION-VET intervention is delivered over a shorter period of time. However, as illustrated in the *"Content of DRT Sessions as used in MISSION-VET"* table, the content of the DRT sessions remains the same.

Content of DRT Sessions as used in MISSION-VET Program

1. Veterans learn how mental health and substance abuse problems can affect one another.
2. Problems in specific life domains are identified to determine the impact each of these problems has had on the Veteran's life.
3. Motivation, confidence, and readiness to address each problem area are assessed to help Veterans understand their willingness or reluctance to begin work on each identified issue.
4. Treatment goals are reviewed and emphasis is placed on the importance of participating and remaining engaged in substance abuse and mental health treatment.
5. Benefits and consequences of continuing undesirable behaviors are explored.
6. Veterans learn about the importance of developing effective communication skills.
7. Orientation to or revisiting the role 12-step programs play throughout recovery is discussed.
8. Identification of situations that trigger anger and strategies to manage emotions during those situations are explored.
9. Veterans learn specific relapse prevention strategies to increase the likelihood of sobriety and decrease the chance for relapse. Special emphasis is placed on how the presence of mental health problems can lead to a relapse.
10. Veterans learn how unhealthy relationships can lead to substance use relapse and/or mental health symptom exacerbation.
11. Veterans learn how unhealthy thinking patterns can perpetuate emotional problems and result in substance use relapse. The interplay among thoughts, behaviors, and emotions is explored.
12. Veterans learn how to modify dysfunctional beliefs to maintain flexibility in thinking.
13. Veterans learn how participating in regularly scheduled healthy activities can promote recovery from substance abuse and mental illness.

D. Peer Support

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

MISSION-VET PSSs who serve as providers can empathize and provide unique support to the Veterans they serve because they know what it is like to suffer from mental illness, struggle with substance abuse, experience homelessness, and face unemployment. Many MISSION-VET PSSs 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 – but also know what it feels like to win back their lives. Because of these shared experiences, MISSION-VET PSSs tend to help Veterans set personally meaningful and realistic goals. As role models, they share their recovery stories and wellness strategies, offering mutual support and practical guidance to "their" Veterans. Often, MISSION-VET PSSs are able to develop a great sense of rapport and very trusting relationships that are special and intrinsically different from those of other MISSION-VET team members.

Perhaps the most important contribution of MISSION-VET's peer support component is the role PSSs play in offering inspiration: the hope that Veterans can and do overcome the barriers and obstacles that confront them. MISSION-VET PSSs convey that recovery is a self-directed process wherein Veterans 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, from both mental illness and substance abuse. As members of the treatment team, PSSs also enhance the Veteran's voice in the formal treatment process, helping to ensure that professional services are individualized to the Veteran's needs. This liaison/coach role has been shown to enhance the likelihood that Veterans will complete and/or stay engaged in treatment as needed.

Specific services offered to Veterans by MISSION-VET Peer Support Specialists

- Facilitate the use of the *MISSION-VET Consumer Workbook*
- Help Veterans maintain stability and avoid hospitalization
- Encourage attendance at 12-step and other supportive meeting and groups
- Further Veterans' acceptance of their problems
- Help Veterans rebuild relationships disrupted by substance abuse and mental illness
- Enhance Veterans' social and community living skills
- Enhance Veterans' activities of daily living (ADL) skills
- Help Veterans relieve stress or anxiety that could lead to relapse or loss of employment, housing, friends or supportive family relationships
- Monitor signs of relapse or decompensation
- Address stigma associated with substance use and mental illness

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

Additionally, MISSION-VET PSSs arrange and participate in social activities suggested by "their" Veterans 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 Veterans participating in the MISSION-VET program. Examples of activities might include trips to bowl, see movies, attend sporting events, visit museums, or have dinner. As reinforced during DRT sessions, Veterans in MISSION-VET are encouraged to participate in regularly scheduled healthy and safe activities as part of their recovery. PSSs who organize group activities should recognize the importance of scheduling activities that are local and diverse and meet the unique interests and abilities of each Veteran. Additionally, activities can be simple at first, such as shooting baskets at the local gym. If that is going well, PSSs can make

arrangements for full-court basketball games between Veterans. PSSs may even facilitate the formation of a MISSION-VET basketball team if there is enough interest among participating Veterans.

E. Vocational and Educational Supports

Another core need for Veterans enrolled in the MISSION-VET program is vocational and educational support. If MISSION-VET services are initiated while the Veteran is in residential treatment, vocational rehabilitation services are often provided through specialists associated with the residential treatment facility. However, if MISSION-VET services are initiated in the community, MISSION-VET CMs and PSSs will have to take extra care to ensure that linkages to vocational specialists are provided and that vocational rehabilitation plans are developed. Once developed, the MISSION-VET CM/PSS team facilitates the vocational rehabilitation plan and takes action based on changes in the Veteran's employment status. For example, if the Veteran loses his or her job, the MISSION-VET CM/PSS team 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 Veterans are struggling to maintain employment, the MISSION-VET team provides support and helps the Veteran to understand and follow operating procedures of the employment site, maintain peer and supervisor relationships, and manage job-related stresses.

The MISSION-VET team might also discuss educational options that would help the Veteran broaden his or her qualifications or move to another career where there are further opportunities for advancement. MISSION-VET CMs and PSSs can provide linkages to help Veterans understand their educational benefits, learn how to apply for these benefits, and how to appropriately adjust work and treatment meeting schedules to attend classes. Additionally, MISSION-VET CM's link Veterans to campus-based Veteran services offices who offer additional information about enrolling in classes or tuition/fee assistance. This type of support is critical to those Veterans who wish to further their education.

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

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

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

Benefits of Vocational/Educational Support as Used in MISSION-VET

- Develop an understanding that patience and hard work are more important than short cuts
- Improve problem-solving skills
- Learn to feel proud of work and educational accomplishments
- Learn to take constructive criticism and stay focused during conflicts

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

F. Trauma-Informed Care Considerations

MISSION-VET is not a PTSD intervention, nor is it designed to treat co-occurring PTSD and addiction. However, given the high rate of trauma present among this population, the MISSION-VET CM/PSS team must be prepared either to assist Veterans with these issues directly or, for those Veterans who are acutely symptomatic, through a referral to specialized clinical care. Moreover, the MISSION-VET team must assist in identifying and monitoring any symptoms of trauma that may impact treatment and recovery. Veterans may relate information regarding exacerbation of these symptoms to their MISSION-VET PSS, and communication among team members during such instances is crucial. Remaining sensitive to fluctuations in symptoms will allow MISSION-VET CMs, in concert with the Clinical Supervisor, to make informed decisions on whether or not Veterans need to be referred out to a specialized program to stabilize acute symptoms and to develop necessary coping skills prior to admission or readmission into the MISSION-VET program. The *"Goal of Trauma-Informed Care as Used in MISSION-VET"* table illustrates how the role and importance of Trauma-Informed care considerations have been incorporated into the MISSION-VET approach.

Goals of Trauma-Informed Care as Used in MISSION-VET

- ***Establish strong rapport with the Veteran to make him/her feel comfortable in raising any trauma-related concerns.*** MISSION-VET staff are encouraged to communicate with each other to ensure that all team members are apprised of fluctuations regarding trauma symptoms. Veterans should be informed about the importance of open communication between MISSION-VET CMs and PSSs to avoid any setbacks toward the progress made in establishing rapport.
- ***Document any trauma-related issues and review with Clinical Supervisor.*** Documentation and review should be completed in a timely fashion in order to ensure that all providers involved in the Veteran's care have access to important information that may influence treatment. MISSION-VET Clinical Supervisors should be immediately notified of any emergency situations that arise during the Veteran's enrollment in MISSION-VET. In the event that a Clinical Supervisor is unavailable and a Veteran is in need of immediate treatment, Veterans should be escorted by MISSION-VET staff to the walk-in mental health clinic for assistance with exacerbated symptoms.
- ***Monitor these trauma-related issues on an ongoing basis.*** MISSION-VET CMs are encouraged to use the assessment tools found in Appendix K to identify existing trauma-related symptoms during initial meetings with the Veteran. Regular use of these assessment tools may be further encouraged during weekly follow-up meetings with Veterans to ascertain decreases and increases in symptoms that may impact treatment. For optimal delivery of care, information acquired through these assessments should be shared with the MISSION-VET PSS.
- ***Develop a plan for increased safety when necessary.*** MISSION-VET CMs and PSSs are encouraged to have a plan in place for situations involving exacerbation of symptoms, suicidality, homicidality, and drug/alcohol relapse. Veterans who are suicidal or homicidal with a clear plan or intent should not be left unattended and should be evaluated by a mental health professional immediately. Once emergency situations have been stabilized and the Veteran is safe, MISSION-VET CMs are encouraged to develop a plan with their Clinical Supervisor that will continue to address the issue adequately and avoid any further exacerbation of symptoms. Documentation should immediately follow to ensure that all treatment staff is aware of any new developments in the Veteran's care. Plans should be appropriately adjusted as the Veteran continues to make progress.
- ***Provide referrals to specialized clinicians and coordinate services as needed.*** As MISSION-VET is not a PTSD intervention or one designed to treat co-occurring PTSD and addiction, Veterans with severe or chronic symptoms should be referred to a program that specializes in the treatment of trauma-related symptoms. Once symptoms have been stabilized and the Veteran has developed some coping skills to manage these symptoms, the Veteran is encouraged to reconnect to MISSION-VET services.

Chapter VII, *Trauma-Informed Care*, which focuses on Trauma-Informed Care considerations, serves as a resource to help guide the MISSION-VET treatment team regarding these issues. Additionally, Appendix K includes additional resources to help identify trauma-related symptoms. This Appendix also contains tools that will assist the MISSION-VET CM/PSS team in monitoring symptoms, fact sheets and handouts for Veterans, and additional links to useful trauma-related resources.

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NOTES

IV. Case Management

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

A. Overview of the MISSION-VET Case Manager's Responsibilities

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

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

- Work effectively as a team with the Peer Support Specialist (PSS),
- Orient the Veteran to MISSION-VET services,
- Collaborate with other care providers and the Veteran to develop a treatment plan,
- Deliver sessions on Dual Recovery Therapy (DRT) to help Veterans understand and manage their substance abuse and mental health problems, and
- Support Veterans during this critical transition period, including helping them secure and maintain employment or pursue continuing education.

The MISSION-VET approach uses the "Critical Time Intervention" (CTI) case management model to guide its delivery of direct treatment services and service linkages. This approach offers different types of support to the Veteran in different phases of the transition and adjustment to community living. The three distinct phases of care are (1) Transition to community (the initial phase of intense support), (2) Try-Out (in which the Veteran accepts increasing responsibility for maintaining a healthy approach to life), and (3) Transfer of care (in which the Veteran relies increasingly on community supports rather than the MISSION-VET team, and the program comes to an end). Consistent with the CTI approach, the MISSION-VET CM/PSS gradually reduce their frequency of contact with the Veteran over the course of the intervention to reinforce the use of community supports and promote independent living.

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

1. ***The MISSION-VET program begins while the Veteran is in an inpatient or residential treatment setting.*** This is seen as the start of CTI Phase 1: *Transition to Community.* The MISSION-VET CM works in cooperation and coordination with the staff from the treatment facility while they serve as the primary treatment provider. The MISSION-VET CM follows the Veteran's progress through inpatient/residential treatment by attending meetings led by staff from the inpatient/residential treatment facility and by conducting DRT psychoeducational co-occurring disorders treatment sessions. Upon the Veteran's discharge from the inpatient/residential facility, the MISSION-

VET CM assumes primary responsibility in executing the Veteran's discharge plan by ensuring the necessary treatment, housing, and vocational/educational supports are in place. The discharge is the start of the second phase of CTI, *Try-Out.* During this phase, linkages to supports are tested and any gaps in service or barriers to accessing services are identified and addressed. Next, during CTI Phase 3: *Transfer of Care*, linkages are fine-tuned,as the Veteran assumes the primary responsibility for his/her own self-care. MISSION-VET services are terminated and the CM/PSS team says goodbye to the Veteran.

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

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

The "Overview of the MISSION-VET Case Manager's Responsibilities," table outlines some of the ways the MISSION-VET CM's role may vary depending on the situation in which the program is initiated.

Overview of MISSION-VET Case Manager's Responsibilities

CTI Phase 1: Transition to the Community	
Program is Initiated in Inpatient/ Residential Treatment	**MISSION-VET CM:** • Meets with the Veteran and inpatient/residential treatment staff to discuss program expectations and boundaries, including the responsibilities of the inpatient/residential treatment team and the MISSION-VET treatment team. ***Note: MISSION-VET staff always serves as secondary provider while Veteran is in inpatient/residential care.*** • Meets with inpatient/residential staff to review the Veteran's treatment plan. • Conducts 13 psychoeducational **DRT** co-occurring disorders treatment sessions. • Attends discharge planning meetings prior to the Veteran's discharge to assist inpatient/residential staff in identifying community resources essential for successful community integration. • Assists with executing the discharge plan and provides linkages to key community supports.

Table continued on next page.

Program is Initiated in the Community	**MISSION-VET CM:** • Meets with Veteran alone or with other assigned care providers (such as HUD-VASH case manager) to discuss program expectations and boundaries. • Completes treatment plan or works with other care providers to review/modify treatment plan. • Serves as either the Veteran's primary or secondary provider of care, depending on whether or not the Veteran is enrolled in another treatment, rehabilitation, or case management program. • Conducts individual **DRT** sessions (unless Veteran is residing in congregate living, in which case, consider group format). • Provides linkages to community resources such as mental health, substance abuse, vocational/educational, trauma-related treatment supports. • Tracks Veteran's progress in use of community resources and supports.

CTI Phase 2: Try-Out

MISSION-VET CM:

- Continues to facilitate linkages that have already been established either by bringing the Veteran into treatment or other related programs assertively or by working with the Veteran to attend sessions on their own (discuss barriers with the Veteran and consider use of telephone reminder calls).
- Facilitates new service linkages for identified problem areas.
- Identifies any gaps in support system, barriers in accessing services, or areas where the Veteran needs more support.

CTI Phase 3: Transfer of Care

MISSION-VET CM:

- Fine-tunes connections with community-based resources and supports.
- Meets with VA and community providers to review transfer of care and identify any gaps in service.
- Reflects (with the Veteran) on work that has been accomplished thus far and acknowledges end of participation in MISSION-VET program.
- Reminds Veteran of supports that have been established, says goodbye, and wishes the Veteran the best of luck in his/her recovery.

B. Working Effectively as a MISSION-VET Treatment Team

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

Responsibilities of the MISSION-VET Case Manager and Peer Support Specialist

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

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

Depending on the issues to be addressed and the preferences of each Veteran, MISSION-VET CMs and PSSs may meet with the Veteran together or separately. When the CM and

PSS meet with the Veteran separately, the authors suggest that the CM and PSS meet and discuss their observations and concerns regarding the Veteran regularly. By working together smoothly, MISSION-VET team members can enhance their effectiveness and ensure each Veteran enrolled in the MISSION-VET program is receiving consistent messages and support. Veterans are informed at the outset of their participation that information is shared among MISSION-VET team members to better facilitate their care.

MISSION-VET CMs should have the judgment to make well-grounded decisions independently, but, at the same time be open to receiving assistance and guidance from others, primarily the MISSION-VET Clinical Supervisor. CMs must be willing to enhance their clinical skills, follow applicable VA policies and procedures, and work within laws and regulations. Weekly clinical coordination meetings, led by the Clinical Supervisor, provide another opportunity for the CM and PSS to share their perspectives and benefit from additional insights and suggestions offered by the other team member. In the event of a disagreement between assigned team members, the Clinical Supervisor listens to both the CM and PSS, providing guidance to resolve the disagreement. The MISSION-VET Clinical Supervisor also coordinates vacation schedules and manages service interruptions due to illness, providing coverage to ensure that Veterans are not left unexpectedly without support.

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

C. Initiating the Delivery of MISSION-VET Services

The MISSION-VET CM has the primary responsibility of orienting the Veteran to the MISSION-VET program and the expectations that come with being a participant. The Veteran learns about the different services provided, what is expected of those who participate in the program, the different members of the MISSION-VET treatment team and their responsibilities, and how to communicate with each member of the treatment team. The Veteran also receives the *MISSION-VET Consumer Workbook* at this time. The CM begins the process of developing a treatment plan, involving the MISSION-VET PSS as well as VA and community treatment providers as applicable.

Identifying and Orienting MISSION-VET Participants

Identifying Program Participants

When the MISSION-VET treatment team is physically located on a Veterans Administration Medical Center (VAMC) campus and MISSION-VET CMs have access to the Computerized Patient Record System (CPRS), CMs (with authorized access to the CPRS system) can screen medical records to get a cursory sense of which Veterans currently receiving residential treatment services may be eligible for the program.

MISSION-VET CMs may also receive referrals from staff members who work in other VA programs. For example, during implementation of the 6-month MISSION-VET service curriculum used to augment services for those Veterans who have received housing placements through HUD-VASH, HUD-VASH Case Managers contact MISSION-VET CMs to refer Veterans who they feel may be eligible for the MISSION-VET program.

Screening Prospective Participants

Regardless of whether MISSION-VET services are commenced in an institutional setting or in the community, the MISSION-VET CM screens prospective Veterans for program eligibility. In general, Veterans are eligible for MISSION-VET services if they are homeless, in imminent danger of becoming homeless, or recently removed from homelessness and now living on their own in the community. Additionally, in order to be eligible for MISSION-VET treatment services, Veterans must also meet the criteria listed below:

- Homeless or at risk for homelessness
- Diagnosed with both a substance use disorder and mental illness
- Willing to take part in the program and receive services
- Able and willing to live in the community

After confirming eligibility, the MISSION-VET CM explains how the program works, explains potential benefits, and also clarifies expectations of Veterans who enroll in the program.

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

are initiated, and the Veteran should be made aware of this. Once the Veteran is screened and eligibility is confirmed by the MISSION- VET Clinical Supervisor, a CM from the MISSION-VET team is permanently assigned to the Veteran.

Clinical Assessment

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

Orientation to the MISSION-VET Program

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

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

Introducing the MISSION-VET Consumer Workbook.

During the orientation session, the MISSION-VET CM and/or PSS give the Veteran the *MISSION-VET Consumer Workbook* and explain that the Workbook contains three important components:

1. Tools that will be used as part of Dual Recovery Therapy sessions led by the CM,
2. Exercises that are keyed to the DRT sessions which are reviewed in the Peer-led sessions,
3. Advice from Veterans who have made similar transitions which will help program participants settle and adjust into their communities.

The Workbook is seen as an important component of program orientation and symbolically offers the Veteran a "gift" of support materials that will assist in the journey of recovery and community independence. While PSS's have a more critical role in the Veteran's use of exercises and readings contained in the MISSION-VET Consumer Workbook (other than those used in DRT), the CM will want to review any significant issues raised by these materials with the Veteran. A more extended discussion of the Consumer Workbook and its use can be found in Chapter V, Peer Support.

Initiating Treatment Planning

Treatment planning is a critical component of the MISSION-VET approach and serves as the foundation for future program goals. While it is likely that the treatment plan will not be completed in the first session, it is suggested that the MISSION-VET CM begin to introduce the idea of treatment planning and prioritization of goals during the orientation session. The direction of the treatment plan will follow logically from discussion on the Veteran's goals, available supports and personal strengths, and potential obstacles to recovery. When the program is initiated in a treatment setting with an existing treatment plan, the MISSION-VET team reviews the existing plan and coordinates their treatment plan accordingly ensuring that the Veteran sees his/her treatment goals as consistent.

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

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

MISSION-VET Treatment Plan

Primary Diagnosis

_____

Secondary Diagnosis

_____

Other Treatment Providers

_____

_____

Service Needs

- MISSION-VET
- Residential substance abuse treatment
- Acute psychiatric care
- Other needed services
- Housing needs
- Outpatient mental health/substance abuse treatment
- Medical care
- Medication management
- Dental services
- Benefit entitlements
- Vocational support

MISSION-VET Service Delivery

Frequency (Weekly, Bi-weekly, Monthly)

Length (2 months, 6 months, 12 months)

D. Delivering Dual Recovery Therapy (DRT)

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

DRT addresses the problems Veterans face in recovering from both mental health and substance use disorders, each of which may be a "trigger" for the other. DRT is particularly applicable to homeless Veterans because of the many system and service-related barriers they routinely encounter. The DRT sessions use a collection of worksheets and tools to help CMs initiate and carry out therapy. All MISSION-VET CMs should be trained to deliver the 13 psychoeducational DRT co-occurring disorder treatment sessions.

The MISSION-VET CM begins each DRT session by administering the Dual Recovery Status Exam. This status exam helps the CM ensure that both mental health and substance use problems are monitored equally. The CM then reviews treatment goals and the Veteran's work on the MISSION-VET Workbook exercises before introducing the topic for the present session.

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

As shown in the table, "DRT Session Topics," each session focuses on a particular task. For more detailed information on the DRT sessions and worksheets keyed to each session, please see Appendix E. Participating Veterans use the exercises and readings in the *MISSION-VET Consumer Workbook* to follow along with the material covered during DRT sessions

and to record their answers to the exercises. Any questions related to the additional exercises and readings contained in the *Consumer Workbook* (especially those not part of DRT) should be discussed with the MISSION-VET PSS, but if questions are relevant to a discussion that arises during a particular DRT session, the Veteran should be encouraged to discuss and share his or her thoughts with the CM as well.

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

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

DRT Session Topics in MISSION-VET

1. ***Onset of Problems.*** Veterans learn about the dynamic relationship between mental health and substance abuse problems – that is, how one set of problems can affect the other.
2. ***Life Problem Areas Affected by the Individual's Co-occurring Disorder.*** MISSION-VET Case Managers and Veterans review problems the Veteran has experienced in a number of major life domains and examine the degree to which these problems have affected their lives. The Case Manager will learn more about the Veteran's level of motivation for recovery from each problem.
3. ***Motivation, Confidence, and Readiness for Change.*** The Veteran completes a "readiness ruler" worksheet for each domain or life problem that was identified during Session 2. Completed rulers will help the Veteran understand their stage of readiness to address each problem area.
4. ***Developing a Personal Recovery Plan.*** This session marks the end of the assessment and engagement stage. Treatment goals are reviewed and emphasis is placed on the importance of using community substance abuse and mental health resources necessary to meet treatment goals.
5. ***Decisional Balance.*** A "decisional balance" worksheet is used to help Veterans identify the benefits and negative consequences of maintaining problematic behaviors and weighing the costs and benefits of continuing a behavior (e.g., substance use, missing appointments).
6. ***Communication Skills Development.*** Veterans learn to recognize effective and problematic communication styles by using the "elements of good communication" and "elements of poor communication" worksheets. These worksheets will assist the Veteran in developing effective communication skills necessary for communication with mental health, substance abuse, and medical treatment providers.
7. ***Twelve-Step Orientation and Recollections.*** Emphasis is placed on orienting Veterans who have never attended 12-step meetings to the structure, culture, rules, and language of the program. Emphasis is also placed on improving attendance for those Veterans who have attended in the past, but who dropped out or attended inconsistently.
8. ***Anger Management.*** This session focuses on identifying situations that trigger anger and strategies to manage those emotions.
9. ***Relapse Prevention.*** Using a "relapse prevention" worksheet, Veterans learn to identify and review strategies that can be used to increase the likelihood of sobriety and decrease the chance for relapse with special emphasis placed on how the Veteran's mental health problems can lead to a relapse and strategies that can be employed to prevent this from occurring.
10. ***Interpersonal Relationships.*** Using a worksheet on "relationship-related triggers," Veterans learn how unhealthy relationships can contribute to a high risk of mental health symptom exacerbation and/or substance use relapse.
11. ***Changing Unhealthy Thinking Patterns.*** Veterans learn how unhealthy thinking patterns can perpetuate emotional problems and result in substance abuse as a maladaptive coping mechanism. Basic cognitive behavioral principles are taught during this session, including the interplay among thoughts, behaviors, and emotions.
12. ***Changing Irrational Beliefs.*** Using a worksheet and a list of irrational beliefs, Veterans learn how imposing rigid rules on oneself and others can have negative consequences. Veterans identify dysfunctional beliefs and learn how to modify those beliefs to maintain flexibility in thinking.
13. ***Activity Scheduling.*** Veterans learn the importance of scheduling regular healthy activities in maintaining recovery.

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

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

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

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

E. Using Critical Time Intervention (CTI) Case Management

CTI case management, the cornerstone of the MISSION-VET model, is an empirically supported, time-limited case management model (Susser, et al., 1997) that is designed to prevent homelessness and other adverse outcomes among those with mental illness following discharge from hospitals, shelters, prisons, and other institutional facilities. This transition is often difficult, as there are many challenges associated with re-establishing oneself in satisfactory community living with access to needed mental health, substance abuse, and vocational/educational supports (*www.criticaltime.org*). Focused, time-limited assistance during this critical transitional and adjustment period has been shown to have positive impacts (Susser et al., 1997; Kasprow & Rosenheck, 2007; Dixon et al., 2009; Herman & Mandiberg, 2010).

The length of CTI within MISSION-VET can be modified depending on the Veteran's situation and the available resources of the treatment program. Appendix D shows adjustments

that may be made to the MISSION-VET program based on the total period of time available to deliver services. Sample 2-, 6-, and 12-month service delivery schedules have been included. Regardless of the period of time available to deliver MISSION-VET services, the basic tasks and considerations described here still apply in each of the three phases.

CTI Phase 1: Transition to Community

MISSION-VET services may be implemented while a Veteran is receiving care in an institutional setting, such as an inpatient or residential treatment facility, or while the Veteran has already transitioned into the community (e.g., a community shelter) and is actively trying to acquire stable housing. The MISSION-VET CM's role in Phase 1 will be somewhat different in each of these settings.

In circumstances when the Veteran is in institutional care, CMs are responsible for tracking the Veteran's progress through inpatient or residential treatment by attending meetings led by inpatient/residential treatment staff. MISSION-VET CMs also meet with the Veteran at intervals appropriate for the length of the intervention (but no less then bimonthly) throughout his or her stay to discuss treatment progress and to establish a trusting relationship with the Veteran. In this service setting, the MISSION-VET CM always serves as a secondary provider of care and works in cooperation with treatment staff from the institutional facility. The MISSION-VET CM supports the inpatient/residential facility treatment team and the Veteran by: providing specialized COD treatment, including the delivery of the 13 DRT psychoeducational co-occurring disorders treatment sessions discussed previously in this chapter; providing input on discharge planning, and helping to identify the resources and supports needed to facilitate a successful community transition.

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

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

CTI Phase 2: Try-Out

In the second phase of CTI, MISSION-VET CMs continue to fine-tune community resources that may aid in recovery as the Veteran makes progress toward his/her goals. Therefore, CMs may adjust the treatment plan to accommodate other goals that may have been difficult to achieve without the progress made during Phase 1. For example, once a Veteran has made sufficient progress towards securing housing and stabilizing mental health symptoms, he or she can begin to focus on other factors that may aid in recovery, such as rebuilding relationships with loved ones.

The primary goal of the *Try-Out* phase is for Veterans to become more self-sufficient in the community. Thus, the MISSION-VET CM offers guided support in the attainment of the Veteran's goals, as they are documented in the MISSION-VET Treatment Plan, while encouraging the Veteran to begin tackling some of these issues on their own. In this Phase, the MISSION-VET CM helps the Veteran to build strong relationships with community providers as opposed to relying on the MISSION-VET CM as the only treatment provider for the Veteran. As the frequency of visits between the MISSION-VET CM and Veteran decreases, it is important that, whenever possible, the MISSION-VET CM acts as a liaison between the Veteran and other treatment providers rather than as a direct provider of supports. For example, in Phase 1, the MISSION-VET CM may make calls to community providers on the Veteran's behalf, even scheduling appointments if necessary. However, in Phase 2, the CM may assist the Veteran in identifying a suitable provider, but will encourage the Veteran to call and schedule the appointment on his or her own. This reduces the amount of services provided by the MISSION-VET CM while reinforcing skills learned during Phase 1.

It is important to note, however, that crises and other setbacks are common in this phase of the treatment intervention. MISSION-VET CMs must be prepared to offer support and guidance to assist with the reestablishment of the Veteran's stability and sobriety as needed. Additionally, Veteran's goals often change, and new and unanticipated obstacles may present themselves. Veterans may find they have taken on more than

they can handle in their financial obligations, encounter difficulty managing relationships, or find themselves overwhelmed by other responsibilities. As these situations arise, the MISSION-VET CM works with the PSS to play a steadying role and help the Veteran find the way forward.

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

MISSION-VET CMs should never punish a Veteran for a relapse; rather, they should frame the relapse as something that can occur on the road to recovery. Every relapse is seen as an opportunity for growth by the Veteran and additional support for facilitating a deeper Veteran/CM/PSS connection.

Another key role of the MISSION-VET CM during the *Try-Out* phase is to provide increased linkages to both VA and community-based vocational/educational rehabilitation programs and track the Veteran's participation and progress in these programs. Because a great deal of vocational/educational rehabilitation is delivered by others, the MISSION-VET CM's responsibility is to help facilitate the vocational/educational rehabilitation treatment plan, be sure it is working well to help meet the Veteran's goals, and be prepared fill in gaps as needed.

MISSION-VET CMs also identify and address any barriers that prevent the Veteran from fully participating in outpatient VA and community-based treatment and rehabilitation programs. It is the responsibility of the MISSION-VET CM to continuously maintain appropriate documentation of services needed and services rendered, as this is essential in identifying the Veteran's most troubling problems that need to be targeted immediately. Prioritizing problems is always a team effort among the Veteran, CM, PSS, and the primary treatment provider (when appropriate).

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

CTI Phase 3: Transfer of Care

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

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

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

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

- ***Remember special events in the Veteran's life when you can.*** Wish him or her luck on a new job; offer congratulations on a daughter's graduation. Find ways to let these Veterans know you are thinking of them, you remember them, and you wish them well.
- ***Don't let either the Veteran or yourself become too complacent about his or her recovery.*** It's important to make sure the Veteran stays connected with support groups and peers in recovery. Sometimes, when things seem to be going too smoothly to be believed, the Veteran is really on the verge of relapse.
- ***Foster independence.*** Where you once might have made a phone call on the Veteran's behalf, as Phase 2 and 3 progress, you now give the Veteran the number and let him or her make the call themselves.
- ***Recognize the possibility of late-stage relapse.*** Some Veterans will need to re-enter inpatient/residential care and start over.

F. Providing Vocational and Educational Support

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

The MISSION-VET CM helps the Veteran to overcome barriers to obtaining employment or enrolling in educational programs by connecting Veterans to employment and educational resources within VA and the community, including Compensated Work Therapy (CWT), Supported Employment, State Department of Labor resources, and local colleges and universities. The MISSION-VET CM also provides practical assistance to the Veteran to help him or her maintain employment satisfaction and cope with "on the job" stresses. Throughout the MISSION-VET program, the CM and Veteran frequently discuss barriers to obtaining and maintaining employment and/or achieving education goals.

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

Vocational/Educational Support Provided by MISSION-VET Case Managers

- Help Veterans learn to manage their time and develop a work ethic.
- Help Veterans establish a positive, viable work history by demonstrating longevity and dependability.
- Manage conflicts.
- Help Veterans understand benefits packages, including medical and dental coverage, as well as vacation, sick, and personal leave.
- Help Veterans plan for retirement.
- Connect Veterans to university-based Veteran service departments and Veteran service coordinators.
- Connect Veterans to campus-based support groups for Veterans.

G. Trauma-Informed Care Considerations

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

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

Considerations in Trauma-Informed Care: What CMs Need to Know

- Be aware of the possibility of trauma among Veterans.
- Know and be able to recognize symptoms of trauma.
- Be aware of the impact trauma has on the lives of Veterans.
- Be able to screen Veterans for trauma.
- Know how and when to refer Veterans out for specialized help.

H. Ending the MISSION-VET Program

As services to the Veteran taper off, the Veteran should be gradually preparing for the day when he or she will rely on community resources to help maintain recovery. At the final meeting with the MISSION-VET CM (or with the CM/PSS team), it is helpful to review the Veteran's goals and accomplishments. The CM will also do well to review next steps with the Veteran, supporting his or her plans to maintain recovery. MISSION-VET CMs may want to encourage Veterans to share good news and stay in touch, but they also want to be sure the Veteran understands that once the program ends, the CM is no longer available as their care provider. While these discussions may bring up separation issues for some Veterans, successful completion of the MISSION-VET program should be seen as an accomplishment in recovery.

Topics for Discussion During Final MISSION-VET Session

Review the Veteran's progress throughout the program:

- How has it gone for you? What have been the highlights and difficulties?
- What are your goals now as you move forward beyond MISSION-VET?
- What challenges/barriers do you see to achieving those goals? How do you plan to overcome them?
- What are you going to do to achieve those goals for yourself?
- Do you have a list of emergency numbers and VA/community resources?
- Do you have a list of your upcoming appointments?

Say goodbye.

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

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NOTES

V. Peer Support

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

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

- MISSION-VET Peer Support Specialist

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

During the often lengthy and difficult process of rebuilding a life in the community, Veterans receiving MISSION-VET services can benefit greatly from the support of someone with similar experiences — someone who can offer advice and empathy when the Veteran faces challenges along the way. In addition to being a Veteran themselves, each Peer Support Specialist (PSS) on the MISSION-VET treatment team has recovered from challenges (homelessness, unemployment, substance abuse, and mental illness) similar to those faced by the Veterans with whom they are working. Each has also received training specific to serving as a PSS. As MISSION-VET PSSs advocate for the Veterans on their caseload, share wellness and relapse prevention strategies, and provide practical supports to improve socialization and community life skills, the unique mix of camaraderie and leadership empowers Veterans to self-determine their own recovery goals.

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

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

In their "check in" sessions with Veterans, MISSION-VET PSSs can reinforce both the work Veterans have done in Dual Recovery Therapy (DRT) sessions (led by a MISSION-VET CM) as well as the work Veterans have done on the Self-Guided Exercises contained in the *MISSION-VET Consumer Workbook*.

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

Implications of the "Critical Time Intervention" Model

The MISSION-VET approach uses the tested model of "Critical Time Intervention" (CTI) case management. This approach offers different types of support to the Veteran in different phases of the transition to community life. The three

distinct phases of care are: (1) Transition to community (the initial phase of intense support), (2) Try-Out (in which the Veteran accepts increasing responsibility for maintaining a healthy approach to life), and (3) Transfer of care (in which the Veteran relies increasingly on community supports rather than the MISSION-VET team, and the program comes to an end).

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

Overview of the MISSION-VET Peer Support Specialist's Responsibilities

CTI Phase 1: Transition to the Community

The MISSION-VET PSS:

- Meets with the Veteran periodically to establish rapport and encourage the Veteran in the changes he or she is making.
- Provides input on the MISSION-VET treatment plan.
- Conducts group or individual peer support sessions on topics related to the transition to healthy living in a community setting.
- Discusses exercises and readings in the MISSION-VET Consumer Workbook with the Veteran.
- Works with the MISSION-VET CM to identify community resources essential for successful community integration.
- Assists with executing the discharge plan and helps the Veteran overcome barriers that arise in using key community supports, including accompanying the Veteran to appointments and meetings when helpful.

CTI Phase 2: Try-Out

The MISSION-VET PSS:

- Continues to facilitate linkages that have already been established, helping the Veteran think through and resolve obstacles and challenges.
- Redirects the Veteran's attention to exercises in the *MISSION-VET Consumer Workbook* as needed, helping the Veteran recommit to goals and strategies or, when needed, express new ones.
- Identifies any gaps in support system, barriers in accessing services, or areas where the Veteran needs more support, and works with the CM and other providers to address these gaps.

CTI Phase 3: Transfer of Care

The MISSION-VET PSS:

- Celebrates the Veteran's ability to maintain goals in healthy living and puts relapses or slips in perspective.
- Reflects (with the Veteran) on work that has been accomplished thus far and acknowledges end of participation in MISSION-VET program.
- Reminds Veteran of supports that have been established, says goodbye, and wishes the Veteran the best of luck in continued recovery.

B. Working Effectively as a MISSION-VET Treatment Team

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

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

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

Within individual teams, the PSS and the CM coordinate care in order to promote consistency in service delivery. Many roles and responsibilities are shared, with each member offering his or her skills and perspectives to assist the Veteran in achieving important goals. Each team member, however, also has areas of primary responsibility (see the table, "Responsibilities/ Roles of the MISSION-VET Peer Support Specialist and Case Manager"). The MISSION-VET CM takes the lead in the developing treatment plans, but the plans should reflect the PSS's input. When one team member assumes a primary role in a certain area, the other team member provides assistance and serves in the primary or lead capacity when the primary team member is temporarily unable to fulfill that duty (for example, due to absence or sickness). While both PSSs and CMs share responsibility for assisting Veterans with use of the *MISSION-VET Consumer Workbook*, it is really the PSS who checks in with the Veteran regularly; while CMs ensure that the appropriate 12-step supports are in place, it is the PSS who actually accompanies Veterans to meetings if necessary.

Responsibilities/Roles of MISSION-VET Peer Support Specialist and Case Manager

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

C. Initiating Relationships with Veterans

Orientation to the MISSION-VET Program

The initial MISSION-VET session occurs after the intake conducted by staff of the inpatient/residential treatment facility or upon referral from clinicians/case managers in other VA or community programs. Before the MISSION-VET CM and PSS meet the Veteran, the MISSION-VET Clinical Supervisor (or if necessary the CM) performs a diagnostic assessment and screens the Veteran to determine his or her eligibility for the program.

Once the Veteran has been determined eligible and has agreed to participate in the MISSION-VET program, the Veteran is

introduced to his/her permanent MISSION-VET CM, who schedules an introductory meeting to begin the process of getting to know the Veteran. Both the MISSION-VET CM and PSS should participate in the meeting if possible, but if necessary the Veteran can meet with CM and PSS separately. This initial 45-minute orientation meeting is an opportunity for the MISSION-VET treatment team to learn about the Veteran's goals, barriers, strengths, hopes, and interests as well as the Veteran's triggers, coping skills, and available supports.

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

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

During the orientation session, the CM and/or PSS give the Veteran the *MISSION-VET Consumer Workbook* and explain that the Workbook contains three important components:

1. Tools that will be used as part of DRT sessions led by the CM,
2. Exercises that are keyed to the DRT sessions which are reviewed in peer-led sessions, and
3. Advice from people who have made similar transitions designed to help the Veteran settle into their communities.

While the Workbook is essential to MISSION-VET program orientation and symbolically offers the Veteran a "gift" of support materials, it is our experience that Veterans can initially become somewhat overwhelmed with the content of the Workbook. Therefore, it is the responsibility of the PSS to provide an effective introduction to the Workbook. It is important that the PSS ensures the overview of the Workbook is not seen as overwhelming, but rather as a critical resource that can be used throughout the duration of MISSION-VET services and as a set of tools for recovery beyond the Veteran's time in the MISSION-VET program.

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

Working with Veterans in a Treatment Setting

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

Maintaining proper boundaries between the services and staff of the treatment facility and the MISSION-VET team is important; however, the role of the MISSION-VET PSS is less likely than that of the MISSION-VET CM to be seen as conflicting with that of the clinician or case manager in charge of providing services in the inpatient or residential facility. Thus, the MISSION-VET PSS typically has more extensive contacts with the Veteran in the treatment facility prior to community transition than the CM.

Opportunities for Contact in the Treatment Facility with Veterans Receiving MISSION-VET Services

1. An initial meeting orienting the Veteran to the MISSION-VET program
2. Informal contacts
3. A transitional session near the end of the stay in the treatment facility
4. Weekly group sessions led by the Peer Support Specialist

D. Using the *MISSION-VET Consumer Workbook*

As described earlier, the *MISSION-VET Consumer Workbook* is given to the Veteran during the orientation session. The

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

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

PSSs have a brief weekly check-in session to review each exercise that the Veteran has completed in the *MISSION-VET Consumer Workbook*. Although Veterans receiving MISSION-VET services while they are in inpatient/residential care participate in DRT sessions and other structured sessions, MISSION-VET peer-led sessions are unique because they offer the PSSs "been there, done that" perspective. The amount of time spent is variable, depending in part on whether a Veteran needs to work through an issue raised by the DRT worksheets, the *MISSION-VET Consumer Workbook* Self-Guided Exercises, or the readings. Approximately 10 minutes a week is set aside for this purpose. This could also be done in a longer individual session with the MISSION-VET PSS or, if appropriate, it could be brought into the PSS group session as an issue for everyone to discuss.

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

Part 2 of the *MISSION-VET Consumer Workbook* includes a brief explanation of the most common mental health conditions of those Veterans entering the MISSION-VET program. This explanation is meant to serve as a resource for Veterans as they work their way through the different phases of the program. In addition to the explanation of these mental health conditions, the Workbook also offers 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:

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

E. Peer Support Sessions

For Veterans in residential treatment or a congregate living facility, the PSS leads a weekly group session of approximately 60-90 minutes (see Appendix H). These group sessions are scheduled at different times and conducted by different PSSs in order to accommodate the varying schedules of Veterans; however, each MISSION-VET PSS covers the same selected topic for the week. The 11 topics (see *Peer-led Sessions* table) have been identified by PSSs from past MISSION-based projects as having particular relevance to those Veterans currently residing in treatment facilities or congregate living arrangements as they prepare themselves for independent community living.

These group discussions serve several purposes. From the standpoint of the MISSION-VET program, the primary purpose is to establish a sense of camaraderie among Veterans and the PSS, so that, after the Veteran is discharged from the institutional setting, he or she is already comfortable seeking and accepting support and advice from the MISSION-VET PSS. The weekly peer-led sessions offer Veterans 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 the MISSION-VET PSS and their fellow Veterans) will support them. These sessions also offer a chance to begin work (on developing some of the skills and achieving some of the goals) that will continue post-discharge.

For Veterans who are already living independently–for example, if housing has been obtained through the HUD-VASH program–peer-led sessions often occur at the Veteran's residence. While these sessions are delivered individually rather than in a group setting, they use the same 11 topic areas as in

the group format, and the purpose of each session is the same. The peer-led sessions allow the Veteran to air any concerns with living arrangements or adjustment to the community; the MISSION-VET PSS can then identify problems and relay information back to the treatment team. Additionally, these sessions allow the Veteran to discuss concerns, ask additional questions, and express their future hopes in a comfortable, relaxed environment free of judgment and full of support.

Topic Exercises for Peer-led Sessions

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

Format

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

Structure of Weekly Peer-led MISSION-VET Meetings in the Treatment Facility

- A brief introduction to the day's topic, why it was chosen, and why it is something important for Veterans to think about
- Personal insight or a story offered by the Peer Support Specialist in order to further set up the topic
- Questions to spark discussion, if needed
- A facilitated discussion on the topic

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

F. Providing Support in the Community

Providing Input into the Discharge Plan from a Treatment Facility

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

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

After the discharge plan from the facility is completed, the assigned MISSION-VET PSS/CM meets with the Veteran to discuss the plan and the role that the team will play in supporting the plan. This meeting, which occurs prior to the Veteran's discharge from the institutional facility, is called the "Transitional Session." As MISSION-VET PSSs may have already formed strong bonds with "their" Veterans while they were in the institutional treatment facility, PSSs play a crucial role in helping Veterans achieve the goals that they have set for themselves as they fully integrate into the community.

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

If the MISSION-VET PSS did not work with the Veteran while he or she was in the institutional facility, as is the case when MISSION-VET is implemented with Veterans in the HUD-VASH program, the PSS actively works with the MISSION-VET CM and Clinical Supervisor (as well as the HUD-VASH Case Manager) to develop a MISSION-VET treatment plan that provides a clear path to achieving the Veteran's goals.

Types of Support Provided by Peer Support Specialist

MISSION-VET PSSs offer individual support to the Veteran in areas that overlap with the support provided by the MISSION-VET CM. This includes offering support in getting and maintaining safe housing, sustaining recovery from substance abuse, managing mental health symptoms, obtaining gainful employment, and achieving educational goals. The type of support that MISSION-VET PSSs offer can be practical and/or emotional; for example, they might offer to accompany Veterans to initial mental health appointments, bring them to AA or NA meetings, tell them what to expect in a particular housing program, or offer advice and support as Veterans try to reconnect with their families. They also use specific tools and techniques, such as the "PICBA" tool for personal problem-solving (see the *MISSION-VET Consumer Workbook*), to empower "their" Veterans to become more involved in treatment decisions. Like MISSION-VET CMs, PSSs make ready use of the tools and narratives contained in the Workbook on an as-needed basis.

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

Reducing Fear

Achieving life goals requires overcoming fear of failure and fear of the unknown. Having been homeless and through institutional treatment, Veterans might doubt their ability to succeed on their own, to remain sober, and to adjust to work and other aspects of community life with which they have become unfamiliar. Veterans might also fear taking medications or being stigmatized in the community as a result of their conditions or treatment. Having been through similar experiences, MISSION-VET PSSs are able to provide emotional support and practical advice for facing these challenges. A Veteran 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 VA residential treatment facility due to his continued use, and his MISSION-VET PSS had helped him find transitional housing. Now, Isaac faced eviction from transitional housing after he relapsed, and in a panic he called the same PSS for help.

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

Accompanying Veterans

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

This support can be especially critical in times when the Veteran stumbles on his or her recovery path. The MISSION-VET PSS can provide moral support if the Veteran becomes homeless or begins using again by accompanying him/her 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 can all play a positive role in relieving stress and improving mood, while smoking and caffeine might have negative impacts. While recognizing that "old habits die hard," the MISSION-VET PSS can help to promote healthy lifestyles with new habits of self-care.

Peer Support in Action: Example 2

"Ricardo" had recently received housing in the community after completing residential treatment at the VA. However, one month after he had gotten his own housing, he relapsed and subsequently became homeless due his inability to pay rent. Ricardo started living on the street, stopped eating and bathing, and could not hold down a job. His MISSION-VET PSS arranged a face-to-face meeting with him and talked to him about his weight loss, disheveled appearance, and inattention to personal hygiene. His PSS asked him directly, "What do you need to get back on the road to recovery?" Ricardo knew that he needed the very things he had given up—a roof over his head, a place to shower, and food. This meeting with his PSS helped Ricardo realize that before he could value and retain these things in the future, he needed to understand the reasons that he gave them up in the first place. Ricardo acknowledged that he had gotten comfortable with his present condition and stopped putting in the necessary work to maintain his recovery.

Once Ricardo determined to pursue a healthy way of life, his PSS helped link him to a detoxification program and then a bed at the Salvation Army. Because there were no available apartments in his previous community and the VA homeless program did not have any openings, his PSS helped Ricardo find another long-term residential program in the community. His PSS also helped him retrieve and use the healthy living tools he learned while enrolled in MISSION-VET during an earlier VA residential stay, including information on the importance of hydration, selecting healthy foods, avoiding unhealthy foods, monitoring caloric intake, and exercising. With ongoing peer support, Ricardo began reclaiming his recovery by attending programs, taking classes, and seeing his family. He began feeling better about himself and regained his confidence in his ability to achieve his recovery goals and has just received a permanent housing placement through the HUD-VASH program.

Socializing

For Veterans who are transitioning back into the community, having drug-free social events in which to participate and friends with whom to spend time can have a positive impact upon recovery. Because the MISSION-VET intervention lasts only a limited period of time (2 months, 6 months, or 12 months), developing positive and drug-free social relationships can become an important source of support after the program ends.

The MISSION-VET PSS primarily relies on AA and NA social events because these events tend to be larger and better established, offering Veterans in the MISSION-VET program certainty that the event will be well-attended and thus worth their time. Such 12-step events might include dances or other enjoyable activities.

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

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

Achieving goals

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

Peer Support in Action: Example 3

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

(smoking cessation). Through perseverance, Earl got that VA job and was finally able to pay off his fines.

Working

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

Many Veterans in the MISSION-VET program have extensive criminal records and limited work experience; therefore, they often have difficulty finding a job or have to start out working in less desirable positions. The role of the MISSION-VET PSS is to reinforce the work that the staff from the institutional treatment facility does in preparing Veterans 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 to cocaine use. He asked for support from his MISSION-VET PSS, who understood first-hand the impact of losing a good job. Other opportunities for Marcus were very limited, and his PSS offered to help Marcus find a temporary job at a nursing home where he had previously worked. The pay for this job was much lower than Marcus's previous position at the VA, and Marcus was not sure he could get by on the reduced income. In fact, he did lose his apartment, but his MISSION-VET PSS helped him to return to the VA residential facility. Throughout the process, his PSS helped him keep his head up, pointing out that the job in the nursing home was "a step down in wages, but a step up in humility." His PSS also encouraged him to learn from his experience, suggesting that "he was being tested on the little things before he could go back to the bigger things."

This particular MISSION-VET PSS drew from his own experience working at the nursing home for nine dollars an hour, explaining to Marcus the new perspective he had gained. He told Marcus, "you must have gratitude for what you are accomplishing 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. Yet he helped Marcus realize that he would have to take things slowly in rebuilding his finances and helped him use his limited income to his advantage.

Addressing Stigma

While reports indicate that mental illness and substance abuse problems are widespread, stigma continues to be a prominent problem individuals face during recovery (Corrigan, 2004; NAMI, 2010) and has been linked to an increased risk for negative outcomes, which include reduced employability, imprisonment, and homelessness (Browne, 2007; Corrigan, et al., 2007; McNiel, et al., 2005). As such, stigma is a barrier that may impede treatment and recovery goals integral to the MISSION-VET program.

Traditionally, stigmatization has been defined as the process by which individuals who lack certain characteristics or traits belittle other individuals who have them (Piner & Kahle, 1984); however, stigma has further been broken down into two critical components: public and self-stigma. Public stigma occurs when there is a reaction toward a specific group of individuals who share a negatively viewed trait (Corrigan, 2004), while self-stigma results from one's own reactions toward oneself due to membership in a stigmatized group (Corrigan & Watson, 2002). Moreover, self-stigma has been associated with decreases in self-esteem and self-efficacy, which may hinder motivation toward participation in activities that would promote recovery (Corrigan, et al., 2006), such as applying for a job or approaching a landlord for a housing application after one or more failed attempts. Although public and self-stigma can be viewed as separate, it is important that MISSION-VET PSSs consider both, as each of these components often act together and build upon each other.

For example, if a Veteran with COD encounters a landlord who is hesitant to rent to them due to their diagnoses (public stigma), he/she may internalize this stigma (self-stigma), which in turn may negatively impact perceptions of his/her own capabilities and decrease his/her motivation toward approaching another landlord with a new housing application. However, MISSION-VET PSSs who can identify with "their" Veterans may provide an essential safeguard that helps prevent the negative consequences of stigma cited above by using two key strategies: contact and education (Corrigan, 2004).

Contact. Contact usually involves face-to-face interactions with individuals from the stigmatized group and has sometimes been paired with brief education programs that have been associated with changes in stigmatizing behavior (Corrigan, 2004). Unique to the MISSION-VET model is the opportunity to combat self-stigma in Veterans struggling with recovery by providing regular contact with a positive role model. This has two benefits. First, participating Veterans have an opportunity to witness that another Veteran with a mental illness and substance abuse disorder can be successful (dispelling the myth that this group cannot succeed). Second, Veterans can learn concrete strategies from those who have faced and successfully overcome the challenges of stigma while working toward recovery.

Education. Having direct access to a contact, or role model that they can turn to may not only serve to combat negative reactions toward the self, but may replace these same

reactions with hope. Furthermore, MISSION-VET PSSs can share the knowledge that they acquired through their own similar experiences to educate the Veteran on how to best approach these and other similar situations in which the Veteran feels stigmatized. In this way, MISSION-VET PSSs can help divert otherwise potentially debilitating outcomes associated with stigma.

MISSION-VET PSSs are encouraged to check in with Veterans to assess and address any issues surrounding stigma that may ultimately impede recovery, as they may not always be directly reported by the Veteran. In addition, as Veterans make their way through the MISSION-VET program, they will experience varying degrees of progress in comparison to other Veterans. MISSION-VET PSSs are encouraged to monitor and address any situations involving stigma among Veterans in order to promote a safe environment where each Veteran can continue to share, grow, and progress comfortably at his/her own pace. Due to their unique role, MISSION-VET PSSs are also encouraged to monitor and address any issues regarding stigma that may impede their own recovery with a source of support outside the program.

G. Helpful Training for the MISSION-VET PSS

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

Internal Training

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

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

VA Stance on Training of Peers

Currently, PSS's hired as official VA Peer Support Technicians are required to "demonstrate competency" within one year of their hire. This could involve either taking and passing one of the approved peer certification courses mentioned above or passing the competency assessment developed by the VA. To support the training of VA Peer Support Technicians, the VA's Office of Mental Health Services, Psychosocial Rehabilitation Section, will soon be releasing the VA's *Peer Support Technician Training Manual.* The manual was adapted from the 2007 National Association of Peer Specialists (NAPS) *Training Manual* with input from peer support practitioners across the United States. The manual will focus on the Peer Support Technicians' competencies, which were derived from a synthesis of six prominent peer training and certification programs in the United States. It is anticipated that various staff all across the VA will use the *Instructors Manual* to develop a course that Peer Support Technicians can complete.

Third-Party Training Nationwide

Currently, training for PSSs varies widely across the country in breadth, scope, and length, ranging from 30 hours to 28 weeks. One of the most highly regarded training programs is the curriculum developed through the Georgia Peer Support Certification Project. The Georgia program is a comprehensive, classroom-based, 40-hour, 30-module curriculum covering peer support, psychosocial rehabilitation and recovery, the impact of diagnosis on self-image, effective communication skills, and the basics of documentation. In addition, the Depression and Bipolar Support Alliance (DBSA), which works in collaboration with staff from the Georgia Peer Support Certification Program, provides an on-site, classroom-based, 40-hour training program. Both training programs include an exam that requires a minimum score of 80 percent in order to pass the course.

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

Training Topics for Peer Support Specialists in MISSION-VET

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

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

Training on the Critical Time Intervention (CTI) Model

Previous MISSION-VET PSSs have also participated in training offered by the CTI Project at the Mailman School of Public Health of Columbia University. This training is particularly helpful in ensuring that MISSION-VET PSSs are able to work smoothly with CMs, with a common understanding of the foundations of this type of intervention for Veterans with COD.

Topics Covered in CTI Training

- 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
- Psychiatric Medications

Training on Dual Recovery Therapy (DRT)

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

DRT Training Topics

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

Training for MISSION-VET PSSs and Clinical Supervisors

MISSION-VET PSSs and their supervisors should pursue continuing education. The VA offers a yearly conference for all PSSs and their supervisors. The National Association of Peer Specialists, Inc. (NAPS), a private, non-profit organization dedicated to peer support in mental health systems, offers

an annual conference (see *http://www.naops.org/*). The U.S. Psychiatric Rehabilitation Association also sponsors a national conference and other training opportunities for peers (see *http://www.iapsrs.org/*).

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NOTES

VI. Vocational and Educational Support for Veterans

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Veterans with co-occurring disorders can and do want to work. Additionally, many may wish to further their education. Though barriers to these achievements can be formidable, there are several VA programs that can be accessed to promote Veteran employment, including VetSuccess and Supported Employment. Community supports include One-Stop Career Centers. The unique challenges to employment have been successfully addressed by the principles and practices of the Individual Placement and Support (IPS) model developed by the Dartmouth Psychiatric Research Center. These principles and practices, adapted from a published guide on supported employment, are listed and described in this chapter (Swanson, Becker, Drake, & Merrens, 2008). They include competitive integrated employment in the community based on Veteran preference, rapid job entry, unlimited and varying intensity of support on the job, and integration with a clinical team.

A. The Importance of Work

Work, or goal-directed productive activity, is seen as central to anyone's well being, including Veterans with co-occurring disorders (COD). A growing body of evidence indicates that most adults with psychiatric disabilities want to and consider themselves able to work (Cook, 2006). However, barriers to successful employment can be numerous. Many Veterans with COD will have had spotty or remote work histories and may have great ambivalence towards working again. Additionally, prior criminal justice involvement or other gaps in employment histories may make a Veteran less likely to be selected for a job. Unemployed Veterans readjusting to community living may have limited resources and be unprepared for competing for jobs today. They will often need resources for and training in basic skills such as looking for a job, preparing and sending out resumes, and interviewing with prospective employers.

Furthermore, there are many external and environmental barriers to obtaining employment. The possible loss of disability income or health care benefits as income increases has been shown to be a deterrent to maximizing one's potential to work. Clinicians and family members may hold more traditional views of adults with mental illness as being "unemployable" and may discourage employment. Despite advances made by the Americans with Disabilities Act, employers may be ignorant about or cautious in providing reasonable accommodations on the job. Additionally, there are often family care issues that interfere with one's ability to be consistent at work.

Even if a job is obtained, the job tenure for Veterans with COD is low. Job quits and high turnover can be frequent; there may be difficulties interacting with co-workers or supervisors, handling relapses, or coping with symptoms on the job (e.g., poor concentration or lack of stamina).

Although these barriers are formidable, in the last thirty years great strides have been made in the knowledge of interventions that contribute to successful work outcomes. MISSION-VET Case Managers (CM) and Peer Support Specialists (PSS) can link Veterans to existing VA and community vocational supports. The MISSION-VET team can also incorporate many Supported Employment principles and skills into their ongoing relationship with Veterans to improve their chance for obtaining and retaining employment.

B. Linking Veterans to VA Employment Supports

The VA has embraced many principles and programs to support the employment of Veterans with COD. MISSION-VET CMs and PSSs can take advantage of these VA programs on behalf of the Veterans they serve. These opportunities to provide or to link Veterans to VA employment supports are described below.

Vocational Rehabilitation through the Veteran Benefits Administration (VBA; Chapter 31)

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

Veteran to achieve his/her goals. The VR&E counselor or Case Manager will work with the Veteran to implement the plan, related to the five tracks of services described in the following table.

Five Tracks of VBA Rehabilitation Services

1. Reemployment (with a former) employer
2. Direct job placement
3. Self-employment
4. Training or education to achieve employment goals
5. Independent living services

Veterans may be eligible for services for up to 12 years from a service-connected disability rating. Please refer to *http://www.vba.va.gov/bln/vre* for more information on the VA's VR&E Service. Additionally, MISSION-VET CMs and PSSs can help Veterans apply for benefits on-line through the Veterans ON-line APPlication (VONAPP) system: *http://vabenefits.vba.va.gov/vonapp/main.asp*.

Compensated Work Therapy Program (CWT) through the Veterans Health Administration (VHA)

An alternative employment program is available to Veterans through the VHA. The CWT program's mission is to provide realistic and meaningful vocational opportunities to Veterans, encouraging successful reintegration into the community at the Veterans' highest functional level. CWT staff will match an individual Veteran's vocational strengths and areas of interest to employment opportunities with local businesses and industries in many occupational sectors. CWT programs develop an individual rehabilitation plan for each Veteran and provide a wide range of support services, such as vocational case management and workplace supports at CWT locations (see *http://www.cwt.va.gov/locations.asp)*. Veterans are eligible for CWT if they are homeless, have mental illness, physical disability, and/or are diagnosed with substance abuse. Veterans will need to be "clinically stable" and abstinent from substance use. Participating CWT Veterans must be referred by someone privileged in a VAMC for vocational services. CWT programs are present at all 186 VA Medical Centers (VAMC), but do vary by site in terms of how large the program is and the range of services they provide. To begin a referral process, contact the CWT program in your area: *http://www.cwt.va.gov/*

A component of CWT operating in many VAMCs is Transitional Work Experience (TWE), a pre-employment vocational assessment and experience program that operates in the VAMC and in local community businesses. Much like the transitional work programs found in the Clubhouse or "Fountain House model" for individuals with serious mental illness (SMI), TWE participants are screened and assessed by vocational rehabilitation staff and matched to a work assignment for a limited time, as deemed clinically appropriate. TWE work assignments are not jobs that the Veteran competes for with the rest of the labor force; rather, the job is typically arranged between the VAMC and the employer, and the VA will fill the job with a rotating set of workers. The goal of TWE is to provide the Veteran with a paid work activity that functions as a stepping stone in their efforts to obtain a job of their own in the community.

The emphasis in TWE is more on paid employment activity rather than a competitive job in the traditional sense, with hourly payments made to the Veteran by the VA and not by the employer. Veterans at the work assignment are supervised by worksite staff. The same job expectations are imposed on the Veteran as would be of non-CWT workers in the company. CWT provides employers a source for temporary and permanent workers or a means for completing work on a piece rate or job rate basis.

Supported Employment Program

CWT also offers "supported employment" at every VAMC in the country. Supported Employment (SE) provides vocational services to those Veterans with psychosis, PTSD, and other SMI who need the highest level of staff support offered by this program in order to obtain competitive, meaningful employment. With SE, Veterans perceived to have significant barriers to competitive work are able to engage in full and part-time employment with appropriate supports and workplace accommodations.

In the SE model, the emphasis is on the Veteran obtaining a desired job in the community, with the support of a CWT staff member. Staff provide a wide range of supports, including assistance with finding employers and potential job matches as well as help to keep a job or transition to a different job that is a better fit. SE follow-up continues based on the Veteran's need for employment services and supports. Participation and supports may be phased out after the Veteran is able to maintain employment independently.

VA SE is modeled directly after the evidence-based approach called Individual Placement and Support (IPS), developed by the Dartmouth Psychiatric Rehabilitation Center and adopted for national roll-out in the VA in 2004. The SE model has been studied in at least 20 randomized controlled trials using a variety of alternative vocational models as comparison conditions. The results document SE's efficacy in helping disabled adults enter employment at higher rates than any of the comparison

conditions, making SE one of the most well-documented evidence-based practices in healthcare (Bond et al., 2008; Cambell et al., 2009). SE utilizes the fundamental principles of the IPS model, including integration of an employment specialist with the clinical team, rapid job development, placement based on preferences and skills of the Veteran, and no mandatory pre-vocational assessment or work experience. SE is available regardless of prior work history or clinical status. Support and follow-up is provided indefinitely and in varying intensity as needed. Supported employment is designed to be delivered by a full-time employment specialist who is part of a clinical team that embraces employment objectives. There is a very low caseload ratio for employment specialists, and specialists are expected to work closely with employers (when approved by the Veteran) on job development and problem solving, including negotiation for accommodations.

C. What can MISSION-VET Staff do to Support the Employment of Veterans?

MISSION-VET CMs should gauge the interest of each Veteran on their caseload and make a referral to SE, TWE, or Chapter 31 staff when appropriate. A review of SE principles and practices can be useful to MISSION-VET CMs seeking to promote the employment of Veterans on their caseload. SE principles and practices are described in this section.

The following principles are adapted from *Supported Employment, A Practical Guide for Practitioners and Supervisors* (Swanson, Becker, Drake, & Merrens, 2008), published by the Dartmouth Psychiatric Research Center. Additional and more detailed information on Supported Employment can be found in the recently released Toolkit by the Substance Abuse and Mental Health Services Administration (SAMHSA) on *Supported Employment: Training Frontline Staff: http://download.ncadi.samhsa.gov/ken/pdf/toolkits/employment/SE_Training_Frontline_Staff.pdf*

Seven Supported Employment Principles:

1. ***Zero exclusion:*** Research has not been able to reliably distinguish those who will or will not succeed in employment. Anyone who has a stated wish to work deserves help to achieve this goal, irrespective of their current clinical status or past work history.
2. ***Integration of vocational and treatment services.*** Frequent communication is needed between employment specialists and the health care treatment team in order to apply a consistent, hopeful message about work and to troubleshoot clinical issues that may relate to work success, such as timing of appointments, control of psychiatric symptoms, or dealing with side effects of medication when on the job.
3. ***Competitive employment.*** Jobs should be obtained in the competitive economy (not sheltered work or segregated placements for people with disabilities) and pay at least minimum wage.
4. ***Benefits planning.*** Veterans and their helpers must think through and obtain reliable information on the potential impact of income on any disability benefits. Many people with SMI will restrict their work for fear of losing health insurance or having benefits reduced.
5. ***Rapid job search.*** Job search based on Veteran preferences should begin shortly after or within a few weeks of determining that the Veteran has a goal to work. Veterans can seek jobs without pre-employment training, formal assessment, or job readiness skill development. The job search should be tied to a simple vocational profile that specifies the Veteran's preferred industry sectors, the type of job skills s/he has, and the number of hours per week desired. An Individual Placement and Support (IPS) framework for developing an employment plan is supplied in Appendix J.
6. ***Follow-along supports.*** Veterans with mental health or substance abuse problems may need support of varying intensity for a period of time in order to succeed. In SE, "cases" can remain open indefinitely.
7. ***Veteran preferences.*** Key tenets of SE are recovery, choice, and self-determination. Veteran preferences are always taken into consideration and given primary value when making decisions about what jobs are sought, how many hours are worked, how SE services are provided, and whether or not to disclose one's disability on the job.

Practitioner Skills for Supported Employment

Putting the seven supported employment principles into practice will require special skills. Some of these will be novel to traditional Case Managers and may require additional training, though others are also central to standard CM practice. Given training, MISSION-VET PSSs also may be able to put these skills into practice. Some essential skills for SE are listed below.

Skills for Interviewing Veterans. Interviews with Veterans should be focused and goal oriented, but the first goal is to develop a trusting relationship. Skills that will foster an open relationship with the Veteran are use of open-ended questions, active listening, and paraphrasing techniques. Always convey respect, hope and a positive attitude, while being careful to not give advice, convey judgment or paternalism, or argue with the Veteran. Motivational interviewing (MI) techniques (See Appendix J) have been shown to be highly successful in creating behavioral changes in other domains. There is some initial evidence that using these techniques can help address ambivalence about work and help Veterans to consider

exploring potential employment opportunities. MISSION-VET CMs are encouraged to seek more information on MI: *http://www.motivationalinterview.org*

Helping Veterans Find Work. A supported employment specialist spends over half of his or her time in the community developing job leads and working closely with employers. (A sample "letter to employers" is included in Appendix J). Although this is not feasible for MISSION-VET CMs because of time constraints, some aspects of conducting a job search can be incorporated into CM activities.

The first of these is helping the Veteran to develop an employment goal that is in line with their life situation. CMs can help Veterans figure out what their preferences and aptitudes are for a job, in what kind of setting, and for how many hours per week. For example, an outdoor job may be better suited to a Veteran who is unprepared to work in a formal business setting. Efforts to create a better "job match" with the Veteran will pay off in terms of longer job tenure. A sample "job profile" is included in Appendix J.

SAMHSA indicates that job finding is "where the rubber hits road" (SAMHSA, 2009, "Supported Employment: Training Frontline Staff," p.4). In order to maintain a Veteran's motivation to work, the job search should begin as soon as possible. MISSION-VET CMs can use community resources to help Veterans identify a job lead, such as the local state department of labor career centers, the state agency for vocational rehabilitation, and community groups such as the local chamber of commerce. These groups may offer free assistance with resume development and interviewing skills. Job leads can also be found among personal and family contacts, previous employers, and other standard job search mechanisms such as the Internet and local advertisements.

CMs will also need to find out to what degree the Veteran is comfortable with someone else searching for a job on his/her behalf. CMs can either work with the employer directly around a job lead (which is often appreciated by the employer), or may work behind the scenes, providing the Veteran guidance and support as they go forward with the job application and interview phase.

Providing Individualized Job Supports. There is a tremendous accomplishment in getting a job; however, the next stage of supported employment is of equal or greater importance - keeping the job. Employment specialists need to be able to provide a wide variety of follow-along job supports that are highly individualized, flexible, and creative. Because impaired cognition can be a co-morbid feature of serious mental illnesses, cognitive training programs, such computer based trainings, can be important job supports (McGurk, et al., 2009). Some job support examples are developing a successful transportation strategy, assisting with negotiating for reasonable accommodations with the employer, figuring out how to handle disclosure of the disability, advising the Veteran on how to handle symptom exacerbations on the job, offering assistance with organizing workload and keeping track of assignments, hands-on job coaching at the job site (when possible), handling disagreements or problematic interactions with co-workers or supervisors, providing morning phone calls to help encourage the Veteran to get ready for work, communicating with the clinical team about possible treatment changes, handling paychecks and budgets, and problem solving with employers. There are many resources available for MISSION-VET CMs and PSSs to utilize when these problems arise, many of which are found on the following Websites.

Helpful Job Support Websites

- Job Accommodation Network: *http://askjan.org*
- Boston University Center for Psychiatric Rehabilitation: *http://www.bu.edu/cpr*
- Supported Employment at the Dartmouth Psychiatric Rehabilitation Center: *http://www.dartmouth.edu/~ips/*
- Benefits counseling: *http://www.ssa.gov/work/WIPA.html*
- Substance and Mental Health Services Administration on Work: *http://www.promoteacceptance.samhsa.gov/topic/employment/*
- Overview of employment supports and vocational rehabilitation for people with disabilities: *http://www.disability.gov/employment/jobs & career planning/vocational_rehabilitation*
- General employment supports and state departments of labor *http://www.careeronestop.org/*

D. Helping Veterans with COD

The principles of supported employment apply equally to Veterans with COD. However, some special considerations may be needed for these Veterans, as is the case with the population of Veterans eligible for MISSION-VET services. First, the vocational profile used to guide the job search should include information about their substance use. Information to be recorded includes what substances are used and how often, recovery status and stability, presence or absence of recovery supports, and relapse triggers. It will be important to choose jobs that support recovery; e.g., jobs in drug stores or restaurants may provide greater temptation to use.

Communication with the treatment team is essential to arranging for sufficient support and interventions to prevent relapses. Ongoing supports may require special attention to prevent and attend to relapse issues. As always, when treating

anyone with a mental illness, it is helpful to take setbacks in stride while continuing to take note of any accomplishments or gains. Share your belief and hope that the Veteran can get more out of life.

E. Supported Education

Many Veterans, especially young adults from the OIF/OEF conflicts, will have an interest in using their GI Bill benefits to further their education. The recent "Post-9/11 GI Bill" provides increased educational tuition benefits, housing stipends, and payments for books and computers for Veterans who served after 2001. However, for homeless Veterans with COD, obstacles may seem insurmountable. These can include difficulty accessing GI Bill benefits or unawareness of these benefits, lack of knowledge or uncertainly about which college or program to apply to, trouble with negotiating the admission and enrollment processes, feeling isolated or stigmatized on campus by virtue of being a Veteran with a disability, difficulties keeping up with course demands due to symptoms, or lack of needed study skills.

Supported education is a service that is similar to supported employment and has been dubbed an "emerging" evidence-based practice for people with serious mental illness by the Substance Abuse and Mental Health Services Administration (SAMHSA). The seven principles of supported employment described above can be applied similarly by MISSION-VET CMs and PSSs when Veterans indicate having an interest or goal to further their education. For example, integration of education support services with clinical treatment will be important; Veteran preferences in education should always be solicited and followed; and any Veteran's interest in education should be respected without requiring extensive educational assessments or testing.

The skills described above for supported employment are also highly relevant to a supported education service, though some adaptation to the specific setting will be needed. Research has shown that education benefits counseling is equally important and that an emphasis should be placed on the Veteran developing an understanding of these potential benefits. Additionally, MISSION-VET staff should facilitate and encourage application for and acquisition of these benefits. Also, the rapid job search needs to be adapted to the semester schedule of higher education, and greater care may be needed in planning educational/career goals, as enrolling in an academic program and arranging payment for classes can be a larger commitment than trying out an entry level job. Some of the unique adaptations of supported employment to better serve Veterans seeking to further their education are described:

Interacting with the Campus System

Similar to working with an employer, providing supported education can include making contact with the school that the Veteran has chosen. Most supported education specialists will need to contact and get information or assistance from staff members of administrative departments such as admissions, financial aid, or the registrar. Other supports on campus can be obtained through the school student disability services office, which should be knowledgeable about acquiring educational accommodations. Educational accommodations can include a note-taker in class, being allowed to record classes, being provided both written and verbal instructions, extended time for test taking, access to quiet spaces, or small groups for test-taking and for classes.

It may become necessary to make contact with specific instructors or professors to negotiate accommodations or to problem solve if the Veteran is having trouble in a particular class. It is also valuable to attempt to identify an advocate or support person on campus. Many schools will have a Veteran coordinator; some will have student Veteran centers. Establishing a link for the Veteran to a person who can provide support and advocacy onsite will be important and helpful.

Choosing Educational Goals

Some Veterans may know exactly what they want to get out of continuing their education; others have never been asked or have clearly thought about their career goals and the educational planning required to achieve them. The Boston University model of "choosing" an education goal or setting refers to an "exploration of past experiences in school and work, identification of vocational interests, examination of skill and support needs in making the change, brainstorming options, research into potential occupations, and environment and decision making" (Yim, Nicolellis & Fahey, 2002, p.76). Many colleges will have pre-enrollment entry assessments that can let the Veteran know whether and which college readiness classes may be needed. A significant part of educational goal-setting will be to determine the number of classes in which the Veteran should enroll, or whether to enroll as a part-time or full-time student. Many Veterans going back to school will do best by trying a small credit load at first.

Access GI Bill benefits. Although the GI Bill provides many benefits, Veterans may need assistance in deciding whether to use the GI Bill or other VA supports. They may also need help with applying for and receiving benefits. Often, information on the GI Bill can be confusing and hard to access; moreover, legislative changes to qualifications and benefits further complicate understanding of these benefits.

Ongoing education monitoring and support. Like supported employment, ongoing support is recommended to help the

Veteran stay in school and succeed. Regular and periodic "check-in's" are useful to find out how the Veteran is doing and to be proactive about identifying emerging problems.

The need for support and advocacy will vary in intensity and may diminish over time. Prior programs have shown that supported education services tend to be used most intensively in the first year and finish by the end of the second year of enrollment.

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NOTES

VII. Trauma-Informed Care

Lisa M. Najavits, Ph.D.

This chapter addresses the importance of trauma and trauma-informed care to help the MISSION-VET treatment team, including the Clinical Supervisor, identify and assist Veterans who have symptoms of trauma. This chapter has been included because of the high rate of trauma experienced by Veterans, particularly those in the current cohort of returning Veterans. MISSION-VET is not a PTSD intervention or one designed to treat co-occurring PTSD and addiction. However, this chapter does address the need to screen and refer Veterans who may have symptoms of serious trauma. For Veterans whose PTSD is severe or chronic, referral to a specialized program to stabilize and treat symptoms is advised. Suggestions for interacting with Veterans who have experienced trauma are also provided.

A. What is Trauma-Informed Care?

In the past decade, the term "Trauma-Informed Care" (TIC) has become a central component of treatment services for all vulnerable populations, including Veterans and the homeless. TIC is based on the idea that trauma is common and thus has important impact on how treatment is best delivered (Fallot & Harris, 2001). The more providers are aware of trauma and its impact, the better they can attend to it in treatment to promote recovery.

"Trauma" refers to the experience, threat, or witnessing of physical harm (American Psychiatric Association, 1994). It includes various types of experiences such as military combat, military sexual trauma, terrorist attacks, serious car accidents, natural disasters, major medical illnesses and injuries, childhood physical or sexual abuse, assault, and violence. Most Americans (about 61% of males and 51% of females) experience one or more traumas during their lifetime (Kessler et al., 1995). Globally, too, trauma is common (Kessler, 2000). Various stressors related to military service in particular may cause trauma (Seal, et al., 2007).

Trauma is an important treatment consideration for MISSION-VET Case Managers (CMs) and Peer Support Specialists (PSSs) because it can have varied and major impacts on functioning, the development of mental disorders, and life problems of all kinds (Najavits, et al., 1997; Ballenger, et al., 2000; Felitti et al., 1998). Trauma is associated with numerous symptoms, including depression, suicidality and self-harm, anxiety, social skills problems, dissociation, somatization, and psychotic symptoms (Mueser, et al., 2002). Trauma victims are also at "much higher risk for co-occurring mental health and substance abuse disorders (COD), violence victimization and perpetration, self-injury, and a host of other coping mechanisms which themselves have devastating human, social, and economic costs. Trauma has been linked to social, emotional and cognitive impairments, disease, disability, serious social problems, and premature death" (Witness Justice, ND).

The MISSION-VET treatment team can also benefit from considering some important contextual factors that may impact how a person responds to trauma. These include gender differences in response to trauma, how culture may play a role (Hudnall-Stamm, 2001), delayed response (i.e., some people may react months or years after the traumatic event), single versus repeated trauma (how many times it occurred), age at time of trauma (child versus adult), the biological impact of trauma (mind-body connections), and how others reacted (family, community, colleagues, and society at large) (Najavits & Cottler, in press). Thus, it is important to remember that even traumas that appear similar in nature (for example, a car accident) may have a different impact depending on the individual and the context.

B. Trauma-related Disorders

Several psychiatric disorders can directly arise from trauma (American Psychiatric Association, 1994). These are important to assess and to treat when present. However, most people exposed to trauma, including Veterans, do not develop psychiatric disorders from trauma. Those more likely to develop trauma-related psychiatric disorders are those who experience repeated trauma (e.g., multiple military deployments), those who suffered greater physical injuries, and those were more vulnerable before the trauma (e.g., younger persons with a pre-existing history of mental illness themselves or history of mental illness in their family) (Kessler et al., 2005; Najavits & Cottler, in press; Seal et al. 2007, 2009). Disorders related to trauma include the following:

Acute stress disorder occurs during or up to four weeks after trauma. It is characterized by various symptoms including a sense of numbing or detachment; reduced awareness of surroundings (being in a "daze"); difficulty recalling important aspects of the trauma); feeling unreal; feelings of anxiety, avoiding reminders of the trauma; re-experiencing the trauma, such as through flashbacks or nightmares; and significant decline in functioning.

Post-traumatic stress disorder can only be diagnosed four weeks or more after the trauma, thus indicating a persistence of trauma-related symptoms that do not diminish with time. Symptoms include many of the same symptoms as acute stress disorder, as well as others. In general, the symptoms fall into three main categories: re-experiencing the trauma (such as through nightmares and intense physical and emotional "triggering" when reminded of the trauma); avoidance of reminders of the trauma; and intense arousal (e.g., difficulty sleeping, anger outbursts, and startle reactions).

The two brief screening tools provided in Appendix K, can be used by the MISSION-VET team to assist in making treatment decisions: the PTSD four-item screen (originally developed for primary care settings, but used more broadly as well) and the PTSD Checklist (which maps onto the full list of DSM-IV criteria for PTSD).

Dissociative disorders may occur in a small percentage of the population after exposure to extreme and chronic trauma, such as in repeated childhood or prisoner-of-war trauma experiences. Dissociative disorders are marked by changes to consciousness, memory, identity, or perception. For example, the Veteran may have major memory gaps or feel unreal. In severe cases, dissociative identity disorder may be present, which is characterized by the presence of "alters" (different personalities) within the self, with switching between them that may occur without awareness or control of the Veteran. If this is noticed among Veterans in MISSION-VET, the CM/PSS team should work closely with the Clinical Supervisor and consider a referral to a specialized PTSD program as part of the treatment plan. In those instances, the MISSION-VET treatment team can assist by helping the Veteran accept a referral and engage in those services, and by continuing to support their ongoing attendance as part of the broader and more comprehensive treatment plan. The MISSION-VET treatment team should work closely with the PTSD team whenever possible. Additionally, every VA currently has a PTSD specialist who can assist with additional treatment considerations and ongoing supports in the community.

C. Elements of Trauma-informed Care

All MISSION-VET team members need education on the importance of incorporating trauma-informed care (Fallot & Harris, 2001) into MISSION-VET into service delivery. According to the National Center for Trauma-Informed Care, "When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma impacts the life of an individual seeking services" (*http://mentalhealth.samhsa.gov/nctic).*

Specifics of trauma-informed care include the following (Elliott *et al.*, 2005; Fallot & Harris, 2001; Morrissey *et al.*, 2005; Weine *et al.*, 2002):

- Training all MISSION-VET staff in basics of trauma education (rates, impact of trauma, how to interact with traumatized Veterans, etc.);
- Taking steps to avoid retriggering trauma (e.g., restraints, isolation, or coercion);
- Creating advance directives on how to manage intense emotions (i.e., concrete plans of what to do if the Veteran becomes agitated, such as who s/he will talk to and what strategies help to calm the person);
- Eliciting input from survivors of trauma on how to design services that are trauma-sensitive;
- Focusing on dynamics that empower the traumatized Veteran, such as offering choices, expressing compassion, and listening;
- Learning how to help Veterans understand how some behavioral patterns may have developed from trauma; and
- Modifying policies to respect trauma sensitivity (e.g., a Veteran may need lights on at night while in residential treatment).

Note that all of the above are within the scope of the MISSION-VET team, but may require training or guidance from their local VA PTSD specialist and/or PTSD treatment team. In addition, resources for incorporating such trauma-informed care approaches are also available from some of the references and web resources listed in Appendix K.

Trauma-informed Treatment versus Trauma-specific Services

It is important to distinguish trauma-informed from trauma-specific treatment (Fallot & Harris, 2001):

- ***Trauma-informed services:*** basic trauma education, where all staff are trained to become *trauma-aware* (knowledgeable about trauma symptoms and the impact of trauma on Veterans' lives, able to implement basic skills such as grounding and trauma screening, and aware of how and when to refer Veterans out for specialized help). An example of a model that is used in VA for trauma education is Seeking Safety (Najavits, 2002).
- ***Trauma-specific services:*** trauma therapy models in which a smaller number of staff become *trauma-competent* (able to effectively treat trauma-related disorders using evidence-based models. Examples of trauma-therapy models that are used in VA include Prolonged Exposure (PE) (Foa, 2007) and Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 1999).

Present- versus Past-Focused Trauma Treatments

Another key distinction in the trauma treatment field is between present- focused and past-focused trauma treatments (Najavits, 2006).

In ***past-focused*** models, the client focuses on intense details of the trauma story as a way to face the feelings that arise from it. Typical interventions include having the client tell the trauma narrative in detail, having the client focus on body sensations they associate with the trauma, and having them seek out real-life reminders of the trauma (e.g., look at the clothes worn at the time of the trauma). Examples of past-focused models used in VA include EMDR, Prolonged Exposure Therapy, and Cognitive Processing Therapy.

In ***present-focused*** models, the client learns coping skills and education to improve functioning. Typical interventions include grounding (using sensory experience to reconnect with the present environment), relaxation, learning to ask for help, cognitive restructuring, and coping with triggers of trauma. Examples of present-focused models include Seeking Safety, Trauma Recovery and Empowerment Model, and Stress Inoculation Training.

Research indicates, overall, that both present- and past-focused models are effective, and in virtually all head-to-head research studies, they perform with no significant difference between them in outcomes (Najavits, 2007). This means there is a lot of choice in what models clinicians can conduct. Choices should be made based on the setting, the client, and the clinicians' own training and skills.

D. Trauma Services in MISSION-VET

When delivering MISSION-VET services to Veterans, the goal is to be sensitive to trauma and how it may manifest in Veterans. CMs and PSSs delivering MISSION-VET services should be trauma-informed. All Veterans enrolled in a MISSION-VET program should be screened for PTSD and, if positive, should be formally assessed by a qualified assessor. Additionally, MISSION-VET CMs and PSSs should use an empathic stance (as described in the next sections) with Veterans on their caseloads.

Some MISSION-VET CMs (under the direction of their Clinical Supervisor) may also choose to engage in present-focused trauma-specific treatments (or parts of such models) in conjunction with their MISSION-VET work. Such models have been found to be very safe for clinicians to use, even with a very broad range of co-morbid clients, even if they do not have a formal background in mental health (Morrissey et al., 2005). For example, MISSION-VET CMs and PSSs may choose to do grounding with Veterans, in which they provide brief psychoeducation about trauma and its impact (See Appendix K for more information on grounding). However, it is important to emphasize that CMs and PSSs delivering MISSION-VET services are advised not to conduct intensive past-focused trauma-specific services unless they have formal training and supervision in those models (e.g., EMDR, Prolonged Exposure, Cognitive Processing Therapy). These treatments can result in negative outcomes or harm to Veterans if conducted poorly. "First do no harm" remains the central principle of all treatment.

Keys in Interacting with a Veteran who has Trauma-Related Symptoms

- Anticipate proceeding slowly with a Veteran who has trauma-related symptoms. Consider the effect of a trauma history on the Veteran's current emotional state, such as an increased level of fear or irritability.
- Develop a plan for increased safety where warranted.
- Establish both perceived and real trust.
- Respond more to the Veteran's behavior than his or her words.
- Limit questioning about details of trauma.
- Recognize that trauma injures a Veteran's capacity for attachment. The establishment of a trusting relationship will be a goal of treatment, not a starting point.
- Recognize the importance of one's own trauma history and countertransference.
- Help the Veteran learn to de-escalate intense emotions.
- Help the Veteran to link trauma and substance abuse.
- Provide psychoeducation about trauma and substance abuse.
- Teach coping skills to control trauma symptoms.
- Recognize that Veterans may have a more difficult time in trauma/substance abuse treatment and that treatment for trauma may be long term, especially for those who have a history of serious trauma.
- Refer to trauma experts for trauma exploratory work.

Reprinted from SAMHSA's *Treatment Improvement Protocol: Trauma and Substance Abuse (in press). Consensus panel chairs: Lisa M. Najavits, PhD and Linda B. Cottler, PhD, MPH

Style of Interaction

According to VA's National Center for PTSD *(http://www.ptsd.va.gov),* style interaction is a key element of Trauma-Informed Care. Those interacting with the Veteran should interact with Veterans in ways that promote the best response possible. The following advice is provided:

> *"Another consideration within the therapeutic relationship between client and clinician is placing less emphasis on confrontation and more tolerance of the problem. Many individuals who treat substance use disorders can use a harsh confrontational style. They can draw the line in a very specific way and say to their client things like "You need to get yourself together," or "You need to stop doing this." And can really push on the client in a way that is very confrontational. The thing to consider when working with somebody who has trauma is that their trauma may have occurred under conditions of harsh confrontation and so the very intervention may be triggering the individual, thus causing problems within the therapeutic relationship and perhaps even affecting treatment. On the other side of that is misguided sympathy. There are providers who feel that their clients have had too many traumas and really over-sympathize with what's happening for them, and they don't hold them responsible for doing homework or engaging in the responsible actions that are necessary for them to recover. So you want to think of this as harsh confrontation on one end of a continuum and misguided sympathy on the other end of the continuum and see if you can put yourself right in the middle using a soft confrontational style and holding the client responsible for the different things that they need to do to promote recovery."*

The Importance of Culture and Gender

It is also important to be sensitive to how culture and gender may play a role in how trauma is perceived, addressed and treated. For example, culture and gender may affect whether a MISISON-VET client is able to identify trauma symptoms as "legitimate" (e.g., in some cultures psychological problems are considered more taboo to discuss than in others); may affect how symptoms are expressed (e.g., as emotional versus more physical in nature); may affect co-morbidity (e.g., the likelihood of using certain substances as ways of coping with trauma symptoms); and may affect treatment response (e.g., whether the counselor is aware of cultural and gender subgroup issues). Thus, MISSION-VET CMs and PSSs are encouraged to seek training in cultural, diversity, and gender-based issues so as to provide the most compassionate care possible to "their" Veterans.

Trauma and the Clinician

It is also important to recognize that members of the MISSION-VET treatment team themselves may have experienced trauma. Given that the majority of people in the U.S. population experience one or more traumas in their lifetime, a large percentage of clinicians may have their own trauma history. Sometimes working with traumatized Veterans may activate the MISSION-VET CM's or PSS's own trauma reactions, or it may result in strong feelings toward the Veteran. These may be especially powerful if the MISSION-VET CM or PSS still has trauma symptoms that are not "worked through" or treated sufficiently (Pearlman & Saakvitne, 1995). Thus, self-care is a necessary principle. This includes attending to one's reactions while working with traumatized Veterans, getting help if needed, and maintaining boundaries between one's own experience and the Veteran's.

When to Refer a Client out for Trauma-Related Treatment

MISSION-VET team members should know when to refer a Veteran on their caseload out for specialized PTSD or trauma-related assessment or treatment. Key examples of such scenarios are as follows.

- The Veteran has emotional or behavioral problems that are consistent with PTSD (e.g., intense anger, hypervigilance, nightmares).
- The Veteran screens positive for PTSD, and there is a need for formal diagnostic assessment.
- The Veteran requests additional PTSD treatment.
- The Veteran keeps relapsing on substances and has a major trauma history.
- Members of the MISSION-VET treatment team notice the Veteran dissociating during sessions (e.g., spacing out, blank stare) and feel the need for additional therapeutic help.
- The MISSION-VET treatment team suspects PTSD may be present, but are not sure and would like a consult to offer expert advice.

In all of these cases, we suggest that the MISSION-VET CM work closely with the Clinical Supervisor to make an appropriate referral. It is also important to note that in the MISSION-VET treatment model, the referral does not end treatment. It is the MISSION-VET treatment team's job to facilitate the referral and offer assistance to the treatment team during the assessment process, at other times when the treatment team deems it appropriate and helpful, during discharge planning, and in execution of the new discharge treatment plan.

There are numerous situations where the Veteran's presentation may suggest the need for a stronger PTSD treatment focus than can be provided as part of MISSION-VET services. However, many CMs conducting MISSION-

VET can deliver elements of Trauma-Informed Care and exercise some trauma-specific coping skills, even while seeking out additional PTSD expertise.

Case Example

Jason is a returning Veteran from OIF, who is currently in residential care at VA due to homelessness and multiple psychiatric problems. He struggles with alcohol dependence that arose about six months after returning home from Iraq. He was exposed to multiple traumas during his deployment, including seeing a fellow soldier, Bill, die in a blast from a roadside bomb. Jason was nearby and was almost killed himself. He said he felt dead inside ever since losing Bill, who was a good friend.

Jason had nightmares many nights and became afraid to go to sleep. He became more isolated and withdrawn and volunteered for the most dangerous assignments, not caring if he lived or died. On returning home, his wife and children seemed afraid of him, as he would burst into angry episodes over small things, such as someone not putting things away correctly. He had been an easy-going, quiet person before Iraq, and they felt they barely recognized him now. His wife told him to get treatment or she would leave him. He refused and then moved out.

Without a job, Jason ended up on the streets, where he became a low-level worker for a drug dealer in an attempt to try to earn some money. An outreach worker from the VA talked him into trying to get into VA care. He felt hopeless that anything would make a difference but agreed to an intake, where they diagnosed him with post-traumatic stress disorder, substance dependence (alcohol), dysthymia, and intermittent explosive disorder. He entered a residential program where he was required to attend treatment as a condition of receiving temporary housing.

Initially, Jason was withdrawn, distrusting, and somewhat paranoid, but as he settled in, he began to speak a bit in groups and was able to connect with a counselor whom he trusted. The counselor helped him to understand the impact of trauma on his life and helped him see how his misuse of alcohol and prescription medications had been a way to try to cope with trauma-related symptoms. He now says,

> *"My counselor got it, even when I didn't, that trauma had played a huge role in how I ended up homeless and at my bottom. I kept blaming myself, but my counselor helped me see that the traumas I had been through had festered inside me and affected everything I did, yet I never dealt with it or even acknowledged how important they were. My counselor was kind, and moved slowly, pacing to what I was able to do at any time and never pushing or judging me."*

Jason ultimately entered individual PTSD treatment with a VA therapist trained in this area, continued to work on his alcohol dependence, and gradually learned new coping skills and engaged in family therapy. Ultimately, about three years from the date when he left home, he was able to reunite with his family and move back in with them.

Case questions

Consider the following questions about Jason's story above.

1. How did trauma play a role in Jason's problems?
2. What helped him to recover?
3. What elements of Trauma-Informed Care do you notice in his treatment?
4. Are there other things his counselor could have done to create a trauma-sensitive treatment experience?
5. When you work with clients, how much do you practice Trauma-Informed Care? What could you do differently to increase this aspect?

Case discussion

Jason is typical of some returning Veterans in his exposure to trauma during deployment to Iraq and in his development of alcohol dependence after coming home. His family problems, homelessness, and multiple psychiatric problems are also representative of some of the more severe clients. His hopelessness, sleep problems, difficulty taking care of himself, and downward spiral are all typical trauma-related problems that have even greater impact in the context of substance dependence and other psychiatric disorders. Yet Jason is a success story in several ways:

- A VA outreach worker was able to engage him into treatment, even amid Jason's significant distrust and isolation.
- Jason's counselor used a trauma-informed approach focusing on building trust, pacing, and education about trauma and related problems.
- Jason was referred to a VA PTSD specialist for treatment of the PTSD, and, eventually, when ready, to family treatment to help re-unite with his family.

In sum, a trauma-sensitive approach helped Jason engage in recovery and through specialized treatment for PTSD, he was able to make significant progress in addressing alcohol dependence and family problems.

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NOTES

VIII. Core Competencies for Clinical Supervisors

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This chapter provides useful strategies that will help guide clinical supervisors who oversee and support the work of MISSION-VET Case Managers and Peer Support Specialists. It includes an overview of the MISSION-VET supervisor's role and a description of each team member's primary area of responsibility within the MISSION-VET program. The remainder of the chapter describes key strategies that MISSION-VET supervisors will need in order to establish productive working relationships with MISSION Case Managers and Peer Support Specialists. These strategies, which are designed to foster a strong supervisory alliance and assure that services are being delivered with fidelity to the MISSION-VET model, will ensure the provision of the highest quality of care. Several brief vignettes are included to illustrate these strategies.

A. The Role of the Clinical Supervisor in the MISSION-VET Model

As described in previous chapters, the MISSION-VET model utilizes Critical Time Intervention (CTI) case management and Dual Recovery Therapy (DRT) integrated co-occurring disorders (COD) treatment to provide a smooth transition into the community, maximize skills through practice, and ensure a secure foundation while terminating/transferring care. CTI is a time-limited community-based approach in which MISSION-VET case managers (CM) help Veterans identify and work to eliminate behaviors that have previously endangered housing stability. As part of the CTI model, MISSION-VET Case Managers (CMs) and Peer Support Specialists (PSSs) work with Veterans to identify the most useful community-based, resources, identify and eliminate any gaps in service and support, and establish long-term connections with community providers and resources to help the Veteran achieve his/her treatment goals. These steps are meant to enhance the Veteran's functioning and ultimately help him/her become self-sufficient in the community.

By combining evidence-based practices like Cognitive Behavioral Therapy (CBT), including Relapse Prevention, 12-Step Facilitation, and Motivational Enhancement Therapy (MET), DRT delivers an integrated treatment approach that addresses the biopsychosocial needs of Veterans with COD. In order to address mental health problems, the DRT treatment approach uses CBT to identify and change maladaptive beliefs to more adaptive ways of thinking. In order to address substance abuse, DRT uses Relapse Prevention and 12-Step Facilitation to address recovery from the use of substances. These integrated practices are employed to contribute to successful gains toward the treatment goals of the Veteran.

The role of the MISSION-VET Clinical Supervisor is to ensure that each CM/PSS team is working effectively to support Veterans as they transition to independent community living. To accomplish this role, the supervisor will need to develop an effective supervisory alliance with the team; respond appropriately to each team member's learning needs and styles; negotiate an agreement with the team about the nature and tasks of supervision; ensure fidelity to the MISSION-VET treatment model through regular supervision meetings with each team member, provide clinical direction to CM/PSS teams when emergency situations arise; monitor and help manage the team's stress and the potential for burnout; and attend to issues related to diversity that can, if unnoticed, impair team cohesion and, potentially, the Veteran's recovery. Each of these key responsibilities is discussed in the remaining sections of this chapter.

B. Developing the Supervisory Alliance

Treatment effectiveness rests, to an important degree, on the quality of the treatment relationship MISSION-VET CMs and PSSs have with the Veterans on their caseloads. The same can be said for supervision: its effectiveness rests, to a very large extent, on the quality of the supervisory relationship. The qualities supervisees most highly value in their supervisors are empathy, respect, and emotional warmth. These qualities foster "conditions of safety" which allow MISSION-VET CMs and PSSs to engage cognitively and emotionally in the supervisory relationship, which includes, but is not limited to the sharing and discussion of difficult clinical material. By contrast, supervisor behaviors that impede the development of a positive working alliance include arguing, interrupting, blaming, and being judgmental. MISSION-VET supervisors can also foster "conditions of safety" by providing CMs and PSSs with feedback about their strengths and what they are doing well.

MISSION-VET supervisors with collaborative styles naturally possess empathetic, respectful, and emotionally warm qualities. A collaborative style may be defined as one in which the MISSION-VET supervisor works with the MISSION-VET CM and PSS to jointly develop and work toward achieving a set of goals for supervision in an atmosphere of mutual respect. These goals, which may vary from session to session, are developed in the service of assuring good clinical practice.

However, they are also developed for the purpose of promoting the professional development of both MISSION-VET CMs and PSSs. Indeed, it is important to remember that the MISSION-VET supervisor's responsibility is to promote the welfare of both Veterans receiving MISSION-VET services and the CMs and PSSs that they supervise. Happily, the welfare of the former is best served when supervision promotes the welfare of the latter.

The techniques of Motivational Interviewing (MI), which were specifically developed to foster a strong therapeutic alliance based on collaboration between helper and client (Miller & Rollnick, 2002), are clearly relevant to this discussion. These same techniques (e.g., asking open-ended questions, using reflective statements, affirmation) also foster a strong supervisory alliance. For example, asking a series of well-directed, open-ended questions encourages a process of "guided discovery" that cannot be achieved by simply giving the MISSION-VET CM and PSS instructions on how to deliver the intervention. In other words, a learning model based on the principle of guided discovery (or, put somewhat differently, mutual exploration of the clinical material) applies equally well to CMs and PSSs, as well as to the Veterans receiving MISSION-VET services. Of course, the process of guided discovery takes time, and sometimes there simply is not enough time to accommodate a full unfolding of this process. However, the MISSION-VET supervisor's task is to find a balance between the benefits of drawing on this preferred model of learning and managing the exigencies of time.

MISSION-VET supervisors should also employ reflective statements, another fundamental MI skill, as these statements help to build trust in relationships in a variety of ways. Paraphrasing, a type of reflective listening, is a skill MISSION-VET supervisors can use to demonstrate that that they are listening carefully. Similarly, the MISSION-VET supervisor who offers statements that attempt to empathically capture or reflect the feeling behind the description of a difficult encounter with a Veteran communicates a caring and understanding that is likely to deepen the discussion of the case material. Again, the MISSION-VET supervisor must also consider the exigencies of time. However, this approach will go a long way toward shaping the value supervision has for MISSION-VET CMs and PSSs and, therefore, cannot be short-circuited without seriously compromising the quality of the work accomplished. Lastly, and very importantly, the MISSION-VET supervisor who utilizes MI techniques in supervision will also be demonstrating the very skills supervision is designed to teach.

MISSION-VET supervisors who approach supervision as a collaborative enterprise understand and appreciate that this work also provides them with valuable learning opportunities. Thus, while it is important for MISSION-VET supervisors to provide structure and a sense of direction to case discussions, they should not feel that they must have all the answers. MISSION-VET supervisors are no more able to meet this expectation in their work with the CMs and PSSs that they supervise than are the CMs and PSSs in their work with Veterans. Accordingly, supervision that is conducted in the spirit of "guided discovery" benefits both the MISSION-VET supervisor as well as the CM and PSS. Below is an example of how the aforementioned MI techniques may be used by MISSION-VET supervisors during supervision.

Example 1: Using MI Techniques in Clinical Supervision

During supervision, "Carl," a MISSION-VET PSS, mentions that he has been feeling devalued in relation to how "Jim," the MISSION-VET CM is treated.

Carl: "Lately, I haven't felt like I've been of much use to the Veterans."

Supervisor: "Tell me what's been happening since we last met." *(example of an open-ended question)*

Carl: "Well, the case manager, Jim, I've been working with is a really nice guy and does a lot for the Veterans. They all seem to go to him, even for things that I thought they should come to me for. Like they ask him to go to AA meetings with them when they get nervous going by themselves or ask him to organize recreational outings as a group."

Supervisor: "That sounds very discouraging. *(example of a reflective statement that captures feeling)* What are your thoughts about what to do?" *(example of a question that is both open-ended and directive)*

Carl: "The Veterans used to come to me before, but Jim covered for me when I was out on sick leave two weeks ago and have been going to him ever since. So, I've thought about talking to him about it, but I don't want to cause any problems either."

Supervisor: "I can understand that. But let's say you don't say anything. What problems would that cause?" *(the supervisor trying to promote guided discovery*

Carl: "Well, knowing me, I'd probably just stay angry and things would just get worse. And that wouldn't do me or anyone any good. So I guess I better talk to him about it."

Supervisor: "That sounds like a great place to start! *(example of affirmation)* Please let me know how everything works out or if I can further help you out in any way." *(expression of concern and support)*

Carl: "Thanks for your help."

C. Determining Learning Needs and Learning Styles

MISSION-VET CM and PSS learning needs can be understood primarily as a function of experience. A MISSION-VET CM and PSS with little experience using the clinical approaches described in this manual clearly have different learning needs than an experienced CM and PSS. Stoltenberg et al. (1998) proposed three levels of development in which counselors display varying degrees of autonomy and awareness. Knowing the developmental level of MISSION-VET CMs and PSSs will help the MISSION-VET supervisors make decisions about the optimal supervision environment.

Considerations in Achieving the Optimal Supervision Environment

- The balance of supportive versus challenging interventions needed
- The degree of structure provided
- The amount of teaching, skill development, and direct suggestions needed
- The degree to which MISSION-VET Case Manager's and Peer Support Specialist's personal reactions are explored

MISSION-VET CMs and PSSs at level one of development (i.e., those with little experience), typically have the least autonomy and are highly anxious and dependent on the MISSION-VET supervisor for direction, instruction, and support. They are also more focused on their own feelings and thoughts and, subsequently, less aware of Veterans' needs and process dynamics. For example, case presentations by less experienced MISSION-VET CMs are more likely to be characterized by what Gilbert and Evans (2002) call an "information flooding approach." In essence, these case presentations provide an overabundance of detail about a Veteran's history, making it difficult for the MISSION-VET supervisor to make sense of the clinical data being presented. At the root of the problem is the MISSION-VET CM and PSS's inexperience with organization and conceptualization of clinical data in light of relevant theory (e.g., CBT). This uncertainty, in turn, causes the MISSION-VET CM and PSS to feel anxious about their work with both the Veteran receiving MISSION-VET services as well as with the MISSION-VET supervisor.

The MISSION-VET supervisor's first task in these situations is to avoid impatience and to recognize the critical learning needs of the MISSION-VET CM and PSS receiving supervision. Furthermore, the anxiety of a less experienced supervisee is best managed through structure and direction, and therefore, discourages the use of personal exploration of feelings. Accordingly, the MISSION-VET supervisor's second task in working with inexperienced CMs and PSSs is to take an active role in structuring the case discussions (i.e., actively helping to organize the case data). By providing ideas for how to intervene, based on both theory and clinical experience, for the thinking behind these ideas, the MISSION-VET CM and PSS will gradually develop his or her clinical skills and become less anxious and more competent in both clinical and supervisory encounters.

In addition to case discussions, role-plays may be especially helpful for relatively inexperienced MISSION-VET CMs and PSSs. Through role-plays and other approaches to "experiential learning", MISSION-VET CMs and PSSs practice essential clinical skills under the direction of a MISSION-VET supervisor who provides immediate feedback, encourages self-reflection and correction, and who also models these skills. The first edition of Miller and Rollnick's, Motivational Interviewing (1991), describes role-play exercises for many of the strategies discussed throughout the book, including those related to basic techniques (e.g., formulating different types of reflective statements), responding to resistance, and strengthening commitment to behavior change. Miller and Rollnick provide scenarios to facilitate role plays of MI techniques that can easily be adapted by the MISSION-VET supervisor to particular clinical circumstances. Similarly, Padesky (1996) describes experiential exercises, specific to clinical supervision, aimed at developing core CBT skills (e.g., identification of schemas, the process of guided discovery, and development of a thought record) that are easily adaptable for a variety of situations. As MISSION-VET CMs and PSSs may become anxious when asked to use role-plays to practice a skill in supervision, it is generally advisable for the MISSION-VET supervisor to play the CM role (with the CM or PSS playing the role of the Veteran receiving MISSION-VET services) in order to demonstrate the skill or skills before having the CM or PSS assume this side in the role play.

As previously discussed, MISSION-VET supervisors are encouraged to establish collaborative relationships with the MISSION-VET CMs and PSSs they supervise. However, as the present discussion implies, MISSION-VET supervisors need to consider the level of experience and competence of each MISSION-VET CM and PSS. The collaboration will be more fully developed with experienced MISSION VET CMs and PSSs, but should provide room for less experienced MISSION-VET CMs and PSSs to grow and develop. As MISSION-VET CMs and PSSs gain experience and confidence, their supervision needs will change. For the most experienced MISSION-VET CMs and PSSs, where autonomy and awareness are the greatest, supervision comes alive with a challenging atmosphere, primarily in the form of self-challenge

and a deeper exploration of personal reactions and relationship processes. At this level, the MISSION-VET CM and PSS help the MISSION-VET supervisor determine the content of the supervision sessions.

The MISSION-VET supervisor should also consider the learning style of CMs and PSSs. While some are more comfortable with learning through theory-based discussions, others are more comfortable with a brainstorming approach. In the former case, the MISSION-VET supervisor will want to facilitate a discussion in which theoretical considerations are used to make decisions about how to proceed with the case being presented. In the latter case, the MISSION-VET supervisor will want to encourage the MISSION-VET CM and PSS to link his or her observations and ideas about how to proceed to relevant theory. The MISSION-VET supervisor will want to help the CM and PSS further strengthen his or her preferred mode of learning, while also helping to further develop the less preferred mode. Ideally, both MISSION-VET supervisor and CM and PSS should agree that the ultimate goal is to apply and blend both approaches to case conceptualization and treatment planning. However, in the early stages of supervision, it can be useful for the MISSION-VET supervisor to allow the MISSION-VET CM and PSS to lead with his or her preferred approach and, over time, challenge them to approach cases from the less preferred mode.

In the following section, we discuss the importance of negotiating a supervision contract with the MISSION-VET CM and PSS being supervised. An understanding of a MISSION-VET CM's and PSS's preferred mode of learning is an important element of the negotiation process. Of course, MISSION-VET supervisors should also discuss with the MISSION-VET CM and PSS their own preferred learning and teaching styles. Where the stylistic "match" between MISSION-VET supervisor and CM/PSS is not ideal, the effort each party takes to understand how the other approaches the work, will make supervision more enjoyable and productive. MISSION-VET supervisors may want to consult the book by Osland and colleagues (2006) on experiential learning for further discussion of learning styles and their relevance to creating a learning environment that best supports the professional development and competence of MISSION-VET CMs and PSSs.

D. Negotiating a Mutual Agreement about the Nature and Tasks of Supervision

Supervision encompasses many tasks, and discussion of these tasks and related issues will help create a mutual understanding of the expectations and responsibilities of the MISSION-VET clinical supervisor, as well as those of the CM and PSS. The supervision process pertains to the goals of supervision, how they will be achieved, the responsibilities of each party, and the type of interaction and preparation expected of the MISSION-VET CM and PSS (e.g., formal or informal case presentation, written case notes). Negotiating such an agreement and ensuring that MISSION-VET supervisors implement these tasks as part of their responsibilities will promote adherence to a strong code of professional conduct. Similar to the treatment process itself, ongoing monitoring and review of the agreement is an important function of the supervision process.

At the outset of a supervisory relationship, the MISSION-VET supervisor should discuss the following topics with the MISSION-VET CM and PSS:

- the MISSION-VET supervisor's areas of expertise,
- the supervision process,
- evaluation criteria and procedures,
- boundaries of confidentiality, and
- ethical considerations.

Discussion of evaluation criteria and procedures should include an agreement about how the MISSION-VET CM and PSS will provide feedback to the MISSION-VET supervisor, as well as, how the MISSION-VET CM and PSS will be evaluated. Additionally, the boundaries of confidentiality and standards of ethical practice should also be discussed. Relevant state regulations and VA policies should also be reviewed. As part of this discussion, MISSION-VET supervisors should also explain that the MISSION-VET CM and PSS may encounter ethical dilemmas as they work with Veterans through the MISSION-VET program and that discussion of these dilemmas is an important task that falls within the scope of supervision.

Discussion of these topics may take more than a single session. However, it is time well spent. It is also worth noting that discussions between the MISSION-VET supervisor and CMs/PSSs will provide a model for subsequent conversations between CMs and PSSs and their Veterans. Similarly, that discussion should include goal development (in this case, treatment-oriented), methods for achieving those goals, responsibilities of each party, boundaries of confidentiality, etc. MISSION-VET supervisors should also recommend that MISSION-VET CMs and PSSs read an article or book chapter that describes the supervisory process. Examples may be found in Bernard and Goodyear (2004), Pearson (2001), and Falendar and Shafranske (2004).

E. Ensuring Fidelity to the MISSION-VET Treatment Model

The MISSION-VET supervisor is responsible for ensuring fidelity to the MISSION-VET treatment model. For example, consistent with the DRT model, MISSION-VET supervisors might ask CMs and PSSs to review the agenda that was set for a session with a Veteran on their caseload, taking time to discuss and understand the extent to which the MISSION-VET CM and PSS attended to the Veteran's concerns. These reviews can help MISSION-VET CMs and PSSs conduct a "course correction" if it becomes apparent, through supervision, that the MISSION-VET CM or PSS is not sufficiently attending to concerns identified by the Veteran and is, instead, focusing mainly on concerns that they see as important and pressing.

For example, a Veteran may suggest that the meeting focus on problems he is having with his living situation, while the MISSION-VET CM or PSS may want to focus on a recent drug relapse. The MISSION-VET supervisor's task in this case would be to help the CM or PSS plan an intervention in which they attend to the Veteran's concern while also helping him to link this concern with the recent relapse. In another example, some MISSION-VET CMs and PSSs may be more attuned to concerns about substance abuse than to other mental health problems. Again, the MISSION-VET supervisor's task is to help CMs and PSSs become aware of this tendency and the need to conceptualize cases and intervene in ways that are consistent with the DRT framework.

To accomplish these tasks, it can be especially useful for the MISSION-VET supervisor to help CMs and PSSs structure their case presentations around the information gathered from the Dual Recovery Status exam described in Chapter IV on Case Management. To ensure fidelity, MISSION-VET supervisors are encouraged to use the MISSION-VET Fidelity Index as a method to track CM's and PSS's adherence to the model and core therapeutic components. The MISSION-VET fidelity index is located in Appendix L.

F. Managing Emergency Situations

MISSION-VET supervisors have a vital responsibility to help CMs and PSSs manage emergencies that arise during the course of the MISSION-VET treatment program. While it is impossible to foresee every emergency that may occur, having a plan in place for the most common emergencies is recommended. Examples of these situations include suicidal/homicidal ideation, alcohol and/or drug relapses, loss of residency, and loss of contact with a Veteran despite multiple follow-up attempts. Thus, if a MISSION-VET supervisor has already spoken with a CM and/or PSS about how to proceed when a Veteran reports suicidal ideation, that CM and/or PSS will be prepared to conduct a suicidality assessment and will know the appropriate course of action based on assessment results. Below are examples of emergency plans for managing emergent issues surrounding suicidal and homicidal ideation; however, it is important to note that emergency plans should be modified to most appropriately accommodate your local facility.

DEVELOPING AN EMERGENCY PLAN

During initial supervision meetings with both MISSION-VET CMs and PSSs, the MISSION-VET supervisor may address experiences with emergent situations like suicidal or homicidal ideation, as well as, establish a plan in the event that either should occur. For instance, the following plan may be agreed upon:

In the event that a Veteran indicates that he/she is suicidal with a clear plan or definite intent, the MISSION-VET clinical supervisor should be notified and the Veteran should be escorted to his/her current therapist, if possible. If his/her therapist is unavailable, the Veteran should be escorted to the walk-in mental health clinic to be seen by the next available clinician. Veterans should not be left alone during this time. MISSION-VET CMs and PSSs should stay with the Veteran until they are able to see a mental health clinician for evaluation. MISSION-VET CMs and PSSs should also remind Veterans of emergency contact options throughout the course of treatment as well as during emergent situations. Examples of emergency contact options include: current VA therapist (during business hours)/ walk-in mental health clinic, 911, and the 24-hour National Suicide Hotline, 1-800-273-8255 (TALK).

In the event that a Veteran indicates clear intent and a definite plan to harm a specific person, the MISSION-VET supervisor should be notified and the Veteran should be directed to his/her current therapist, if possible. If his/her therapist is unavailable, the Veteran should be escorted to the walk-in mental health clinic to be seen by the next available clinician. VA police and/or local police and targeted person may also need to be notified to ensure the safety of all involved.

Plans may need to be modified in order accommodate each facility.

Similarly, supervision should be used to establish procedures to respond to substance use relapses. In each type of emergency situation, supervision should be used to identify high-risk Veterans and develop appropriate plans based on Veteran-specific considerations. Early dialogues regarding emergency

management, particularly with Veterans identified as high-risk cases (e.g., Veterans with a recent history of psychiatric hospitalization), allows for more rapid and effective crisis management, so that the MISSION-VET CM and PSS does not always have to wait for an emergency consultation with the MISSION-VET supervisor. At the same time, MISSION-VET CMs and PSSs must notify MISSION-VET supervisors of emergency situations as quickly as possible and use supervision to debrief the crisis.

We also wish to emphasize that handling emergencies can be just as stressful for MISSION-VET supervisors who feel that they are expected to know all the answers; this is especially the case when they are faced with the unique challenges or circumstances that usually accompany emergencies. MISSION-VET supervisors should understand that this is an unrealistic expectation and should recognize that such expectations could impede his/her ability to help MISSION-VET CMs and PSSs effectively manage emergencies. Additionally, in these situations, MISSION-VET supervisors should seek feedback from colleagues as needed.

Issues related to availability and emergency coverage should be discussed with MISSION-VET CMs and PSSs early in the supervisory relationship. Most importantly, MISSION-VET supervisors are responsible for arranging coverage during planned absences and assuring there are procedures in place for coverage in the event of an unplanned absence (e.g., due to illness or vacation). Ensuring that the MISSION-VET supervisor is not only accessible to the MISSION-VET CM and PSS, but also has a plan for coverage when unavailable, will provide much-needed reassurance to MISSION-VET CMs and PSSs and assure that Veterans in the MISSION-VET program receive a high standard of care during emergencies.

G. Managing Stress and Burnout

While different approaches to managing stress and reducing the likelihood of burnout have been proposed, an excellent place to begin is with regular "check-in's" and discussions in supervision about the stress level of MISSION-VET CMs and PSSs. In this way, MISSION-VET supervisors can provide support and guidance that will enable MISSION-VET CMs and PSSs to better cope with work-related stress. Such transparency on the part of the MISSION-VET supervisor has many important benefits: in addition to the obvious benefit of helping CMs and PSSs consider ways of dealing with work-related stress, it also normalizes the experience and is an effective means of strengthening the supervisory alliance. In addition, control-oriented methods, planning, the seeking of support, and communication, seem to have the most long-lasting effects on the emotional resiliency of treatment providers. For example, while emergencies (e.g., Veterans with suicidal intent) are inherently stressful, MISSION-VET supervisors who discuss ways to deal with these situations in advance, as highlighted in the previous section, will help CMs and PSSs avoid the added stress that arises from a lack of forethought and planning. An example of how a MISSION-VET supervisor may approach a situation involving the potential for burnout during supervision is provided.

Example 2: Managing Potential Burnout

During a supervision meeting, a MISSION-VET PSS reveals that a Veteran on his caseload has been struggling with recovery and leaning on him quite a bit for support, asking him to go to several AA meetings, which have doubled the amount of AA meetings in the MISSION-VET PSS's regular attendance schedule. The Veteran has also been calling the MISSION-VET PSS several times a day after hours for support. While the MISSION-VET PSS explains to his MISSION-VET supervisor that he wants to remain supportive, he is finding it hard to focus on his own or any other Veteran's recovery. This MISSION-VET PSS is further concerned that the Veteran is neglecting helpful avenues of recovery, such as obtaining an AA sponsor, by relying on him instead.

Together, the MISSION-VET PSS and supervisor discuss this situation and agree that a course of action is needed to help the Veteran utilize available community resources. Because it is clear that the Veteran currently needs a lot of support and has established a good rapport with the MISSION-VET PSS, a gradual reduction in the current level of support offered by the MISSION-VET PSS is agreed upon. The MISSION-VET supervisor also involves the Veteran's assigned MISSION-VET CM to set up and encourage the use of alternative community services and supports to assure that the needs of the Veteran's are being met, reducing the PSS's likelihood for burnout.

H. Attending to Diversity Issues

Diversity has been called "one of the most neglected areas in supervision training and research" (Falender & Shafranske, 2004). Some of the issues that have contributed to this neglect are differences between color/race, supervisor concern over their own perceived incompetence regarding diversity, limited research supporting models of diversity, the impact on treatment, and inattention to self-knowledge and exploration during professional training. However, in order to engage in ethical and responsible practices, MISSION-VET supervisors must consider and integrate multicultural considerations as part of the supervisory process. While standards of cultural competence are evolving, professional codes of ethics are clear about the importance of demonstrating cultural sensitivity in

practice. MISSION-VET supervisors can accomplish this by initiating discussions of cultural differences with MISSION-VET CMs and PSSs and by encouraging these supervisees to have similar discussions with the Veterans on their caseloads. An open, engaging discussion with their MISSION-VET supervisor will help prepare CMs and PSSs to discuss these issues directly with "their" Veterans.

In addition to race and ethnicity, topics to consider include age, disability, socio-economic status, gender, religion, and sexual orientation. More broadly, even within a group of men and women whose collective efforts are aimed at serving a country, different issues may arise that serve as reminders of the importance of considering diversity. Examples include Service (Army, Navy, Air Force, Marines, Coast Guard); branch of service (artillery, infantry, medical corps, chaplaincy, quartermaster, etc., or Military Occupational Specialty (MOS, or job); active duty versus National Guard or Reserves; rank; reasons for joining (draft for Vietnam Veterans, moral imperative, lack of options, etc.); theater of service (Iraq, Afghanistan), etc. It is important for MISSION-VET supervisors to encourage CMs and PSSs to explore differences in these experiences and to include these experiences in their treatment planning. In a similar way, issues regarding diversity in economic status may arise in the treatment of homeless Veterans, especially between MISSION-VET CMs and Veterans. MISSION-VET CMs who have never experienced homelessness may have some difficulty fully understanding the hardships associated with these circumstances and may need supervisory guidance to remain sensitive to Veteran concerns.

Ultimately, a culturally sensitive supervisory experience depends on "the willingness of the supervisor to open up the cultural door and walk through it with the supervisee" (Bernard & Goodyear, 2004, p. 125). MISSION-VET CMs and PSSs who are encouraged to consider issues of diversity in supervision are more likely to explore them while interacting with Veterans. Additionally, MISSION-VET supervisors who foster an appreciation of each individual's (supervisor, case manager, peer specialist, Veteran) unique world view will open the door for mutual understanding. Ultimately, this incorporation of and appreciation for other perspectives within the MISSION-VET team will promote greater understanding and collaboration within the team and ultimately, a more sensitive and understanding approach to treatment. Below is an example of how a MISSION-VET supervisor may address issues of diversity during supervision.

Example 3. Attending to Diversity

During supervision, a case manager explains to her MISSION-VET supervisor that with the exception of a couple of Veterans, many of them come from the same branch of service. The MISSION-VET PSS who she works with, is also from this branch of service. While this common link has served to benefit these Veterans by facilitating stronger relationships through a common bond, it has also served to alienate a few of the Veterans who have come from different branches of service. Both the MISSION-VET supervisor and the CM agree that it would be best to ask the PSS to take part in this conversation not only to identify the issue, but also to help brainstorm ways of maintaining the established camaraderie while expanding it to include all of the Veterans currently on their caseloads.

The MISSION-VET supervisor sets up a group supervision session with the CM and the PSS to address these issues as a team and after identifying the problem and brainstorming some solutions, a plan of action and a timeline to implement that plan is agreed upon by the MISSION-VET supervisor, CM, and PSS. The MISSION-VET supervisor checks in with both the CM and PSS to assess for any further need for follow-up on this issue and encourages continued open communication on this and any other issues that may arise in the future.

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NOTES

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Glossary of Acronyms and Terms

AA: Alcoholics Anonymous

ACT: Assertive Community Treatment

ADL: Activities of Daily Living

AHAR: Annual Homeless Assessment Report to Congress

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

CHALENG: Community Homeless Assessment, Local Education and Networking Group

CHQOER: Center for Health Quality, Outcomes, and Economic Research

CM: Case Manager

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

COD: Co-occurring psychiatric and substance use disorders

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

CTI: Critical Time Intervention. CTI 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.

CWT: Compensated Work Therapy Program

DCHV: Domiciliary Care for Homeless Veterans

DOL: Department of Labor

Domiciliary Residential Program (DOM): 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. DRT is the integrated mental health and substance abuse treatment model of care used in the MISSION and MISSION-VET programs.

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

DVOP: Disabled Veterans Outreach Program

EMDR: Eye Movement Desensitization and Reprocessing

GDP: Grant and Per Diem Program

HBM: Health Belief Model

HCHV: Health Care for Homeless Veterans

HCRV: Health Care for Re-entry Veterans

HHS: U.S. Department of Health and Human Services

HSR&D: VA Health Services Research and Development Service

HUD-VASH: Department of Housing and Urban Development and the Department of Veterans Affairs Supportive Housing Program

IOP: Intensive Outpatient Program

IPS: Individual Placement and Support

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

MH RRTPs: Mental Health Residential Rehabilitation and Treatment Programs

MI: Motivational interviewing

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

MISSION-VET: Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking: Veterans Edition

MOS: Military Occupational Specialty

NA: Narcotics Anonymous

NAPS: National Association of Peer Specialists

OIF: Operation Iraqi Freedom

OEF: Operation Enduring Freedom

ORD: VA Office of Research and Development

PE: Prolonged Exposure

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

Peer Support Specialist (PSS): Peer Support Specialists, PSS, are individuals in recovery from mental illness and/or addictions who have been trained to provide and foster development of peer support services, and who are often referred to as "consumer providers."

PHA: Public Housing Authority

President's New Freedom Commission: A commission 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. PTSD is a DSM-IV diagnosis that refers to a set of specific symptoms that develop in response to experiencing an unusual traumatic event such as a car accident or seeing someone injured in combat.

SAMHSA: Substance Abuse and Mental Health Services Administration. SAMHSA supports clinical research in addictions. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

SE: Supported Employment

SMI: Serious Mental Illness

TIC: Trauma-Informed Care

TLC: Time-Limited Case Management. TLC is a program that served as the foundation for MISSION and MISSION-VET.

TW: Transitional Work

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

VAMC: Veterans Administration Medical Center

VANJ: VA New Jersey Health Care System

VHA: Veterans Healthcare Administration

VISN 1: VA New England Healthcare System

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

VONAPP: Veterans ON-line APPlication system

VR: Vocational Rehabilitation

VSO: Veteran Services Organization

Appendix A: Key Clinical Outcomes

After examining the MISSION model through several studies (Smelson et al, 2005; Smelson et al, 2007; Smelson et al, 2010), we have found that the MISSION intervention helps Veterans address their co-occurring substance abuse and non-psychotic mental illness and other psychosocial issues, including problems with housing, employment, family, and the criminal justice system. The model is an ideal service delivery platform for helping these Veterans transition from residential to outpatient care as they continue to work on their sobriety from substance use and recovery from mental illness. A comparison of outcomes of MISSION and Veterans receiving Treatment as Usual (TAU) in VA residential treatment at 12 months post-baseline showed that both groups made significant improvements as a result of treatment. However, individuals who received MISSION treatment services achieved better outcomes in a number of key domains including treatment engagement, behavioral outcomes such as substance use and mental health symptoms, housing stability, and satisfaction of services received during the 12-month evaluation period.

From baseline to 12 months follow-up, Veterans who received MISSION treatment services showed the following improvements:

- Reduced use of illicit drugs (71% to 13%)
- Reduced use of alcohol to intoxication (19% to 8%)
- Reduced symptoms of depression (66% to 34%), symptoms of anxiety (72% to 35%), and any mental health symptoms (88% to 57%)
- Fewer hospitalizations for psychiatric reasons (6.5 days prior to enrollment to 2.7 days 12-months post baseline)
- Fewer problems controlling violent behavior (15.0% to 7%)

Furthermore, improvements were found in the number of Veterans receiving MISSION services at 12-months post-baseline who

- Obtained full time employment (5% at baseline to 46%)
- Were living in stable housing (0% to 83%)
- Were still in contact with their case manager (81%) and peer support specialist (61%)

MISSION participants also performed better than those who received TAU in the following service areas at 12-month follow-up:

- Lower use of costly inpatient (22% vs. 31%) and somewhat higher use of outpatient (29% vs. 20%) services
- Receipt of housing assistance (46% vs. 32%)
- Employment assistance (36% vs. 21%), including 31% vs. 20% who received employment counseling and 9% vs. 5% who received vocational training
- Financial assistance and help with government benefits (21% vs. 15%)

Overall MISSION participants also reported higher satisfaction in their receipt of services with particular respect to

- Mental health services (67% vs. 53%),
- Medical services (72% vs. 55%), and
- Dental services (57% vs. 43%).

The following figures illustrate some of our most important key target outcomes comparing those who received MISSION treatment services to those who received TAU alone.

Figure 1: Mean Days of Psychiatric Hospitalization during the 12 Months Pre-Admission, and the 12 Months Post-Admission: MISSION vs. TAU

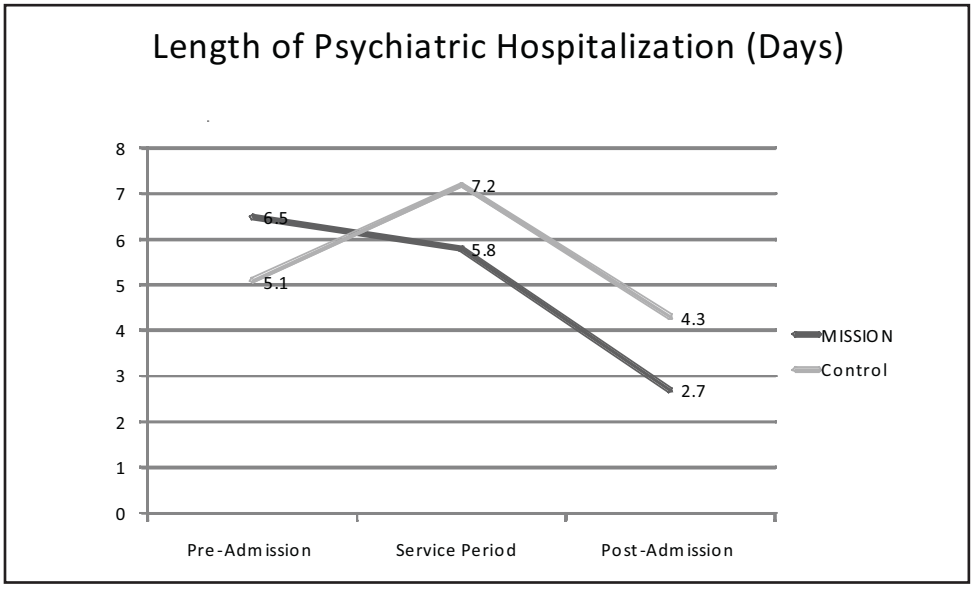


Figure 1 illustrates the significant reduction in hospitalization days among the MISSION group as compared to those Veterans receiving TAU.

Figure 2: Trouble Controlling Violent Behavior in the Last 30 Days at Baseline, 6-months, and 12-months Post-Baseline: MISSION vs. TAU

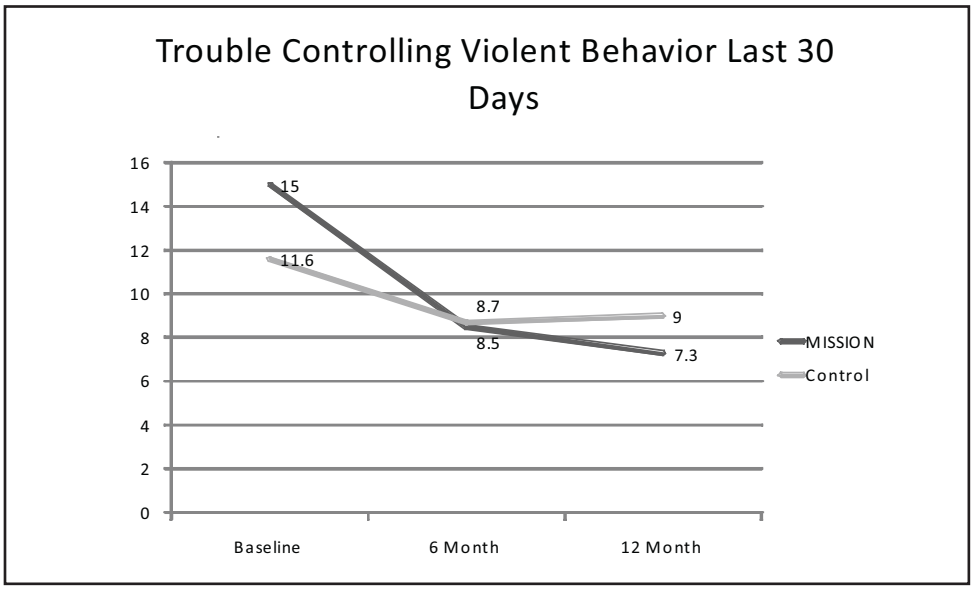


Figure 2 shows the significant improvement among Veterans receiving MISSION services in controlling violent behavior at the end of the study compared to those receiving TAU.

Figure 3: Use of Alcohol to Intoxication in the Last 30 Days at Baseline and 12-Months Post-Baseline: MISSION vs. TAU

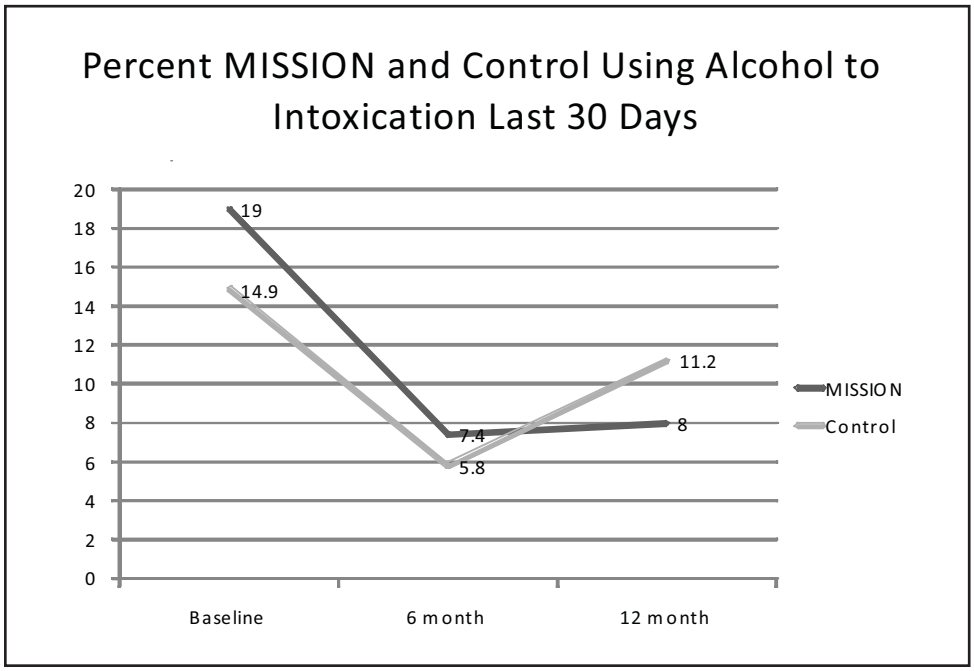


Figure 3 illustrates the reduction in drinking to intoxication in the MISSION group as compared to those receiving TAU.

Figure 4: Proportion of Participants Who Felt They Received All the Services They Needed at 12 Months Post-Admission, by Service Type: MISSION vs. TAU

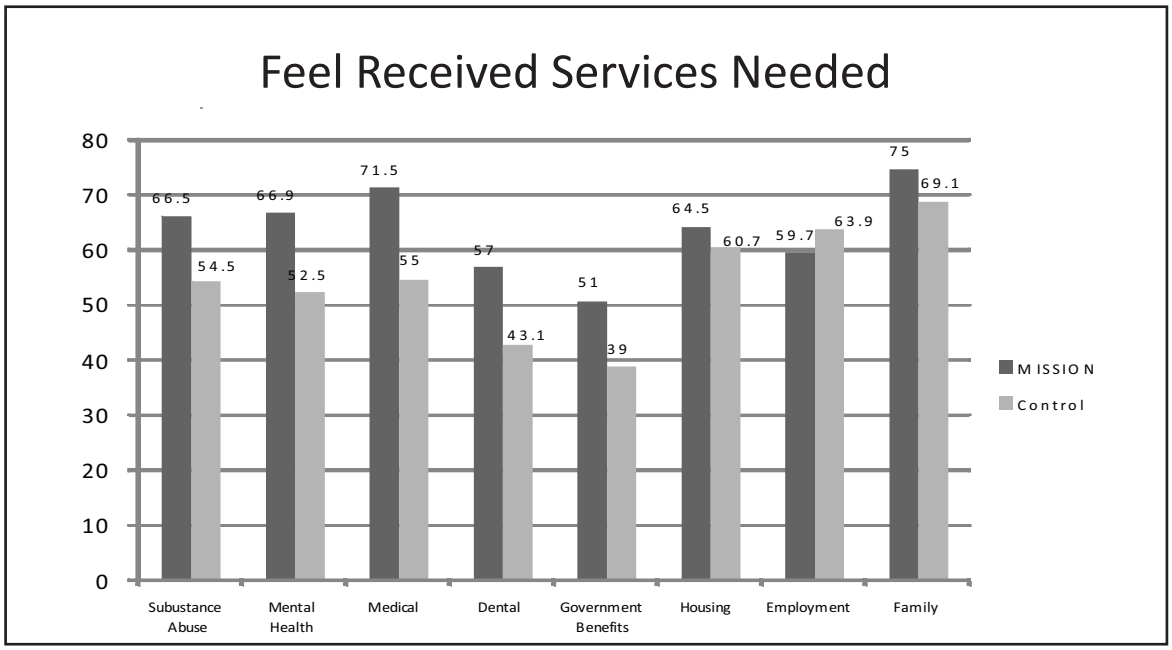


Figure 4 illustrates that compared to TAU, those in Mission felt more satisfied with receiving key ervices that reflected their baseline treatment plan requests on the majority of the domains.

Study Implications

Findings provide evidence that a low-intensity intervention (2.5 to 5 additional hours of services per week, delivered by a case manager and/or peer specialist) to augment treatment as usual in VA or community homeless service programs can improve treatment engagement, patient satisfaction, and behavioral outcomes among those Veterans receiving homeless services who suffer from co-occurring substance abuse problems and non-psychotic mental illness. These results suggest that Veterans who are discharged from institutional settings, but continue to receive MISSION services, can achieve successful treatment outcomes, highlighting the adaptability and flexibility of the MISSION treatment model. While these data suggest VA provides comprehensive homeless services, augmentation with MISSION treatment services can improve treatment engagement, patient satisfaction, and other behavioral outcomes, providing evidence that the enhanced MISSION-VET approach might offer unique programming opportunities within the substantially expanded national HUD-VA Supportive Housing program.

**Note: These data were presented in a Final Project Report prepared by Drs. Smelson and Kline and submitted to SAMHSA. Initial results were also presented at the 2008 Annual VA QUERI Meeting:*

Kline, A; Smelson, D.; Callahan, L; Bruzios, C.; Losonczy, M. " A Community Linkage Program for Homeless Dually-Diagnosed Veterans: Preliminary Outcomes ." VA QUERI Annual Meeting, December, 2008, Phoenix, AZ.

The following journal articles regarding MISSION might also be of interest:

Smelson, D.A., Losonczy, M., Castles-Fonseca, K., Stewart, P., Kaune, M., & Ziedonis, D. (2005). Preliminary outcomes from a booster case management program for individuals with a co-occurring substance abuse and a persistent psychiatric disorder. Journal of Dual Diagnosis, 3(1), 47-59.

Smelson, D.A., Losonczy, M., Ziedonis, D., Castles-Fonseca, K., & Kaune, M. (2007). Six-month outcomes from a booster case management program for individuals with a co-occurring substance abuse and a persistent psychiatric disorder. European Journal of Psychiatry, 21(2), 143-152.

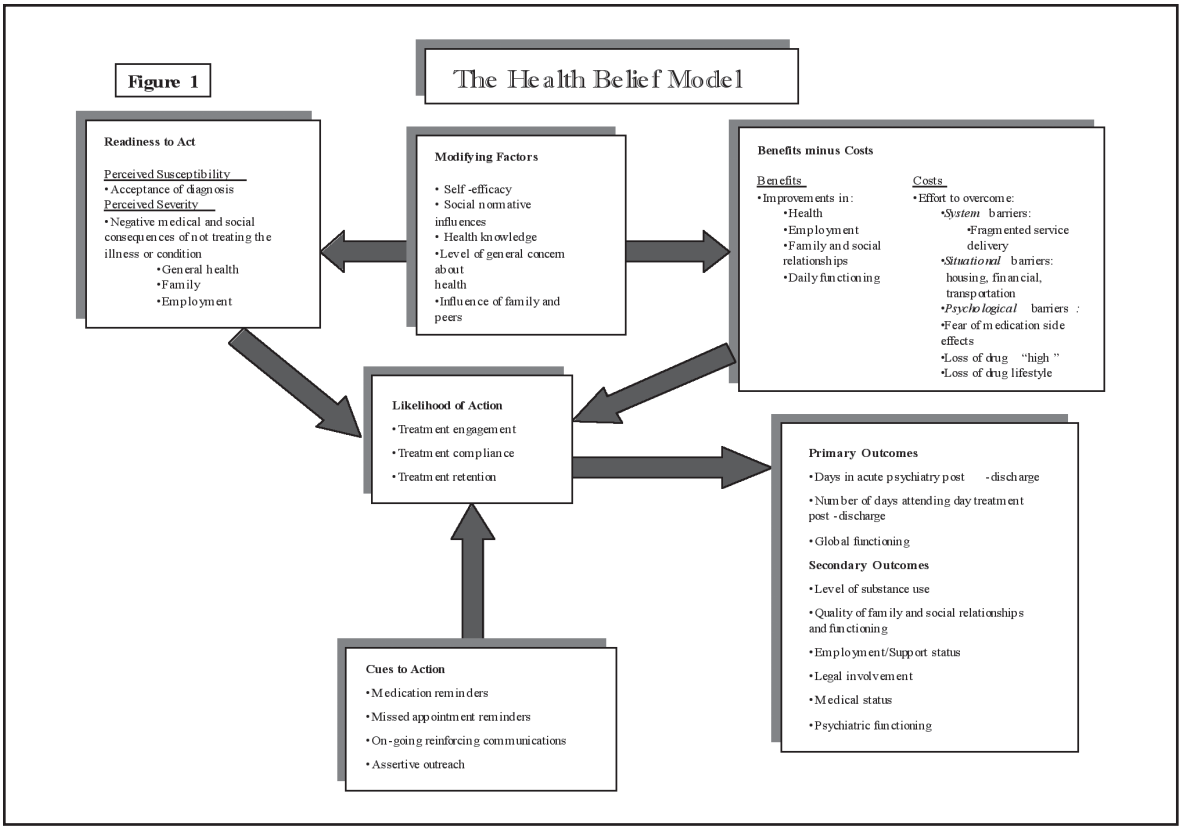
Kline, A., Callahan, L., Butler, M. St. Hill, L., Losonczy, M., & Smelson, D. (2009). The relationship between military service era and psychosocial treatment needs among homeless veterans with a co-occurring substance abuse and mental health disorder. Journal of Dual Diagnosis, 5(3), 357 – 374.

Smelson, D., Kalman, D., Losonczy, M., Kline, A., Sambamoorthi, U., Hill, L., et al. (2010). A Brief Treatment Engagement Intervention for Individuals with Co-occurring Mental Illness and Substance Use Disorders: Results of a Randomized Clinical Trial. Community Mental Health Journal, 1-6.

Appendix B: Theoretical Framework Underlying the MISSION-VET Model

The theoretical framework of the MISSION-VET model is derived from the Health Belief Model (HBM) (Rosenstock, 1966; Becker & Maiman, 1975; Janz & Becker, 1984), which presents a broad structure for understanding the major components of the health decision-making process. Originally proposed to explain preventive health behavior, the HBM has been found to predict compliance with treatment regimens as well as utilization of services for preventive and therapeutic purposes (Janz and Becker, 1984). The HBM has provided a valuable framework for understanding treatment compliance among the severely and persistently mentally ill (Budd et al., 1996; Nageotte, et al., 1997; Perkins, 1999; Adams & Scott, 2000; Perkins, 2002) as well as those with co-occurring psychiatric and substance use disorders [COD] (Mulaik,1992; Fenton et al., 1997). Researchers have also applied the model to outpatient psychiatric attendance for people with bipolar disorder (Connely, 1984), compliance with discharge plans after psychiatric ER visits (Porter-Tibbetts, 1986), decisions to abuse drugs (Lindsay & Rainey, 1997; Minugh et al., 1998), participation in recovery programs (Weisner, 1987; Bardsley and Beckman; 1988), and treatment attrition (Rees, 1985).

The HBM posits a rational-choice explanation of health seeking in which individuals weigh the costs of performing a health action against the possible benefits. In addition to actual financial costs, treatment costs may include such situational barriers as provider inaccessibility, scheduling conflicts, transportation problems, etc, while benefits include the potential physical, psychological, and lifestyle improvements deriving from treatment. In the original formulation of the HBM, the cost/benefit calculation was influenced by the individual's "readiness" or motivation to engage in health-seeking behavior. Readiness to act was dependent on two factors: (1) perceived susceptibility to a condition (or, belief in the accuracy of an existing diagnosis); and (2) perceived severity of the condition, including evaluations of both medical (e.g. pain, death, disability) and social (e.g. effects on work or family) consequences if the condition were contracted or left untreated (Janz and Becker, 1984). More recent formulations of the HBM have synthesized concepts from other health behavior models as indirect, mediating influences. These include self-efficacy beliefs regarding one's ability to perform the required action, social normative beliefs regarding how peers and other "influentials" would perceive the action, "cues to action," which may be either external or internal stimuli that trigger the individual to act, and a basic level of health knowledge (Janz and Becker, 1984). The combination of DRT, CTI, and Peer Support in the MISSION-VET model is designed to address each of the key HBM constructs in an effort to increase treatment readiness, decrease perceived treatment costs, and increase perceived treatment benefits. A formulation of the HBM in terms of the specific health behaviors and psychosocial influences targeted by MISSION-VET appears in Figure 1 below.



As indicated in Figure 1, the primary health behaviors we are attempting to promote include engagement and retention in psychosocial and pharmacological treatments. We expect these actions to result in positive outcomes, including reduced re-hospitalizations, reduced substance use, enhanced daily functioning, and improvements in other life domains, such as family relationships, employment, legal involvement, and physical health. Factors affecting treatment compliance will be influenced by the extent to which Veterans acknowledge their substance use and mental health problems and understand the severe health and social consequences of leaving these problems untreated. Mediating factors include the feelings of self-efficacy in refraining from substance use and following treatment regimens; the influence of peers and others in reinforcing beliefs that such actions are not only desirable, but possible; and access to sufficient information about the disease to promote informed decision-making. We expect Veterans to identify improvements in health and social functioning as possible benefits of treatment and to identify a variety of potentially limiting barriers, or costs, including fears about medication side-effects, relinquishing the desirable physical and psychological feelings associated with substance use, and the difficulty of negotiating possible institutional and situational barriers to treatment. Finally, we identify cues to action, in the form of communications from providers, to encourage compliance.

DRT, CTI, and Peer Support, as used in MISSION-VET, are expected to dovetail nicely and are designed to intervene in key aspects of the health decision-making process to promote treatment retention and compliance. The relationship between our intervention strategies and the HBM constructs is described in detail in Figure 2 below.

Figure 2: Relationship between HBM Constructs and MISSION-VET Components

Health Belief Model Constructs		MISSION-VET Component
Readiness to Act	Perceived Severity	DRT • Diagnostic Assessment • Psychoeducation About Mental Illness and Substance Abuse • 12-Step Therapy • Peer Counseling • Mentoring
	Perceived Susceptibility	DRT • Evaluation of Psychiatric Vulnerabilities • Psychoeducation • Analysis of Substance Abuse Relapse Patterns • 12-Step Therapy • Relapse Prevention • Peer Counseling • Mentoring
Modifying Factors	Self-Efficacy	DRT • Motivational Enhancement Therapy • Skills Training • 12-Step Therapy CTI • Professional Support • Life Skills Training • Gradual Reduction in Outreach • Peer Counseling • Peer-to-Peer Support
	Social Norms	DRT • Skills Training • 12-Step Therapy • CTI • Community Reintegration • Peer Counseling • Mentoring

Health Belief Model Constructs		MISSION-VET Component
	Health Knowledge	DRT • Psychoeducation • Skills Training • Relapse Prevention • 12-Step Therapy • Peer Counseling • Mentoring
	Community Resources Knowledge	CTI • Identification and Utilization of Community Resources
Perceived Benefits	Improvements in Health	DRT • Motivational Enhancement Therapy • Psychoeducation • Medication Management Training • 12-Step Therapy • Relapse Prevention • Peer Counseling • Modeling
	Improvements in Social Functioning	DRT • Motivational Enhancement Therapy • Skills Training • 12-Step Therapy • Relapse Prevention CTI • Facilitation of Family Involvement • Professional Support • Peer Counseling • Modeling Peer-to-Peer Support
Perceived Costs	Medication Side Effects	DRT • Psychoeducation • Medication Management Training CTI • Facilitating Linkages Among Patient, Physician, and Pharmacy
	Loss of Drug "High"	DRT • Motivational Enhancement Therapy • 12-Step Therapy • Peer Counseling • Modeling • Mentoring • Peer-to-Peer Support
	Institutional Barriers	CTI • Identification of and Linkage with Community Resources • Early and Consistent Involvement with the Patient • Patient Advocacy

Health Belief Model Constructs		MISSION-VET Component
	Personal and Practical Barriers	CTI • Assertive Outreach • Transportation Assistance • Money Management • Housing Assistance • Facilitation of Family Involvement • Patient Advocacy Vocational and Educational Assistance
Cues to Action	Follow-up on missed appointments	CTI • Assertive Outreach
	Medication checks	CTI • Professional Support • Facilitating Linkages Among Patient, Physician, and Pharmacy DRT • Psychoeducation • Medication Management
	Ongoing reinforcing Communications	DRT • 12-Step Therapy to Provide Support and Feedback CTI • Professional Support and Feedback • Peer counseling • Peer-to-Peer Support and Feedback

DRT, through its use of Motivational Enhancement Therapy (MET), psychoeducation, 12-step facilitation, relapse analysis, and medication management, will enhance beliefs about disease severity and susceptibility, increase self-efficacy and health knowledge, and promote a more favorable analysis of the costs and benefits of treatment. DRT, for example, includes a Dual Recovery Status Exam, which monitors medication compliance and provides Veterans with support and feedback regarding their medication management. CTI will affect perceived treatment costs/benefits by enhancing treatment accessibility and reducing fragmented service delivery through coordinated treatment planning. CTI will also address situational barriers to treatment and will provide cues to action in the form of additional medication monitoring, follow-up phone calls for missed visits, and ongoing encouragement and positive reinforcement. Peer Support will affect social normative attitudes by providing social reinforcement for continued abstinence and compliance with treatment protocols. Interaction with MISSION-VET Peer Support Specialists [PSS] who have had similar problems yet who have also achieved a successful recoveries, will reinforce the normative value of maintaining sobriety and add to the Veteran's sense of self-efficacy in being able to achieve comparable goals. The MISSION-VET PSS will also assist Veterans in accepting and understanding the severity of their addiction problems and understanding the benefits of treatment. Finally, PSSs provide cues to action through frequent communication with Veterans around treatment compliance issues.

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Appendix C: MISSION-VET Sample Position Descriptions

Generic Case Manager Position Description

Major Duties and Responsibilities

- Case management and community outreach with homeless and formerly homeless Veterans with co-occurring substance abuse and mental health problems in the MISSION-VET (Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking) program. 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/educational support to help Veterans maintain employment and find new employment/educational opportunities.

Factor 1: Scope and effect

- The objective of this position is to provide case management and outreach services to homeless and formerly homeless Veterans with co-occurring mental health and substance abuse problems for the MISSION-VET program under the direction of a Clinical Supervisor. These tasks will contribute to the overall effectiveness of the MISSION-VET program.

Factor 2: Knowledge Required by the Position

- The incumbent will have experience working with people with a history of mental health and substance abuse problems.
- The incumbent must have experience providing case management services.

Factor 3: Supervisory Controls

- The incumbent works under the supervision of a Clinical Supervisor. The incumbent is required to function independently, but he/or she also meets regularly with his/her Clinical Supervisor to provide regular updates and status reports regarding contact with Veterans in the MISSION-VET program.

Factor 4: Guidelines

- Guidelines include regional and organizational directives, manuals, bulletins and proposals, as well as established program policies. Written and oral instructions will be received from the Clinical Supervisor. Incumbent uses these guides as a base, but functions flexibly depending on the needs of the Veteran's problem or situation.

Factor 5: Complexity

- Working with homeless and formerly homeless Veterans with co-occurring mental health and substance abuse problems requires a sensitive individual who has theoretical knowledge and experience to provide case management and assertive outreach. He or she must also have the ability to quickly assess a situation and follow protocol for handling emergency situations.

Factor 6: Personal Contacts

- The incumbent will have direct contact with homeless and formerly homeless Veterans with co-occurring 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-VET program and other treatment providers.

Factor 7: Purpose of Contacts

- The incumbent will contact Veterans to help them maintain residence, engage in treatment services, and locate/maintain 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 other treatment providers to promote the smooth integration of MISSION-VET services with other providers.

Factor 8: Physical Demands

- The physical demands of the position will be minimal. The incumbent will be required to drive to the communities of the Veterans in the MISSION-VET program.

Factor 9: Work Environment

- The incumbent will have a designated workspace. However, he/she will spend the majority of his/her time in the community meeting with Veterans and members of various VA and community programs.

Generic Peer Support Specialist Position Description

Major duties and responsibilities

- The Peer Support Specialist (PSS) is a full member of the MISSION-VET program treatment team and provides peer support services to Veterans with co-occurring psychiatric and substance use disorders. Under supervision of the MISSION-VET Clinical Supervisor, the PSS functions as a role model to Veterans enrolled in the MISSION-VET program; 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 institutional and community settings. The PSS performs a wide range of tasks to help Veteran clients regain independence within the community and mastery over their own recovery processes. The PSS introduces and uses the *MISSION VET Consumer Workbook*, as well as other relevant media, publications, and tools, as he/she provides services.

The PSS assists the Veteran's recovery by…

- Using a formal goal-setting process to help him or her articulate personal goals for recovery. By attending one-on-one and group sessions, the PSS supports Veterans and helps them identify objectives, create goals, and develop recovery plans. The PSS and the Veteran will discuss the skills, strengths, supports, and resources that are necessary to help achieve these goals.
- Encouraging and facilitating an effective working and treatment relationship with the Veteran's MISSION-VET Case Manager.
- Prioritizing the formation of new and/or sustainment of existing self-help (mutual support) groups. The PSS works to help the Veteran locate and join existing support groups, and will attend initial meetings with the Veteran if desired, therefore stressing the importance of joining and regularly attending these groups.
- Using tools such as the MISSION-VET Consumer Workbook and other appropriate tools, to assist Veterans in achieving their own recovery and treatment goals.
- Independently, or with periodic assistance from the MISSION-VET Case Manager or other providers, teach, through instruction and/or example, problem solving skills to both individuals and groups. The PSS also leads discussions that encourage Veterans to share common problems of daily living and methods they have employed to manage and cope with these problems. As individuals who can relate to the Veterans through their own experiences, PSSs highlight the skills, strengths, supports, and resources they share and/or have used. As much as is helpful, the PSSs will share their own recovery stories and, as facilitators of these sessions, demonstrate how they have directed their own recoveries.
- Using ongoing individual and group sessions to teach Veterans how to identify and combat negative self-talk. By using identified literature, DVDs, etc., PSSs help Veterans gain hope, learn to identify their strengths, and combat negative self-talk. Through this process, the PSS will help Veterans identify their fears, insecurities, and underlying barriers to success, and develop action plans to counter these.
- Supporting Veterans' vocational choices and assisting them in choosing a job that matches their strengths. Recognizing the likely presence of job-related anxiety, the PSS will help the Veteran by reviewing job applications, locating resume-building volunteer and/or temporary job opportunities, coaching the Veteran through an interview processes, and by recommending strategies for achieving job expectations and, therefore, maintaining employment.
- Assisting with the development of social skills that, when applied in the community, will enhance job acquisition and tenure, encourage continued involvement in community and self-help groups, and improve quality of life.
- Keeping records that document the Veteran's treatment/recovery plan, including
  - Identified person-centered strengths, needs, abilities, and recovery goals;
  - Interventions to assist the Veteran with reaching his/her goals for recovery;
  - Progress made toward goals;
  - Maintaining a working knowledge of current trends and developments in the mental health field books through review of books, journals, and other relevant materials; and
  - Attending continuing education seminars and other in-service training when offered.

Drawing on recovery experiences, the PSS will

- Assist the Veteran in obtaining safe, stable, and affordable housing of his/her choice in the most integrated, independent, and least intrusive or restrictive environment possible. The PSS will facilitate this by accompanying the Veteran on housing searches, either by driving the Veteran or riding with them on public transportation.
- Serve as a recovery agent by providing and advocating for any effective recovery-based services that will aid the Veteran in daily living. The PSS's role is critical, as he or she models effective coping techniques and self-help strategies.

- Assist in obtaining services that advance the Veteran's recovery needs. By providing points of contact and relevant information for community resources, self-help groups, and other useful services, the PSS serves as an information conduit, relaying information about community and natural supports and how these can be used in the recovery process. These may include, but are not limited to, connections with federal government agencies, such as Social Security offices; state and local programs, such as child welfare and social services agencies; local community organizations such as the YMCA or JCC; public libraries; Veterans' Services Organizations; neighborhood and community associations; and other relative organizations and community resources.
- Empower Veterans to combat stigma through self-advocacy. By attending regular group and individual meetings with Veterans, and employing role play and modeling techniques, Peer Support Specialists create an environment that is conducive to sharing how they, and other Veterans, have handled difficult recovery situations. As the PSS models respect for each Veteran's individual recovery experience, s/he demonstrates appropriate social interactions, problem-solving skills, and techniques for managing interpersonal relationships.

Factor 1: Knowledge Required by the Position

a. Familiarity with substance abuse recovery processes and the ability to facilitate recovery in Veterans using established standardized mental health and peer support processes.

b. Strategies for treatment and engagement that encourage basic problem solving skills and self-directed recovery.

c. Ability to recognize the signs and symptoms of mental illness, and the concomitant ability to assist the Veteran to address these symptoms using mental health providers.

d. Incorporation of relapse prevention strategies, including the ability to recognize signs of substance abuse relapse; and mental health symptom instability, and the ability to initiate appropriate responses.

e. Awareness of and connections to community resources that facilitate a Veteran's independent living and ability to teach those skills to other individuals with histories of mental illness, substance abuse, and homelessness.

f. Organization and management skills that will facilitate formation and/or maintenance of self-help (mutual support) and educational groups.

g. As a valid driver's license is required for this position, due to the requirement of some driving and/or transportation of Veterans to medical appointments, job sites, social activities, and other community resources, the PSS must also be able to maintain a safe driving record and help Veterans establish or re-establish their own abilities to obtain public or private transportation.

Factor 2: Supervisory Controls

The PSS is administratively assigned to the MISSION-VET program and receives supervision from the MISSION-VET Clinical Supervisor. While the supervisor provides regular supervision and generally helps the treatment team guide and prioritize issues, the incumbent is expected to handle routine duties independently and to establish common priorities for his/her assignments. Some teaching and facilitation work may be performed with the assistance of other mental health treatment team members. Work is reviewed by the supervisor to ensure that it is technically correct and that it conforms to established policies and previously given instructions. Assignments that are routine and repetitive are not reviewed by the supervisor unless there are problems. The incumbent will follow all legal, medical, and organizational policies as mandated by the VA and the MISSION-VET program.

Factor 3: Guidelines

Established procedures and specific guidelines are available to the PSS to cover the work assignment. Guidelines are applicable and specific to most situations. The incumbent will use judgment in determining the most appropriate standard and/or instruction for the circumstances and for tailoring his or her information gathering procedures as required. In situations where existing guidelines are not applicable, or where norms do not exist or are unclear, the PSS refers the problem to the Clinical Supervisor.

Factor 4: Complexity

The work involves provision of support services for the Veteran client by helping him or her establish goals and means to reach those goals. Decisions on establishing goals and formal action plans will always be made in conjunction with the Veteran and MISSION-VET Case Manager with the Clinical Supervisor. It is important to understand that the mental health and substance abuse recovery needs of Veterans are extremely complex; therefore, the PSS is expected to draw on all resources at the Veteran's disposal.

Factor 5: Scope and Effect

The PSS assists and guides Veterans toward the identification and achievement of specific goals as 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. However, there may be some walking, standing, bending, carrying of light items such as books and papers, accessing transportation, and driving involved.

Factor 9: Work Environment

Work will be performed in a wide range of settings, including in a Veterans Administration Medical Center, in a Veteran's place of residence (both inpatient and in the community); group or family homes; in community-based outpatient settings and/or community agencies; in government transport vehicles (public or government), and elsewhere. Work areas are often noisy, irregular, and unpredictable and can be stressful at times. As participating Veterans demonstrate varying levels of recovery and symptoms, including many environmental triggers, the MISSION-VET Peer Support and Case Management teams must be aware of these issues, and have alternate plans in place.

Other Significant Requirements:

Customer Service

Consistently communicates and treats customers (patients, visitors, volunteers, and all Medical Center staff) in a courteous, tactful, and respectful manner. Provides the customer with consistent information according to established policies and procedures. Handles conflict and problems in dealing with the customer constructively and appropriately.

ADP Security

Protects printed and electronic files containing sensitive data in accordance with the provisions of the Privacy Act of 1974 and other applicable laws, federal regulations, 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. Comprehension is indicated and compliance is pledged with the employee's signature on a standard agreement.

Age-Related Competency Statement

Provides care and/or services appropriate to the age of the Veterans being served. Assesses data reflective of the Veteran's status and interprets the information needed to identify each Veteran'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 D: MISSION-VET Sample Service Delivery Schedules

Schedule for MISSION-VET Service Delivery:

The following provides an overview of the sequence of services provided by MISSION-VET over 2-month, 6-month, or 12-month treatment windows.

Screening and Orientation to MISSION-VET

- Veteran is identified as a potential MISSION-VET program participant by MISSION-VET staff or treatment provider from another VA program or community treatment provider.
- Veteran is approached by MISSION-VET staff about eligibility.
- Veteran receives a comprehensive co-occurring disorder evaluation.
- Veteran is deemed eligible.
- Veteran meets with Case Manager/Peer Support Specialist team for "orientation to the MISSION-VET program" including overview to DRT Sessions and overview of both Case Manager and Peer Support Specialist roles in MISSION-VET program.

Groundwork and Relationship Building

- Veterans participate in DRT psychoeducational co-occurring disorders treatment sessions. If initiated in an inpatient/residential treatment session, it is important to note that Veterans may participate in DRT sessions while receiving inpatient/residential treatment services. DRT sessions are designed so Veterans can begin at any time, so if delivered in a group setting he/she does not have to wait for a new group of other Veterans to enroll in MISSION-VET to begin DRT sessions.
- Veterans participate in Peer-led sessions with Peer Support Specialist (PSS).
- Veterans participate in regular "check-in" sessions with PSS regarding Consumer Workbook Exercises.
- If Veteran is receiving inpatient/residential treatment services, MISSION-VET staff attends treatment team meetings with inpatient/residential staff and provides input on the Veteran's treatment plan and discharge plan from the facility.
- PSS has an "open door policy" for informal discussions with Veterans on caseload.
- MISSION-VET staff ensures Veterans are linked to appropriate addiction, mental health, vocational/educational, and trauma-informed care treatment services via referral to VA Medical Center or community programs.

Further Defining Relationship with MISSION-VET Treatment Team

- Veterans continue to participate in DRT sessions facilitated by Case Manager.
- Veterans continue to participate in Peer-led sessions with Peer Support Specialist (PSS).
- If Veteran is still receiving inpatient/residential treatment services, MISSION-VET staff continue to attend treatment team meetings with inpatient/residential treatment staff and provide input on the Veteran's continuing treatment and discharge plan.
- PSS maintains "open door policy" for informal discussion with Veterans on caseload.
- Linkages to appropriate addiction, mental health, vocational/educational, and trauma-informed care treatment services are tested and confirmed.
- MISSION-VET staff continue to meet with Veterans to discuss issues related to recovery. Yet, because the ultimate goal of MISSION-VET is to facilitate self-sufficiency, Veterans interact with the MISSION-VET team more often during the initial stages of service delivery. By gradually decreasing frequency of contact, Veterans begin using community resources and service linkages more heavily.

Transitioning to Community-based Services

- The MISSION-VET case manager and peer conduct outreach sessions together. Focus of these sessions is on mental health stability and abstinence from substance use, adjustment to community, and employment obtainment and maintenance. Modifications to treatment plans are made as new needs arise.
- The MISSION-VET PSS participates in community activities with the Veteran (going to 12-step meetings, social events, lunch, recreational activities, etc.)
- The MISSION-VET Case Manager and PSS conduct outreach weekly to every other week as needed by the Veteran. These meetings can also be supplemented by telephone contacts if necessary. MISSION-VET staff continue to focus on "fine-tuning" community linkages and conducting DRT co-occurring disorder "booster" sessions as needed, providing ongoing employment/educational support, including conflict resolution and stress management and provide connections to Department of Vocational Rehabilitation or Department of Labor resources as needed.

Note: The MISSION-VET Case Manager and PSS can schedule additional sessions as needed if Veteran is having difficulty completing tasks on their own.

Transfer of Care

- MISSION-VET Case Manager and PSS outreach sessions are less frequent. Sessions may occur every other week to monthly or less, depending on the needs of the Veteran. Supplemental telephone contacts occur as needed.
- MISSION-VET Case Manager and PSS facilitate use of community-based supports, health care services, and other resources to prepare the Veteran for completely transitioning to independent community living. MISSION-VET staff work through issues around termination from MISSION-VET program, foster self-determination, and build Veteran's confidence in independent community living. The MISSION-VET Case Manager provides DRT booster sessions if needed.
- PSSs continue to participate in community activities with MISSION-VETs such as attending 12-step meetings and/or social events.

*Note: Termination is often difficult for those receiving treatment services and brings up such core issues as loss, dependency, etc. The CTI manual can serve as an additional resource for this component of treatment and is seen as a critical component of the treatment process. Furthermore, should Veteran 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 Veteran to identify additional support as needed. Again, it must remain clear to the MISSION-VET, case manager and PSS that the goal in the transitional phase in this stage of treatment is to empower Veterans to believe that they can live independently in the community, without the assistance they have been receiving from the MISSION-VET Case Manager and PSS.

Discharge from MISSION-VET

- The MISSION-VET Case Manager and PSS review progress and goals; discuss the Veteran's strengths, resiliency, and available resources; and reinforce the use of community supports. Then MISSION-VET staff say goodbye to the Veteran.

Note: Preparation for discharge really begins during Transfer of Care, however care is transferred gradually. Should the Veteran relapse at this point during treatment or request more services, the Veteran is encouraged to use community-based supports to meet these needs.

MISSION-VET 2-MONTH PROGRAM TIMELINE

Acute Psychiatry (approximately 10 days)
-Diagnostic assessment, medication stabilization, and psycho-educational groups

CTI Phase 1: Transition Planning
-Identification of needed community services and resources through comprehensive evaluation
-Establish connections with community supports

DRT: Onset of Problems (delivered over 2 sessions)
-Introduction to DRT
-Development of individualized treatment plan
-Identify patterns of use and interaction with MH symptom

Peer-led session focuses on reinforcing completion of exercises in MISSION-VET Consumer Workbook

Week 1

CTI Phase 1: Transition Planning
-Provide linkages to community supports

DRT: Problem Areas Worksheet to Address (delivered over 2 sessions)
-Motivate veterans to develop a change plan and and/or actively stop using
-help veteran commit to COD treatment upon discharge

Peer-led session focuses on reinforcing completion of exercises in MISSION-VET Consumer Workbook

Week 2

CTI Phase 1: Transition Planning
-Ensure that community supports are in place in preparation for discharge
-Identify vocational rehabilitation programs
-Probe for any trauma-related issues

DRT: Sessions: Motivation to change & Personal Recovery Plan
-Clarification of steps needed for recovery
-Elicitation of self-motivation statements
-Identification of triggers and early warning signs of relapse

Peer-led session focuses on reinforcing completion of exercises in MISSION-VET

Week 3

CTI Phase 1: Transition Planning
-Discharge session
-Transportation from the hospital after discharge

DRT Sessions: Decisional Balance & Communication Skills
-Pros/Cons of behaviors
-Work to improve communication with important people

Peer-led session focuses on reinforcing completion of exercises in MISSION-VET Consumer Workbook

Week 4

CTI Phase 2: Tryout
-Assertive outreach
-Fine-tune connections with community supports
-Identify barriers and fix
-Empower veteran to tackle issues on their own
-Ongoing monitoring of vocational/educational needs and trauma-related issues

DRT Sessions: 12-Step & Anger Management
-Provide orientation to 12-step programs and facilitate attendance
-Help control reactions

Peer-led session focuses on reinforcing completion of exercises in MISSION-VET Consumer Workbook

Week 5

CTI Phase 2: Tryout
-Assertive outreach
-Continue to monitor that veteran is engaged in community treatment and rehabilitation programs

DRT: Relapse Prevention & Triggers
-Recognize signs of relapse
-Monitoring of substance abuse triggers and craving levels

Peer-led session focuses on reinforcing completion of exercises in MISSION-VET Consumer Workbook

Week 6

CTI Phase 3: Transfer of Care
-Case manager may meet with veteran and community providers to discuss transfer of care and long-term goals
-Long-term community-based linkages established and finalized including vocational/educational and trauma-related services

DRT Session: Unhealthy Thinking & Irrational Beliefs
-Application of CBT techniques through role plays

Peer-led session focuses on reinforcing completion of exercises in MISSION-VET Consumer Workbook

Week 7

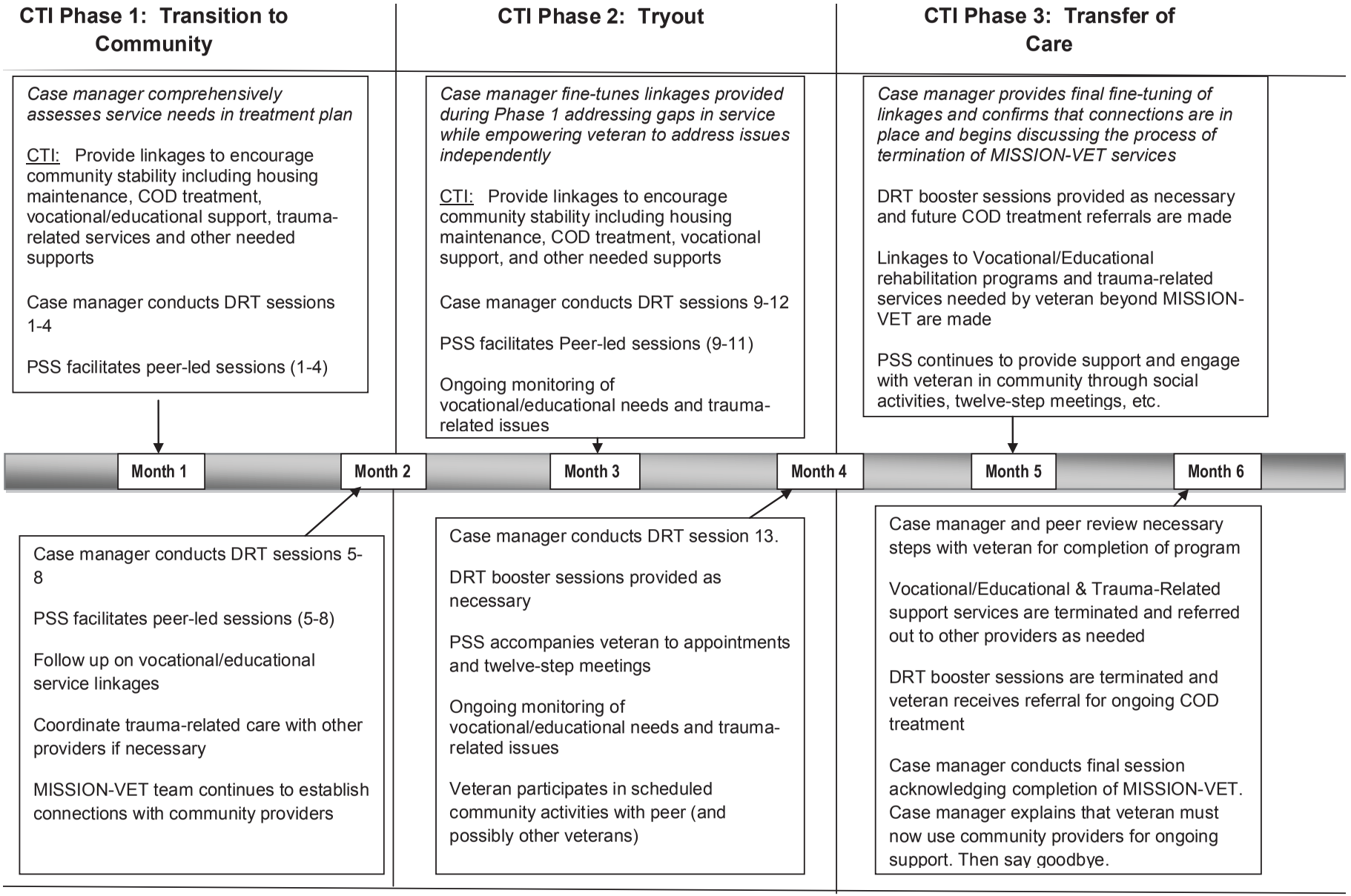
CTI Phase 3: Transfer of Care
-Final session acknowledging completion of MISSION-VET
-Case manager explains veteran must use community providers for support
-Transfer of care is complete
-Case manager says goodbye

DRT Session: Activity Scheduling
-Time management
-Activities w/o drugs or alcohol

Peer-led session focuses on reinforcing completion of exercises in MISSION-VET Consumer Workbook

Week 8

MISSION-VET 6-MONTH PROGRAM TIMELINE



MISSION-VET 12-MONTH PROGRAM TIMELINE

CTI Phase 1: Transition to Community

(Note CTI begins immediately if services initiated in community)

Case manager comprehensively assesses service needs in treatment plan

Case Manager conducts DRT sessions 1-12

PSS conducts peer-led sessions 1-11

Provide linkages to encourage community stability including housing maintenance, COD treatment, vocational support, and other needed supports

Assess for any trauma-related issues and make appropriate referrals and continue to monitor symptoms

Vocational/Educational needs assessed. Plan care in coordination with VA & community rehabilitation programs and continue to monitor needs

MISSION-VET team continues to establish connections with community resources and other treatment providers

CTI Phase 2: Tryout

Case manager fine-tunes linkages that were provided during Phase 1 addressing any issues and gaps in service while offering guided support in the attainment of these goals and empowering veteran to begin to independently tackle some of these issues

Care coordination continues with decreased frequency of contact between MISSION-VET staff and veteran (where contact may have been weekly it is now bi-weekly)

Attend to any crises/issues that arise

Conduct *in vivo* needs assessment in community to examine support structure

Resolve identified issues

Adjust systems of support as needed

Conduct final DRT Session 13

After Session 13, case manager conducts DRT "Booster" sessions as needed/ reinforces connections to community supports

Ongoing monitoring of vocational/educational needs and trauma-related issues

Peer continues work in community with veteran accompanying him/her to medical/therapy appointments, job interviews, 12-step meetings, etc.

CTI Phase 3: Transfer of Care

Case manager provides final fine-tuning of linkages and confirms that connections are in place

Case manager can conduct DRT Booster sessions as necessary and makes any necessary referrals to COD treatment providers in preparation for termination of MISSION-VET services.

Vocational/Educational supports and trauma-related services needed by veteran are finalized

Case manager may meet with veteran and community providers to discuss transfer of care and long-term goals

Transfer of care is complete. Case manager conducts final session acknowledging completion of MISSION-VET. Case manager explains to veteran that he/she must now use community providers for ongoing support. Then say goodbye.

If MISSION-VET initiated in residential setting, CTI Phase 1 begins a few weeks before discharge

If MISSION-VET initiated in residential setting, CTI Phase 2 begins between month 6 and month 7

If MISSION-VET initiated in residential setting, CTI Phase 3 begins between months 9 and 10

Appendix E: Leading Exercises in Dual Recovery Therapy

The following section presents exercises as they appear in the MISSION-VET Consumer Workbook, with the addition of a section called "Notes for the Session Facilitator." Of course, each leader may want to make adaptations based on the particular session, group, time limits, and/or other factors.

1. Onset of Problems

What's it for?

To help you recognize when your psychiatric and substance abuse problems began and relate them to what was happening in your life. Timelines of each symptom or psychological problem can be developed in order to help understand the factors involved in the problems. This can help you see patterns so you know how one set of problems in your life might impact other areas; then you can take actions that work for you to prevent this from happening.

Why does it work?

This exercise lets you look at patterns on a single page where it is easy to see how one thing relates to another.

When to use it:

You can consult the timeline you did in class anytime to give you insight on how your life experiences in one area relate to those in another area. You may want to try the same exercise at another time and see if you make more discoveries that you can use.

How to use it:

The following pages show three different timelines. First, you will see a sample; then, you will see timelines you can fill out based on your own experiences.

- One of these timelines is for psychiatric symptoms. This timeline asks you to remember when you have experienced them in your life.
- Another timeline is for interpersonal problems, such as quarreling more than usual with family members, having trouble at work, or falling into debt.
- The third timeline is for substance abuse. When were you using or drinking?

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

Notes for the Session Facilitator:

Explain to the Veteran that there is usually a pattern to when symptoms begin and that symptoms for substance abuse and mental health problems are often interrelated. After showing the Veteran how to fill out the timelines and going over the example, give the Veteran time to fill out their own timelines. If completed in a group environment, you can ask the Veteran to share his or her insights, leading to a discussion of common patterns and useful discoveries.

2. Life Problem Areas

What's it for?

To help you see where the problems are in your life that you want to change.

Why does it work?

Sometimes things can seem overwhelming, but just naming them can help.

When to use it:

You can consult the list you did in DRT class anytime so you can see how things are changing for you and what areas need more work.

How to use it:

Every few months, you might want to look at the problems you listed in class and ask yourself:

1. What's getting better? What helped me change?
2. What's about the same? Why? What else could I do to make it better?
3. What's worse? Why? What can I do to change that? Who could help?

Notes for the Session Facilitator:

Explain that this exercise will help the Veteran, peer support specialists, and case managers understand how problems related to mental health and substance abuse are each affecting the Veteran'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. If facilitated in a group environment, give Veterans about 30 minutes to work on the worksheet, then begin sharing around problems in each area, focusing on areas one at a time and asking for examples from group members. You may want to ask them to continue with the exercise for homework and continue the discussion in the next session.

3. Motivation, Confidence, and Readiness to Change

What's it for?

To help you look at something you want to change in your life and see whether you have the motivation, confidence, and readiness to make something different happen. This can include changes in substance abuse, mental health, family, and other interpersonal relationships.

Why does it work?

We know that we need all three of these things working in our favor to be in the best position to move ahead. When we honestly admit we're just not there, we can ask ourselves what we need to do differently to increase our motivation, confidence, or readiness to change. For example, maybe you would be more confident about making a change if you had a good role model rooting for you.

When to use it:

When you are thinking about change in your life - or wondering why it isn't happening - you can return to this exercise. It's really helpful to look at the way you filled out the rulers for the same subject area (for example, drinking) a few months later and see where you are now. Once you're out in the community again, for example, are you more or less confident? Why?

How to use it:

Whenever you want to look at a change in your life, circle the numbers on the rulers and think about where you are with the change. What would it take to make the number a little higher? How can you get more going in your favor?

Notes for the Session Facilitator:

Explain to the Veteran that a sense of importance, confidence, and readiness are all different aspects of motivation. Encourage the Veteran 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 Veterans fill these out. If in a group environment, consider encouraging Veterans to share around some of the problems explored, the motivation Veterans find to address them, and implications for recovery.

4. Developing a Personal Recovery Plan

What's it for?

To help you think through - and commit to - the things you want to do to recover. When you have mental health and substance abuse problems, they affect many areas of your life. It can seem overwhelming. But you can use this tool to get a handle on how to address them so things get better and better over time.

Why does it work?

Instead of having all the different things you need to do stressing you out, perhaps even causing mental health problems or making you want to use substances, this exercise helps you take control in a calm, thoughtful manner. It will help you see what you can do and think through where you might need to ask others to help you carry out your plan.

When to use it:

You will want to look at your personal plan periodically - maybe every three months - and redo it. Some problems will be resolved, but you may need new strategies to address others.

How to use it:

This may be an exercise that you do a little at a time, so you can really think through each problem area. You may want to use Exercise 3 in Part 1, section A of this manual, the "PICBA" Approach to Problem Solving, to decide how you want to address each set of problems.

Notes for the Session Facilitator:

This exercise builds on the life problem areas identified in the second session. Encourage Veterans 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 case managers, and others who play a key role in their hopes for recovery. Provide an opportunity for sharing around various strategies Veterans have suggested for themselves in each area.

5. Decisional Balance

What's it for?

If it were easy to make changes in our behavior, we probably wouldn't be doing a lot of the things that make trouble in our lives. It isn't easy because the same things that cause problems also have some benefits. We have to look honestly at what we're getting out of the behavior and what's driving it. Then maybe we can think of another way to meet the same need that doesn't cause us so much trouble.

Why does it work?

We can't just change by snapping our fingers. We have to decide. This tool helps us lay out and look at why we're doing what we're doing, what benefits it gives us, and what problems it's causing.

When to use it:

When there is a behavior you feel ambivalent about changing, even though it has a definite down side.

How to use it:

Identify the behavior you're thinking about changing (for example, substance abuse) and write down honestly the benefits and the negative consequences of that behavior.

Notes for the Session Facilitator:

This session marks the beginning of the skills building phase of DRT. Ask the Veteran to pick the biggest problem area in his or her life. What behavior is at the root of these problems? How could it be changed? What are the benefits and negative consequences of change? Then encourage sharing if in a group environment.

6. Developing Strong Communication Skills

What's it for?

As we become stronger in recovery, we are increasingly able to have healthy relationships. A critical element in relationships that work well and feel good is skillful communication. The better we are able to communicate what we think, what we need, and what we are experiencing, the more likely we are to be understood and to have our needs met. The better we are at listening well to others, the more likely it is that others will show us the same empathy and respect in return.

Why does it work?

The simple lists that follow can do nothing on their own. But if you read them thoughtfully and relate them to your own life, they can help you identify areas where you can make improvements that will help you have better relationships with the people that matter to you.

When to use it:

It is especially helpful to review this material when you're working on improving communication with people who are important in your life - whether they are family members, friends, counselors or clinicians, significant others, or people you work with.

How to use it:

Review the "Elements of Good Communication" and "Elements of Poor Communication." Which patterns of good communication would you like to adopt? Which elements of poor communication apply to you?

One way to change your patterns of communication for the better is to pick just a couple changes to practice at a time. Stay conscious of them as you interact with other people and keep it up until the new behavior becomes part of you. Then keep 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 Session Facilitator:

After Veterans identify the elements of poor communication they believe apply to them and the elements of good communication they would like to use, it is often helpful to encourage discussion of why they have used the forms of poor communication they employed in the past. Sometimes, for example, people mistake aggressive and hurtful forms of communication for assertiveness and necessary self-protection. Men in particular often find it difficult to "let their guard down." To give people a chance to practice new ways of communicating, you may want to improvise a role play using good and poor communication skills. Let them know that if they really want new behaviors to sink in, they should begin now to practice them regularly, so they can get useful feedback.

Elements of Good Communication

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

2. ***Stop and think*** before commenting on things that bother you: Decide not to bring up issues unless they are ***really important.***

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

4. Make sure to ***express lots of positive feelings*** and to reward your partner rather than taking things for granted when they are going well.

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

6. ***Go out of your way to offer to do tasks around the house.*** Give to the other without expecting anything back and without saying "I'll do it only if you do."

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

8. Use good ***listening skills:*** Look at your partner when he/she speaks to you. Don't interrupt! Take turns talking and listening. Validate what your partner says even if you don't agree ("I can understand why you're worried about my spending a lot of money. Maybe we can decide together how much cash I should have each week").

9. Try to be ***assertive - not aggressive.*** Think about what you want before you speak. Start with a positive statement and then use "I" statements. For example, instead of, "You're a spendthrift and we'll end up in the poorhouse. Try being a responsible adult!" try, "I'm very worried about the amount of money we're spending. I would like to try to figure out a way we can stop spending money and start saving. What do you think?"

Elements of Poor Communication

1. Don't listen: Don't look at partner when he/she is speaking. Ignore what they said.

2. Mindreading: Assume you know what the other person is thinking, and base your response on that rather than checking out what they are really thinking or what they mean.

3. Cross-complaining: Complain in response to your partner's complaint. "I hate it when you don't come home when you say you will." "Well I hate it when you complain all the time."

4. Drifting away from the point of the conversation: Bring up another issue before resolving the first one.

5. Interrupting: Talk over your partner. Don't let him or her finish a sentence.

6. "Yes butting": Agree but don't address the issue. "Yes but what about when you embarrassed me that day," or "yes but you've embarrassed me lots of times…"

7. Heavy silence (standoff routine): Try to punish the other person by ignoring him/her.

8. Escalate arguments: Become louder and louder, and more and more vicious.

9. Never call a time out or ask for feedback: Forget to stop the conversation if it's getting tooheated. Forget to ask partner what he/she really meant.

10. Insult each other (character assassination): Call each other names, "you always…you never…you're a….")

11. Don't validate: Say things like "That's ridiculous…" "You're just creating problems. If you would just leave me alone everything would be okay." "You're crazy to think that."

12. "Kitchen sinking:" Throw in more and more accusations and topics until you don't know what it is you're arguing about.

13. Not take responsibility: Always talk about what your partner is doing wrong instead of what you are doing.

7. Orientation to 12-Step Programs

What's it for?

This section will help you use a powerful tool: the support of peers who are also in recovery. People who use this proven program, or others like it, are more likely to be able to practice new behaviors and claim the lives they want.

Why does it work?

Seeing others further down the road who have overcome obstacles like our own can inspire us and give us hope. The twelve steps have helped many people find the spiritual strength and insight they need to stay in recovery. Eventually, when our healthier habits and lifestyle have become a stable pattern in our lives, we may take deep satisfaction in being role models for others.

When to use it:

Many people practice the 12 steps and attend groups their entire lives. Most people find it especially important to attend groups more frequently in early recovery. A regular pattern of attendance is a gift to yourself. It gives you allies and tools to help you stay on track.

How to use it:

Read this material carefully. If you have been part of a 12-step group in the past, reflect on your experience and discuss it with peers and counselors. If you have not, ask someone to go with you to your first meeting (perhaps one of the peer support specialists). Research local groups and make a commitment to attend regularly.

Notes for the Session Facilitator:

You will probably find this to be a lively session (particularly in group environments), since many people in recovery have experienced 12-step groups. Encourage them to share their experiences, role play ways to overcome any barriers to attendance, and share information about types of groups and meeting times in the immediate area. You may also want to encourage them to talk about each step and what it means to them.

Alcoholics and Narcotics Anonymous (AA/NA)

AA historians trace the genesis of AA to the meeting of Bill Wilson and Dr. Bob Smith in 1935. Both men found that, with mutual assistance, they were able for the first time to remain abstinent from alcohol. Shortly thereafter, they went on to found AA groups in Akron, Cleveland and New York. Since that time, Twelve Step programs have grown at an astonishing rate. Recent data suggest that there are approximately 100,000 chapters of various Twelve Step groups worldwide, approximately two-thirds of which are AA groups. Despite rapid growth, AA and other Twelve Step recovery programs have steadfastly maintained a stance of independent non-professionalism, mutual assistance, and adherence to original principles.

AA and NA emphasize complete abstinence from substances of abuse through a combination of mutual support, spiritual practices, and a personal dedication to a structured program of recovery known as the Twelve Steps. Most 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 Session Facilitator:

Good questions to start the discussion are:

- Why is it that one person gets really angry at something where another person just gets annoyed at the exact same thing?
- How do you know when you're getting really angry?
- What is the difference between anger and frustration? Sometimes people use the word "angry" for a wide variety of feelings and emotions; it can be helpful to distinguish between annoyance, frustration, impatience, irritation, anger, real rage, and other feelings. Ask the Veteran to mention some of the negative consequences that could occur if a person becomes angry and out of control. After they fill out the worksheet that follows on things that anger them, share some techniques for "cooling down." How can they hit the "pause" button?

9. Relapse Prevention

What's it for?

Preventing relapse is much easier than trying to recover after one, retracing difficult steps and refighting the same battles. We can learn to recognize the signs that a relapse could happen and then take action to avoid it. This exercise can help.

Why does it work?

The more we become conscious of the signs that indicate we might be about to relapse, the more we are able to take control and "steer away" from trouble.

When to use it:

Work through this carefully when you are not in immediate danger of relapse and can think clearly. It helps to discuss your experiences and plans with others.

How to use it:

Review the chart on warning signs of relapse and discuss it with others. Read through the material on safe coping strategies and mark those you think would be especially helpful for you. Then work on a change plan that you have faith in and believe can help prevent a relapse. Then - use it!

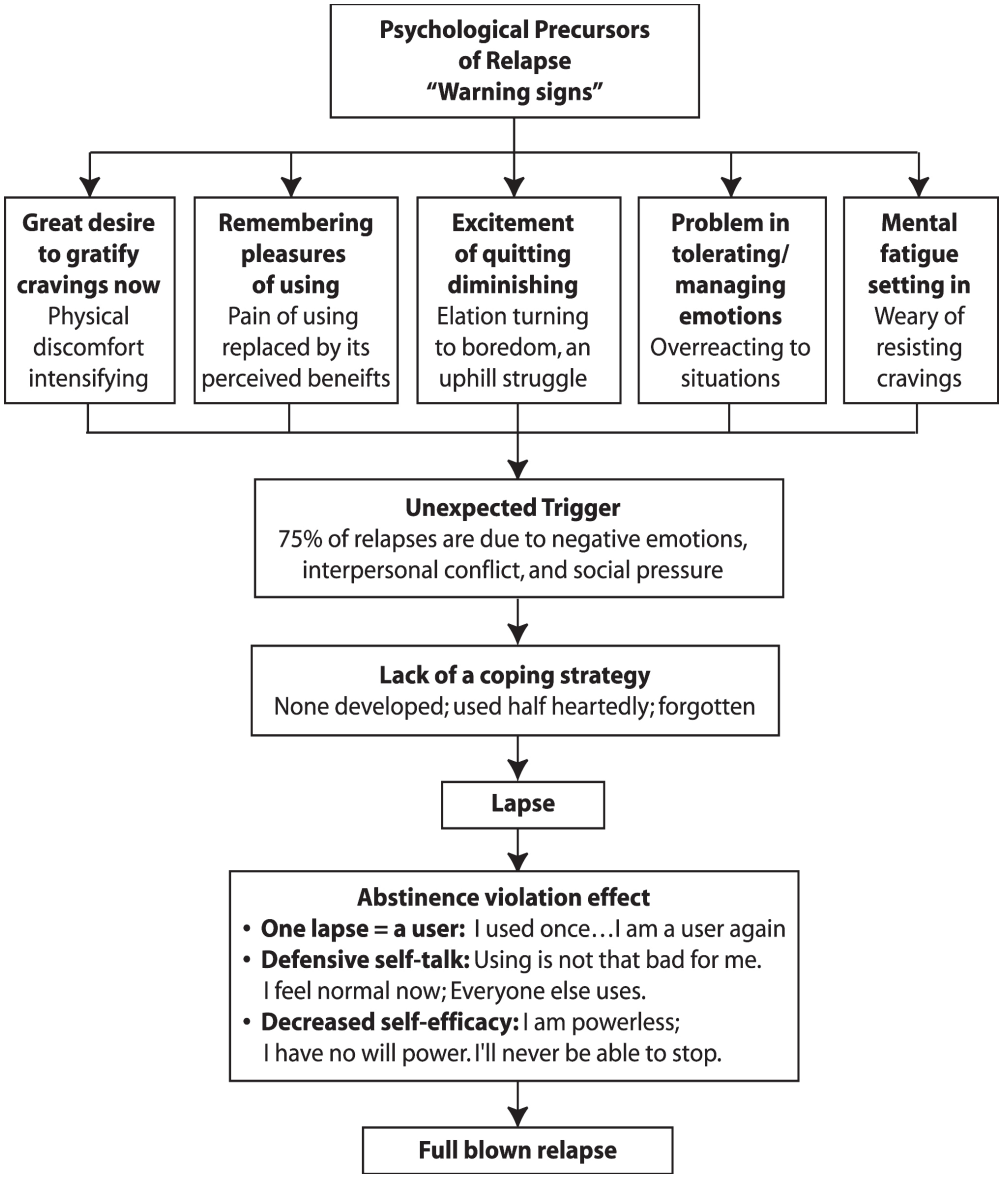
Notes for the Session Facilitator:

You will want to talk through the chart on relapse prevention that follows, eliciting examples of several of the boxes. After reviewing the coping strategies, ask them to share some of the others they have found effective, as well as their experience using the ones listed. Take time to fill out the worksheet on the "Change Plan" and encourage the Veteran 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 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.

10. Relationship-Related Triggers

What's it for?

To help identify some of the things that other people do that can trigger your substance abuse and understand why you react the way you do.

Why does it work?

Sometimes we don't really "get" what's happening with people we care about. They can always get under our skin. It helps to get specific about what the triggers are that really get to us and say honestly what it is we're really feeling when those things happen or those words are said.

When to use it:

When you feel an urge to use, you can think about what just happened that set it off. If there's another person involved you care about, maybe they will be willing to change what they're doing in some way so it doesn't get to you so much.

How to use it:

Fill out the first three questions on the worksheet. When you're feeling calm and ready to listen, approach the other person. Explain the trigger and how it makes you feel. Find out if the other person sees a way to change what they are doing. Or maybe you'll understand why they do this better and it will not bother you so much.

Notes for the Session Facilitator:

Give the Veteran time to finish the reading that comes just before the worksheet. Elicit some additional examples of "chain" reactions. Then ask the Veteran to answer the first two questions. If in a group environment, encourage Veterans to share their answers.

11. Changing Unhealthy Thinking Patterns

What's it for?

To help you think about and change the ways you think about problems.

Why does it work?

The thinking patterns we get used to can keep us from changing, undermining our attempts to change. But if we build new ones and practice them, we can feel better.

When we change the way we're thinking, we change the way we feel and act. But we can't pull this off until we go through an exercise of listening to ourselves and really hearing what we are telling ourselves - and questioning it. We need to begin to recognize when we are giving ourselves friendly counsel and when the old ways of thinking can keep us in a trap.

When to use it:

This is a good exercise to use every once in a while as you move through recovery to see where you're making progress, where you need to remind yourself of something you want to change, and where you're falling back into old habits.

How to use it:

Read through the examples of old ways of thinking from your DRT class, and read through the worksheet in which you thought about how you wanted to change. How are you doing? Have you had the old negative thoughts lately? Are you beginning to use the new messages more? If not, it's time to bump up the level of consciousness of what you want to change and let it happen.

Notes for the Session Facilitator:

You may want to start by taking turns reading the description of each of the various forms of unhealthy thinking. Then, discuss the examples of "stinking thinking" and give the Veteran time to write at least one example on the worksheet. Review 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. If in a group environment, you may want to assign participants to think of healthy responses for some of their unhelpful ways of thinking as homework to be discussed next week, if you run out of time. This is an important topic that is worth returning to collect new examples and new ways of thinking.

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."

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 Session Facilitator:

Ask Veterans to read through the examples of irrational thoughts and check those they find apply to them. Review the examples with the Veterans. If in a group environment, challenge the group as a whole to think of different ways to "reframe" each of the examples. Go over the sample worksheet and give group members time to think of different, healthier ways of thinking for each type of irrational thought they have experienced. Share several of these with the group as a whole.

10 Popular Irrational Beliefs

When we live by rigid, irrational rules, we set ourselves up for disappointment, overreaction to problems, and needless unhappiness. When we challenge those beliefs and think of how we want to change us, we take another step toward recovery and make our lives a little easier.

Here are ten irrational beliefs that people often believe anyway.

1. I must be loved, or at least liked, and approved by every significant person I meet.

2. I must be completely competent, make no mistakes, and achieve in every possible way, if I am to be worthwhile.

3. Some people are bad, wicked, or evil, and they should be blamed and punished for this.

4. It is dreadful, nearly the end of the world, when things aren't how I would like them to be.

5. Human unhappiness, including mine, is caused by factors outside of my control, so little can be done about it.

6. If something might be dangerous, unpleasant, or frightening, I should worry about it a great deal.

7. It's easier to put off something difficult or unpleasant than it is to face up to it.

8. I need someone stronger than myself to depend on.

9. My problem(s) were caused by event(s) in my past, and that's why I have my problem(s) now.

10. I should be very upset by other people's problems and difficulties.

13. Scheduling Activities in Early Recovery

What's it for?

To help organize your time so that your life is full and rewarding - without the need for drugs or alcohol.

Why does it work?

This exercise is especially helpful when you are in early recovery and building the habits that will help you stay in recovery. If you just let yourself drift without any plans for the days and weeks to come, it is very easy to slide into the old habits that caused so much trouble before.

When to use it:

Before you return to the community, plan how you want to structure your time using the worksheet that follows. It will help you make room for all that life offers that is real and rewarding. Reclaim the sports, caring friendships, relationships, and good health you enjoyed at good times in your life. If you haven't had those good times - it's time to start!

How to use it:

Answer each question thoughtfully. If you're not sure, talk over options with a trusted friend or counselor. Then revisit the plan periodically to see how it's working and add things you find that work for you. Reflect on what you're doing in your journal. If you write about what you did and how it worked, or how it didn't work, you can learn a lot about yourself.

Notes for the Session Facilitator:

This activity is extremely important-even potentially life-saving. As consumers move back into the community, they each need a strong guiding vision of what they want their lives to be like and how they want to use their time. Encourage Veterans to be as concrete and realistic as possible. It is easy to create a cotton-candy reality that just won't happen. Instead, Veterans need to think of choices that really appeal to them and activities they really would enjoy.

Appendix F: Helpful Therapeutic Techniques Underlying MISSION-VET Components

MISSION-VET Case Managers will need to employ several core therapeutic techniques to appropriately facilitate DRT sessions. MISSION-VET Peer Support Specialists should be familiar with these techniques as well. Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, and behavioral role plays techniques are discussed.

DRT blends and modifies core addiction therapy approaches with core mental health therapy approaches.

- Core addiction therapy approaches included in DRT are
    - Motivational Enhancement Therapy (MET),
    - Relapse Prevention,
    - 12-step program facilitation.

- Core mental health therapy approaches included in DRT are
    - Cognitive Behavioral Therapy, and
    - Skills Training.

As MISSION-VET staff use this integrated approach, we encourage them to

- Be client-centered; demonstrate respect and empathy.
- Be aware of coping and personality styles.
- Be flexible.
- Be active.
- Be aware of how disorders interact.
- Provide education.
- Assess and enhance client motivation.
- Maintain a focus on recovery.
- Ensure that treatment fits the Veteran's stage of recovery.
- Incorporate spirituality when appropriate.
- Recognize the interpersonal context of change and involve significant others in treatment.
- Provide gender and culturally competent services.
- Be open to the complementary and alternative approaches that interest the client.
- Focus on problem solving and developing skills.
- Integrate more active learning therapy techniques.

However, there are some specific considerations when working with a population of currently or formerly homeless Veterans who have also been diagnosed with substance abuse and other mental health disorders. These changes are particularly evident in **Motivation** and **Assessment.**

Motivation

Motivating Veterans over the duration of DRT involves the following considerations:

- Motivation changes over time.
- Motivation is affected by therapist behavior.
- Motivation is not "all or nothing." Clients may have different levels of motivation to address mental health and substance abuse issues.
- Motivation is influenced by the treatment setting.
- Treatment strategies should be based on the client's stage of readiness to change.

Given this, modifications to MET could increase its efficacy for Veterans who have been diagnosed with co-occurring disorders. The Veteran, faced with the complex challenges of dual recovery, may

- Have more problems to address;
- Have a longer engagement period;
- Experience lower self-efficacy/confidence;
- Need modified feedback and Change Plans;
- Be limited by cognitive abilities;
- Experience higher therapist activity;
- Need brief, simple, and repetitive statements;
- Need integrated mental health and substance abuse treatments;
- Be aided by assessing motivation to change for each issue on the problem list;
- Require more engagement when selecting and sequencing Change Plan interventions;
- Maintain MET spirit when making the transition to other modes of treatment;
- Find other dimensions of assessment useful;
- Need guidance addressing substance use, mental health symptoms, and the interactions among these;
- Be aided by inclusion of motivation and/or discussions of spirituality.

Assessment Strategies

DRT with Veteran clients, while incorporating several traditional assessment strategies, also may be further optimized by emphasizing certain types of and modifications to assessments.

- When using Time-Line Follow Back, include prior history of both substance abuse and mental health issues, including
    - Onset of symptoms;
    - Periods of stability/sobriety;
    - Periods of exacerbations and triggers;
    - Impacts on self and others, legal ramifications, and employment consequences.
- Information gathering should include detailed assessments of prior treatment (integrated treatments and treatments for each disorder), information from significant others, and family history.
- Other symptom scales and diagnostic tools should be incorporated when needed.
- Using a Stages of Change Assessment can be helpful in discerning the Veteran's readiness to modify behavior. The following categories may help guide treatment planning.
    - ***Precontemplation:*** not considering change in the foreseeable future
    - ***Contemplation:*** ambivalent, but considering the possibility of change
    - ***Preparation:*** expresses commitment and is developing a specific plan for change
    - ***Action:*** is engaged in active and sustained efforts to quit
    - ***Maintenance:*** has successfully sustained change (for at least six months)

Components and Structure of DRT

It is helpful during DRT to consider the components of treatment. Discussions of treatment components with the Veteran should include

- **Type of treatment provided:** individual therapy, group therapy, medication management;
- **Amount of treatment provided:** How often will treatment be provided? How long will treatment last? How long does each treatment session last? In what program?
- **Focus of treatment:** What will each treatment address? Since treatment should not attempt to address all problems simultaneously, which treatments address which issues?
- **Treatment goals:** what desired end does the Veteran need/want to achieve?
- **Treatment objectives:** The means toward these ends. Objectives are the strategies by which goals are achieved.

Dual Recovery Therapy consists of thirteen structured sessions. Generally, the program is

- More intense in the initial stages to encourage early skill development.
- Provided as an adjunct to other treatment programs.
- Also deliverable as "booster sessions" by case managers in the community when needed.
- Provided to lay the groundwork for the Peer Support Specialist's work with the Veteran

The Dual Recovery Status Exam provides a framework for each session, which includes

- An agenda set by MISSION-VET Case Manager/Peer Support Specialist and Veteran;
- Check-in with regard to any substances used since last session;
- Assessments of substance use and motivational level;
- Symptom tracking for depressive and anxiety disorders, etc.;
- Evaluations of prescription medication regimen compliance;
- Discussions of attendance at twelve-step groups, other therapy sessions, work/vocational training sessions, and other treatment plan elements;
- Ensuring that the primary agenda topics are addressed.

Considerations and Techniques

During DRT sessions, it is important to recognize some mechanisms a Veteran may use to discount successes and/or perpetuate failures:

- ***Catastrophization*** - turning relatively minor disappointments into major catastrophes.
- ***All-or-none thinking*** - viewing the world in absolute, mutually exclusive terms.
- ***Personalization*** - relating external events to oneself based on little or no evidence.
- ***Arbitrary inference*** - drawing inappropriate conclusions based upon faulty, insufficient, or contradictory information.

- ***Disqualifying the positive*** - rejecting positive experiences by interpreting them as trivial or undeserved.
- ***Emotional reasoning*** - assuming that negative emotions invariably reflect the true state of the world.

During DRT sessions, MISSION-VET staff are encouraged to use behavioral role plays to help Veterans develop coping abilities, problem-solving skills, and confidence in their abilities to manage interpersonal relationships.

- **As the role play begins, the Veteran and the MISSION-VET Case Manager or Peer Support Specialist should**
  - Discuss rationale and gain Veteran commitment.
  - Learn about issues significant to the Veteran.
  - Discuss the goals, skills to be learned, and criteria for success.
  - Do the role play. Consider letting the Veteran play the "client" so he/she feels comfortable.
  - Elicit and give feedback.

- **As a MISSION-VET Case Manager or Peer Support Specialist, you should**
  - Actively help the Veteran set specific interpersonal goals;
  - Promote favorable expectations and motivation before role playing begins;
  - Assist the Veteran in building possible scenes in terms of emotion and setting;
  - Structure the role-play by setting the scene and assigning roles;
  - Use the role-play to model alternative behaviors;
  - Prompt and cue the Veteran during the role-play;
  - Use an active style of training through coaching and support;
  - Give positive feedback for specific verbal and nonverbal behavioral skill;
  - Identify specific verbal and nonverbal behavioral deficits or excesses and suggest constructive alternatives;
  - Shape behavioral improvements in small, attainable steps;
  - Elicit or suggest alternative behaviors;
  - Give specific and attainable "homework" assignments;
  - Continue with active relapse prevention by helping the Veteran identify cues / triggers for substance use;
  - Discern and recognize early warning signs of mental illness recurrence;
  - Discuss ways of improving self-efficacy in dealing with specific people, places, things, or moods. Specific drug refusal skills rehearsal, strategies for making even seemingly irrelevant decisions, techniques for managing moods or persistent thoughts, and ideas for stimulus control should be covered.

Modifications of and enhancements to the 12-Step philosophy for addiction recovery may be especially helpful to Veterans with COD.

- Recovery concepts support increased sense of hope and connection to others through shared goals and shared experiences.
- Recovery is not a cure, but rather a way of living a meaningful life. Applying this to substance use disorders as well as mental health illness may be helpful.
- Recovery is a process of restoring self-esteem–personal commitment to growth, discovery, and transformation. This is relevant to mental health illnesses, as well.

Since Veterans receiving DRT through MISSION-VET may be medicated for combat injuries, both physical and mental/emotional; mental health illnesses; acute withdrawal from substances; or other health problems, it is important to acknowledge the role of medication as part of recovery by stressing that

- ***Medications are not a panacea.*** Substance-abusing clients are accustomed to addressing complex problems with simple answers and to viewing pills as the ideal solution to a variety of problems.
- ***Medications can take time.*** Clients often have little ability or willingness to delay gratification and tend to "want what they want when they want it." Without considerable support and education, they are prone to lose patience.
- ***Illegal substances can make a medication ineffective***. Clients often want the best of both worlds – the emotional stability or relief from anxiety or depression provided by a medication and the euphoria obtained through illicit drugs. It is important to realize that the therapeutic effects of a medication can be easily overwhelmed by simultaneously misusing other substances.
- ***Some types of dependence are healthy.*** For clients committed to abstinence, the idea of relying upon any substance may seem distasteful or even frightening. They may view all medications as "mind-altering" or "addictive" and need to be educated about the important differences about therapeutic medications and drugs of abuse.

In general, DRT is optimized when

- The treatment alliance is empathetic and therapeutic;
- Interventions are brief and involve feedback, advice, choices, optimism, responsibility, and follow-up;
- Resistance is managed;
- The Veteran is monitored for relapse and relapse prevention strategies are utilized;
- Families and significant others are involved; and
- The Veteran is provided with a variety of recovery tools, including a treatment plan and contract, linkages to self-help groups, medications, and therapy.

Appendix G: Supplemental Materials for Case Managers

Developing Relationships with a Broad Network of Community Agencies

"Systems brokering" - building relationships with community agencies that provide the services Veterans need to adjust to community life - is the responsibility of the entire MISSION-VET team, but MISSION-VET Case Managers (CM) are seen as being in a unique position to foster these relationships. Veterans benefit from the connections that are established with community agencies already maintained by staff at the inpatient, residential, or outpatient treatment programs. For example, the facility strives to place each veteran in employment or education programs and coordinates with a number of potential employers or colleges to accomplish this goal. In turn, staff from these programs also have community contacts that help secure housing. Often, needed contacts are found through "someone who knows someone." As such, networking skills are essential ingredients in successful implementation of the MISSION-VET program.

Second, MISSION-VET CMs enter their jobs with existing relationships in the community and areas in which they are particularly suited to build and maintain certain kinds of relationships. For example, one of the MISSION-VET CMs joined the MISSION-VET team with experience in vocational rehabilitation and connections that helped facilitate employment; she also had years of experience in vocational counseling. Another MISSION-VET CM, a Veteran, brought in-depth expertise in resources available to Veterans. We encourage a team approach, in which MISSION-VET CMs pool their strengths so that each CM can be a resource for the others based on their unique background, experiences and professional training.

Third, MISSION-VET CMs often build relationships "from scratch" through Internet searches or referrals from others in the field who know of useful resources. MISSION-VET CMs divide the responsibility to research programs that address certain needs. Such teamwork has helped them identify resources that can help Veterans 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. MISSION-VET CMs document this shared knowledge and explain the process for applying for services or goods to Veterans.

Training Needs

Training is seen as essential for personal growth and development, and all staff are required to participate in MISSION-VET training activities. MISSION-VET CMs receive ongoing internal training through group sessions and individual sessions led by their clinical supervisor. In addition, they receive:

- Internal training, to help them implement the program in accordance with the organization's expectations.
- Supplementary training from outside sources, to help them build clinical skills and acquire the knowledge they need to help enrolled Veterans navigate health care systems and access community services. They may also receive training on pertinent techniques and subjects, such as Motivational Interviewing and employment issues for persons who have a criminal or legal history.

Internal Training

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

- Confidentiality policies
- Research integrity
- Documentation policies
- Crisis management
- Expectations of the position

Supplementary Training

In addition, it is recommended that MISSION-VET CMs receive and retain certification from the Red Cross cardiopulmonary resuscitation. Consistent with their own credentials and professional affiliations, MISSION-VET CMs are encouraged to attend continuing education training events both within and outside of their employer. MISSION-VET CMs are also strongly encouraged to attend mental health grand rounds when possible. Additional trainings may be provided by psychologists, doctors, social workers and others who are very familiar with all of the topics listed below.

SUPPLEMENTARY TRAINING TOPICS OF INTEREST

- Assessment and Prevention of Suicidal Behavior
- Counseling and Interviewing Skills
- Motivational Interviewing
- Harm Reduction
- Drug Craving
- DSM-IV 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
- Psychiatric Medications

Case Examples

The next section offers examples of situations MISSION-VET CMs may encounter in their work with Veterans. Each example presents a problem and is followed by strategies MISSION-VET CMs might employ to assist Veterans during different phases of the CTI model highlighted in Chapter V: Case Management.

CTI Phase 1: Transition to community

Due to the flexibility of the MISSION-VET program, Veterans may begin receiving services while in an institutional setting, such as an inpatient or residential treatment facility, or after their transition into the community while trying to acquire stable housing. During the first phase of CTI, MISSION-VET CMs follow Veterans in each of these settings closely. For example, MISSION-VET CMs function as a secondary provider, collaborating with inpatient or residential treatment staff by attending weekly meetings to discuss treatment progress. In doing so, the MISSION-VET CM supports the treatment team and the Veteran, by providing specialized co-occurring disorder treatment; assistance with regard to discharge planning; and identification of resources needed to facilitate a successful community transition. As Veterans prepare for discharge, they will need a lot of support from their MISSION-VET CMs to ensure that their treatment plan links them to the community resources necessary for a successful recovery and that this plan is implemented once the Veteran transitions into the community. Similarly, if MISSION-VET services begin in the community, the MISSION-VET CM may be either the primary or secondary provider of care, depending on whether the Veteran is enrolled in a structured outpatient treatment program, such as an Intensive Outpatient Program (IOP). Ultimately, the common goal of the first phase of CTI is to identify and begin to implement additional and critical community resources that will help promote the successful recovery of each MISSION-VET in a supportive environment.

Example 1. A Veteran, who is about to transition to the community, voices concerns with her MISSION-VET CM about the lack of public transportation in her community and how this might impact her work. Specifically, the Veteran explains that she needs to rely on public transportation until she can regain her license, but that the buses are infrequent and that she worries about getting to work late and losing her job. If she were leaving from her family home, she would get there more easily, but program staff feels she needs the support provided in transitional housing for a while. The MISSION-VET CM 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 Veteran to get to work when needed, easing the Veteran's anxiety.

Example 2. Due to a miscommunication about his home address, a Veteran has not received the medications he needs to control severe pain. The MISSION-VET CM realizes that the Veteran is in danger of starting to drink again to relieve the pain. The MISSION-VET CM straightens out the problem with the address, elevates the priority given to fulfilling the prescription by contacting the Veteran's primary care provider and ensures that the medication arrives before the Veteran relapses.

CTI Phase 2: Try Out Phase

As the Veteran's transition to the community becomes more securely grounded, MISSION-VET CMs gradually decrease the frequency of their visits with the Veteran. The Veteran's goals often change, and new kinds of obstacles present themselves. Veterans may find they have taken on more than they can handle in their financial obligations, especially rent. They may feel overwhelmed by responsibility or have difficulty managing relationships. Spouses and friends may seem nagging and unsupportive. The MISSION-VET CM plays a steadying role in fostering independence, while helping Veterans see the way forward. For example, the MISSION-VET CM may suggest that the Veteran and his/her significant other enroll in couples counseling, help with money management, or suggest a way for the Veteran to gain the skills that would qualify him or her for a higher-paying job. The continuity of the relationship with the MISSION-VET CM encourages the Veteran and increases the likelihood that he/she will stay on course long enough to stabilize.

Example 3. During an early session with his MISSION-VET CM, a Veteran 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 Veteran 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 MISSION-VET CM uses connections at an outreach office for Veterans to help him find a place to live quickly. She also gives him a referral to a nonprofit agency that will give him a refrigerator and some basic furniture. She works with him on his resume and helps him set up several job interviews. Soon, he has his confidence back and is settling into the community successfully.

Example 4. A Veteran who has not seen his children or spoken to his former spouse for years wants to see the children again. The MISSION-VET CM helps this Veteran (who tends to become inpatient and have angry outbursts) to stay calm, focus on the goal, and avoid antagonizing his ex-wife. The MISSION-VET CM reinforces the anger management skills this Veteran learned while he was in the residential VA homeless program and in the DRT group sessions. The MISSION-VET CM also helps the Veteran get the information he needs to request visitation rights properly through the court system. The Veteran is able to handle his frustration, keep focused on his goal, and attain visitation rights. He is now enjoying getting to know his children again and they have become a stabilizing and motivating factor in his recovery.

CTI Phase 3: Transfer of Care to Community Supports

In this phase, MISSION-VET case management support, continues to decrease in intensity and gradually "tapers off" as the Veteran's supports within the community stabilize. Meetings stretch from weekly to every other week. Towards the end of a Veteran's participation in MISSION-VET, meetings may be as infrequent as once a month. MISSION-VET CMs should vary the frequency of their meetings according to the Veteran's needs: some are reluctant to let go of the friendly hand, while some are self-determined and independent. For some, it may make sense to replace in-person contact with telephone contact on occasion. The goal is to have less frequent sessions with the Veteran and to foster independence and reliance on available community supports that have been reviewed with the Veteran by their MISSION-VET CM. This will also assist with his/her termination from MISSION-VET, the process of which begins slowly as sessions become less frequent.

The MISSION-VET CM should first and foremost, make sure that he or she has the correct telephone numbers and addresses to contact the Veteran (both at present and in the community) including numbers for family members or others likely to know where the Veteran is if he or she moves. In their meetings with Veterans, the MISSION-VET CM should also devote time towards the MISSION-VET Consumer Workbook readings that focus on transitioning to the community. Though the Veteran's discharge plan remains the primary responsibility of the inpatient or residential care provider, sessions that address the Veteran's transition back into the community will allow MISSION-VET CMs to contribute valuable input to their Veteran's discharge plans. For high-risk cases, the MISSION-VET CM may meet with the primary care provider to ensure they are "on the same page" about how best to manage the Veteran's critical transition back to the community and ensure that needed supports are in place. In rare cases, the MISSION-VET CM may need to provide additional support in locating housing, a job, or other resources needed for the Veteran's transition at this stage; in this circumstance, assistance would be coordinated with the primary care provider.

Effective aftercare to ensure that functional community supports are in place is central to the MISSION-VET program. The support provided by the MISSION-VET CM changes to match the Veteran's status, usually evolving as the period of community living continues. In some cases, a Veteran receiving MISSION-VET services may leave their primary treatment programs prematurely, usually because he or she has relapsed. It is important to underscore that while a relapse to substance use is not a reason for termination from the MISSION-VET program, by policy, it is a reason for immediate discharge from a VA residential facility. If this occurs, the MISSION-VET CM begins immediately to provide supportive assistance. While this is obviously not an ideal situation, some Veterans

have successfully completed their transition to community life despite a precipitous early start.

The MISSION-VET CM may present a list of local resources and referrals for reference at the closing meeting, if the Veteran has not received these before. Often, MISSION-VET CMs send a positive, personalized closing note that thanks each Veteran and expresses good wishes. Depending on the institutional policy, one might even encourage these former Veterans to call and "check in" after three months. This offer has helped some Veterans who have participated in MISSION-VET, as it conveys the MISSION-VET CM's continuing interest in their welfare and continued progress with sobriety, managing mental health issues, other health related issues, obtaining employment and maintaining healthy family and other personal relationships.

Example of Completed MISSION-VET Treatment Plan

This completed example of a MISSION-VET treatment plan is provided as a guide for MISSION-VET CMs; however, each MISSION-VET will have unique considerations that will need to be accounted for by MISSION-VET CMs.

Considerations for MISSION-VET Treatment Planning

Primary Diagnosis

Major Depressive Disorder, severe, without psychotic symptoms

Secondary Diagnosis

Cocaine Dependence, Early Full Remission

Other Treatment Providers

Dr. Smith, VA Primary Care Provider

Dr. Jones, VA Psychiatrist

Service Needs

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

Considerations for MISSION-VET Treatment Planning (cont'd)

MISSION-VET Service Delivery

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

Treatment Goal & Objectives: Veteran is currently receiving care in VA residential substance abuse treatment program. In addition, Veteran is being followed by MISSION-VET staff. Veteran has identified the following treatment goals/objectives below:

Treatment Goal #1: maintain abstinence from drugs

Treatment Goal #2: gain job-related experience

Treatment Goal #3: transition to independent housing

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

Provider:

Location:

Example of MISSION-VET Case Manager Note

The sample MISSION-VET CM note provided below is based off of the sample MISSION-VET treatment plan provided above to provide a fluid example of documentation during different stages of the MISSION-VET program.

Sample Case Manager Note from MISSION-VET Orientation Session

Date: 5/1/2010

Individual Session: Orientation to the MISSION-VET Program

The Veteran attended an orientation session with this MISSION VET case manager to learn the goals, structure, and schedule of the MISSION-VET program. The Veteran was given the opportunity to ask questions about the program and these questions were answered to his satisfaction. The Veteran's goals during his treatment in the 14-week VA MISSION-VET program and following completion of the program were discussed. The Veteran stated that his primary goals were to maintain his abstinence from drugs, gain job-related experience, and to transition to independent housing during his participation in the MISSION-VET program. After completing the program, 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 continue outpatient psychotherapy. His strengths are his stable work history and his commitment to his faith and sobriety. His barriers to success include his tendency to relapse during times of emotional stress and a lack of social support.

The Veteran reported feeling hopeful about his future and less depressed than when he was initially admitted to the VA MISSION-VET program. Despite this improvement, his affect continues to be somewhat sad and constricted. The Veteran denied any suicidal/homicidal ideation*, as well as, any intent or plans to hurt himself or others. The Veteran denied any current alcohol or drug use. His thought process was goal-directed and linear.

This MISSION-VET case manager will contact the Veteran's primary care provider, the purpose of which is to communicate information gathered during the MISSION-VET orientation session to aid in the development of his treatment plan.

**In the event that a Veteran indicates that he/she is suicidal with a clear plan or definite intent, the Veteran should be escorted to his/her current therapist, if possible. If his/her therapist is unavailable, the Veteran should be escorted to the walk-in mental health clinic to be seen by the next available clinician. Veterans should not be left alone. MISSION-VET CMs should stay with Veterans until they are able to see a mental health clinician for evaluation. MISSION_VET CMs should also remind Veterans of emergency contact options: current VA therapist (during business hours)/ walk-in mental health clinic, 911, and the 24-hour National Suicide Hotline, 1-800-273-8255 (TALK).*

In the event that a Veteran indicates clear intent and a definite plan to harm a specific person, the Veteran should be directed to his/her current therapist, if possible. If his/her therapist is unavailable, the Veteran should be escorted to the walk-in mental health clinic to be seen by the next available clinician. VA police and/or local police and targeted person may also need to be notified to ensure the safety of all involved.

Example of a Template Note for A DRT Sesssion

Template for Notes on Individual Particiation in DRD

Group: Dual Recovery Therapy for MISSION-VET Program

Date: 7/12/2010

Agenda: Relapse Prevention	**LOW**	**MEDIUM**	**HIGH**
GROUP BEHAVIOR RATING:			
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-VET Program. Group members discussed methods of relapse prevention.

Appendix H: Leading Peer-led Sessions

The following sessions were designed based upon collaboration between previous MISSION-VET Peer Support Specialists (PSS) and Veterans. The goal of these sessions is to focus on a different topic each week but impose a minimum amount of structure in order to promote free discussion and provide an alternative to the many structured activities in which these Veterans engage during time spent in their treatment programs.

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

Some of the descriptions below also include a short passage written by a veteran who has previously participated in that particular session. If desired, the PSS facilitating the session can read these passages as a way to spark discussion, asking the Veteran 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 Veterans to pursue a course of action leading to recovery through their own choice.

Learning goals: Veterans 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 Veterans understand that the assistance people are offering them will be helpful only if they are willing to accept it. With willingness, the journey to a new life can begin, and change will come.

Questions to spark discussion:

- What are some things that you have been willing to change in your life? Unwilling to change?
- Would you agree that willingness is an important part of the recovery process?
- Have you acted on your willingness?
- What are some results from taking a course of action based on your will?

2. Self-Acceptance and Respect

Description: A discussion on how self-acceptance and respect are important in recovery from addiction and promotion of mental health.

Learning goals: Veterans will

(1) understand that denial of illnesses and lack of respect inhibits recovery;

(2) become informed that self-acceptance of their addiction and mental health issues is needed in order to grow and maintain their recovery;

(3) grasp the idea that through self-respect they will become more comfortable with themselves and others;

(4) perceive that acceptance and respect of self can help them overcome stigma and prejudice in society; and

(5) understand that self-acceptance and respect can turn around someone's perception of them.

How to introduce the topic: Make sure that Veterans understand that denial and being down on oneself is common, but by gaining self-acceptance and respect, they begin their healing process.

Question to spark discussion:

- Are you having difficulty accepting the fact that you are living with addiction and mental health issues?
- Where are you on a scale of 1 to 10, 1 being the lowest and 10 being the highest, with self-acceptance and respect for yourself?
- Can you explain something that you have already accepted about yourself?
- Could you explain how you have increased your respect for yourself?

Here's what a Veteran who previously participated in this session wrote:

It's taken me most of my life to admit the truth about myself, to be honest, and accept me as me. The moment I did that, it seemed like a switch went off in my head. It was like I could see things I could not see before my thinking changed. I was able to handle things better and make better decisions. Once I was able to be honest with myself and see myself for who and what I was, I could adjust and make changes to improve myself, my attitude, and my outlook on my life.

Self-respect is my ability to accept myself and to project a positive image, to hold my head up with pride and dignity, to treat myself as well as others as human beings. When things aren't going right, I need to keep myself together, hold onto my composure, and remain humble. I've learned that I must respect myself, I must respect others, and I must respect my disease. If I don't, I'm doomed to fail. I must have respect for myself or no one else will.

3. Gratitude

Description: In order to maintain motivation in recovery, Veterans should learn to recognize and be mindful of what they have to be thankful for.

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

Questions to spark discussion:

- Have you experienced gratitude in situations pertaining to your recovery?
- Has being grateful brought about change for you?
- What can you say about your gratitude for recovery?

4. Humility

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

Learning goals: Veterans will

(1) come to recognize situations in which humility can be helpful;

(2) learn to identify how they react with others when they are not humble;

(3) understand how their interactions when not humble affect them; and

(4) learn strategies for being humble in chaotic or stressful situations.

How to introduce the topic: Make sure the veteran understands that being humble is a positive thing. Do not portray being humble as being passive.

Questions to spark discussion:

- Who do you know who is humble, and how has it helped them?
- Can you think of a way to relate humility to personal growth?
- Has humility been a factor in your change?

5. Dealing with Frustration

Description: A discussion of methods of processing frustration and developing coping skills.

Learning goals: Veterans 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 Veterans are aware that frustration happens, it is normal, and the goal is to help people become more aware of their issues with frustration and improve their resolve when dealing with frustration.

Questions to spark discussion:

- Can you share a situation that was frustrating to you?
- How did you resolve it?
- How did you feel after resolving the situation?
- Have you dealt with frustration with emotion or with intellect?
- What was the result from dealing with the situation with emotional behavior?
- What resulted from use of a rational approach to the situation?
- Which resulted in a better outcome in dealing with frustration, the emotional or the rational approach?

6. Handling Painful Situations

Description: A discussion of how to handle circumstances, conditions, and surroundings that cause extreme uneasiness or pain.

Learning goals: Veterans will

(1) identify types of situations that are particularly painful for them;

(2) learn to identify how they react when they are not aware of how they handle painful situations;

(3) understand how their interactions when handling painful situations affect them; and

(4) learn strategies for not becoming stressed while handling painful situations.

How to introduce the topic: Make sure that Veterans know that experiencing great discomfort, uneasiness, or anxiety in certain situations is normal, and the goal is not to surrender to the situation but to develop a way to acknowledge, cope, and deal with the issue or issues causing the situation.

Questions to spark discussion:

- How did you handle a circumstance that was painful?
- Would you say that processing through a painful situation has been beneficial to recovery process?
- Would you say that communication is an important factor in working through a painful situation?

7. Significance of Honesty

Description: A discussion of the ways in which honesty to oneself and others is necessary in building a new way of life.

Learning goals: Veterans 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 Veterans know that honesty is something that is not always rewarded or recognized, but it is placed in high value. Veterans should not retreat from situations where honesty is needed.

Questions to spark discussion:

- When feeling cornered or trapped in a situation where honesty is needed, how do you handle it?
- When you use honesty in a trying circumstance, how do you feel?
- When you can be honest with yourself do you feel that you can be honest with others?
- Would you agree that being honest helps you grow in recovery?

Here's what one participant wrote:

Being honest with myself allows me to see me for who I really am, and sometimes it hurts. Also, hearing what other people think or feel when I ask a question is not easy, but it is not as hard as using drugs every day, lying just to kill the pain, and seeing how I have screwed up my life, with so many years wasted. If I feel bad, I want to say I feel bad; when I say no, I don't mean yes, I mean no.

Since my last relapse and returning to the DOM, I'm choosing to be honest about myself. I don't ever want to live that kind of life again, so I must remain true "to [mine] own self." I know there is going to be a whole lot of life's honesty coming at me, and this time I'm ready.

8. Courage

Description: An exploration of various types of courage—for example, courage needed to deal with life on its terms, cope with mental health and addiction issues, adjust to changes in life, and let go of the past.

Learning goals: Veterans 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 affects them; and

(4) learn strategies for being courageous even in chaotic and stressful situations.

How to introduce the topic: Make sure that Veterans know that the lack of courage may be normal in some situations. The goal is not to undermine people but to help them understand the need for courage.

Questions to spark discussion:

- Can you share a time when you needed to call on your courage?
- Would you agree that it takes courage to stand up for yourself?
- How is courage needed in your recovery process?

Here's what one participant wrote:

I spent the latter part of high school just making it by a thread. Courage and eagerness to be the best got lost in transition, and not making the grade seemed to be a tool of defiance. Once I gave up my will to give the best attempt at success, then failure turned into the acceptable thing to do.

After not fulfilling what should have been, it seemed the only thing to do was give up! The importance of being number one just wasn't there anymore, and like anything you practice well, I got good at being bad.

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: Veterans 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 Veterans know that impatience is normal, but the goal here is to help them become more patient. Consider starting with an anecdote to which Veterans can relate - perhaps the desire for recovery to happen more quickly than it does.

Questions to spark discussion:

- How often do you wish your recovery was going faster?
- When has wanting something too fast interfered with getting it at all?
- What do other people say about you when you're impatient?
- Have you ever lost a job or ended a relationship because of impatience?
- What do you do to calm yourself when you're impatient?

Here's what one participant wrote:

Currently I try to practice patience because I find myself wanting to do too much in the course of the day. I do realize that if I did attempt to do everything in one day that I would be doing nothing more than bringing unnecessary stress upon myself and probably would make more mistakes than accomplishments due to this added stress. This exact behavior played a role in my relapse. So I am grateful to have learned something from that. In practicing patience I put forth effort, but I don't rush the results. I just gradually watch them fall into place at God's timing.

10. Medicine Maintenance

Description: Reinforcement of the urgent importance of maintaining a medicine schedule and discussion of how medicine relates to the recovery process.

Learning goals: Veterans 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 Veterans know that medicine maintenance is part of life for people living with co-occurring mental illness and substance use disorders, and the goal is not to cause alarm but to become more knowledgeable of the importance of using helpful medications as prescribed.

Questions to spark discussion:

- Would you say that you have difficulty keeping up with your medication maintenance sometimes?
- Is the reason why that you may not want to?
- How about the side effects? Do they turn you away from taking your dosage?
- Do you understand the importance of your medication and taking it regularly?
- What strategies do you use for remembering to take your medication or anything else you need to do regularly?

11. Making a Good Thing Last

Description: Discussion of how to develop a lifestyle that supports mental health and recovery from addiction, as well as the benefits of living clean. Veterans 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: Veterans 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 Veterans know that wanting a good thing to last is normal, but making a good thing last requires work.

Questions to spark discussion:

- What good things in your life are you working to keep?
- Did anything good ever come easy for you?
- Would you say that keeping this good thing was difficult?
- Are there times when you have had to contribute more of yourself in order in order to maintain a good thing?
- Do you feel that it is really worth it to put in the effort of maintaining the good things in life?

Here's what one participant wrote:

With past adventures left in the past, I've moved on, taking new responsibilities in my life. I'm accepting the un-manageability I've experienced in my life and using it as a learning tool, to find the success I know my heart calls for.

It doesn't take much to understand the places you really don't want or need to be in your life, so today I've learned to appreciate life on life's terms. Making a good thing last takes a decision, dedication, perseverance, and a large amount of courage. Starting with my change of attitude and new respect for spirituality, I have faith in myself, which gives hope a more positive space in my head, allowing for the successes as well as the setbacks to become motivators and a means to an end.

Appendix I: Supplemental Materials for Initiating Peer Support

As stated in Chapter 1 of this manual, Replicating the MISSION-VET Program: Guidance for Administrators, we have learned many lessons in the process of setting up the peer support component of the treatment approach. We hope this appendix serves as a valuable resource regarding these lessons and some of the key issues one might consider when setting up peer support services. It is, however, not meant to be exhaustive, but rather a starting point.

First and foremost, we have learned that Peer Support Specialists (PSS) are incredibly valuable members of the treatment team. However, we believe that delays in fully benefiting from their valuable contributions can be avoided as the MISSION-VET program is replicated. We believe that our process of hiring PSS for the MISSION-VET project with little or no formal training in peer support minimized and confused their unique and important role. We would, therefore, encourage those replicating the MISSION-VET 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 PSS into mental health care systems.

The role of MISSION-VET's PSS evolved over time. It started out in a more limited way than originally intended due to certain issues associated with aspects of program design, funding limitations which affected the applicant pool and the introduction of this service component within a system that was early in adopting a full recovery orientation. Thus, from a strategic standpoint, this component evolved slowly but steadily.

At the outset, MISSION-VET'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 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 PSS activities were significantly curtailed. This has presented significant challenges associated with understanding the role of the PSS, their acceptance as full-time members, and the achievement of their full potential.

The system in which the original 12-month MISSION study was implemented was just beginning to embrace the role of peers as equal team members. Thus, the PSS initially did not have access to CPRS, which necessitated that the case manager be the conduit for all information collected by the PSS and required that the case manager be counted upon to relay any relevant medical record information to the PSS. The delay in access to CPRS impeded the PSS's ability to act as—and feel like—a full member of the treatment team.

Likewise, concerns regarding safety and independent judgment began to surface, resulting in VANJ policy decisions to temporarily limit the independent work of peer specialists in the community until lengthy training could be completed. This deficit in training prior to employment inadvertently set up a dynamic of peers and case managers not recognizing that they hold equal value on the team and that they perform different, but equally important, roles. This was perhaps one of the most difficult struggles for the team to overcome. Since then, the VA system has developed a national system-wide infrastructure for peer support services. A more formalized MISSION-VET on-the-job training program (including "shadowing assignments") has been implemented, and existing PSS have completed on-the-job training.

These experiences are shared as a means of conveying "lessons learned" from which others replicating MISSION-VET services may benefit. As stated above, the employment of PSS is an emerging practice and a key aspect of mental health systems transformation towards a recovery-orientation of services. As with any occupation, recruitment of personnel already trained in the foundational aspects of their position is recommended over 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 PSS 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-VET program.

1) Hiring criteria: What are appropriate hiring criteria for PSS?

- Is a certain type of mental illness required, or not?
- Should the PSS be free of substance use? For how long?
- Should the PSS not have been hospitalized for some period of time?
- How should the above be documented?
- Is hiring "from within" a good practice or not?

It is essential for Administrators to understand that the Americans with Disabilities Act prohibits employers from asking applicants about their medical/psychiatric conditions or history. Rather, the hiring criteria for PSS should be based on the knowledge, skills, abilities, and personal characteristics required to perform the duties of the position. Position descriptions and recruitment announcements should describe the population served and the expectation that the PSS will utilize their own recovery experiences as a means of role-modeling successful community integration and providing peer support to foster achievement of Veterans' recovery goals. Employment application forms and interview questions should be carefully designed to elicit the necessary information to determine if the applicant's training and personal experiences have afforded them the knowledge and skills necessary to successfully perform the duties of a PSS. (Examples of key knowledge, skills, and abilities and some suggested interview questions identified for the MISSION-VET PSS position description can be found at the end of this Appendix).

It is generally recommended that organizations aggressively recruit individuals who are not currently, or have not recently received mental health services from the same organization in which they would be employed. Most organizations do not strictly prohibit this, and the negative impacts of doing so are minimized in large organizations where PSSs can be employed in a program that is remote from where they have recently received or currently receive their own mental health services. Should the selected candidate be one who currently receives services from the same organization, it is generally advised they make every effort to distance their personal service providers from their supervisor and direct co-workers. Under no circumstances should a PSS also be that person's mental health services provider.

PSS training and certification programs may have criteria that specify the need for particular types of diagnoses and/or periods of sobriety or non-hospitalization; however, such criteria cannot legally be applied directly in the hiring process.

2) Confidentiality: Is there a different level of confidentiality for PSSs than for other service providers? Does everything that gets stated to a PSSs by a Veteran automatically get transmitted to the rest of the team?

PSS are members of a treatment team. As such, they are expected to help the Veteran share information with the rest of the team that is pertinent to the team's effort to support the Veteran's treatment/recovery goals. In the case of critical information conveyed in peer support groups (which are confidential by their nature), the Peer Support Specialist would generally raise discussion with the Veteran outside of the peer support meeting as a means of processing with the Veteran the value and importance of including the team in addressing the issue. Should the Veteran refuse to share information with the team that is deemed vital to their safety, the PSS would be expected to inform the Veteran that they must (and will) convey such information to the team anyway.

3) Fraternization: Can PSS spend time with their Veterans after hours? What are the boundaries of Veterans and PSS giving money to each other? Can a PSS buy a Veteran a cup of coffee or not?

PSS are staff of the mental health system in which they are employed, and any organizational policies regarding financial transactions, intimate relationships, etc. that apply to other providers would also apply to the PSS. The fact that PSS may more often live, socialize, attend meetings, etc. where Veterans are likely to be does not change organizational policies designed to protect both the mental health system employee and the Veterans served by that system.

Most all friendships outside of the work environment have the potential to influence behaviors within the work setting and should therefore be avoided. PSSs are, however, likely to have more social contact with Veterans than traditional healthcare providers, and as peers have a more mutual relationship with Veterans in the context of their work. It is therefore recommended that there be a safe environment for PSS to discuss these situations with their supervisor as they may arise, to include assistance with discussing healthy boundaries with Veterans. Like all employees (and perhaps even more so), it is important that PSS balance and have a healthy separation between their work and their personal lives. Where a strong personal friendship may have previously been established between a PSS and a new Veteran coming into the program, the PSS (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 Veteran to a different case management/peer specialist team. Where assignment to another team is not possible, the employee and their supervisor should discuss appropriate boundaries to minimize real or perceived conflicts of interest that could jeopardize the PSS/Veteran relationship and goals of the program.

4) Supervision/performance appraisal: How does a supervisor appraise performance of a PSS?

Performance standards for PSSs should be developed based on the work of the position, as with any other staff member. In the case of MISSION-VET PSS, the supervisor's appraisal should focus on the PSS's effectiveness in developing supportive relationships with Veterans 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 PSS is what will happen if the PSS relapses. Should special sick leave policies be in place for them?**

The sick leave policy should be no different for PSS than for any other employee. Employers should not probe for personal medical information, nor require medical documentation beyond existing organizational policies that apply to all employees. A PSS, like any other employee, should be oriented as a part of his or her general employment orientation to their rights and responsibilities under the American's with Disabilities Act. As such, 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 is a PSS required to disclose his/her personal history of mental illness/addictions in the context of their work with Veterans?**

Unlike more traditional mental health providers, such as social workers, psychologists, etc. who may also be (and disclose their personal experience as) consumers of mental health services, the unique role of the PSS requires them to do so. Their training as a PSS should comprehensively address how to utilize their own experiences effectively, so as to connect with, empathize with, and support Veterans. PSS training also generally includes learning to "tell one's story" from a recovery versus an illness perspective, and how to ensure that their self-disclosure is pertinent to the situation and does not dominate the conversation. Under no circumstances should a PSS feel compelled to disclose aspects of their personal experiences that they would be uncomfortable sharing.

Knowledge, Skills, and Abilities considered essential for the MISSION-VET PSS position include

1. Knowledge of the recovery process and ability to facilitate recovery dialogues.
2. Knowledge and skills to teach and engage in problem solving and conflict resolution strategies.
3. Knowledge of community resources to facilitate community integration.
4. Knowledge of co-occurring mental illness and addictions diagnoses, including signs and symptoms and current trends and developments in the mental health field including self-help/peer support arenas.
5. Ability to teach self-advocacy through role-playing, 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-VET PSS position:

1. The position you have applied for is a Peer Support Specialist. Please describe what you believe a peer support specialist's role should be and what you would envision yourself doing in this role. Give an example of how you have provided this type of service in the past.
2. Please share a couple of specific examples of progress you've made in personal and/or work life where you experienced a setback or challenge and then turned the situation around to a positive outcome.
3. Please provide specific examples of how you have provided informal or formal support to one or more of your peers.
4. Please discuss a specific time when you had to negotiate with a group of people to obtain their cooperation. Tell us specifically who you negotiated with and what the outcome was. What did you learn from the situation?
5. Think of a time when you had to communicate something that you knew the other person did not want to hear. How did you go about communicating it? What was the outcome?
6. Please describe a time when you assumed a leadership role (in any context). What sort of problems came up? What did you learn about yourself?
7. What was the most recent skill that you set out to learn? How did you go about it?
8. Give an example of an important goal that you have set for yourself 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-VET program fit in with your overall life plan goals for yourself? Please be specific.

Appendix J: Vocational and Educational Support Materials

This appendix is meant to accompany Chapter VI, Vocational and Educational Supports for Veterans. The supplementary material found in this appendix is intended to provide the MISSION-VET team with resources to help ensure that MISSION-VET clients make successful strides towards employment, education, and recovery goals.

SAMPLE INDIVIDUAL EMPLOYMENT PLAN

DATE: _____

OVERALL EMPLOYMENT GOAL:

_____

_____

STRENGTHS, SKILLS, RESOURCES:

_____

_____

_____

OBJECTIVE 1:

_____

INTERVENTIONS:

_____

_____

_____

_____

_____

_____

PERSONS RESPONSIBLE:

TARGET DATE: _____

DATE ACHIEVED: _____

SIGNATURES/DATES:

OBJECTIVE 2:

INTERVENTIONS:

PERSONS RESPONSIBLE:

TARGET DATE: _____

DATE ACHIEVED: _____

SIGNATURE/DATES:

REPRODUCED WITH PERMISSION FROM THE AUTHORS:

Swanson, S. J., Becker, D. R., Drake, R. E., & Merrens, M. R. (2008). ***Supported employment: A practical guide for practitioners and supervisors.*** **Lebanon, NH: Dartmouth Psychiatric Research Center.**

JOB START FORM

CLIENT:

CASE MANAGER:

EMPLOYMENT SPECIALIST:

EMPLOYER:

EMPLOYER'S ADDRESS:

START DATE:

HOURS PER WEEK:

JOB TITLE:

JOB DUTIES:

PAY:

BENEFITS:

UNION POSITION: _____ YES _____ NO

DISCLOSURE: _____ YES. CLIENT HAS AGREED TO EMPLOYER CONTACT AND HAS SIGNED A RELEASE. HOWEVER, CLIENT DOES NOT WANT TO DISCLOSE THE FOLLOWING:

SUPERVISOR'S NAME:

_____ NO. CLIENT DOES NOT WISH EMPLOYMENT SPECIALIST TO HAVE CONTACT WITH EMPLOYER.

STAFF SIGNATURE DATE

SAMPLE LETTER TO EMPLOYER

October 29, 2010

Mr. John Smith
Sunnyside Bowling Lanes
One Employment Way
Bedford, MA 07130

Dear Mr. Smith,

Thank you very much for taking the time to meet with me today in regards to Henry Miller's application for a cashier position at Sunnyside Bowling Lanes, Although you do not have cashier openings at this time, I encourage you to consider Mr. Miller for future positions. He is very interested in working at Sunnyside Bowling Lanes in particular, because he lives in the neighborhood and has had prior experience working in a similar position. I believe you will find him to be a reliable and responsible employee.

I will contact you again about future openings for him. Thank you for your time and consideration.

Sincerely,

Jane Taylor
Case Manager
444-4444

REPRODUCED WITH PERMISSION FROM THE AUTHORS:

Swanson, S. J., Becker, D. R., Drake, R. E., & Merrens, M. R. (2008). ***Supported employment: A practical guide for practitioners and supervisors.*** **Lebanon, NH: Dartmouth Psychiatric Research Center.**

RECOVERY ASSESSMENT SCALE (RAS)

Name or ID Number_____ Date _____

PLEASE ANSWER THESE ITEMS ON AN AGREEMENT SCALE WHERE 1 IS "STRONGLY DISAGREE" AND 5 IS "STRONGLY AGREE."

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. I have a desire to succeed.	1	2	3	4	5
2. I have my own plan for how to stay or become well.	1	2	3	4	5
3. I have goals in life that I want to reach.	1	2	3	4	5
4. I believe I can meet my current personal goals.	1	2	3	4	5
5. I have a purpose in life.	1	2	3	4	5
6. Even when I don't care about myself, other people do.	1	2	3	4	5
7. Fear doesn't stop me from living the way I want to.	1	2	3	4	5
8. I can handle what happens in my life.	1	2	3	4	5
9. I like myself.	1	2	3	4	5
10. I have an idea of who I want to become.	1	2	3	4	5
11. Something good will eventually happen.	1	2	3	4	5
12. I'm hopeful about my future.	1	2	3	4	5

Continued on next page.

RECOVERY ASSESSMENT SCALE (RAS) (CON'T)

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
13. Coping with my mental illness is no longer the main focus of my life.	1	2	3	4	5
14. My symptoms interfere less and less with my life.	1	2	3	4	5
15. My symptoms seem to be a problem for shorter periods of time each time they occur.	1	2	3	4	5
16. I know when to ask for help.	1	2	3	4	5
17. I am willing to ask for help.	1	2	3	4	5
18. I ask for help, when I need it.	1	2	3	4	5
19. I can handle stress.	1	2	3	4	5
20. I have people I can count on.	1	2	3	4	5
21. Even when I don't believe in myself, other people do	1	2	3	4	5
21. It is important to have a variety of friends	1	2	3	4	5

REPRODUCED WITH PERMISSION FROM THE AUTHORS:

Corrigan, P.W., Giffort, D., Rashid, F., Leary, M., & Okeke, I. (1999). Recovery as a psychological construct. ***Community Mental Health Journal, 35, 231-240.***

The RAS Score Sheet

Name or ID Number_____ Date _____

Factor scores are obtained by adding up the parenthetical items which load into each factor.

_____ Personal Confidence and Hope (Sum of items 7, 8, 9, 10, 11, 12, & 19)

_____ Willingness to ask for Help (Sum of items 16, 17, & 18)

_____ Goal and Success Orientation (Sum of items 1, 2, 3, 4, & 5)

_____ Reliance on Others (Sum of items 6, 20, 21, & 22)

_____ Not Dominated by Symptoms (Sum of items 13, 14, and 15)

RECOVERY-PROMOTING RELATIONSHIPS SCALE (RPRS)

The following statements describe different aspects of the relationship people with psychiatric conditions might have with a mental health or rehabilitation provider.

Please think of the relationship you have with _____

Please circle the answer that best describes your relationship with this provider.

1. My provider helps me recognize my strengths.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

2. My provider tries to help me see the glass as "half-full" instead of "half-empty."

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

3. My provider helps me put things in perspective.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

4. My provider helps me feel I can have a meaningful life.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

5. I have a trusting relationship with my provider.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

6. My provider helps me not to feel ashamed about my psychiatric condition.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

7. My provider helps me recognize my limitations.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

8. My provider helps me find meaning in living with a psychiatric condition.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

9. My provider helps me learn how to stand up for myself.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

10. My provider accepts my down times.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

11. My provider encourages me to take changes and try things.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

12. My provider reminds me of my achievements.

RECOVERY-PROMOTING RELATIONSHIPS SCALE (RPRS) Con't

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

13. My provider understands me.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

14. My provider tries to help me feel good about myself.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

15. My provider helps me learn from challenging experiences.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

16. My provider really listens to what I have to say.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

17. My provider cares about me as a person.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

18. My provider treats me with respect.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

19. My provider helps me feel hopeful about the future.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

20. My provider helps me build self-confidence.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

21. My provider sees me as a person and not just a diagnosis.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

22. My provider helps me develop ways to live with my psychiatric condition.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

23. My provider has helped me understand the nature of my psychiatric condition.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

24. My provider believes in me.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

Appendix K: Trauma-Informed Care Resources

This appendix is meant to accompany Chapter VII: Trauma-Informed Care. As previously noted, MISSION-VET is not a PTSD intervention or one designed to treat co-occurring PTSD and addiction. Clients with severe or chronic PTSD should first be referred to a program that specializes in PTSD treatment. The supplementary material found in this appendix seeks to provide the MISSION-VET team with a list of resources to help assist MISSION-VET clients with PTSD issues that may occur during the course of treatment.

What is PTSD?

Posttraumatic Stress Disorder (PTSD) is an anxiety disorder that can occur following the experience or witnessing of a traumatic event. A traumatic event is a life-threatening event such as military combat, natural disasters, terrorist incidents, serious accidents, or physical or sexual assault in adult or childhood. Most survivors of trauma return to normal given a little time. However, some people will have stress reactions that do not go away on their own, or may even get worse over time. These individuals may develop PTSD.

People with PTSD experience three different kinds of symptoms. The first set of symptoms involves reliving the trauma in some way such as becoming upset when confronted with a traumatic reminder or thinking about the trauma when you are trying to do something else. The second set of symptoms involves either staying away from places or people that remind you of the trauma, isolating from other people, or feeling numb. The third set of symptoms includes things such as feeling on guard, irritable, or startling easily.

In addition to the symptoms described above, we now know that there are clear biological changes that are associated with PTSD. PTSD is complicated by the fact that people with PTSD often may develop additional disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health. These problems may lead to impairment of the person's ability to function in social or family life, including occupational instability, marital problems, and family problems.

PTSD can be treated with psychotherapy ("talk" therapy) and medicines such as antidepressants. Early treatment is important and may help reduce long-term symptoms. Unfortunately, many people do not know that they have PTSD or do not seek treatment. This handout will help you to better understand PTSD and the how it can be treated.

How does PTSD develop?

PTSD develops in response to a traumatic event. About 60% of men and 50% of women experience a traumatic event in their lifetime. Most people who are exposed to a traumatic event will have some of the symptoms of PTSD in the days and weeks after the event. For some people these symptoms are more severe and long lasting. The reasons why some people develop PTSD are still being studied. There are biological, psychological and social factors that affect the development of PTSD.

What are the symptoms of PTSD?

Although PTSD symptoms can begin right after a traumatic event, PTSD is not diagnosed unless the symptoms last for at least one month, and either cause significant distress or interfere with work or home life. In order to be diagnosed with PTSD, a person must have three different types of symptoms: re-experiencing symptoms, avoidance and numbing symptoms, and arousal symptoms.

Re-experiencing Symptoms:

Re-experiencing symptoms involve reliving the traumatic event. There are a number of ways in which people may relive a trauma. They may have upsetting memories of the traumatic event. These memories can come back when they are not expecting them. At other times the memories may be triggered by a traumatic reminder such as when a combat Veteran hears a car backfire, a motor vehicle accident victim drives by a car accident or a rape victim sees a news report of a recent sexual assault. These memories can cause both emotional and physical reactions. Sometimes these memories can feel so real it is as if the event is actually happening again. This is called a "flashback." Reliving the event may cause intense feelings of fear, helplessness, and horror similar to the feelings they had when the event took place.

Avoidance and Numbing Symptoms:

Avoidance symptoms are efforts people make to avoid the traumatic event. Individuals with PTSD may try to avoid situations that trigger memories of the traumatic event. They may avoid going near places where the trauma occurred or seeing TV programs or news reports about similar events. They may avoid other sights, sounds, smells, or people that are reminders of the traumatic event. Some people find that they try and distract themselves as one way to avoid thinking about the traumatic event.

Numbing symptoms are another way to avoid the traumatic event. Individuals with PTSD may find it difficult to be in

touch with their feelings or express emotions toward other people. For example, they may feel emotionally "numb" and may isolate from others. They may be less interested in activities they once enjoyed. Some people forget, or are unable to talk about, important parts of the event. Some think that they will have a shortened life span or will not reach personal goals such as having a career or family.

Arousal Symptoms:

People with PTSD may feel constantly alert after the traumatic event. This is known as increased emotional arousal, and it can cause difficulty sleeping, outbursts of anger or irritability, and difficulty concentrating. They may find that they are constantly "on guard" and on the lookout for signs of danger. They may also find that they are easily startled.

How common is PTSD?

PTSD is common. In the entire population, an estimated 6.8% of Americans will experience PTSD at some point in their lives. Women (9.7%) are more than two and a half times as likely as men (3.6%) to develop PTSD. About 3.6% of U.S. adults (5.2 million people) have PTSD during the course of a given year. This is only a small portion of those who have experienced at least one traumatic event. In people who have experienced a traumatic event, about 8% of men and 20% of women develop PTSD after a trauma and roughly 30% of these individuals develop a chronic form that continues on throughout their lifetime. The traumatic events most often associated with PTSD for men are rape, combat exposure, childhood neglect, and childhood physical abuse. The most traumatic events for women are rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse.

PTSD is more common in "at-risk" groups such as those serving in combat. About 30% of the men and women who served in Vietnam experience PTSD. An additional 20% to 25% have had partial PTSD at some point in their lives. More than half of all male Vietnam Veterans and almost half of all female Vietnam Veterans have experienced "clinically serious stress reaction symptoms." PTSD has also been detected among Veterans of other wars. Estimates of PTSD from the Gulf War are as high as 10%. Estimates from the war in Afghanistan are between 6 and 11%. Current estimates of PTSD in military personnel who served in Iraq range from 12% to 20%.

Who is most likely to develop PTSD?

Most people who experience a traumatic event will not develop PTSD. However, the risk for developing PTSD increases when someone has

- been directly exposed to the traumatic event as a victim or a witness;
- been seriously injured during the trauma;
- experienced a trauma that is long lasting or very severe;
- seen themselves or a family member as being in imminent danger;
- had a severe negative reaction during the event, such as feeling detached from ones surroundings or having a panic attack;
- felt helpless during the trauma and unable to help themselves or a loved one.

Individuals are also more likely to develop PTSD if they

- have experienced an earlier life threatening event or trauma,
- have a current mental health issue,
- have less education,
- are younger,
- are a woman,
- lack social support,
- have recent, stressful life changes.

Some research shows that ethnic minorities, such as blacks and Hispanics, are more likely than whites to develop PTSD. One reason for these differences is that minorities may have more contact with traumatic events. For example, in Vietnam, whites were in less combat than blacks, Hispanics, and American Indians. Researchers are trying to understand other reasons for the differences in PTSD between the ethnic groups. A person's culture or ethnic group can affect how that person reacts to a problem like PTSD. For example, some people may be more willing than others to talk about their problems or to seek help.

How long does PTSD last?

The course of PTSD is variable. This means it can be different for different people and that it can change over time. PTSD usually begins right after the traumatic event but it can also be delayed for many years. For most people symptoms improve over the first year. Treatment also reduces symptoms but for some symptoms can last a lifetime. Roughly 30% of individuals develop a chronic form.

PTSD usually involves periods of symptom increase followed by remission or decrease, although some individuals may experience symptoms that are long-lasting and severe. Some older Veterans who report a lifetime of only mild symptoms experience significant increases in symptoms following retirement, severe medical illness in themselves or their spouses, or reminders of their military service, such as reunions and anniversaries.

What other problems do people with PTSD experience?

It is very common for other conditions to occur along with PTSD, such as depression, anxiety, or substance abuse. More than half of men with PTSD also have problems with alcohol. The next most common co-occurring problems in men are depression, followed by conduct disorder, and then problems with drugs. In women, the most common co-occurring problem is depression. Just under half of women with PTSD also experience depression. The next most common co-occurring problems in women are specific fears, social anxiety, and then problems with alcohol.

People with PTSD often have problems functioning. In general, people with PTSD have more unemployment, divorce or separation, spouse abuse, and chance of being fired than people without PTSD. Vietnam Veterans with PTSD were found to have many problems with family and other interpersonal relationships, problems with employment, and increased incidents of violence.

People with PTSD also may experience a wide variety of physical symptoms. This is a common occurrence in people who have depression and other anxiety disorders. Some evidence suggests that PTSD may be associated with increased likelihood of developing medical disorders. Research is ongoing, and it is too soon to draw firm conclusions about which disorders are associated with PTSD.

PTSD is associated with a number of distinctive neurobiological and physiological changes. PTSD may be associated with stable neurobiological alterations in both the central and autonomic nervous systems, such as altered brainwave activity, decreased volume of the hippocampus, and abnormal activation of the amygdala. Both the hippocampus and the amygdala are involved in the processing and integration of memory. The amygdala has also been found to be involved in coordinating the body's fear response.

What treatments are available?

PTSD is treated by a variety of forms of psychotherapy (talk therapy) and pharmacotherapy (medication). There is no single best treatment, but some treatments appear to be quite promising, especially cognitive-behavioral therapy (CBT). CBT includes a number of diverse but related techniques such as cognitive restructuring, exposure therapy, and eye movement desensitization and reprocessing (EMDR). See the National Center for PTSD's website for more information about treatment types and providers (http://www.ptsd.va.gov/).

I think I have PTSD. What can I do now?

Many people who might need help for something like PTSD are afraid to go for help. One out of five people say they might not get help because of what other people might think. One out of three people say they would not want anyone else to know they were in therapy. But almost 50% of people say that there is less shame in seeking help now than there has been in the past.

A study that's been done of soldiers coming home from Iraq found that only 40% of service members with mental problems said they would get help. In many cases this was due to the soldiers' fears about what others would think, and how it could hurt their military careers.

If you think you have PTSD, there are a number of things you can do. You may want to be evaluated for PTSD by a psychiatrist, psychologist, or clinical social worker specifically trained to assess psychological problems. You could also discuss your symptoms with your doctor. Talk to your doctor about the treatments discussed in this handout.

If you do not want to be evaluated, but feel you have symptoms of PTSD, you may choose "watchful waiting." Watchful waiting means taking a wait-and-see approach. If you get better on your own, you may not need treatment. If your symptoms do not improve after 3 months or if they are causing you distress or getting in the way of your work or home life, talk with a health professional.

In a few cases, your symptoms may be so severe that you need immediate help. Call 911 or other emergency services immediately if you think that you cannot keep from hurting yourself or someone else. 1-800-273-TALK (8255) is a 24-hour national suicide prevention hotline staffed by trained professionals that is available to help you during an immediate crisis.

SOURCE:

Adapted from *http://www.ptsd.va.gov/public/pages/what-is-ptsd.asp* (National Center for PTSD)

Traumautic Stress in Femaie Veterans

Women's changing roles in our military

A growing number of women are serving in the US military. In 2008, 11% of Veterans from the Afghanistan and Iraq military operations were women. These numbers are expected to keep rising. In fact, women are the fastest growing group of Veterans.

What stressors do women face in the military?

Here are some stressful things that women might have gone through while deployed:

Combat Missions: Women are not always trained for combat. Yet they often take part in stressful and dangerous combat or combat-support missions. More women are receiving hostile fire, returning fire, and seeing themselves or others getting hurt. An "urban warfare" setting like the one in Iraq can be even more stressful. After coming home, many male and female Veterans continue to be bothered by the combat they went through.

Military Sexual Trauma (MST): A number of women (and men) who have served in the military experience MST. MST is any kind of unwanted sexual attention. MST includes insulting sexual comments, unwanted sexual advances, or even sexual assault. Being a victim of MST can leave women feeling alone, depressed and anxious.

Feeling Alone: In tough military missions, feeling that you are part of a group is important. In some theaters, though, personnel are deployed to new groups where they do not know the other service members. It can take time to build friendships and trusting relationships. Not feeling supported can be very hard.

Worrying About Family: It can be very hard for women with young children or elderly parents to be deployed for long periods of time. Service members are often given little notice. They may have to be away from home for a year or longer. Some women feel like they are "putting their lives on hold." They worry that they can't be watching over their loved ones. If there are troubles at home, both women and men in the field might start to feel overloaded. After returning home, some women find it is hard to return to the "mommy role." They may find that they have more conflicts with their children.

Because of these stressors, many women who return from deployment have trouble moving back into civilian life. While in time most will adjust, a small number will go on to have more serious problems like PTSD.

How many Female Veterans have PTSD?

Among women Veterans of the conflicts in Iraq and Afghanistan, almost 20% have been diagnosed with PTSD. We also know the rates of PTSD in female Vietnam Veterans. An important study found that about 27% of women Vietnam Veterans suffered from PTSD sometime during their postwar lives. To compare, in men who served in Vietnam, the lifetime rate of PTSD was 31%.

What helps?

Research shows that high levels of social support after the war were important for those female Veterans. Women who reported that they had close friends and family were less likely to have symptoms of PTSD. Having someone to talk to and someone who really cared helped women to adjust better to postwar life. It was also important for the returning women Veterans to feel that they could rely on others to assist them with tasks in times of need. Veterans who had this form of support suffered less from PTSD.

In response to the recent increase in women Veterans, the VA has put in place a number of health care and research programs just for women. This includes the Women Veterans Health Program and the Center for Women Veterans. Every VA in this country now has a Women Veterans Program Manager.

SOURCE:

This is based on a more detailed version, located in the "For Providers and Researchers" section of our website, *Traumatic Stress in Female Veterans: http://www.ptsd.va.gov/professional/pages/traumatic_stress_in_female_Veterans.asp*

Alcohol, Medication, and Drug Use

Some people increase their use of alcohol, prescription medications, or other drugs after a trauma. You may feel that using drugs and alcohol seem to help you escape bad feelings or physical symptoms related to stress responses (for example, headaches, muscle tension). However, they can actually make these things worse in the long term because they interrupt natural sleep cycles, create health problems, interfere with relationships, and create potential dependence on the substance. If your use of alcohol or drugs has increased since the trauma or is causing problems for you, it is important for you to reduce your level of use or seek help in gaining control over your use.

Managing alcohol, medication, and drug use:

- Pay attention to any change in your use of alcohol and/or drugs.
- Correctly use prescription and over-the-counter medications as indicated.
- Eat well, exercise, get enough sleep, and use your family and others for support.
- If you find that you have greater difficulty controlling alcohol/substance use since the trauma, seek support in doing so.
- Consult with a healthcare professional about safe ways to reduce anxiety, depression, muscle tension, and sleep difficulties.
- If you believe you have a problem with substance abuse, talk to your doctor or counselor about it.
- If you feel like using larger amounts of either prescribed or over-the-counter medications, consult a healthcare professional.

If you have had an alcohol, medication, or drug problem in the past:

For people who have successfully stopped drinking or using drugs, experiencing a trauma can sometimes result in strong urges to drink or use again. Sometimes it can lead them to strengthen their commitment to recovery. Whatever your experience, it is important to consciously choose to stay in recovery.

- Increase your attendance at substance abuse support groups.
- If you are receiving counseling, talk to your counselor about your past alcohol or drug use.
- Increase your use of other supports that have helped you avoid relapse in the past.
- Talk with family and friends about supporting you to avoid use of alcohol or substances.
- If you have a 12-Step sponsor or substance abuse counselor, talk to him or her about your situation.
- If you are new to the community, talk to your counselor, family, or friends about helping to locate nearby alcohol or drug recovery groups.

GROUNDING: technique that can be therapist or client guided to help redirect attention from internal experiences, or emotional pain, by shifting one's attention to the external world. MISSION-VET clients can think of this as turning the dial on their radio to find a different radio station and listen to a different song. MISSION-VET clients should keep their eyes open during the exercise and are encouraged to notice their surroundings. Practice is encouraged. Grounding can be easily employed at any time and in any setting. MISSION-VET clients are encouraged to rate their level of emotional distress on a scale from 1-10 both before and after to gage efficacy of the exercise. Grounding is NOT relaxation.

EXAMPLE

This is the Five Countdown.

Count out five things you can touch. Touch each one as you name it and count it off.

Count out five things you can see. Look at each one as you name it and count if off.

Count out five things you can hear. Listen to each one as you name it and count if off.

Count out five things you can taste or smell. Taste/smell each one as you name it and count it off.

Now...

Count off four things you can touch. Touch each one as you name it and count it off.

Count off four things you can see. Look at each one as you name it and count it off.

Count off four things you can hear. Listen to each one as you name it and count it off.

Count off four things you can taste or smell. Taste/smell each one as you name it and count it off.

Now...

Count off three things you can touch. Touch each one as you name it and count it off.

Count off three things you can see. Look at each one as you name it and count it off.

Count off three things you can hear. Listen to each one as you name it and count it off.

Count of three things you can taste or smell. Taste/smell each one as you name it and count it off.

Now…

Count off two things you can touch. Touch each one as you name it and count it off.

Count off two things you can see. Look at each one as you name it and count it off.

Count off two things you can hear. Listen to each one as you name it and count it off.

Count off two things you can taste or smell. Taste/smell each one as you name it and count it off.

Now…

Count off one thing you can touch. Touch it as you name it and count it off.

Count off one thing you can see. Look at it as you name it and count it off.

Count off one thing you can hear. Listen to it as you name it and count it off.

Count off one thing you can taste or smell. Taste/smell it as you name it and count it off.

You can repeat this exercise. It works best with someone guiding you through each step to help you maintain your focus.

SOURCE:

Adapted with permission from http://www.ptsdforum.org/content/308-Grounding-Exercise-for-Dissociating (10/23/10)

Tips for Relaxation

Tension and anxiety are common after experiencing a trauma. Unfortunately, they can make it more difficult to cope with the many things that must be done to recover. There is no easy solution to coping with post-trauma problems, but taking time during the day to calm yourself through relaxation exercises may make it easier to sleep, concentrate, and have energy for coping with life. These can include muscular relaxation exercises, breathing exercises, meditation, swimming, stretching, yoga, prayer, exercise, listening to quiet music, spending time in nature, and so on. Here are some basic breathing exercises that may help:

FOR YOURSELF:

1. Inhale slowly (one-thousand one; one-thousand two; one-thousand three) through your nose and comfortably fill your lungs all the way down to your belly.
2. Silently and gently say to yourself, "My body is filled with calmness." Exhale slowly (one-thousand one, one-thousand two, one-thousand three) through your mouth and comfortably empty your lungs all the way down to your abdomen.
3. Silently and gently say to yourself, "My body is releasing the tension."
4. Repeat five times slowly and comfortably.
5. Do this as many times a day as needed.

PTSD Screening Questions

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you...

1. Have had nightmares about it or thought about it when you did not want to?

   YES NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

   YES NO

3. Were constantly on guard, watchful, or easily startled?

   YES NO

4. Felt numb or detached from others, activities, or your surroundings?

   YES NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items. Above questionnaire is an example of a brief screen.

Prins, A., Kimerling, R., Cameron, R., Oumiette, P.C., Shaw, J., Thrailkill, A., Sheikh, J. & Gusman, F. (1999). The Primary Care PTSD Screen (PC-PTSD). Paper presented at the 15th annual meeting of the International Society for Traumatic Stress Studies, Miami, FL.

http://ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_screen_disaster.html

PTSD Checklist-Civilian Version* (Weathers et al., 1993)

INSTRUCTIONS:

1) List here the trauma (stressful event) that is being rated:

_____

[Clinician: be sure to check that the trauma listed fits criterion A – see DSM-IV or DSM-IV-TR]

2) Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully, and check off the box to indicate how much you have been bothered by that problem *in the past month, in relation to the trauma you listed in "1" above.*

		Not at all	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience?	1	2	3	4	5
2.	Repeated, disturbing *dreams* of a stressful experience?	1	2	3	4	5
3.	Suddenly acting or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?	1	2	3	4	5
4.	Feeling *very upset* when something *reminded you* of a stressful experience?	1	2	3	4	5
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful experience?	1	2	3	4	5
6.	Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it?	1	2	3	4	5
7.	Avoiding *activities* or *situations* because *they remind you* of a stressful experience?	1	2	3	4	5
8.	Trouble *remembering important* parts of a stressful experience?	1	2	3	4	5
9.	*Loss* of *interest* in activities that you used to enjoy?	1	2	3	4	5
10.	Feeling *distant* or *cut off* from other people?	1	2	3	4	5
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	1	2	3	4	5
12.	Feeling as if your *future* will somehow be *cut short?*	1	2	3	4	5

PTSD Checklist-Civilian Version* (Weathers et al., 1993)

		Not at all	A little bit	Moderately	Quite a bit	Extremely
13.	Trouble *falling* or *staying asleep?*	1	2	3	4	5
14.	Feeling *irritable* or having *angry outbursts?*	1	2	3	4	5
15.	Having *difficulty concentrating?*	1	2	3	4	5
16.	Being "super-alert" or watchful or on guard?	1	2	3	4	5
17.	Feeling jumpy or easily startled?	1	2	3	4	5

PCL-M for DSM-IV (11/1/94) END OF TEST

Citation: *This is a government document in the public domain.

The instructions have been adapted by Lisa Najavits, Ph.D. to include the listing of the trauma, and to include the scoring below. For other information on the measure, go to *www.ncptsd.org.*

Please note that this instrument can be used to obtain baseline and follow-up data regarding individual PTSD symptoms to track symptom severity over time.

Before administering, remove scoring below

----------Scoring for PCL-C----------

Scoring: any item endorsed at 3 or higher counts as a symptom. PTSD Criterion B: 2 or more from items 1-5; criterion C: 3 or more from items 6-12; criterion D: 2 or more from items 13-17.

Stressful Life Experiences Screening

Please fill in the number that best represents how much the following statements describe your experiences. You will need to use two scales, one for how well the statement describes your experiences and one for how stressful you found this experience. The two scales are below.

Describes your Experience:

0	1	2	3	4	5	6	7	8	9	10
Did not experience This	a little like my experiences				somewhat like my experiences					exactly like my experiences

Stressfulness of Experience:

0	1	2	3	4	5	6	7	8	9	10
Not at all Stressful	not very stressful				somewha t stressful					extremely stressful

Describes your Experience	Life Experience	Stressfulness Then		Stressfulness Now
	I have witnessed or experienced a natural disaster, like a hurricane or earthquake.			
	I have witnessed or experienced a human-made disaster like a plane crash or industrial disaster.			
	I have witnessed or experienced a serious accident or injury.			
	I have witnessed or experienced chemical or radiation exposure happening to me, a close friend or a family member.			
	I have witnessed or experienced a life-threatening illness happening to me, a close friend or a family member.			
	I have witnessed or experienced the death of my spouse or child.			
	I have witnessed or experienced the death of a close friend or family member (other than my spouse or child).			
	I/or a close friend or family member, have been kidnapped or taken hostage.			
	I/or a close friend or family member, have been the victim of a terrorist attack or torture.			
	I have been involved in combat or a war or lived in a war-affected area.			
	I have seen or handled dead bodies other than at a funeral.			
	I have felt responsible for the serious injury or death of another person.			
	I have witnessed or been attacked with a weapon other than in combat or family setting.			
	As a child/teen I was hit, spanked, choked or pushed hard enough to cause injury.			
	As an adult, I was hit, choked or pushed hard enough to cause injury			
	As an adult or child, I have witnessed someone else being choked, hit, spanked, or pushed hard enough to cause injury.			
	As a child/teen I was forced to have unwanted sexual contact.			
	As an adult I was forced to have unwanted sexual contact.			
	As a child or adult I have witnessed someone else being forced to have unwanted sexual contact			
	I have witnessed or experienced an extremely stressful event not already mentioned. Please explain: _____ _____			

Useful Resources

- VA National Center for PTSD (www.ptsd.va.gov). This site is provided by the US Department of Veterans Affairs to offer education and materials related to trauma and PTSD. It also includes the PILOTS database (the world's largest literature base on PTSD and related disorders).
- Witness Justice (www.witnessjustice.org). Created by survivors for survivors. Their mission is to provide support and advocacy for victims of violence and trauma.
- National Center for Trauma-Informed Care (http://mentalhealth.samhsa.gov/nctic). Site developed by the Substance Abuse Mental Health Services Administration to provide resources for trauma-informed care.
- National Child Traumatic Stress Network (www.nctsn.org). Joint effort by university, government and community agencies to provide materials, education, and resources to improve care for traumatized children and families.
- International Society for Traumatic Stress Studies (www.istss.org). Professional society devoted to science, practice, and policy related to trauma and PTSD.
- International Society for the Study of Dissociation (www.issd.org). Professional society devoted to science, practice, and policy related to trauma and dissociation.
- Sidran Foundation (www.sidran.org). Provides information related to recovery from traumatic stress (including PTSD), dissociative disorders, and co-occurring issues, such as addictions, self injury, and suicidality.
- National Resource Center on Domestic Violence (www.vawnet.org). An online resource for advocates working to end domestic violence, sexual assault, and other violence.
- EMDR International Association (www.emdria.org). and EMDR Humanitarian Assistance Program. The first of these, EMDRIA, is a membership organization of mental health professionals dedicated to the highest standards of excellence and integrity in EMDR (eye movement desensitization and reprocessing therapy for trauma and PTSD). The second, EMDRHAP, is a global network of clinicians who travel anywhere there is a need to stop suffering and prevent the after-effects of trauma and violence. Their primary focus is on training local therapists within crisis or underserved communities to treat trauma using EMDR (Eye Movement Desensitization and Reprocessing).
- Seeking Safety (www.seekingsafety.org). Offers resources on trauma and substance abuse, including general information as well as material to implement the Seeking Safety model.

Appendix L: MISSION-VET Fidelity Index

This fidelity index is designed to document services delivered as indicated by the MISSION-VET approach. Therefore any services the Veteran has been receiving prior to enrollment should not be recorded as a referral. Additionally, this fidelity index should be completed based on ONLY the documentation contained in the medical record.

1. Comprehensive Assessment

a) Did the Veteran have an orientation session to the MISSION-VET program which included learning about the program's requirements and receiving the Consumer Workbook? Yes No

b) Did the MISSION-VET Case Manager either develop or participate in developing a comprehensive treatment plan that includes a list of problem areas to address such as Mental Health, Substance Abuse, Employment, Housing Stability, and other service needs? Yes No

c) Did the Veteran sign the treatment plan? Or was it documented that the Veteran verbally approved the treatment plan after discussing its components with his/her case manager? Yes No N/A

d) Was the development of an individualized treatment plan targeting problem areas (Mental Health, Substance Abuse, Employment, Housing Stability, and other service needs) discussed during clinical supervision with the MISSION-VET Case Manager/Peer Support Specialist team? Yes No N/A

2. Case Management Services

Please complete corresponding section for appropriate curriculum delivered

2-month curriculum

a) Did the case manager have and document a face to face visit with the Veteran within the first 2 weeks of program enrollment? Yes No N/A

b) As an outpatient, did the case manager see the Veteran at least weekly? Yes No N/A

c) During the next 5 weeks, did they meet bi-weekly? Yes No N/A

d) Were dual recovery issues addressed as an outpatient? Yes No N/A

e) Did the case manager conduct a MISSION-VET discharge session with the Veteran in which they reviewed discharge plan and goals? Yes No N/A

f) Were the case management services provided by the MISSION-VET Case Manager reviewed and discussed during clinical supervision meetings (e.g. Did the Case Manager meet the Veteran within a reasonable amount of time from program enrollment? Did subsequent meetings occur at the prescribed intervals (weekly, bi-weekly, or monthly), tapering off as the Veteran approached the end of MISSION-VET service delivery)? Yes No N/A

6-month curriculum

a) Did the case manager have and document a face-to-face visit with the Veteran within the first 2 weeks of program enrollment? Yes No N/A

b) During the Veteran's first 2 months as an outpatient, did the case manager see the Veteran at least weekly? Yes No N/A

c) During the next 3 months, did they meet bi-weekly? Yes No N/A

d) In the last month, did they have at least one meeting? Yes No N/A

e) Were dual recovery issues addressed at least monthly as an outpatient? Yes No N/A

f) Did the case manager conduct a MISSION-VET discharge session with the Veteran in which they reviewed discharge plan and goals? Yes No N/A

g) Were the case management services provided by the MISSION-VET Case Manager reviewed and discussed during clinical supervision meetings (e.g. did the Case Manager meet the Veteran within a reasonable amount of time from program enrollment? Did subsequent meetings occur at the prescribed intervals (weekly, bi-weekly, or monthly), tapering off as the Veteran approached the end of MISSION-VET service delivery)? Yes No N/A

12-month curriculum

a) Did the case manager have and document a face-to-face visit with the Veteran within the first 2 weeks of program enrollment? Yes No N/A

b) During the Veteran's first two months as an outpatient, did the case manager see the Veteran at least weekly? Yes No N/A

c) During the next five months, did they meet bi-weekly? Yes No N/A

d) During the following 2 months, did they meet monthly? Yes No N/A

e) Were dual recovery issues addressed at least monthly as an outpatient? Yes No N/A

f) Did the case manager conduct a MISSION-VET discharge session with the Veteran in which they reviewed discharge plan and goals? Yes No N/A

g) Were the case management services provided by the MISSION-VET Case Manager reviewed and discussed during clinical supervision meetings (e.g. Did the Case Manager meet the Veteran within a reasonable amount of time from program enrollment? Did subsequent meetings occur at the prescribed intervals (weekly, bi-weekly, or monthly), tapering off as the Veteran approached the end of MISSION-VET service delivery)? Yes No N/A

3. Co-occurring Disorders Treatment

a) Do the notes reflect that the case manager discussed the Veteran's awareness of the interaction between his/her mental health symptoms and substance use? Yes No

b) Did the Veteran attend at least 8 DRT co-occurring disorder treatment sessions? Yes No

c) Was it documented that both the Veteran's mental health and substance abuse treatment needs were addressed with equal attention as reflected in the session notes and the treatment plan? Yes No

d) During clinical supervision with the Case Manager/Peer Support Specialist, was particular attention paid to the Veteran's need of both mental health and substance abuse treatment services? Yes No N/A

Mental Health

a) Was the Veteran referred to a psychiatrist for a psychiatric evaluation? Yes No N/A

b) Do the notes reflect that the Veteran was asked about medication compliance? Yes No N/A

c) Was the Veteran referred to a mental health clinician for ongoing mental health treatment? Yes No N/A

d) Is there evidence that care was coordinated between the MISSION-VET Case Manager and any other mental health treatment providers? Yes No N/A

i) Were there any documented releases of information? Yes No N/A

ii) Was there any documented communication with other mental health treatment providers? Yes No N/A

Substance Abuse

a) Did the treatment plan address substance abuse treatment needs?	Yes	No	
b) Did case manager provide a referral to any substance abuse treatment program other than NA or AA?	Yes	No	N/A
c) Did the Veteran receive an orientation to 12-step groups such as NA or AA?	Yes	No	
d) Is there evidence that care was coordinated between the MISSION-VET Case Manager and any other substance abuse treatment providers?	Yes	No	N/A
i) Were there any documented releases of information?	Yes	No	N/A
ii) Was there any documented communication with other substance abuse treatment providers?	Yes	No	N/A

4. Housing Placement and Daily living

a) Did the case manager document a need for housing services?	Yes	No	N/A
b) If the Veteran transitioned from an institutional facility, was there a documented session to prepare them for transition to the community?	Yes	No	N/A
c) Were the Veteran's housing needs reevaluated at any point post-enrollment?	Yes	No	N/A
d) If problems in adjustment to housing were noted, were they addressed?	Yes	No	N/A
e) Was the Veteran given assistance with money management?	Yes	No	N/A
f) Was the Veteran given assistance with transportation?	Yes	No	N/A
g) Were the Veteran's housing needs and services discussed during clinical supervision with the Case Manager/Peer Support Specialist treatment team (e.g. referral to housing services, support for transition into housing placement, ongoing monitoring of housing stability)?	Yes	No	N/A
h) Were the Veteran's daily functioning needs and services discussed during clinical supervision with the Case Manager/Peer Support Specialist treatment team (e.g. money management, transportation, hygiene, etc.)?	Yes	No	N/A

5. Vocational/Educational Rehabilitation Service Needs

a) Did the case manager document a need for employment/educational services?	Yes	No	
b) Were the Veteran's employment/educational needs reevaluated post-enrollment?	Yes	No	N/A
c) If service needs were identified, did the case manager provide linkages to offer the Veteran support in these areas?	Yes	No	N/A
d) Did the Veteran receive ongoing employment support once they started working?	Yes	No	N/A
e) If indicated in the treatment plan, did the case manager conduct "on site" job coaching?	Yes	No	N/A
f) Did the Veteran receive ongoing educational support once enrolling in a school/ training program?	Yes	No	N/A
g) Were the Veteran's Vocational/Educational Rehabilitation service needs (e.g. referral to vocational/educational services, ongoing support for job maintenance, support for school-related needs) discussed during clinical supervision with the Case Manager/Peer Support Specialist team?	Yes	No	N/A

6. Trauma-Informed Care Coordination Services

a) Did the case manager document trauma-informed care needs in the treatment plan?	Yes	No	N/A
b) Were referrals provided if there was an increase in trauma-related symptoms?	Yes	No	N/A
c) Is there evidence that care was coordinated between the MISSION-VET Case Manager and trauma-related treatment providers?	Yes	No	N/A
i) Were there any documented releases of information?	Yes	No	N/A
ii) Was there any documented communication with trauma-related treatment providers?	Yes	No	N/A
d) Was the Veteran's need of Trauma-Informed Care coordination (e.g. monitoring of symptoms, assessment, referral to specialized treatment providers, etc.) discussed during clinical supervision with the Case Manager/Peer Support Specialist team?	Yes	No	N/A

7. Peer & Community Services

a) Did Veteran participate in any peer-scheduled community activities (such as NA, AA or recreational activities)?	Yes	No	
b) Did the Veteran engage in other community activities to build his/her social network?	Yes	No	
c) Did the Veteran attend at least 6 Peer Support Specialist-led sessions?	Yes	No	
d) If indicated in the treatment plan, did the peer support specialist accompany the Veteran to appointments, meetings, interviews, etc.?	Yes	No	N/A
e) Did the peer support specialist assist the Veteran in obtaining a drivers license, if help was needed?	Yes	No	N/A
f) Did the peer support specialist provide assistance in using public transportation, if help was needed?	Yes	No	N/A
g) Were services provided by the Peer Support Specialist (e.g., obtaining a drivers license, using public transportation, accompanying Veteran to appointments and 12-step meetings, etc.) discussed during clinical supervision?	Yes	No	N/A

8. Medical Services – Primary Care/Specialty Care/General Health

a) If not already connected to a primary care provider, was the Veteran referred to one?	Yes	No	N/A
b) If needed, did the Veteran receive referrals for all specialty health care needs?	Yes	No	N/A
c) Did MISSION-VET staff facilitate attendance to any health care appointments (i.e. reminder calls, transportation, etc.)?	Yes	No	N/A
d) Were the Veteran's medical treatment services documented in the treatment plan?	Yes	No	N/A
e) Was there discussion during clinical supervision of the Veteran's medical care needs and plans to link the Veteran to the necessary healthcare providers?	Yes	No	N/A

9. Record Keeping

a) Were individual sessions with the MISSION-VET Case Manager documented?	Yes	No	
b) Were individual sessions with the MISSION-VET Peer Support Specialist documented?	Yes	No	

c) Were group sessions with the MISSION-VET Case Manager documented?	Yes	No	N/A
d) Were group sessions with the MISSION Peer Support Specialist documented?	Yes	No	N/A
e) Were all assessments documented?	Yes	No	
f) Were all re-assessments documented?	Yes	No	
g) Were releases of information documented?	Yes	No	

T H E

MISSION-VET

TREATMENT MANUAL

This Treatment Manual was supported by grants from the United States Department of Veterans Affairs, Office of Research and Development, Health Services Research and Development and The National Center on Homelessness Among Veterans