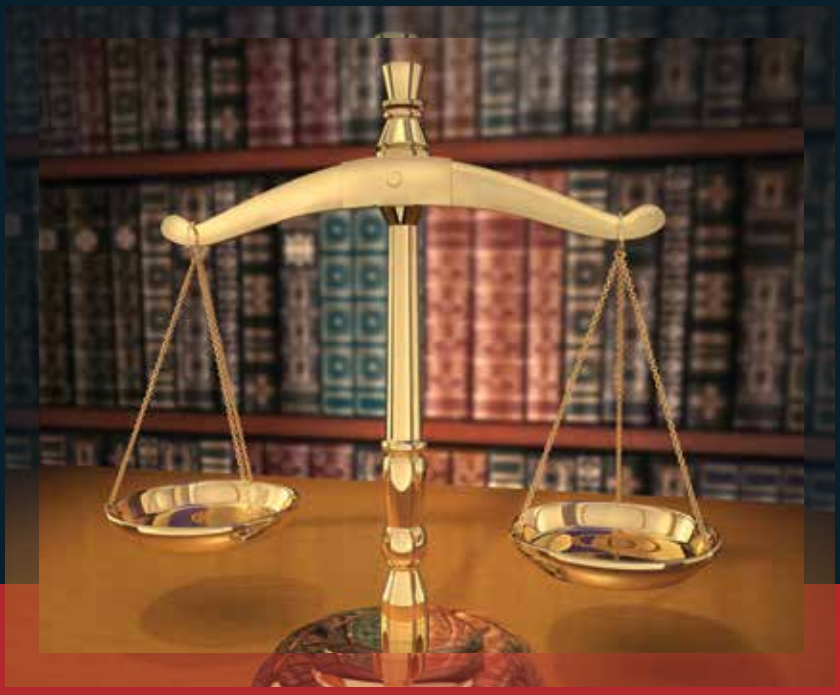
Maintaining Independence and Sobriety
through Systems Integration, Outreach, and Networking:

THE MISSION Criminal Justice

TREATMENT MANUAL



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Criminal Justice Edition

T H E

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This Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking (MISSION) Treatment Manual- Criminal Justice Edition (MISSION-CJ) is a publication built upon experience and support by grants from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS; Grant #'s SM 58804 (MISSION Direct Vet), TI16576, TI 023562) and its contents were augmented by lessons learned developing programs and services supported by the Bureau of Justice Assistance (BJA) (Grant #'s 2009-MO-BX-0037 and 2011-RW-BX-0010) and through the Massachusetts Department of Mental Health, the Veteran's Administration, and the University of Massachusetts Medical School, in collaboration with other agencies and entities.

We wish to thank our dedicated and wonderful MISSION-Direct Vet team, which includes Carl Fulwiler, David Goldstein, Peggy Wiinikainen, William Dimmick, Michael Hagmaier, Dominick Sondrini, Steve Como, and our extended peer network through the Massachusetts Department of Veterans Services. We are also indebted to our terrific program managers, Elizabeth Orvek, and Stephanie Singer, who kept our project and this manual and workbook on track and made everything seem effortless. Paul Christopher, Merrill Rotter, Matthew Stimmel, Stephanie Hartwell, Hank Steadman, Daniel Abreu, Patti Griffin, Brian Case, Lester Blumberg, and Stan Goldman have also helped us conceptualize the criminal justice treatment aspects of this manual and workbook, and we are grateful to them for their help and consultation. Leadership and technical assistance through SAMHSA and our project officer for MISSION-Direct Vet, David Morrissette, have helped make this manual a reality by supporting program development and delivery.

We are grateful for 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). Reviewers included Pat Corrigan, Moe Armstrong, Miklos Losonczy, Sarah Guzofski, Manny Guantez, Chris Barton, Bradley Sussner, Mark Benson, Chandra Mustafa, Louise Romalis, Mike Somers, Stephen White, Hamilton Cook, and Ray Gaines. We also appreciate the feedback from reviewers on the Veteran editions of the MISSION Treatment Manual (Smelson et al., 2011) and MISSION Consumer Workbook (Smelson et al., 2011). Reviewers included Kathleen Browne, Philip E. Thomas, Richard De Blasio, Jesse K. Vazzano, Shara Katsos, Kenneth Link, Cheryl Coviello, Robert Hallett, Teresa Pittman, Roger Casey, Daniel O'Brien-Mazza, Gerald Carmichael, Julie Irwin, and John O'Brien.

In developing the original MISSION approach and now MISSION-CJ, we have drawn from the groundbreaking work of Douglas M. Ziedonis, 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 our work. We have also benefited from the critical contribution of Ezra Susser, Alan Felix, and the other members of the Critical Time Intervention (CTI) development team. Separately, we wish to acknowledge our Reentry Service Specialists and Peer Support Specialists from Span, Inc., who assisted numerous female offenders within prison and in the community as they transitioned toward a successful reentry. These individuals have helped us with the adaptation of MISSION for a criminal justice population, while doing a terrific job serving many clients through the program. Thank you so much for teaching us about the clients you have served and for the unwavering support you have offered to those who have needed your assistance.

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Last but not least, we would like to acknowledge the individuals who have agreed to receive various versions of MISSION services who have entrusted their lives to a model of support that has been in various stages of development. We are grateful for their willingness to take part in these programs to help us refine our program models and learn from the feedback we have received by them along the way. Although we know that these individuals have had personal challenges to overcome, we have been proud to stand beside them in tougher times while cheering their many successes on their individual roads to recovery. Finally, we hope that you find this manual to be a useful resource as you provide day-to-day support to your clients.

NOTE OF CAUTION

This version of MISSION services and its manual are based on experiences using MISSION in a program aimed at diverting court-involved Veterans from incarceration to alternative community-based programming, as well as professional experience of the authors in working on several programs involving justice-involved individuals with co-occurring mental illness and substance use disorders. These individuals all too frequently have trauma histories, and knowledge of this background provides an important context for the work and the goals related to MISSION-CJ programs. This manual is also written after decades of collective knowledge in clinical practice among various authors. That said, the population for whom this manual is intended often present complex and unique challenges, and these challenges include their risk of suicide and at times, given their histories, their risk of harm to others.

Nothing in this manual should be construed as a guarantee of no harm. Clinical practice always warrants utilizing practice standards within one's discipline and includes the need to identify risk and safety factors and appropriately refer and optimize care when it is needed to help maximize safety. Proper clinical supervision and consultation within a care delivery model is essential. The authors of this manual respectfully assume that the responsibility for the clinical care of the individuals followed by MISSION-CJ rests with the direct care providers. The treatment providers may work with criminal justice supervising authorities as well, such as probation and parole. This manual does not address approaches to such community criminal justice supervision, and instead focuses on treatment providers. That said, if any element of the manual seems clinically contraindicated in a given situation, local practice and legal requirements should determine how to proceed.

For questions regarding the use of the MISSION-CJ Manual, please go to www.missionmodel.org

For questions about the other non-CJ MISSION Manuals, please contact:

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The following institutions are affiliated with the development of the MISSION-CJ Treatment Manual:

- University of Massachusetts Medical School, Department of Psychiatry
- Massachusetts Department of Mental Health
- Massachusetts Department of Veterans Services
- 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)
- University of Massachusetts Boston

FOREWARD

The original Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION) treatment approach provided case management, peer support, integrated mental health and substance use treatment and vocational support to homeless and formerly homeless clients with co-occurring psychiatric and substance use disorders (CODs) as they worked to obtain stable housing and employment and recover from substance use and mental health issues. The Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking -Veterans Edition (MISSION-VET), like the MISSION program that preceded it, included the same core components, but also added trauma informed care to meet the needs of a military population of homeless Veterans. The Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking- Criminal Justice Edition (MISSION-CJ) treatment approach was built off experience with a primarily male Veteran population utilizing a court-based diversion program. During the development of this program, additional MISSION services were provided for nonviolent, medium and high- risk civilian female offenders who were returning to their communities from a period of incarceration. Experiences with that population further informed the contents of this manual. It also incorporates the work of the authors with over 18 years of experience in forensic services in community, hospital, prison, and court clinic settings with men and women with co-occurring disorders. MISSION-CJ modifies prior MISSION versions (MISSION and MISSION-VET) by incorporating the Risk-Need-Responsivity (RNR) paradigm to facilitate treatment providers' ability to examine aspects of clients' lives and treatment approaches that incorporate a recognition of criminogenic needs and how to address them as part of a recovery-oriented treatment plan that can help improve well-being and reduce the risk of criminal recidivism.

MISSION-CJ recognizes recent literature supporting that most individuals with mental illness are not violent, and that persons with mental illness who commit crimes often do so for the same reasons that persons without mental illness commit crimes. Individuals with mental illness in the criminal justice system need supports with traditional treatment approaches to address symptoms of mental illness and co-occurring substance use, but recent research suggests that additional strategies to target criminogenic needs can be helpful in reducing criminal recidivism specifically. MISSION-CJ aims therefore to add a focus on reduced recidivism compared to prior MISSION models, and emphasizes an increase in clients' use of prosocial thinking, along with positive supports and activities in the community and general recovery principles. Because of the overlap between problem areas facing both our homeless clients and criminally involved clients, much of the original MISSION approach was retained and includes Case Management, Peer Support, Integrated Dual Disorders Treatment, Vocational and Educational Support and Trauma Informed Support, all of which have been shown to address criminogenic needs for individuals who are involved in the criminal justice system.

MISSION-CJ services can be initiated at any point in an individual's life relevant to their involvement in the justice system. For example, services may begin as part of a diversion plan (i.e., as an alternative to incarceration or a pre-trial diversion), a specialty court, or to assist a client with reentry from jail or prison back into his or her community to name a few. MISSION-CJ services are provided by treatment teams consisting of a Case Manager (CM) and a Peer Support Specialist (PSS) who both deliver services and assist clients' in linking to and engaging in the use of prosocial community based supports. The local names for the staff may vary in accordance with the justice-related work that they do. For example, case managers in MISSION-CJ can be referred to as Reentry Support Specialists (RSS) in re-entry programs, and may be referred to as Diversion Support Specialists (DSS) in particular diversion

programs. In this manual the general terms "Case Manager" (CM) and "Peer Support Specialist" (PSS) will be used.

MISSION-CJ CM/PSS teams deliver MISSION-CJ services directly and also provide essential linkages to community-based treatment and programs to help criminal-justice involved clients engage in mental health, substance use, and medical treatment, to locate and participate in recovery support groups (e.g. Alcoholics Anonymous /Narcotics Anonymous), to obtain education and/or maintain employment, and to develop positive social connections, prosocial activities and supports. In addition to these approaches, MISSION-CJ teams collaborate when needed with criminal justice entities (e.g., probation, parole, courts) who may be monitoring and supervising the individual client.

The MISSION-CJ treatment approach is rooted in the theoretical framework of the Health Belief Model (HBM; Rosenstock, 1966; Becker & Maiman, 1975; Janz & Becker, 1984) and is structured upon the principles and phases of Critical Time Intervention (CTI) case management (Susser et al., 1997). The Risk-Need-Responsivity Model (RNR; Bonta & Andrews, 2007) offers a framework for treatment planning and provides the client and CM/PSS team a more objective way to determine client needs, identify risks and monitor ongoing progress and responsivity to interventions.

Overview of Manual Contents

This manual contains chapters targeted to the unique needs of members of the MISSION-CJ team. Background information of interest to all team members and supplementary tools and resources that will assist in the implementation of the program are included. An overview of each of the chapters, their target audience and a list of appendices is described below.

Chapter 1: Overview of the MISSION-CJ Approach. This chapter presents a general overview and introduction to the MISSION-CJ model of care. It provides a brief history of the development of the MISSION-CJ model, the goals of the intervention itself, and the core components that MISSION-CJ delivers. In addition, chapter 1 discusses key theoretical frameworks that help inform the MISSION-CJ intervention, including the Risk-Need-Responsivity (RNR) Model and the Sequential Intercept Model, and evidence in support of their utility. Where MISSION-CJ fits into both the theoretical and applied constructs of jail diversion, specialty court sessions, and re-entry programs is discussed in a manner that makes clear to participants and providers how the intervention works to help people with criminal-justice involvement.

Chapter 2: Criminal Justice Problems among Individuals with Co-Occurring Mental Health and Substance Use and Disorders. This chapter provides a statement of need, describes the origins of the problem, and explains how the MISSION-CJ model can address many of the needs facing those involved in the criminal justice system as discussed in the chapter. It also gives a more in depth description of the RNR framework.

Chapter 3: Replicating the MISSION-CJ Program: Guidance for Program Managers and Administrators. This chapter provides information of particular interest to community-based program managers and administrators who are considering implementing the MISSION-CJ program in their treatment settings. This chapter discusses MISSION-CJ's target audience, treatment settings, service components, previous outcomes, staff training needs, other logistical, staffing, and clinical supervision requirements, and partnerships with criminal justice supervising entities that can be helpful 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-CJ.

Chapter 4. The MISSION-CJ Model of Care. This chapter is important for all members of the MISSION-CJ team involved in the replication of the intervention, but it is of critical importance to the clinical supervisor. It explains how many of MISSION-CJ's components have been incorporated and adapted to meet the needs of criminal justice -involved individuals with co-occurring psychiatric and substance use disorders and trauma histories.

Chapter 5: Case Management. This chapter highlights the role of the MISSION-CJ Case Manager (CM). MISSION-CJ CMs evaluate and track level of risk and ongoing needs, deliver Dual Recovery Therapy (DRT), offer necessary support and assistance, and provide service linkages to community-based treatment providers. It assists the case manager in understanding the impact of the criminal justice system on the individual client and acknowledges that clients may be under criminal justice supervision. The chapter also defines and explains how MISSION-CJ CMs carry out individual and shared responsibilities with the MISSION-CJ Peer Support Specialist (PSS). Given that MISSION-CJ CMs not only deliver services directly, but also serve as liaisons to community-based treatment and service providers, as well as criminal justice authorities, this chapter also addresses the importance of strong communication, collaboration, and interaction with other providers who also deliver services to individuals on their caseload.

Chapter 6: Peer Support. This chapter explains the unique position of Peer Support Specialists (PSSs). Following an overview of their role within the MISSION-CJ treatment program, the chapter explains how PSSs work with MISSION-CJ CMs to carry out individual and shared responsibilities. The chapter also highlights how the MISSION-CJ PSS serves as a role model and as a source of prosocial attitudes, encouragement and support to individuals receiving MISSION-CJ services. Case examples are included to illustrate how PSSs: facilitate discussions on topics of particular concern to individuals involved in the criminal justice system; support these individuals in the community; and help them address problems and challenges that arise during community transition and adjustment.

Chapter 7: Vocational and Educational Supports for Individuals Involved in the Criminal Justice System. This chapter discusses the role and provision of vocational and educational supports offered within the MISSION-CJ treatment approach. MISSION-CJ CMs and PSSs are given a concise review of the critical components of existing vocational and educational supports developed to help individuals involved in the criminal justice system meet their employment goals. Suggestions for linking individuals to these as well as other community-based vocational and educational support programs are provided.

Chapter 8: Trauma as a Critical Consideration in MISSION-Criminal Justice Service Delivery. Because of the high rate of trauma among individuals involved in the criminal justice system, and based on experiences with special populations such as Veterans and female offenders, the principles of Trauma Informed Care (TIC) have been integrated into the MISSION-CJ treatment approach. This chapter is meant to serve as a general resource for MISSION-CJ CMs and PSSs, especially in light of the fact that trauma and its potential sequelae such as full diagnoses of Posttraumatic Stress Disorder (PTSD) can lead to very complex problems for MISSION-CJ participants that require special treatment considerations and a careful case-by-case awareness and review.

Chapter 9: Core Competencies for MISSION-CJ Clinical Supervisors. This chapter will guide clinical supervisors who oversee and support the work of MISSION-CJ 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-CJ 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-CJ 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; offer guidance for the CM/PSS on delivering culturally sensitive services; provide information to ensure an understanding of criminal justice system processes.

Endnote Resource Materials. Following the last chapter are biographical sketches of the authors and a list of key acronyms and terms that have been used throughout the manual.

Appendices. The manual includes a number of appendices to assist with the implementation and service delivery of the MISSION-CJ treatment approach and include the following:

Appendix A: Key Clinical Outcomes for Early MISSION studies and Preliminary Data on MISSION-Criminal Justice. Evidence supporting MISSION-CJ's use and efficacy including results from previous studies are presented.

Appendix B: Theoretical Framework Underlying the MISSION-CJ Model. The MISSION-CJ model is built on the theoretical framework of the Health Belief Model (HBM), with a framework for when to link individuals to services based on the Sequential Intercept Model (Munetz & Griffin, 2006). This appendix presents the structure and premise of both models and how they guide MISSION-CJ service delivery and organization.

Appendix C: Integration RNR Principles into the MISSION-CJ Model: A Concrete Guide for Case Managers, Peer Support Specialists, and Administrators. This appendix reviews approaches to individual treatment, integrating criminogenic needs and responsivity factors to address both recovery and recidivism.

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

Appendix E: MISSION-CJ Sample Service Delivery Schedules. Sample service delivery schedules have been included to serve as a guide for implementation of the MISSION-CJ model. Service delivery models can be shaped to help match the criminal justice program as needed.

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

Appendix G: Helpful Therapeutic Techniques Underlying MISSION-CJ Components. MISSION-CJ 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 H: Supplemental Materials for Case Managers. As the Case Manager's role is critical to successful implementation of the MISSION-CJ treatment approach, additional information is included to supplement the material presented in Chapters 4 and 5.

Apendix I: Topics for Peer-Led Sessions. Information on topics addressed during the MISSION-CJ peer-led sessions is discussed. Programs are encouraged to use these ideas as inspiration rather than as absolute requirements. It is important that MISSION-CJ Peer Support Specialists are able to plan and lead sessions that speak to the most pressing issues of their clients

Appendix J: Supplemental Materials for Initiating Peer Support. This appendix reviews some of the lessons learned during previous implementation of the peer support component of the original MISSION treatment program. In this appendix, suggestions are offered to help address multiple facets of peer support services and how to develop them as MISSION-CJ is implemented.

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

Appendix L: Trauma as a Critical Consideration in MISSION-Criminal Justice Service Delivery: Resources for Case Managers and Peer Support Specialists. Selected screening instruments and assessment tools are provided to assist MISSION-CJ team members to determine if referral for in-depth trauma-informed services is needed.

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

Appendix N: Confidentiality Concepts. This appendix provides basic information regarding privacy, confidentiality and privilege related to testimony in

court. It gives guidance related to court-processes and confidentiality rules for MISSION-CJ service providers.

Appendix O: Sample Program Services Documents. We have included sample forms that include forms such as Consent to Services, Release of Information, Monthly Probation Report, and Incident Reports to provide resources as MISSION-CJ services are being developed.

Appendix P: The Development of Legal Assistance for Homeless and At-Risk Veterans Served by the Department of Veterans Affairs. Given the high number of Veterans that are involved in the criminal justice system, we have included an appendix that outlines some of the VA's programs and services that might be available to some of your clients.

Appendix Q: Traumatic Brain Injury (TBI). This appendix provides an overview of Traumatic Brain Injury (TBI), including common symptoms, tips for prevention, and resources for treatment and further learning.

Appendix R: Outline of Typical Criminal Proceedings and Glossary of Legal Terms. For those less familiar with typical criminal justice proceedings and legal terms, this appendix provides a helpful, detailed outline of court cases processes to include the role of the defendant, defense attorney, prosecution, judge, and jury from arraignment through evaluations and negotiations, plea-bargaining, the trial, and decisions and sentencing. It includes a list of legal terms and their basic definitions.

Appendix S: Accessing Important Resources and New Information at the MISSION Model Website. This appendix provides an overview of the additional resources available on the MISSION model website: www.missionmodel.org.

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-CJ team will want the entire treatment 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. The online version is also useful for this purpose. Because time pressures might prevent you from reading the entire manual, at least as you are getting started, below is a guide for you to determine which chapters would be most relevant for your needs.

Program Managers and Administrators. Administrators or Program Managers of community programs servicing criminally justice-involved clients may want to review the following:

Chapter 3: Replicating the MISION-CJ Program: Guidance for Program Managers and Administrators

Clinical Supervisors. Clinical Supervisors on the MISSION-CJ team should read the entire manual if possible. If time does not permit, they should at least review the following below:

Chapter 1: Overview of the MISSION-CJ Approach

Chapter 5: Case Management

Chapter 6: Peer Support

The role of program/clinical supervisor is described in detail in:

Chapter 9: Core Competencies for MISSION-CJ Clinical Supervisors

Case Managers and Peer Support Specialists. MISSION-CJ Case Managers and Peer Support Specialists will want to pay particular attention to the following sections:

Chapter 3. Replicating the MISSION-CJ Program: Guidance for Program Managers and Administrators

Chapter 5. Case Management

Chapter 6. Peer Support

Chapter 7. Vocational and Educational Supports for Individuals Involved in the Criminal Justice System

Chapter 8. Trauma as a Critical Consideration in MISSION-Criminal Justice Service Delivery

MISSION-CJ Participants. A separate *MISSION-CJ Participant Workbook* (Smelson, Pinals, Harter, Sawh, & Ziedonis, 2014) has been developed specifically for clients who receive services through the MISSION-CJ program. The MISSION-CJ Participant Workbook should be given to each client as he or she enrolls in the MISSION-CJ treatment program. The workbook is divided into two parts: Part 1, which includes exercises and checklists designed to help strengthen and solidify the recovery tools learned during DRT psychoeducational co-occurring disorders treatment sessions; and Part 2, which is intended to help clients live independent in the community. Additionally, Part 3 of the manual includes tools that CMs and PSSs can use to facilitate the client's engagement in prosocial behaviors. The reading materials in the Workbook are intended to help empower clients to succeed in their recovery.

Brief Overview of the MISSION-CJ Approach

Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking-Criminal Justice Edition (MISSION-CJ) is a program developed specifically to meet the mental health, substance misuse and other psychosocial needs of clients identified through a criminal justice setting. The MISSION-CJ program aims to assist individuals who have a reduced ability to remain stable and without further justice involvement. MISSION-CJ includes a framework for exploring and acknowledging criminogenic factors, addressing co-occurring mental health and substance use treatments and linking clients to community based supports to sustain recovery and reduce recidivism. MISSION-CJ is designed to meet the objectives of several federal initiatives that have inspired diversion, specialty court dockets, and reentry programs. Most recently for example, *in Adults with Behavioral Health Needs Under Correctional*

Supervision: A Shared framework for Reducing Recidivism and Promoting Recovery (Osher et al., 2012), a framework is described distinguishing risk levels, mental health and substance use needs across domains and posited as an important strategy to help achieve positive outcomes for individuals with co-occurring disorders in the justice system.

Given the high rate of substance misuse, trauma, and mental illness among those who are involved in the criminal justice system, the MISSION-CJ treatment approach serves the needs of this population. In doing so it recognizes that criminogenic needs, which are seen in some justice-involved individuals with mental illness (Elbogen & Johnson, 2009) and contribute to criminal recidivism more than mental illness alone, are important to examine and acknowledge in treatment.

In characterizing risk factors for criminal recidivism, it is important to pause to think about risk of violence and to clarify basic areas where there is often misunderstanding in a population involving individuals with mental illness. To that end, the following points are critical to understand:

- Most violence is not committed by persons with mental illness, but when combined with substance use, the risk of violence increases.
- Persons with mental illness who commit crimes often do so for the same reasons that persons without mental illness commit crimes.
- Mental illness in and of itself may not be associated with criminal recidivism, but treatment of mental illness can make individuals more responsive to other interventions that target risk factors for further criminal involvement (i.e., criminogenic risk factors).
- Persons with mental illness and substance use disorders who are involved in the criminal justice system have a number of potential risk factors for repeated criminal recidivism.
- Targeted approaches to individuals with mental illness and substance use disorders who engage in criminal activity should therefore examine, explore and address criminogenic features, in addition to traditional treatments for substance use and mental illness.

(See Osher et al., 2012; Lamb & Weinberger, 2013; Monahan et al. 2001; Steadman et al., 1998; and Swanson 1994).

The primary goals of the MISSION-CJ treatment model are to promote recovery, including a goal of reduced recidivism as part of a client's overall recovery. This is done by facilitating community engagement in prosocial supports and activities toward achievement of personal goals and though helping clients engage in a comprehensive array of outpatient mental health and substance use treatment services as well as vocational and educational rehabilitation programs, while attending to criminogenic features and maximizing collaborative approaches, when appropriate, with criminal justice partners who may be providing supervision.

MISSION-CJ considers the Risk-Need-Responsivity framework (RNR; Bonta & Andrews, 2007) to identify treatment needs and monitor progress. Progress is achieved through the use of Critical Time Intervention (CTI) case management (Susser et al., 1997) and Dual Recovery Therapy (Ziedonis & Trudeau, 1997), Peer Support (Chinman et al., 2013) and Trauma Informed Care (Najavits et al., 2011) as the core treatment services to meet the client needs, including many of the criminogenic needs and to enhance responsivity to treatment and criminal justice oversight. A team comprised of one Case Manager and one Peer Support Specialist delivers these services via structured psychoeducational exercises as well as providing prosocial linkages to community based services, including outpatient mental health and substance use treatment programs, primary and specialty medical care, vocational rehabilitation services, educational supports, and trauma-informed treatment. With the support and guidance of an experienced Clinical Supervisor, the MISSION-CJ team helps the client utilize prosocial thinking and behavior, helps resolve problems that arise, teaches and reinforces skills needed to meet personal goals, and celebrates the client's achievements.

MISSION-CJ services can be conducted over a variety of timelines, which most typically include two, six, or twelve month service delivery schedules that can be initiated in a range of settings, such as within prison or jail or while the client is in the community following jail diversion. Modifications to these time frames are also possible such that the supports can

be built with flexibly around the client. Consistent with the CTI model, services provided by MISSION-CJ Case Managers and Peer Support Specialists taper off as the client becomes more confident in his or her ability to access and use essential supports and to function independently and drug and alcohol free in the community.

MISSION-CJ treatment primarily focuses on the delivery of assertive community outreach by Case Managers and Peer Support Specialists. It also includes skills development in the areas of mental health and substance use, vocational support, educational programs, and trauma-informed care to meet the unique needs of clients with co-occurring disorders. Lastly, a comprehensive treatment plan and ongoing tracking as well as fine-tuning is done in the context of the Risk-Need-Responsivity (RNR) framework to address mental illness and factors associated with criminal recidivism simultaneously. The MISSION-CJ treatment also recognizes that individuals may be under a form of community supervision (e.g., probation or parole) and the case manager and peer teams would work with those supervising entities to help the client achieve maximum success, while the supervising authorities provide the level of supervision that they are required to provide.

Brief Description of MISSION-CJ Components:

1. **CTI** case management (Susser et al., 1997) is used within MISSION-CJ as a core treatment intervention to facilitate the treatment plan. CTI is designed to give individuals a "running start" and "safety net" by providing intensive services upon initiation of the treatment relationship and facilitating linkages to other services as needed. At times the case management and peer support will begin with in-reach into a correctional facility, such that a relationship is started and can be continued upon release from incarceration to assist with re-entry into the community. CTI allows for the individual to receive guidance and coordination among programs that can help build a prosocial, treatment-oriented, network around the MISSION-CJ participant.
2. Case managers are also trained to deliver 13 structured psychoeducational Dual Recovery Therapy (**DRT**; Ziedonis & Trudeau, 1997) sessions, which can be delivered in either individual or group formats. Discussion and exercises help raise clients' awareness of the impact of mental illness, substance use, and other harmful behavior on their lives and offers tools to aid in recovery.
3. **Peer support** is provided alongside case management to help clients maintain their mental health and sobriety, to maintain healthy lifestyles, and to participate in needed supports, thus bolstering the effectiveness of the other interventions. Peer Support Specialists offer inspiration, the understanding of one who has "been there," and aid in the client's adjust to new routines, such as attending 12-Step programs. In addition, Peer Support Specialists offer practical strategies and exercises to promote engagement in prosocial attitudes and behavior. Peer support staff will have lived experience in any number of domains shared by the participants served (e.g., mental illness, substance use, Veteran status, etc.) and will use this experience to help support program participants in recovery. In some cases, peer support staff will also have their own criminal justice history and will be able to speak directly about overcoming that background and achieving success. In these cases, there may need to be a review of the individual's background with stakeholders. Regardless of the background, peer support staff will be able to consistently offer supports and make linkages and referrals around day-to-day needs to help shore up the resources of the individual participant.
4. **Vocational and Educational supports** are offered by the MISSION-CJ team to help program participants find and maintain employment, which contributes to daily living stability, improved self-esteem, and reduced engagement in antisocial behaviors. Employment challenges for individuals with criminal histories, and with co-occurring mental health and substance use disorders can be difficult. The vocational support work of MISSION-CJ recognizes opportunities that facilitate overcoming barriers to employment. Similarly, achievements in educational attainment can have a profoundly positive impact on an individual, and as such the MISSION-CJ CM and PSS will assist the program participant in obtaining needed supports related to education.

5. MISSION-CJ incorporates **Trauma-Informed Care Considerations.** MISSION-CJ Case Managers and Peer Support Specialists are trained to screen clients for trauma-related symptoms, including those related to brain injury, and to refer them as needed to treatment providers trained in delivering evidence-based treatments for the management of trauma symptoms or its aftermath. They also recognize trauma as a common denominator among many offenders with mental illness and/or substance use, and as such can provide trauma sensitive services.
6. MISSION-CJ encourages Case Managers and Peer Support Specialists to utilize the **Risk-Need-Responsivity (RNR) framework** (Andrews, Bonta, & Hoge, 1990; Andrews, 2012) in order to ensure the development and execution of a comprehensive treatment plan that encompasses considerations related to criminal recidivism and allows for improved monitoring of progress related to criminogenic needs. The MISSION-CJ Case Manager and Peer Support Specialist teams are trained to use the RNR framework to understand recidivism risks, promote client use of prosocial supports in the community and to monitor client engagement in these prosocial supports. This is also done in collaboration with criminal justice personnel who may be providing community supervision (e.g., probation, parole).

Research Supporting MISSION and Goals for MISSION CJ

While each of the components of MISSION noted above have a great deal of efficacy when delivered separately, our group has also done a number of studies with MISSION. Previous studies have shown that the approach is successful in improved outcomes related to substance use, psychological functioning, housing/employment maintenance, treatment retention, and use of outpatient services (Smelson et al., 2005; Smelson, Losonczy, Ziedonis, Castles-Fonseca, & Kaune, 2007; Smelson et al., 2010; Smelson et al., 2012). Although the research on MISSION-CJ is still evolving, we have had five grants that have included MISSION-CJ for diversion, court-based alternative to incarceration programs, and reentry. Preliminary clinical research data on re-incarceration for Veterans involved in the first pilot of MISSION in the MISSION Direct Vet criminal justice diversion program showed reincarceration rates across the one year of follow up treatment below the reincarceration rates for defendants who were considered to have mental health conditions returning from jails and prison (personal communication of DP with Dr. S Hartwell, 2014). Early findings collectively suggest that MISSION–CJ shows promise for reducing reincarceration and improving mental health, substance use and other outcomes (see Appendix A).

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I. Overview of the Mission-CJ Approach

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The goal of the present chapter is to provide a basic road map to deliver Maintaining Independence Through Systems Integration, Outreach, and Networking-Criminal Justice Edition (MISSION-CJ), which focuses on and supports recovery for individuals with co-occurring mental health and substance use disorders, while simultaneously seeking to decrease their risk of arrest and incarceration. MISSION-CJ thereby addresses social, criminogenic, and clinical factors associated with clinical relapse and criminal recidivism. In this chapter we review the theoretical underpinnings of MISSION-CJ, the target population of MISSION-CJ, its goals and model overview, incorporating key definitional terms related to the program.

What is MISSION-CJ?

MISSION-CJ is a flexible, time-limited, and comprehensive treatment intervention rooted in the Health Belief Model (Becker, 1974), targeting individuals with mental illness and co-occurring substance use disorders. Shifts in models to MISSION-CJ from prior MISSION versions were originally piloted by utilizing MISSION modeling in a post-adjudication court-based alternative to incarceration program for Veterans through SAMHSA Grant #SM58804: Jail Diversion and Trauma Recovery (referred to as MISSION DIRECT VET) and subsequently adapting it further to a re-entry population of female offenders through two Bureau of Justice Assistance, Department of Justice grants, MISSION-CREW (Community Re-Entry for Women; Grant # 2009-MO-BX-0037) and MISSION-RAPS (Re-Entry and Peer Support; Grant #2011-RW-BX-0010). The program models augmented prior MISSION models by having a focus on criminal recidivism and supporting clients who were involved with the justice system. From the work with those projects there were many lessons learned. Ultimately, MISSION-CJ was born from those lessons. Newer uses include its adaptation to a population of individuals involved in a drug court and a Veterans treatment court through MISSION-FORWARD (SAMHSA grant #TI025074).

As it has evolved, MISSION-CJ now incorporates a more structured justice-informed approach to clinical services in order for staff to have: a) a systems level awareness of the criminal justice pathways and the opportunities for program intervention (based on the Sequential Intercept Model (Munetz & Griffin, 2006), and b) an understanding of the importance of assessing and addressing personality, social, and clinical factors associated with criminal recidivism. In doing so, MISSION-CJ has incorporated conceptualization of risk of recidivism and approaches to reducing recidivism through a Risk-Need-Responsivity or "RNR" framework (Bonta & Andrews, 2007).

As noted, MISSION-CJ services may be targeted to work with individuals with mental illness and substance use disorders (i.e., Co-Occurring Disorders or CODs) at any point on the criminal justice continuum. MISSION-CJ offers an array of services to holistically approach these individuals to help them succeed. MISSION-CJ works with justice entities to identify clients with CODs in the justice system. Consideration of client risk for recidivism, client needs and the responsivity of the client and the staff to address these needs is all part of the MISSION-CJ approach. Figure 1 examines several aspects of how MISSION-CJ operates from a variety of perspectives.

Figure 1. MISSION CJ: System, Assessment and Intervention

Systems Level (Sequential Intercept Model)			
Reduce penetration of persons with mental illness into CJ system/ Reduce recidivism	Identify and Link individuals to community-based mental health treatment	Improve mental health outcomes	Improve public safety
Assessment Level (RNR)			
Match level of treatment to the level of risk to re-offend	Identify criminogenic needs and use these to inform treatment	Maximize engagement responsivity of the indiv interventions and the at address the risk factors	understanding ual to treatment y of providers to entified
Intervention/Person Level (MISSION-CJ)			
Provide direct treatment services to address co-occurring disorders with trauma-informed approaches that support recovery	Additional focus on criminogenic needs and responsivity to reduce recidivism	Promote stable and successful living with positive daily activities and health and wellness, with explicit attention to the additional goal of decreased recidivism	Coordinate care, access to housing, employment supports and other services as needed

MISSION-CJ: Systems Level (Sequential Intercept and Diversion)

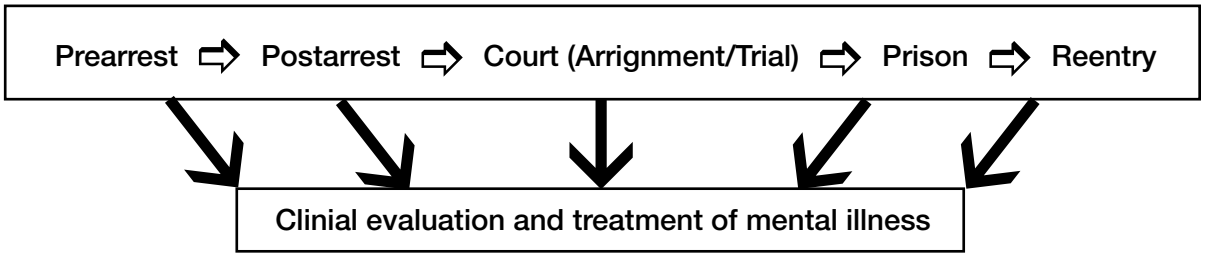
MISSION-CJ is designed to be used with individuals with CODs at any point along the criminal justice continuum from arrest to community supervision, and assumes the critically important role of identifying individuals with CODs so that they can be referred to MISSION-CJ services. In order to provide comprehensive services to criminal justice-involved individuals with CODs, it is necessary to understand the criminal justice pathway through which participants can be identified. MISSION-CJ conceptualizes this pathway by the Sequential Intercept Model (Munetz & Griffin, 2006), and thereby identifies opportunities for intervention along a series of intercept points.

What are Criminal Justice-Related Intercept Points?

Figure 2 presents the multiple intercept points that exist in the Sequential Intercept Model. Intercept points in relationship to the Sequential Intercept model are points within the criminal justice case processing continuum where opportunities arise to identify individuals with mental illness and substance use disorders and for service linkages to occur to prevent individuals from penetrating deeper into the criminal justice system. This model serves as a frame of reference to assist with systems-wide interventions through which individuals can access treatment.

Figure 2. Criminal Justice Pathway

(adapted from Munetz & Griffin, 2006).



Goals Related to the Sequential Intercept Model:

Regardless of the intercept point, the primary goals of the Sequential Intercept Model (such as through jail diversion and re-entry programs) are described in the table below:

Goals Related to the Sequential Intercept Framework (Munetz & Griffin, 2006)

1. Reduce the penetration of persons with mental illness into the criminal justice system as well as reduce recidivism. This is achieved either through less time spent in jail, fewer arrests, and/or lower levels of charges when arrested.
2. Identify and link individuals to community-based mental health treatment that is both comprehensive and effective.
3. Improve mental health outcomes.
4. Improve public safety.

Fitting MISSION-CJ into the Sequential Intercept Frame of Reference:

Unlike routine treatment or wrap around support mechanisms that approach services through usual treatment referral sources, MISSION-CJ staff have and/or receive additional training and experience to understand criminal justice processes, requirements of community supervision, and how to navigate as a boundary spanner across the criminal justice and human services systems. Each step along the criminal justice pathway offers an opportunity to identify individuals with co-occurring disorders and link them to a range of clinical interventions as alternatives to further criminal processing.

Examining Intercept Points for Intervention:

Jail diversion in its broadest sense is a "strategy by which jail time is reduced or avoided by using community-based treatment as an alternative" (Case, Steadman, Dupuis, & Morris, 2009). In that sense "jail diversion" can refer to a collection of efforts to screen and identify individuals with mental illness who may benefit from alternatives to incarceration by providing a linkage to appropriate services in the community (Steadman, Morris, & Dennis, 1995). For court personnel and others, "diversion" may mean diverting an individual away from a criminal charge altogether and before a criminal charge is attached and/or before a criminal case has formally come before a judge (such as through deferred prosecution, criminal case dismissals, and the like). Re-entry refers to the provision of treatment and linkages to community services for individuals who have already been incarcerated and who are transitioning from incarceration to living in the community. In the context of MISSION-CJ, program services are set up to target a point on the criminal justice continuum from which referrals would come, and to work with any criminal justice entities that may remain involved in the client's life (e.g., the court in a

specialty court, probation in the context of a post-adjudication alternative to incarceration program) and collaborate with the community's criminal justice entities, treatment agencies, and other stakeholders.

There is increasing data to support positive outcomes for individuals involved in programming that cuts across treatment and justice systems. Table 1 outlines some of this research.

Table 1. Summary of the research regarding diversion/specialty court/ alternative to incarceration programs

Positive Goals for Persons in the Criminal Justice System	Research
Reduced criminal justice penetration and reduced recidivism	Crisis Intervention Teams (CITs) and other pre-arrest diversion strategies lower arrest rates of individuals with Mental illness (Compton, Bahora, Watson, & Oliva, 2008; GAINS Center, 2004; Steadman & Naples, 2005). Mental health courts and other jail and prison-based diversion programs reduce time spent in jails and prisons (Broner, Maryl, & Landsberg, 2005; Case et al., 2009; Christy, Poythress, Boothroyd, Petrila, & Mehra, 2005; Frisman et al., 2006; GAINS Center, 2004; Hoff, 1999; Lamberti, et al., 2001; Steadman & Naples, 2005).
Identify individuals and provide linkage to mental health treatment	Pre-arrest, jail-based and court-based diversion programs increase linkage to mental health treatment resources including medications, hospitalization, counseling and residential treatment (Broner et al., 2005; Cosden , Ellens, Schnell, & Yamini-Diouf , 2005; Lamb, Weinberger, & Reston-Parham, 1996; Steadman & Naples, 2005). Mental health courts can also improve treatment adherence (Cosden et al., 2005).
Mental health outcomes	Treatment associated with jail diversion programs reduces substance use, improves mental health symptoms, quality of life, and psychosocial functioning of individuals but not any more than treatment following traditional court processing (Broner, Lattimore, Cowell, & Schlenger, 2004, Cosden et al., 2005).
Public safety outcomes	Diverted individuals spend less time in jail/prison following diversion without apparent risk to public safety (Steadman & Naples, 2005). Individuals who are rearrested and have more jail time after diversion are more likely to have had a prior criminal history (Case et al., 2009).

Pre-arrest Diversion: Law enforcement officers, either alone or in collaboration with emergency service workers, are frequently the first point of contact for individuals with mental illness and substance use, placing them in an optimal position to provide early identification, referral and resultant diversion intervention. These personnel may possess the power and authority to bring an individual to an emergency room, mental health facility, or other clinical service as opposed to an arrest (Lamb, Weinberger, & DeCuir, 2002). As the police interface in a community where MISSION-CJ services are available, police and treatment providers may identify individuals that are appropriate or could benefit from MISSION-CJ services, such as those that appear to have high risk for re-arrest, even for low-risk offenses. Some communities may have built robust relationships between police and mental health emergency rooms or crisis centers, through Crisis Intervention Teams, Mobile Emergency Services that partner with police, or other justice and mental health partnership strategies. Administrators of MISSION-CJ services may make efforts to help build these relationships so that there is increased communication and community problem solving between service providers and law enforcement.

Post-booking Diversion and Alternative to Incarceration Programs: Once an arrest has been made, at the court there may be observation of active symptoms of mental illness that could trigger referral and another opportunity to secure clinical assessment and treatment. Identifying appropriate community-based treatment and services at this early point in the criminal justice process improves the likelihood of case processing that results in better outcomes after successful negotiation between the defendant's counsel with the prosecutor, and a reduced sanction by the judge (Lattimore, Broner, Sherman, Frisman & Shafer, 2003). Of course, public safety factors are always of paramount importance in terms of identifying individuals who are considered appropriate for community services, and this can involve many vantage points, including victim input in some jurisdictions.

Referrals to MISSION-CJ services may also be made from jail. In some of those cases, the court personnel or the jails will have had the opportunity to conduct a risk/need assessment that can further inform treatment planning for the MISSION-CJ personnel.

Court-based Diversion and Alternative to Incarceration Programs: There are various court-based approaches that can redirect individuals into alternative programs in lieu of incarceration. Specialized mental health and drug courts are designed specifically to handle cases involving defendants with mental illness and/or substance use problems. Veterans' treatment courts, homelessness courts, and other specialized dockets provide additional supports for unique aspects of an individual's life. These specialty courts offer individuals the opportunity to participate in community treatment while coming to court on a regular basis and having the court play a role in achieving success in their recovery. Some may be post- dispositional after a plea of guilty is entered. Others operate at any point in the criminal case processing including pre-trial. Legal issues for individuals who are pre-trial vs. post-trial are different and are taken into account. Some of these special dockets allow for participation in exchange for dismissal, deferment, or reduction of the individual's criminal charge(s). These specialty courts also typically require that individuals comply with supervision and periodic follow-up with a judge and other criminal justice personnel as a condition of the participation. As noted, in some jurisdictions these programs are referred to as alternatives to incarceration as they may not entirely divert individuals from the criminal justice system.

Other jurisdictions have developed strategies that identify target populations and a specialized community program that works closely with probation in the community under a structured model that brings the participant back to court if there are any concerns about adherence to probationary terms. Community based treatment is negotiated for eligible defendants through an organized system of case referral, and court personnel act as liaisons between criminal justice and mental health agencies and other treatment providers. These programs require outreach coordination between the criminal justice and treatment providers, and they have the potential to target a great number of defendants with CODs who can be in the community but under ongoing supervision. The providers work in the community related to community interface and

outreach and these types of programs are less focused on the court once the case is disposed of in court. If the participant has difficulty, they may be brought back into court to face probation violations. In Massachusetts, for example, a court-based diversion program for Veterans, mentioned above, MISSION DIRECT VET, integrates MISSION team members with court personnel at the initiation of case processing and provides one contact telephone number allowing probation, defense attorneys, family members and others to make referrals to the program when a Veteran is identified in court. As a post-adjudication alternative to incarceration program, the MISSION team members develop relationships with local probation officers to help ensure coordination of services and probation supervision once the individual has been court-ordered to treatment services through MISSION.

Re-entry Services: Even while incarcerated, linkage strategies should be employed to facilitate the transition of individuals with mental illness and substance use problems from prison and houses of correction (HOC) into community-based treatment. MISSION-CJ utilized in a reentry context provides a Prison/HOC-based in-reach and linkage programs that utilize the APIC model (Osher, Steadman, & Barr, 2002) of assessment, planning, identification and coordination. The MISSION-CJ staff are well suited to prepare inmates with co-occurring disorders for release. MISSION Case Managers (which may also be called Re-entry Service specialists in this context) may assist with finding treatment, housing, employment, and other resources for individuals who are released upon completion of their sentence. Many individuals who are re-entering their communities will need to continue in the community on some terms of supervision, such as that provided either through probation or parole. MISSION-CJ at this intercept point therefore would include a component of in-reach to identify needs while developing relationships with participants and planning for their release. The in-reach period is followed by post-release coordination and the delivery of community supports, often in concert with community supervision entities.

MISSION-CJ: Assessment Level (Risk-Need-Responsivity)

The Risk-Need-Responsivity (RNR) model (Bonta & Andrews, 2007) provides a criminal justice framework through which the MISSION-CJ services can be used to better meet the needs of individuals with co-occurring disorders who are in the criminal justice system. The RNR model of assessment and treatment has three core principles that address (1) who should receive specific levels of services and supervision (2) what social and clinical factors should be addressed by those services and (3) how to maximize the effectiveness of those services. The specific principles are:

Risk Need Responsivity Model (Bonta & Andrews, 2007)

Risk: The level of service should be matched to the participant's level of risk to re-offend.

Need: Assess each participant's specific "criminogenic" needs and build treatment around those needs.

Responsivity: Maximize each participant's ability to learn from treatment by providing cognitive behavioral interventions and tailoring those interventions to the unique learning style, motivation, abilities and strengths of the offender.

In order to make sure that the level of service matches the needs of each participant (including need for supervision and recidivism related factors), the participant's unique style of engagement must be understood (including both the manner in which the participant's co-occurring disorders impact upon his or her ability to engage and utilize services and the unique challenges to engagement associated with the incarceration experience itself). In existing MISSION programs, Case Managers (CMs) and Peer Support Specialists (PSSs) are trained in techniques to enhance motivation and assist the client in treatment engagement through motivational interviewing and

rapport building. Given the unique challenges to engagement associated with incarceration experiences themselves, other methods (e.g., SPECTRM; Rotter, McQuistion, Broner, & Steinbacher, 2005) can be employed to help clients remain in treatment. MISSION-CJ adds the incorporation of RNR principles and related assessment and engagement. In some systems, the RNR-focused assessment will be done by jail- or court-based staff or community providers, and the results of this should be able to be accessed by MISSION-CJ personnel. Once the participant has been appropriately assessed and is engaged in treatment, specific interventions can be designed to meet his or her unique needs through the Core and Support services offered by MISSION-CJ, and linkages to necessary recidivism-focused interventions.

Core MISSION-CJ Treatment Services

MISSION-CJ incorporates a number of interventions aimed at risk needs that are consistent with and overlap with recovery goals (See Figure 3).

Figure 3. MISSION-CJ Intervention Level (MISSION Core and Support Services and Criminogenic Need-Focused Interventions)

MISSION CJ					
Core Services			**Support Services**		**Identification of Risk and Needs**
Critical Time Intervention (CTI)	Dual Recovery Therapy (DRT)	Peer Support	Vocational and Educational Support	Trauma-Informed Care (TIC)	Incorporate Risk Assessment Results*

* Formal structured Risk/Need Assessment results may not be available at certain stages of case referral. Where specific RNR measurement tools are not utilized, MISSION-CJ teams would still consider criminogenic risk/need in developing treatment plans. Ideally, however, an evidence-based tool would be utilized to evaluate a participant's risk/need for treatment planning.

Critical Time Intervention (CTI) is a time-limited Case Management program that begins with an individual's re-connection to community services, either as an alternative to incarceration after a court case processing completion or as part of their re-entry process from jail or prison settings. CTI is comprised of three phases: helping participants transition to the community; helping participants adjust their treatment plans or community support providers to ensure all clinical and psychosocial needs are met; and ensuring the presence of long-term community linkages so that care can be transferred from the MISSION-CJ program to community providers.

Dual Recovery Therapy (DRT) is a structured 13-week clinical intervention that blends traditional aspects of addiction treatment therapies (including relapse prevention, motivational enhancement therapy and 12-step facilitation) with traditional psychotherapeutic approaches (including cognitive-behavioral therapy, supportive psychotherapy, and social skills training).

Peer Support Specialists (PSSs) are people who can connect on an experiential level with participants in the MISSION-CJ program. In so doing, they are uniquely situated to help MISSION-CJ participants engage in treatment, through providing personal knowledge of challenges related to recovery, transition to the community, and use of community services. In addition, peers can help link participants to prosocial outlets and

activities in order to foster personal development in a variety of ways.

Support Services

Vocational support helps justice-involved persons find and maintain employment. Employment is particularly important for justice-involved populations, as research suggests that job training and employment are related to decreased recidivism (Wilson, Gallagher, & McKenzie, 2000). Vocational support helps program participants to develop skills related to job searches, to assist with acquiring and maintaining a job and to engage appropriately with co-workers and employers. Vocational supports can also help program participants understand the implications of a criminal record and work with employment issues that may arise as a result. Support aimed at attaining education can also be an important component that MISSION-CJ can target in individual cases.

Trauma-informed care is an essential component of MISSION-CJ. Individuals in the criminal justice system are likely to have experienced significantly greater exposure to traumatic events both in their lifetime and while incarcerated (Beck & Harrison, 2010; Doneley et al., 2012; Elbogen et al., 2012; Weeks & Widom, 1999). (Trauma and its impact on program participants and issues for the MISSION-CJ teams and administrators are described in Chapter 8.) MISSION-CJ team members are trained to screen for and identify trauma-related symptoms and to ensure that program participants who need specialized treatment are referred to resources that are qualified to treat Posttraumatic Stress Disorder (PTSD) and other trauma-related disorders. Team members are trained to serve clients who do not require specialized trauma-related treatment as well as to provide ongoing support for those participants receiving treatment from a specialized PTSD provider. If the onset of traumatic symptoms is acute the participant will return to the Mission-CJ program once symptoms have stabilized and he/she has developed coping skills to better manage symptoms. MISSION-CJ staff also can work with criminal justice personnel to help them learn more about services. MISSION-CJ staff can also help coordinate trainings to court personnel and others on trauma-informed service delivery models and the issues related to trauma in the population served.

Criminogenic Need-focused Interventions

For clients whose assessment indicates additional recidivism-related clinical needs (e.g. substance use, vocational, antisocial thinking), services would include a broad range of interventions that are part of MISSION-CJ or include referrals to specialized programs. For example, for antisocial cognition focused interventions, there might be referral to specialized cognitive behavioral programs that focus on criminogenic needs. These might include interventions such as Moral Reconation Therapy (MRT; Little, Robinson, & Burnette, 1993), Thinking for a Change (Bush, Glick, & Taymanns, 1997), Lifestyle Change Program (Walters, 2005), etc. Research is evolving as to CBT programs that have the most impact on these specific antisocial cognition types of criminogenic needs. It should be noted that some programmatic interventions, such as DBT and mindfulness (Himelstein, 2011), may also be useful even with low-risk offenders and can address antisocial behaviors such as impulsivity and the like. Specialized interventions targeting criminal thinking and other criminogenic needs complement the MISSION-CJ approach in clients whose identified risk needs signal that such interventions would be useful. MISSION-CJ providers thus consider referral to a wide variety of additional interventions to help clients.

Target Population

As described above, MISSION-CJ is a program that offers an augmentation to treatment as usual for justice-involved persons with mental illness and co-occurring substance use disorders. The need for services for this population is clear. In 2010, there were over one million people with serious mental illness (SMI) in the criminal justice system (Peterson, Skeem, Hart, Vidal, & Keith, 2010). Nearly 17% of people entering jails had serious mental illness. This is consistent with the finding that nationwide 16% of people serving time in prison have SMI (Ditton, 1999; Steadman, Osher, Robbins, Case, & Samuels, 2009). Furthermore, studies suggest that among inmates with SMI in jails and prisons, 72% and 59% of those inmates, respectively, have a co-occurring substance use disorder (Abram & Teplin, 1991; Ditton, 1999; Mumola & Karberg, 2006).

These problems persist in post-release populations as well. Less than 20% of individuals on probation or parole receive services for mental illness, and less than 33% receive treatment for substance use disorders (Feucht & Gfroerer, 2011). Compounding this problem, individuals with co-occurring disorders also experience more negative outcomes both while under criminal justice supervision and while living in the community than individuals without mental illness. This includes longer periods of incarceration (Ditton, 1999), increased contact with the criminal justice system when discharged from psychiatric care (Rosenheck, Banks, & Pandiane, 2000), and especially for those in urban areas, increased contact with the criminal justice system (Mueser, Essock, Drake, Wolfe, & Frisman, 2001). Furthermore, individuals with co-occurring disorders and criminal justice involvement often have considerable difficulty engaging in treatment and comprehensive specialty services focused on the treatment/criminal justice interface are often not available (Hartwell et al., 2013).

Specific criteria for MISSION-CJ appropriateness include: (1) active involvement in the criminal justice system or recent release from incarceration (2) diagnosis of both a substance use disorder and mental illness (with trauma history likely) (3) willingness to take part in the program and receive services and (4) willingness to abide by additional requirements as specified by relevant criminal justice authorities (e.g., specialty court docket, probation, parole).

MISSION-CJ Goals

There are three core goals of the MISSION-CJ program:

Figure 4. MISSION-CJ Goals

MISSION-CJ GOALS

- Provide persons coming from the criminal justice system with direct support services to address mental health and substance use problems in a trauma-informed manner, with a focus on decreasing need for hospitalization and intensive inpatient services over time.
- Help persons with criminal justice involvement avoid further arrest and remain out of jail by understanding their risks, needs and responsivity, and promoting the use of integrated treatment and prosocial supports thereby reducing criminal recidivism, and by promoting successful and stable community living.
- Coordinate care for justice-involved persons across providers within the community, including collaboration with community supervising entities, where necessary, thereby increasing their chance of success.

All three of these goals (see Figure 4 above on MISSION-CJ Goals) are designed to improve the lives of justice-involved individuals by providing comprehensive services either directly or through community linkages. For persons with co-occurring mental illness and substance use disorders, recovery is a realistic goal, and the program staff must keep that message of hope in the forefront. Part of the successful journey toward recovery includes understanding how prior behaviors have not helped the individual achieve their personal goals. Thus focusing on decreasing recidivism is a way of charting a course toward full and meaningful lives in the community.

MISSION-CJ Model Brief Overview

Referral and Screening:

In many cases, a person referred for MISSION-CJ will be pre-trial, facing a probation or parole violation, or reentering the community after a period of incarceration. The MISSION-CJ team would collect the risk assessment data (that can be performed by the MISSION case manager or other personnel working with the client, such as probation) as part of the screening from the justice-referral source. If the risk screening is not available during early stages (e.g., if a defendant is pre-trial and this is not included in a particular jurisdiction and the team is not set up to conduct formal risk screenings), the MISSION-CJ team can begin work with standard clinical assessments to focus on such things as quantity and frequency of substance use and severity of mental illness, as well as examination of antisocial traits and behaviors such as showing repetitive criminal conduct, irresponsibility, antisocial attitudes, poor work history, and poor social relationships, which are consistent with risk variables. If a risk assessment tool is or was utilized later in criminal case processing, the results would be incorporated into the treatment planning.

Engagement and Service Delivery:

The MISSION-CJ CM/PSS team provides core and support services, and offers clients links to needed additional community-based services. The core services delivered by the team include Critical Time Intervention, Dual Recovery Therapy, and Peer Support. Peer support activities have been revised to incorporate specific justice-related engagement. In addition, in light of the complex needs of criminal justice-involved individuals, the teams also offer clients support with vocational needs. All services are provided with trauma-informed approaches (see Chapter 7 for vocational support and Chapter 8 for trauma-informed considerations). Interventions related to criminal recidivism as part of an overall recovery framework (such that moving forward to live a full and meaningful life would include a goal of living a life without re-arrest and re-incarceration) are also included in the treatment plan (through direct service or community referral).

Participants are generally enrolled in MISSION-CJ for either the 2, 6, or 12- month durations. However, program length can be modified as needed in accordance with other variables (e.g., if provided in conjunction with a drug court or mental health court). The core curriculum remains the same across the treatment durations. However, the provision of services is accelerated in the shorter formats. The duration of services are determined by the specific needs of each program participant as developed in a person-centered approach and by the resources available to the treating agency. The reader should review Appendix E that includes the sample curriculums for the 2, 6, and 12-month program.

Summary

This chapter has introduced MISSION-CJ and its core components. Specifically, the sequential intercept model serves as the frame of reference to assist with a systems-wide approach to identifying individuals with co-occurring mental illness and substance use disorders, and linking them to MISSION-CJ services regardless of their specific entrée point into the justice system. Informing those services and providing the assessment and treatment planning foundation from the perspective of reducing recidivism for the MISSION-CJ intervention is the RNR model and related concepts. Thus, it is designed to help MISSION-CJ teams work with clients to develop treatment plans and guide supports that extend beyond traditional recovery-oriented services to assist clients across a range of life challenges. The upcoming chapters present additional information on MISSION-CJ, including the roles and responsibilities for the staff delivering MISSION-CJ and materials to help with service delivery.

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II. Criminal Justice Problems

Among Individuals with Co-Occurring Mental Health and Substance Use Disorders

Stephanie Singer • Matthew Stimmel • Merrill Rotter • Debra A. Pinals

A. Statement of Need

At the end of 2011, there were almost seven million adult offenders under correctional supervision; approximately 2.2 million were incarcerated in jails or prisons, and another 4.8 million were under community supervision (Blaze & Parks, 2012). These numbers are concerning given that rates of mental illness and substance use disorders are consistently much higher in criminal justice settings than in the general population. For example, Osher et al. (2012) summarized data related to mental illness in criminal justice systems, noting that although the rate of serious mental illness (SMI) in the general population was estimated to be 5.4%, the rate of SMI is 7% for individuals on parole, 9% for individuals on probation, 16% for individuals housed in prisons, and 17% for individuals housed in jails. Similarly, although rates of substance use disorders (SUD) in the general population were found to be approximately 16%, studies have estimated that 35% of parolees, 40% of probationers, 46-53% of prisoners, and 68% percent of jail inmates have symptoms consistent with alcohol and/or drug use disorders, or have met the DSM-IV criteria for substance dependence or abuse in the year prior to their arrest/admission (see Osher et al., 2012 related to the data above).

Moreover, not only are individuals with mental health and substance use disorders more likely to be under correctional supervision, they are also more likely to experience behavioral difficulties in these correctional settings. Considering inmates with mental illness were expected to serve on average fifteen months longer in prison than inmates without mental illness (Ditton, 1999), these differences raise significant concerns. With regards to inmates under correctional supervision in the community, those with a co-occurring disorder were substantially more likely to have their parole revoked, whether due to a violation or new offense, than those with no disorder (Baillargeon, 2009).

B. Origins of the Problem

Increasingly, in the United States there has been a shift in treatment of individuals from major state and county psychiatric hospitals to community-based alternatives (Lamb & Bachrach, 2001). The reasons for these shifts have been far more complicated than prior theories of "deinstitutionalization", which connotes an era when state psychiatric hospitals began to close in order to make way for community services. Based on the assumptions that community care is more humane, therapeutic, and cost-effective than hospital-based care deinstitutionalization began in the 1960s and 70s; however, although deinstitutionalization is often cited as a reason for the increase of persons with mental illness in the criminal justice system, many people today question this assumption. Other factors thought to support the criminalization hypothesis were more stringent civil commitment criteria, a lack of adequately funded community-based programs to care for persons with mental illness, as well as more rigid laws against drugs that resulted in incarceration as a consequence of drug-related offenses (Lamb & Bachrach, 2001). Cuts in mental health budgets over the years have raised further challenges regarding doing more—or even the same—with less for certain populations. From fiscal year 2009 to fiscal year 2012, $1.6 billion was cut from US state mental health budgets, which generally target those with serious and persistent mental illness (NAMI, 2011).

Despite various factors having an impact on the criminalization of persons with mental illness, at this time, it is increasingly recognized that persons

with mental illness commit crimes for the very same reasons that persons who do not have mental illness commit crimes (Fisher, Hartwell, Deng, Fulwiler, Pinals, & Roy-Bujnowki, in Press). Thus, further emphasis has been placed on the need for our mental health and justice-related service systems to be increasingly knowledgeable about the risk factors that lead to criminal recidivism. Given that individuals who may be at high risk for criminal recidivism may also have mental health and substance use treatment needs and may additionally have challenges that impact their responsivity to traditional treatments, it is important to consider interventions that can address a host of factors simultaneously (Bonta & Andrews, 2007).

To that end, over the past few decades, increasing attention has been paid to addressing the mental health and substance use needs of the justice-involved community in a manner that recognizes the justice system as a point where there can be enhanced identification, referral, and linkage to treatment services. A variety of interventions have been implemented to divert individuals away from the criminal justice system pre- and post-booking and into treatment, including programs that serve as an alternative to incarceration; however, despite these interventions, trends have not changed. For instance, Fisher et al. (2000) found no differences in rates of mental illness between two jails, despite the fact that one was located in a county with significantly greater availability of mental health resources. Similarly, Case et al. (2009) found the best predictor of re-arrests in a sample of jail diversion participants was not related to mental health outcome but rather to prior involvement in the criminal justice system. Consequently, the lack of effective treatment to reduce recidivism for individuals with co-occurring mental health and substance use disorders (CODs) in the criminal justice system-- including those in jails/ prisons and those on probation/parole-- suggests current treatment methods need to be revised to address more than just mental health or substance use needs.

Contributing to the problem of lack of specific treatments that address recidivism and recovery together are the competing priorities and lack of coordination between the criminal justice and behavioral health systems. Whereas the "foremost concern of criminal justice professionals is public safety, so their primary focus is on individuals who are likely to commit another crime… behavioral healthcare administrators and providers target individuals whose disorders cause the greatest impairments or increase risk of harm to themselves or others" (Osher et al., 2012, p. 11). Therefore, the two systems do not always agree on who should receive services, what services they should receive, and how interventions should be coordinated with community correctional supervision. Consequently, individuals who should receive specialized services may not and vice versa, and the quality of the services being delivered by both systems may be challenged by disruptions and complex coordination resulting in continually high rates of individuals with CODs in the criminal justice system. With all this taken together, there is an ongoing need to utilize scarce resources effectively and efficiently through coordinated treatment to maximize the distribution of these resources to achieve public safety and public health goals simultaneously.

MISSION-CJ attempts to look at the mental health and substance use needs of a criminal justice involved population in a unique manner, by both utilizing traditional evidence-based practices of the mental health and substance use services offered, and also by examining issues related to potential for recidivism and expanded linkages with the justice-system.

C. Where MISSION-CJ Fits In

In traditional mental health practice, assessments of suicide and violence risk are routine. Studies on violence and mental illness are numerous, and often show that factors beyond the mental illness itself contribute to risk (e.g. early conduct issues, substance use, etc.) (Elbogen & Johnson, 2009; Webbink, Vujic, Koning, & Martin 2012). In two separate reviews of interventions that connected individuals with mental illness to services at various intercept points along the criminal justice continuum, little to no relationship was found between improved mental health outcomes and reduced criminal justice involvement (Skeem, Manchak, & Peterson, 2011). Although the MISSION-CJ Model does not propose a solution to all the challenges faced across the treatment services and justice systems, it does aim to provide effective and coordinated treatment services to individuals involved in the criminal justice system who have co-occurring mental health and substance use disorders (and likely also have

trauma histories). The MISSION-CJ Model aims to do this in two equally important ways. First, by combining mental health and substance use disorder treatment into a single, trauma-informed care program whose staff communicate regularly with probation, parole, and other service agencies (e.g. housing, medical, etc.), MISSION-CJ provides a framework through which treatment for individuals can be coordinated across the criminal justice and behavioral health systems. Second, MISSION-CJ attempts to incorporate additional individual *criminogenic* needs into treatment plans with an eye toward risk of recidivism.

Risk-Need-Responsivity Model (RNR) focuses less specifically on individuals' risk for violence (although as part of a standard treatment approach, emergency interventions can be initiated for any individual who presents an acute risk of harm to themselves or others) and more on individuals' risk for recidivism (Bonta & Andrews, 2007). As a result, the RNR framework has been utilized in the formulation of the MISSION-CJ program in order to meet the unique needs of individuals with COD in the criminal justice system.

D. Risk-Need-Responsivity (RNR) Model

The RNR Model for offender assessment and rehabilitation is a method for organizing clients' needs and developing a comprehensive treatment plan (Bonta & Andrews, 2007; Rotter, Carr, & Frischer, 2011). As previously described, RNR provides the criminal justice framework for facilitating MISSION-CJ implementation. There is a pressing need for the development of "new, truly integrated responses" to the problem of offenders with CODs (Osher, 2012). MISSION-CJ defines a clear set of responsibilities and goals for both program staff and the criminal justice personnel administering the program. The collaboration results in a personalized treatment plan that identifies the specific criminogenic risks and needs of program participants while also addressing impairments associated with participants' mental illness and substance use via the MISSION-CJ components. Thus, MISSION-CJ's utilization of the RNR Model allows for it to meet the needs of offenders with CODs by offering a framework to prioritize the components of MISSION and a format for ongoing monitoring to ensure that the client's needs are being addressed.

Given its primary focus on recidivism, the RNR framework does not provide direction on the integration of other systems' goals into the overall framework, such goals include improved public health outcomes (systems-level goal) and/or individual improvement in mental health and substance use problems (individual-level goal). The integration of systems' goals are, however, taken into account by the MISSION-CJ Model. Interrupting program participants' continued involvement in the criminal justice system through diversion, alternatives to incarceration, or re-entry programs is conceptualized in MISSION-CJ as an implicit goal of treating their co-occurring disorders and an explicit goal of their participation in the MISSION-CJ program.

As described in Chapter 1, RNR has three core principles that answer the questions: *who* should receive specific types of services, *what* should be addressed by those services, and how to maximize the effectiveness of those services. The following section describes the specific elements of the RNR model in more detail, highlighting how each principle is incorporated in the MISSION-CJ Model.

Risk-Need-Responsivity Model (Bonta & Andrews, 2007)

Risk: The level of service should be matched to the participant's level of risk to re-offend.

Need: Assess each participant's specific "criminogenic" needs and build treatment around those needs.

Responsivity: Maximize each participant's ability to learn from treatment by providing cognitive behavioral interventions and tailoring those interventions to the unique learning style, motivation, abilities and strengths of the offender.

Risk

RNR was developed from a risk-assessment perspective, and focuses heavily upon integrating assessment and monitoring. In RNR, there is also a strong emphasis on accounting for change, as measured by reduced recidivism. Additionally, the RNR framework is instructive regarding the relationship between co-occurring disorders and criminogenic risk. The integration of assessment and

monitoring and accounting for change are two principles of the MISSION-CJ Model, which has been informed by RNR and addresses the connection between the COD and criminogenic risk.

Need

The RNR emphasis on needs also parallels the process of the treatment of co-occurring disorders in MISSION-CJ, namely providing individualized treatment plans for clients. Criminogenic needs are dynamic risk factors that directly link to criminal behavior (Bonta & Andrews, 2007). RNR focuses upon "dynamic" needs, and this is consistent with a clinical intervention approach which maintains that people change and as such, so do their clinical needs. In RNR, eight criminogenic needs are described and are referred to as the "Central Eight". The eight needs are presented in Table 1 below (adapted from Bonta & Andrews, 2007).

Table 1: The Eight Identified Main Criminogenic Needs

Risk Factor	Behavioral Manifestation
History of antisocial (criminal) behavior	Criminal record
Antisocial personality pattern	Impulsivity; Aggression; Irritable
Antisocial cognitions	Rationalize criminal activity; Negative attitudes towards the law
Antisocial associates	Friends with criminal histories, anti-social attitudes; Lack of pro-social supports
Family support	Interpersonal difficulty with primary family members including parents, spouses, siblings, etc.; History of poor parental monitoring and discipline
Leisure activities	Lack of participation in pro-social recreation
Education and employment	Lack of success in school or work settings; Lack of enjoyment in school/work settings; Lack of opportunity for school/work engagement
Substance use	Substance use disorder (abuse or dependency)

A core principle of the RNR Model is that interventions should be directed first to those needs that are related to criminality (Bonta & Andrews, 2007). According to RNR, antisocial personality patterns and attitudes, antisocial peers, and substance use needs must be addressed in addition to addressing the remaining needs (Bonta & Andrews, 2007) consistent with MISSION-CJ. Although Bonta and Andrews emphasize addressing the antisocial personality patterns, in MISSION-CJ needs are examined simultaneously because of the recognition that persons entering MISSION services are referred related to difficulties with co-occurring mental health and substance use disorders, which is explained further below. This simultaneous approach is consistent with the framework noted in *Adults with Behavioral Health Needs under Correctional Supervision* (Osher, 2012). The MISSION-CJ Model addresses the substance use need through Dual Recovery Therapy (DRT), as well as several other needs by providing educational and vocational support, pro-social involvement through Peer Support Specialists (PSSs), and linkages to family therapy when needed.

As MISSION-CJ is a treatment intervention targeting individuals with mental illness *and* substance use disorders, it is important to understand criminogenic needs within the context of mental illness and co-occurring disorders. Indeed, individuals with serious mental illness (SMI) in the criminal justice system have more of the central eight needs than individuals without SMI (Osher, 2012). Of particular note, substance use disorders are a major criminogenic need and contribute to risk of future involvement. Therefore, the MISSION-CJ program addresses the core criminogenic need of substance use of participants, which is an enhancement to traditional mental health services. In fact, integrated treatment of co-occurring disorders, including the provision of vocational supports are empirically based interventions that address criminal recidivism associated with targeted needs (Osher, 2007; Rotter et al., 2011). The MISSION-CJ program also provides linkages to address criminal-justice specific needs, such as family therapy, that can help further reduce criminogenic needs and risk.

Responsivity

The first step of any effective clinical intervention is engaging the client in the treatment, aiming for person-centered care to address the client's personal goals, regardless of what personality factors may be part of the presenting picture. This requires not only building appropriate rapport between the provider (e.g. case manager, peer support specialists) and the client, but also ensuring that the selected intervention will be maximally effective. An individualized treatment approach is central to MISSION-CJ and is consistent with the responsivity principle of RNR. Within this context, responsivity is a term that refers to a program's need to address both the internal and external factors that influence a participant's ability and motivation to engage in treatment (Rotter et al., 2011).

The RNR model also distinguishes between "general responsivity" and "specific responsivity." General responsivity refers to the use of cognitive social learning methods to influence behavior. Specific responsivity refers to specifically modifying the cognitive behavioral intervention by taking into account the personal strengths, learning style, personality, motivation and demographic characteristics of the individual client (Bonta & Andrews, 2007).

The use of Cognitive Behavioral Therapy (CBT) and CBT principles to maximize engagement and effectiveness is also consistent with the selection of therapeutic modalities made in individual treatment planning (Rotter et al., 2011). Research supports CBT as the most effective approach for treating offenders, as well as for treating co-occurring disorders (Andrews & Bonta, 2010; Rotter et al., 2011; Ziedonis & Trudeau, 1997).

When mental illness and co-occurring disorders are a core part of the risk/need presentation for a given participant, these issues should be addressed to further enable those participants to engage and be "responsive" to treatment. As discussed throughout this manual, mental illness may not be the causal factor related to an individual's criminal behavior, but it may be a barrier to engaging in treatment for substance use or repeat criminal behavior. As such, treating mental illness may be a necessary first step to maximizing responsivity, in addition to utilizing other interventions that maximize engagement (Cullen, Clarke, Kuipers, Hodgins, Dean, & Fahy, 2011). Consistent with RNR,

MISSION-CJ utilizes the CBT based intervention DRT as a core service component to address both client need and responsivity.

Specific factors that can influence responsivity in individuals with co-occurring disorders include external factors such as staff characteristics and training, type of setting (e.g. community versus institutional) and the application of legal or other social leverage (Rotter & Massaro, 2011). Internal factors that influence engagement include client characteristics, background and learning style (Kennedy, 2000). Much like the specific interventions designed to address criminogenic needs, there are also several interventions that have been designed to address both external and internal engagement factors related to the responsivity. These include Sensitizing Providers to the Effects of Correctional Incarceration on Treatment and Risk Management (SPECTRM; GAINS, 2007), Motivational Interviewing (McMurran, 2009), and Re-entry After Prison/Jail (RAP; Rotter, & Massaro, 2011).

There are two important final notes regarding the responsivity principle and RNR specifically as they relate to MISSION-CJ. First, as discussed elsewhere in this manual, the majority of individuals in the criminal justice system have extensive trauma histories. These histories may have been part of their developmental trajectory or, as can often be the case with offenders with mental illness, part of their history that has been acquired in their adulthood. Criminal justice interactions and other institutional exposure from arrest to incarceration can either be triggers for reactions based on prior trauma or the development of newly experienced trauma. In most instances for certain populations, it can be a combination of factors that requires nuanced interventions (Covington & Bloom, 2006). As with MISSION-CJ, it is necessary in RNR to address criminogenic needs, risk and responsivity from a trauma-informed perspective on an ongoing basis throughout the development of individual treatment plans.

Second, as a model for offender assessment and intervention, RNR has been demonstrated to generalize across gender, ethnic and age groups (Bonta & Andrews, 2007; Smith, Cullen & Latessa, 2009). As such, although these factors should neither drive the intervention nor override addressing specific criminogenic needs and risk, they should be examined closely especially if they specifically impact engagement in treatment (Osher et al., 2012). In this way, both Mission-CJ and RNR approaches highlight the importance of understanding the unique needs of each program participant, enabling providers to further tailor the interventions selected to address criminogenic and clinical needs. Further information about specific populations within the criminal justice system is provided in the next chapter.

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III. Replicating the MISION CJ Program:

Guidance for Program Managers and Aministrators

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This chapter provides information that will interest administrators and program managers across a variety of settings, ranging from clinical settings to criminal justice settings (e.g. parole, probation, judiciary) who are considering offering MISSION-CJ services. Criminal justice personnel (e.g. jail and prison administrators, judges and probation, parole entities), along with clinical personnel, may find this information useful. This chapter summarizes the MISSION-CJ program and the key elements to be addressed when the program is adapted and implemented, including: the target population, the treatment setting, the service components included in the program, staffing, education and training requirements, and other strategic considerations. At the outset of the chapter, we explain how the MISSION-CJ program has been adapted from the previous MISSION programs. More detailed information on the models of care that inform the MISSION-CJ intervention and on the roles of staff that are crucial to its success are found in later chapters.

A. Introducing MISSION-CJ: History and Background of the Model

Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking: Criminal Justice Edition (MISSION-CJ) is a flexible, time-limited, and integrated treatment intervention rooted in the Health Belief Model (Becker, 1974). MISSION was originally developed and studied in homeless populations with mental health and substance use problems (Smelson et al., 2005; Smelson et al., 2007; Smelson et al., 2010), and successfully adapted and used to serve other vulnerable populations, including court-involved Veterans, and male and female offenders in both re-entry and specialty court programs.

The 2 month MISSION approach was originally developed in 1999 and called Time-Limited Case Management and abbreviated TLC. The TLC approach was first studied in the VA New Jersey Health Care System (VANJ) in several non-randomize and randomized trials. At that time, it integrated elements of Critical Time Intervention (CTI) case management, Dual Recovery Therapy (DRT), and Peer Support to meet the multi-faceted needs of Veterans suffering from co-occurring serious mental illness (SMI) and substance use disorders transitioning from acute psychiatry to outpatient care. Together, CTI and DRT formed the core treatment components of the TLC model, while Peer Support Specialists encouraged community treatment engagement among Veterans. TLC Case Managers and Peer Support Specialists facilitated the transition from inpatient to outpatient care, providing more support than was traditionally provided during this critical time.

In 2004, the brief TLC model was expanded from a two- to a 12-month model in order to provide Veterans with longer support given their expanding service needs. This 12-month service delivery schedule, now called MISSION, originally offered longer community support and service linkages for homeless Veterans with non-psychotic mental health and substance use 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 and found that it was effective for improving community engagement, reducing hospitalization and improving mental health and substance use outcomes (Smelson et al., 2012).

In 2008, the MISSION program was adapted for a criminal justice population with grant support from the Substance and Mental Health Service Administration (grant # SM58804). The 2008 adaptation, entitled MISSION DIRECT VET, was specifically designed as a post-adjudication court-based diversion program for Veterans. In that program, traditional MISSION services were designed as a 12-month post-disposition wrap around model in which individuals would be placed under probation supervision as an alternative to incarceration, with a general aim to reduce penetration of Veterans into the justice system. The decision to expand to utilize a 12-month model stemmed from the pilot nature of the program and the desire to be able to provide services for a period of time that would enhance the likelihood that an alternative to incarceration could be considered by all parties involved including defense, prosecution, and ultimately the judge who had to order participants into MISSION-DIRECT VET services.

The program model underwent further developments in 2009 and 2011 when it was tailored first for a non-violent and then for a moderate- and high- risk female re-entry population with support from the Bureau of Justice Assistance (grant # 2009-MO-BX-0037 and grant number 2011-RW-BX-0010). In the first of these projects, MISSION services were utilized for non-violent female offenders, and in the second, a medium- and high- risk group of offenders were targeted based on risk scores through the Department of Correction. In both those instances, there was a validated risk tool utilized to help ascertain an initial assessment of risk the woman may have carried. As noted above, MISSION was originally developed for a homeless population and later adapted for a homeless Veteran population, the latter of which is called MISSION-VET (Smelson et al., 2005, Smelson et al., 2007c; Smelson, Kline, Hills & Ziedonis, 2007b; Smelson, Kline, Hills, Mizelli, & Trip, 2007a; Smelson, Sawh, Kane, Kuhn, & Ziedonis, 2011; Smelson et al., 2011, Smelson et al., 2012), and data collection and analysis continues on these populations. Researchers are currently doing a large hybrid implementation and effectiveness study funded by the Department of Veterans Affairs (Grant # SDP 11-235) at multiple VAs around the country, but results are not yet available.

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 5: Names and Characteristics of MISSION Programs

TLC (1999) *Note MISSION wa formerly TLC	**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 (aka 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-DIRECT VET (2008-2013)	**Components:** CTI, DRT, Peer Support, Trauma-Informed Care, Vocational/Educational Supports **Treatment Length:** 12 months Target Population: Veterans with co-occurring mental illness (either SMIs or non-psychotic mental illness) and substance use disorder who face active court criminal charges **Setting:** Community-based treatment program which spans inpatient/residential/ outpatient treatment settings as an alternative to incarceration SAMHSA grant #SM58804
MISSION-CREW (Community Reentry for Women; 2009-2011) **MISSION-RAPS** (Re-entry and Peer Support; 2011-2013)	**Components:** CTI, DRT, Peer Support, Trauma-Informed Care, Vocational/Educational Supports **Treatment Length:** 45-90 days pre-release and 6 months post-release Target Population: Incarcerated women with co-occurring mental illness and substance use disorders who are within 45-90 days of release **Setting:** Begins pre-release in correctional facility and concludes post-release as a community-based treatment program BJA grant #s2009-MO-BX-0037, 2011-RW-BX-0010
MISSION-FORWARD (For Offenders Recovering With Awareness, Resources, and Dignity; 2013-2016)	**Components:** CTI, DRT, Peer Support, Vocational/Educational Supports, and Trauma-Informed Care Considerations **Treatment Length:** 6 months, or 12 months Target Population: Individuals with criminal justice involvement, mental illness (either SMIs or non-psychotic mental illness) and co-occurring substance use disorder **Setting:** Individuals in specialty drug or Veterans' courts SAMHSA grant #TI025074
MISSION-IRAPS (Integrated Re-entry and Peer Support; 2013-2015)	**Components:** CTI, DRT, Peer Support, Trauma-Informed Care, Vocational/Educational Supports **Treatment Length:** 45-90 days pre-release and 6 months post-release Target Population: Incarcerated males & females with co-occurring mental illness and substance use disorders who are within 45-90 days of release **Setting:** Begins pre-release in correctional facility and concludes post-release as a community-based treatment program BJA grant # 2013-RW-BX-0003

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, as well as decreased rates of incarceration for participants. (Those interested in learning more about the findings from these treatment studies should go to Appendix A as well as review the following publications: Smelson et al., 2005; Smelson et al., 2007c; Smelson et al., 2010, Smelson et al., 2012; and www.MISSIONModel.org).

B. Adaptation of MISSION for a Criminal Justice Population: MISSION-CJ

The MISSION-CJ program presented in this manual has been enhanced to be responsive to the unique needs of persons with co-occurring disorders and trauma histories involved in the criminal justice system. Chapters and resources included in MISSION-CJ have been modified or changed altogether from prior MISSION Treatment Manuals. Specifically, the MISSION-CJ Treatment manual includes a variety of chapters that focus on concepts of relevance to criminal justice-behavioral health type programming, as well as criminogenic needs that can be a focus in treatment using the Risk Needs Responsively Framework. Additional resources are included in sections throughout the appendix, which Case Managers and Peer Support Specialists will find useful when implementing the MISSION-CJ model.

Given that MISSION-CJ can begin at different points along the criminal justice continuum (see Chapter 1, Figure 2), we have included descriptions of how to begin service delivery at a number of points (see Section E. Settings for Service Delivery below). Yet, regardless of the setting in which justice-involved persons begin receiving MISSION-CJ services, the goals of the program are the same:

Major Goals of MISSION-CJ

- Provide justice-involved persons with direct support services to help them remain in the community, address mental health and substance use problems, reduce criminogenic behaviors, and promote successful and stable community living
- Coordinate care for justice-involved persons across providers within the community
- Help persons with criminal justice involvement avoid further arrest and remain out of jail by understanding their risks, needs and responsivity, and promoting the use of integrated treatment

C. Target Population and the Need for Services

In order to be eligible for MISSION-CJ treatment services, persons must meet the following criteria:

- Active involvement in the criminal justice system or referral from the criminal justice system
- Diagnosed with both a substance use disorder and mental illness
- Willing to take part in the program and receive services
- Willing to abide by other requirements as specified by criminal justice authorities (e.g., probation, parole)
- Competent to partake in services

As of 2009, roughly 2.3 million adults were incarcerated in jails and prisons in the United States (Glaze, 2011), representing a more than four-fold increase over the past 30 years (Mumola, 1999). An estimated 70 to 80% of these inmates have a substance use disorder (Karberg & James, 2005; CASAColumbia, 1998) and 10 to 20% have serious mental illness (Maruschak & Beck &, 2001; Steadman et al., 2009). Of those with serious mental illness, 75% also have a co-occurring substance use disorder (Mumola & Karberg, 2006). Moreover, by recent estimates, over 2 million individuals with serious mental illness are jailed annually (Justice Center, 2009; Sabol & Minton, 2008).

In 2010, 7.1 million adults were under correctional supervision (i.e., probation or parole) (Glaze, 2011). Approximately 30% report using alcohol or illegal drugs in the preceding month, less than a third received substance treatment in the preceding year (Feucht & Gfroerer, 2011). Probationers who have mental illness experience nearly twice the rate of re-arrest compared with those without mental illness (Dauphinot, 1996). At least twenty percent of probationers and parolees report having serious psychological distress in the past year but less than 20% of these individuals report mental health treatment during the same time period (Feucht & Gfroerer, 2011).

MISSION-CJ was developed to 1) link these justice-involved persons, who have a wide variety of treatment and service needs, to providers who can directly deliver the services they require and 2) support them in making the successful transition to and sustainment of community life. Linkages provided by MISSION-CJ Case Managers (CM) and Peer Support Specialists (PSS) include integrated mental health and substance use treatment, trauma-informed care services, prosocial behavior training, a focus on reducing criminal thinking and maximizing positive peer influences, and a range of other community supports aimed at addressing potential criminogenic behaviors (i.e., housing assistance, employment and other social functioning supports).

D. The MISSION-CJ Team

The MISSION-CJ 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 team. The CM and PSS closely work together to help justice-involved persons make the critical transition from incarceration (or potential incarceration) to stable community living.

The PSS role is staffed by persons who themselves have experienced past mental health and/or substance use problems, and who have achieved and maintained successful recovery in these areas. In some cases the PSS will have other elements in common with program participants that can be used as a vehicle for support (e.g., Veteran status or criminal justice background). With first-hand knowledge of just how difficult it can be to overcome these obstacles, MISSION-CJ PSSs serve as role models for their justice-involved clients, providing not only guidance, but hope—that recovery from criminal involvement, substance use, mental illness and other closely related problems (e.g., homelessness, unemployment) is an achievable goal. At the same time, the MISSION-CJ team is aware that overarching the care and treatment of participants, there may be public safety interests that could come to the attention of others and for which there may need to be more specific intervention up to and including the involvement of criminal justice personnel.

E. Settings for Service Delivery

MISSION-CJ Initiated from Criminal Court Setting

When MISSION-CJ is initiated as a the result of a disposition from a criminal court, the MISSION-CJ CM/PSS team begins to interact with its client before the criminal case has been adjudicated or at the point the case is referred (e.g., prior to a potential probation revocation, etc.). Given the often limited time available in such circumstances, the MISSION clinical team must rapidly engage a potential client and work closely with court representatives (i.e., defense attorney and/or probation officer). The objective is to quickly establish a therapeutic foundation that may enable the team to develop a strong relationship that can provide long-term support as the justice-involved person integrates into the community and establish whether there is a clinical basis for the individual to receive MISSION-CJ services (e.g., a mental health and substance use issue to address). By working with the defendant and with criminal justice representatives, members of the MISSION-CJ team seek to understand the issues faced by the potential client and develop a treatment plan to rapidly engage the client in care once in the community. During this “pre-treatment” phase, the MISSION-CJ team identifies the nature and severity of mental health and substance use concerns, prior/existing treatment providers, and additional functional problems that may need to be addressed (e.g., homelessness, unemployment, discord with family/loved ones). By recognizing the role of existing treatment providers, the MISSION-CJ team is able to provide enhanced services, develop functional working relationships with both the treatment facility staff and the client, and monitor progress throughout the length of involvement

in the MISSION-CJ program, while also focusing on identifying unmet treatment needs. For a pre-trial defendant, the MISSION-CJ team must recognize that the defense attorney's role is critical and that information related to alleged criminal conduct may not be able to be part of the screening discussions (see Appendix N).

Once the client's case is formerly adjudicated by the court, the MISSION-CJ CM/PSS team works with the client to help him/her achieve his/her recovery goals and resolve challenges that arise along the way, preventing a return to criminal justice involvement.

Role of MISSION-CJ Staff for Clients Referred from Criminal Courts

- Liaison with court representatives to determine defendant's eligibility for MISSION-CJ program and, as appropriate, to regularly communicate with court personnel about defendant's ongoing compliance with the program
- Perform clinical assessment to identify defendant's treatment needs and develop a treatment plan
- Identify additional areas of concern that may contribute to risk for recidivism (including housing, employment, and other areas of functioning)
- Deliver group sessions on Dual Recovery Therapy (Case Managers) and issues related to integration to community life (Peer Support Specialists)
- Play a key role in helping to facilitate the discharge plan

While the original pilot of a 12-month MISSION-CJ program was developed to be delivered in conjunction with a 12-month period of court-mandated probation, there is no requirement (from a treatment implementation perspective) that MISSION-CJ services run in tandem with probation. Indeed, the flexibility of the MISSION-CJ model permits administrators and program managers to adapt the treatment to accommodate the needs/preference of different criminal justice settings. This means that not only can the length of MISSION-CJ program vary (e.g., 2, 6, or 12 months), but that courts can opt to direct criminal defendants to MISSION-CJ under a continuance without finding, as part of a no contest or "nolo contendere" plea (in jurisdictions in which this exists), or following an adjudication of guilt. On the other hand, where probation is part of the mix, the duration of court-mandated probation can terminate prior to the optimum period of available MISSION-CJ treatment, or probation can continue after MISSION-CJ services have terminated for a particular participant. When a legal mandate to participate in treatment ends, a participant should be encouraged, but cannot be required, to continue his or her participation in MISSION-CJ services.

MISSION-CJ Initiated from Correctional Setting

Ideally, when MISSION-CJ is delivered following a period of incarceration, the MISSION-CJ team begins to interact with clients well before the release date, in order to build a trusting and therapeutic relationship that will enable them to provide longer-term support as the justice-involved person re-enters the community. The CM/PSS team should be introduced to the facility re-entry planners and seek to be permitted routine access to re-entry support personnel as needed to help problem solve. In this way, linkages to community supervising entities (e.g., parole and probation) can also be enhanced. As with the criminal court setting, the focus here is on transitional support. This follows the APIC best practice model for release planning (Assess, Plan, Identify and Coordinate; Osher, Steadman & Barr, 2002). The earlier the referral process begins, the greater opportunity the MISSION-CJ staff members have to carefully assess the inmate's treatment needs and develop a treatment plan that will assist with successful reintegration into the community. In addition, risk assessment measures utilized within the correctional setting can help inform CM/PSS teams to help further treatment planning around criminogenic domains. Again, the MISSION-CJ team identifies the nature and severity of mental health and substance use concerns, prior and existing treatment providers, and additional functional problems that may need to be addressed (homelessness, unemployment, discord with family/loved ones). The overall goals of MISSION-CJ remain consistent: engagement in mental health and substance use treatment, and reduce risk for criminal recidivism.

Role of MISSION-CJ Staff for Clients Referred from Correctional Settings

- Liaison with correctional treatment staff and correctional authorities to identify potential clients' eligibility for MISSION-CJ program
- Perform clinical assessment to identify clients' treatment needs and develop a treatment plan
- Deliver group sessions on Dual Recovery Therapy (Case Managers) and address issues related to integration to community life (Peer Support Specialists)
- Provide linkages to community-based substance use, mental health, and medical treatment services
- Actively identify and address areas of concern that may contribute to risk for recidivism (including prosocial peer and family supports as available, housing, employment, and other areas of functioning)
- Support and inspire clients by helping them pursue and achieve their goals as community members
- Play a key role in helping to facilitate the discharge plan
- Bring in clinical supervisors to review and communicate with, in accordance with a consent signed at the outset of the program; notify criminal justice supervising entities when a public safety issue or illegal behavior by the client emerges

MISSION-CJ Initiated from Other Diversion Points

MISSION-CJ program is also suitable for delivery in the context of pre-booking or pre-arraignment diversion. In such circumstances, there will need to be agreement with the criminal justice partner on whether MISSION-CJ is to be offered in conjunction with pre-trial probation.

F. Service Components

The MISSION-CJ 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-CJ'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 and promotes prosocial behavior; Vocational Support, which helps justice-involved persons reclaim productive lives and achieve personal goals; and Trauma -Informed Care, which acknowledges the implications of trauma for effective treatment (Fallot & Harris, 2001) and ensures that justice-involved persons 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, justice-involved persons return to the MISSION-CJ program once these symptoms have been stabilized. All of these services are delivered within a Risk Needs Responsivity Framework (RNR), which serves to help with treatment planning, benchmarking progress and making treatment adjustments to reinforce use of prosocial community supports and prevent recidivism.

Essential MISSION-CJ Treatment Components*

- CTI case management is used as the foundation of MISSION-CJ's service components. CTI is designed to give justice-involved persons a "running start" then provides a "safety net" of intensive services upon re-entry into the community, thus establishing firm linkages between justice-involved persons and needed services.
- DRT helps educate justice-involved persons on the impacts of substance use, mental illnesses, and harmful behavior, offering exercises and tools to aid in recovery.
- Peer support helps justice-involved persons engage in sobriety and mental health stability services, and avoid future criminal justice involvement with a "buddy" approach. The personal relationship and support provided by someone who "has been there" also bolsters the effectiveness of the other interventions.
- Vocational Support helps justice-involved persons find and maintain employment. This

contributes to stability in daily living and improved self-esteem.

- Trauma-Informed Care Considerations: MISSION-CJ 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 providers with specialized training in the treatment of Post-Traumatic Stress Disorder (PTSD) and other trauma-related disorders. They are also trained to provide ongoing support while clients are receiving treatment from a specialized PTSD program or to serve clients who are not acutely symptomatic and do not require specialized PTSD services.

Note: These interventions can also assist in addressing criminogenic needs.

Risk-Need-Responsivity Framework for Treatment Planning/Benchmarking Success

As noted in Chapter 2, from a criminal justice context, in working with program participants, one would incorporate a framework that examines individuals and conceptualizes services related to risk factors associated with criminal recidivism. This is not typically seen when working with individuals from a treatment context. Because the MISSION component parts are principally driven by treatment needs targeting mental illness and substance use challenges, MISSION-CJ adds an additional conceptualization that layers on the goal of reducing recidivism, thereby enhancing outcomes from both a personal recovery and public safety perspective. The Risk-Need-Responsivity model facilitates the identification of clients' needs and provides a framework for developing a comprehensive treatment plan (Bonta & Andrews, 2007; Rotter, Carr, & Frischer, 2011). As Osher and colleagues (2012) cited, by examining risk levels, and matching services to address levels of addiction and mental illness, critical needs for an individual can be targeted simultaneously. In MISSION-CJ, the criminal justice supervising entity will often have access to information based on a structured risk-assessment tool that can delineate risk of recidivism and specific criminogenic needs. These tools can identify those at low, medium, and high risk and services and supervision can be matched accordingly. If these tools are not available, MISSION-CJ services providers are nonetheless cognizant of the basic criminogenic needs that have been identified in the literature as risk factors for re-arrest for individuals with mental illness (Andrews & Bonta, 2007).

The CM/PSS team incorporates the criminogenic needs into treatment planning at the same time it can work with treatment providers to identify treatment services appropriate for where the client is at any given time, whether that means encouraging detoxification services, inpatient psychiatric hospitalization, or community based outpatient maintenance therapies. As previously described, RNR provides the criminal justice framework for facilitating MISSION-CJ implementation. As described in Chapter 1, RNR has three core principles that answer the questions: who should receive specific types of services, what should be addressed by those services, and how to maximize the effectiveness of those services. The specific elements of the RNR model are described in more detail in Chapter 2.

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

Critical Time Intervention (CTI) case management (Susser et al., 1997), the core intervention component of the MISSION-CJ model, is a time-limited form of Assertive Community Treatment (ACT) that was initially developed for homeless persons 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, Goldberg, Iannone, Lucksted, Brown, & Kreyenbuhl, 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.

Given the complexity of treatment needs faced with criminal-justice involved persons with co-occurring

mental health and substance use disorders (COD), many of which overlap with those experienced by homeless persons with CODs, MISSION-CJ has adapted CTI for use in this setting. The CTI approach begins with the client's reentry into the community and is divided into three phases. The phases are characterized by a decreasing frequency in services.

Three Phases of CTI

- Transition to Community: The client and MISSION-CJ Case Manager formulate an individualized treatment plan and identify community resources and service linkages most consistent with the client's needs. During this phase, the Case Manager may need to pay particular attention to monitoring medication compliance and facilitating appointments with mental health and other service providers.
- Try-Out: Systems of community support are tested and adjusted and the MISSION-CJ Case Manager and Peer Support Specialist identify any service gaps or areas where the client requires more or less support.
- 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-CJ CMs and PSSs "run alongside" clients 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 clients develop a commitment to community-based recovery, remain engaged in treatment, and maintain housing and employment. Successful implementation requires the presence of trained MISSION-CJ CMs who have developed working relationships with key people able to link clients to community-based supports and services. Programs implementing the model need to establish ways of tracking each contact between staff and clients, assessing their progress and making the appropriate referrals to meet their needs. The use of CTI within MISSION-CJ has been developed in collaboration with Dr. Alan Felix from the original CTI development team at Columbia University.

Outcomes Achieved with the CTI Approach

Susser et al. (1997) examined outcomes among 96 individuals who transitioned from a shelter institution to community living and received either a 9-month CTI intervention or usual services. They found that individuals who received CTI experienced fewer days of homelessness, greater continuity of care, and increased use of community supports when compared to individuals who received usual services only. Dixon et al. (2009) compared a brief CTI intervention to treatment as usual in a randomized trial of 135 participants, noting that those receiving CTI had significantly better treatment attendance and engagement. Also, in a recently completed randomized trial that compared homelessness outcomes among 150 participants who also received either CTI or usual services only, a substantial reduction of recurrent homelessness was observed among those who received CTI (Herman & Mandiberg, 2010). 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 criminal justice involved persons suffering from a mental illness as they reintegrate into the community (Draine & Herman, 2007; Jarrett et al., 2012).

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

The co-occurrence of substance use and mental illnesses presents serious challenges to treatment. Until recently, the conventional approach has been to administer treatment for substance use 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 use and psychiatric conditions simultaneously (Bennett, Bellack, & Gearon, 2001; Drake, McFadden, Meuser, McHugo, & Bond, 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 is delivered by the MISSION-CJ CM through 13-weeks of structured psychoeducational sessions. Topics Addressed in the DRT Sessions are presented in the table below.

Topics Addressed in DRT Sessions

- Onset of Problems (History of lifetime substance use and psychological symptoms)
- Life Problem Areas Affected by the Individual's Co-occurring Disorder
- Motivation, Confidence, and Readiness for Change
- Developing a Personal Recovery Plan
- Decisional Balance
- Communication Skills Development
- 12-Step Orientation and Recollections
- Anger Management and Prosocial Skills Training
- Relapse Prevention
- Interpersonal Relationships
- Changing Unhealthy Thinking Patterns
- Changing Irrational Beliefs
- 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. All MISSION-CJ CMs and PSSs should receive training in the principles of DRT to ensure consistency of the approach. See Chapter 5 on Case Management and Chapter 6 on Peer Support for further details on implementing DRT sessions within the MISSION-CJ program.

Peer Support

MISSION-CJ adds the use of Peer Support Specialists (PSS) to the CTI case management model. PSSs offer added benefit of connecting through their own recovery stories (e.g., prior mental health, substance use, Veteran status and/or criminal justice histories) by sharing personal knowledge of challenges and opportunities during community transition and as such help provide positive role modeling and companionship. In this way, the role of the PSS is to directly address the criminogenic risk of having antisocial peers and highlights the importance of positive peer influences. In addition, PSSs can enhance responsivity factors including helping clients with their motivation for change, and assisting them make and get to appointments. Trained PSSs can "run alongside" justice-involved persons suggesting coping strategies, improving access to self-help/mutual support services, and linking justice-involved persons 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 and prosocial connections.

Peer support services provided to justice-involved participants offer role modeling for recovery, and are emerging as an evidence-based practice for individuals with COD (Chinman, Shoai, & Cohen, 2010; Fisk, et al., 2000; Klein, et al., 1998; Roman & Johnson, 2002). PSSs help to move mental health services towards a sharper focus on recovery, as defined by the client, by identifying and eliminating subtle forms of stigma and bias within the health care system that can negatively impact treatment engagement if left unaddressed. Within the MISSION-CJ treatment program, PSSs can play an important role in helping clients to become a more fully integrated member in his or her community. PSSs can help justice-involved persons work toward and achieve their goals and, in collaboration with the MISSION-CJ CM, call on a range of community providers to step up to the plate and help make recovery a reality.

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

As noted above, PSSs should have some common history that helps them assist program participants in their recovery. These commonalities can include a range of factors, including criminal justice experiences. This can raise complexities in terms of hiring and approval by stakeholders within the criminal justice system that need to be reviewed within the individual program (see Appendices J and K regarding initiation of PSSs and hiring individuals with lived mental health and other experience; Miller & Massaro, 2008). In some jurisdictions, individuals with lived experience that includes criminal justice histories are referred to as "forensic" peer support specialists, and are recognized as offering additional vantage points toward recovery (Davidson & Rowe, 2008; Miller & Massaro, 2008).

Thus, each PSS is both a full staff member of the MISSION-CJ program and a person who has experienced significant recovery from challenges similar to those faced by clients receiving MISSION-CJ services. The combination of training and personal experience helps PSSs advocate for clients and empower them to determine their recovery goals, share wellness and relapse prevention strategies, and provide practical support as they establish new lives in the community. The MISSION-CJ PSS may accompany clients to 12-step meetings and may, as needed, help them locate housing, employment, and other reintegration concerns (e.g., learning to use public transit, setting up a bank account, or getting a driver's license).

At the onset of MISSION-CJ, clients attend weekly peer-led sessions (see Appendix I). The sessions reinforce DRT topics (discussed above) covered by the MISSION-CJ CM, but also encompass issues identified by the PSS as part of the recovery process, including humility, courage, and willingness to change. Interaction with MISSION-CJ PSSs who have had similar problems with substance use and mental illness (along with other domains as noted above), who are now maintaining a successful recovery from these problems, reinforces the normative values of maintaining sobriety, adhering to recovery goals, as well as avoiding recidivism, and gives the client added confidence in his or her ability to achieve comparable goals.

Topics Addressed in Peer-led Sessions

- Willingness
- Self-acceptance and respect
- Gratitude
- Humility
- Dealing with frustration
- Handling painful situations
- Significance of honesty
- Courage
- Patience
- Medicine maintenance
- Making a good thing last

Vocational and Educational Support

Besides the stigma accompanying diagnoses of mental illness and substance use and any functional limitations that they may impose, justice-involved persons with COD may face other barriers to achieving their employment goals (Miller & Massaro, 2008), education goals, and stable housing. Having vocational and leisure time activities are an important criminogenic needs component. Justice-involved persons with prior criminal justice involvement or gaps in employment may be less likely to be selected for a job. There may be limitations to the types of jobs they can undertake. Furthermore, justice-involved persons receiving MISSION-CJ services may have limited resources, training or skills for the job market. Often times, these persons are unprepared for job competition and even job application, and often 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 justice-involved persons 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 and appropriate, MISSION-CJ staff link clients to vocational rehabilitation or educational programs. After the client is able to maintain employment or school independently, these services are phased out.

MISSION-CJ CMs and PSSs also provide linkages to other key vocational resources. Some examples include helping clients 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 and Educational Supports, please refer to Chapter 7. Vocational and Educational Supports for Individuals involved in the Criminal Justice System.

Trauma-Informed Care Considerations

MISSION-CJ is not a specific trauma or PTSD intervention. However, as many justice-involved persons have experienced trauma (prior to their criminal involvement, and/or possibly even during a period of incarceration), Trauma-Informed Care considerations have been incorporated into the overall MISSION-CJ treatment model (Wolff & She, 2010; Miller & Najavits, 2012). Addressing the symptoms of trauma can enhance responsivity to other interventions. MISSION-CJ CMs and PSSs receive training on how to consider and screen clients for trauma and how to coordinate care with specialized trauma clinicians, when needed, until trauma-related symptoms stabilize. MISSION-CJ teams are also trained on the importance of trauma sensitivity given the high prevalence of trauma in the population being served. MISSION-CJ CMs and PSSs can provide support to clients with elevated trauma symptoms; however, they are not expected to serve as primary providers of care for trauma-related disorders. Chapter 8 covers trauma informed care considerations more broadly.

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

(See Also MISSION-VET Treatment Manual available at MISSIONModel.org)

1. Establish strong rapport with the client in an attempt to make him/her feel comfortable in raising any trauma-related concerns.
2. Document any trauma-related issues and review with Clinical Supervisor.
3. 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).
4. Provide referrals and coordinate services to specialized clinicians as needed.

G. Replicating MISSION-CJ: Essential Services and Staffing

By blending the delivery of previously tested components of the MISSION model (CTI, DRT, Peer Support, and Vocational Support) with Trauma-Informed care considerations, and infusing information related to criminogenic needs, the authors strongly believe that the MISSION-CJ approach can more comprehensively address the multi-dimensional service needs of justice-

involved persons with COD. The effectiveness of the original MISSION-New Jersey 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 original elements, even if accomplished through partnerships with outside providers. The collaborative efforts of MISSION-CJ CMs and PSSs are seen as the essential conduit of service access and delivery.

Clients that are supported through MISSION-CJ are complex, and the systems in which they must interact either for treatment or related to their criminal issues require further demands on time, coordination and attention to adherence. Thus, although caseloads often vary depending on a variety of factors, the authors generally recommend a caseload of approximately 15-30 clients at any given time. The number of CM/PSS teams should be dictated by the agency implementing the MISSION-CJ program, with consideration of the level of service needs of the clients.

H. Building Stakeholder Support

Perhaps not surprisingly, entities within the clinical and criminal justice systems often have divergent perspectives regarding mental illness and substance use. All treatment and service providers involved, generally speaking are concerned with a client's clinical well being and long-term treatment needs. However, in a criminal justice context, although individual criminal justice personnel may have concern about a person's well-being, they are not treatment providers and thus must play different roles in a person's life, focusing more on public safety. That said, there is increased recognition among justice professionals of the importance of partnership with behavioral health providers in trying to enhance recovery opportunities. As will be described below, it is therefore important that MISSION-CJ team members and managers understand and appreciate that entities within the criminal justice system with whom they will interact, come to the table not only with these different perspectives and responsibilities that shapes their need to answer to different constituencies and to respond to their unique legal and ethical considerations. Judges, defense attorneys, prosecutors, and probation officers have specific and significant roles in the criminal justice process. The interaction between MISSION-CJ staff and these justice-involved professionals can be of critical importance to the success of the MISSION-CJ program and the individuals it serves. The different vantage points of stakeholders can raise inherent tensions and it is important for supervisors and administrators to have a mechanism to help problem solve with a range of stakeholders as issues emerge. MISSION staff such as the PSS, if they have their own criminal justice background, may need to be approved or reviewed to ensure stakeholder support of their work with clients and to avoid any inadvertent difficulties (for example, if a prospective peer has open criminal charges, he or she may not be eligible to work with individuals on probation; support of peers in these contexts might include supporting them as they resolve their legal situation).

The following descriptions help to clarify some of these issues. When MISSION-CJ is delivered through a court-based program, for example, the judge oversees the criminal proceedings and determines whether a defendant's case will be adjudicated in a manner that will permit him or her to enter (or be "ordered into") the MISSION-CJ program and, if so, its parameters. The probationary terms, including the duration and specific conditions, will typically have been negotiated between the defendant's attorney and the prosecutor, possibly with input from the court's probation department. Although the suggested length of a proposed MISSION-CJ treatment program will be an important consideration, ultimately the judge will determine the duration of the probation, in accordance with applicable sentencing guidelines; the MISSION-CJ program may be shorter, the same, or longer than the terms of probation. (Because of legal constraints, the duration of a court-mandated probation may be shorter than the period of MISSION-CJ treatment. In such a case, a client should be encouraged, but cannot be required, to continue his or her participation upon successful completion of the court-mandated program.) Whether the treatment plan administered by MISSION-CJ will constitute the entire set of probationary conditions, or whether other conditions will be imposed (e.g., drug-screening, participation in a specialty court), will be determined by the judge. Further, if there is an allegation of noncompliance with any aspect of treatment, the

judge will determine whether the client has violated his conditions and, if so, what consequences, if any, will result (e.g., modification of conditions, incarceration, increased community monitoring, etc.). A series of sanctions may be followed, for example, in accordance with the court's specifications. Rewards for positive outcomes may also be offered in certain programs (e.g. less monitoring, less frequent court appearances, etc.). Communication with community supervising authorities for any MISSION-CJ client will be a necessary component of the program, with the frequency of communication determined in advance (e.g., through monthly reporting for a community based program, or more routine rapid reporting for a drug-court participant).

In most systems, re-direction or "diversion" of a defendant into a program such as MISSION-CJ cannot occur without the prosecution's agreement. Sometimes prosecutors will seek the input of a specific victim in a case (e.g., in a domestic violence type of case, there may be a desire on the part of the prosecution to ensure that a spouse or family member is comfortable with a defendant receiving community-based services). In virtually all jurisdictions, the lead prosecutor (i.e., the district attorney) will be guided, not by the defendant's clinical interests, but by its primary mandate, public safety, and to some extent by the demands of its constituency, the public at large. Thus, in determining whether to agree to a particular defendant's diversion into the MISSION-CJ program (or, indeed, even whether to agree to consider the MISSION-CJ program as an alternative to incarceration within his or her jurisdiction), the prosecutor will need to take into account many factors that go beyond a treatment perspective.

The defense attorney's role is to protect his or her client's legal interests and, not infrequently, a person's legal interests will appear to be contrary to his or her clinical interests (e.g., while all may agree, perhaps even the defendant him- or herself, that he or she will greatly benefit from MISSION-CJ as an augmentation to treatment as usual, the recommended length of MISSION-CJ services linked to criminal justice supervision may feel excessive in comparison to routine criminal case processing and thus may be rejected as a defense strategy). MISSION-CJ program managers and staff must understand and appreciate that a defendant's attorney must fully advise his or her client of all available options and, before advising the client to agree to participate in the MISSION-CJ program, the attorney must be satisfied that the client is able to understand (i) the ramifications of entering into the MISSION-CJ program as an alternative to remaining within the criminal justice system (e.g., What will this program require? What will be the consequence of failure to complete the program? In a pre-trial system, will failure result in an automatic guilty finding? In a post-disposition system, will failure automatically result in incarceration? In either system, will time completed in the program be credited towards any subsequent sentence?); (ii) the requirements and expectations of the MISSION-CJ treatment plan (i.e., not only the contents of the treatment plan, but also what is expected of the client ... when sessions are to be held, what constitutes compliance failure, who will be notified upon compliance failure, etc.); and (iii) the limits of confidentiality under which his or her participation in the MISSION-CJ program will be conducted and the criminal justice personnel with whom information will be shared.

In some jurisdictions where MISSION-CJ is offered as part of a court-mandated term of probation, the official with whom MISSION-CJ program staff will have the most, if not exclusive, contact will be the probation officer. The probation officer is responsible for ensuring that the client is in compliance with the terms of his or her probationary conditions. In essence, the probation officer serves as the court's "first-responder." Should he or she have reason to believe that the client has failed to comply with the conditions of probation, the probation officer may have the client brought before a judge to determine whether the probationary conditions have, in fact, been violated. And, because a violation of probation can have substantial adverse criminal justice consequences, it is crucial that all involved (MISSION-CJ program staff, the probation officer and the client) have a clear understanding of what is expected of the client and what information will be shared by MISSION-CJ staff with the probation officer.

When MISSION-CJ is offered as a part of a reentry service plan, only some of the inmates will be connected to community supervision (e.g., probation, parole) upon release. In those cases, partnerships

with correctional facility leadership, followed by connections with local staff, will be critical to help in re-entry planning. MISSION-CJ orientation should be offered to correctional staff so that all involved are aware of the program and its component parts. As noted above, MISSION staff such as the PSS, if they have their own criminal justice background, may need to be approved for entry into particular facilities to work with individuals who are justice-involved. When criminal justice supervision is part of the release plan, the in-reach activities of the MISSION-CJ CM/PSS will require communication with supervising entities to line up MISSION-CJ providers and those professionals involved in supervision so that pathways to communication are open. In some cases, MISSION-CJ services will be delivered to those who are not under criminal justice supervision, but the principles of the model will remain important, and planning for release will need to include opportunities for maximal engagement since community release from jails and prisons is such a fragile time for individuals (Binswanger, Blatchford, Mueller & Stern, 2013).

Given the complexities of joining treatment providers with criminal justice stakeholders, it is essential to build strong partnerships with the criminal justice partners prior to beginning MISSION-CJ services. This groundwork should go a long way towards minimizing problems with referrals, service delivery, and communication between MISSION-CJ staff and criminal justice representatives. The authors suggest creating written memoranda of agreement with general shared principles demonstrating a commitment to work together to begin with. Additionally, a written document may be helpful that outlines the policies and procedures governing hiring, communication and other aspects of the interface between the program and criminal justice personnel. Further, recurring informational sessions and stakeholder meetings regarding the availability of and the nature of the services can be useful to maximize referrals, and continually develop services with an ongoing quality improvement framework. In this way, as new issues emerge, and undoubtedly there will be new issues that emerge in any program, there are infrastructures in place that can help develop solutions.

The following list highlights some important issues that MISSION-CJ program administrators will need to address when building partnerships with criminal justice personnel:

Treatment versus correctional supervision: It is important to make clear that MISSION-CJ services are first and foremost a treatment program and should not be considered a substitute for any form of correctional or court-based supervision (i.e., probation or parole) if these are required for the client. Toxicology screening, which may be conducted at times as part of healthcare services that MISSION-CJ participants receive, is separate from MISSION-CJ and will NOT generally supplant any toxicology testing mandated as part of criminal justice supervision, though information about clinical drug and alcohol testing may be part of treatment provider reports to probation/parole if agreed upon at the outset of services. Discussion of these issues between probation and MISSION-CJ treatment providers will be helpful at the outset of services.

Relapse is part of addiction: In the clinical world, it is widely accepted that relapse is part of the recovery process. Criminal justice authorities, on the other hand, may be significantly concerned about a substance use relapse to the point of needing to issue a sanction for a positive drug test. Both clinicians and justice personnel must continually reconcile different approaches to substance use relapses.

Treatment of addiction with pharmacological approaches (Medication Assisted Treatment such as Methadone, Suboxone, Vivitrol, etc.) raises other complexities within justice contexts, especially when reviewing toxicology results from a public safety standpoint. Care should be taken in addressing these differing perspectives, and it needs to be emphasized that clients who relapse while in the MISSION-CJ program will not necessarily be considered as having "failed" from the treatment provider perspective, even if a criminal sanction may be issued. Prior to initiating MISSION-CJ services in a program where MISSION-CJ is part of a court order and term of probation, there should be discussion on what circumstances will lead to a client being reported to the criminal justice authorities. Where MISSION-CJ is not part of a court-order or community mandated approach (e.g., someone re-entering from jail or prison but who is not on parole or probation), MISSION-CJ personnel nonetheless need to work with their clients regarding relapses and provide education regarding risk of further legal involvement.

Confidentiality: Similarly, given the clinical role that MISSION-CJ staff members hold, they are generally obliged to honor their clients' confidentiality (excluding any mandatory reporting requirements that exist in a particular jurisdiction). However, in the context of agreeing to MISSION-CJ services when there are requirements of information sharing with criminal justice personnel, this confidentiality may be limited. Therefore, there needs to be clear understanding and agreement with criminal justice partners around the types of information that will be shared (and in what detail) by MISSION-CJ staff. Typically, information regarding a client's compliance with his or her treatment plan is shared on a regular basis at a frequency decided at program outset. Specific personal information disclosed by the client to MISSION-CJ staff in the context of treatment should not be disclosed, unless disclosure is otherwise mandated by law. Drug Court policies, for example, may include more frequent communication of client recovery stages, and this should be explained to the client from the outset as part of the court-mandated treatment. Clients, in turn, should provide written informed consent authorizing such communication as a condition of their acceptance into the program (Scott, 2008). Protection of information related to substance use treatment under 42 C.F.R. and other aspects of treatment that are covered by HIPAA will require additional consideration and specific releases to authorize the relevant communications.

Criminal history of Peer Support Specialists: As noted above, employment of forensic peers can raise a host of challenges (Miller & Massaro, 2008), and job application practices may include the need to have one's criminal history reviewed and approved prior to hire of the proposed applicant. Different hiring practices of service agencies and criminal justice personnel may need ongoing discussion and problem-solving so that stakeholders can be comfortable with the PSS as a key part of the program. The Peer who is able to speak openly about his or her background can help facilitate conversations, answer questions and participate meaningfully in a mechanism to broker appropriate roles. It should be noted that statutory and regulatory provisions may govern employment contracts and policies with regard to these matters, and they may differ from private to state or federal public entities and, therefore, programs may wish to develop specific protocols regarding how to handle these complex hiring issues.

I. Orientation, Training, and Continuing Education

MISSION-CJ CMs and PSSs receive a general orientation on confidentiality (both related to treatment and criminal matters), documentation, reporting, and crisis management policies and procedures. They are also trained in the theory and application of all service components in the MISSION-CJ program (e.g., DRT, CTI, Peer Support, Vocational Support, and Trauma-Informed care considerations), the respective roles of all staff in the delivery of these key components, and how the MISSION-CJ team functions as a whole to support justice-involved persons. It is also important to consider additional training for the MISSION-CJ 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; and
- The basics of mental health care systems and practices, such as expectations for clinical (medical record) documentation, treatment team processes, HIPAA and confidentiality considerations, issues related to self-incrimination for pre-trial defendants, 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-CJ 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.

J. Logistical Requirements

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

Key Logistical Requirements for MISSION-CJ

Transportation

MISSION-CJ Case Managers and Peer Support Specialists spend a significant portion of their time meeting with justice-involved persons in the community, which requires constant access to reliable transportation. Community outreach is an essential element of MISSION-CJ 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-CJ staff to have a valid driver's license. Ideally, team members should have access to a vehicle that can be used to meet justice-involved persons 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-CJ Case Managers and Peer Support Specialists must have a reliable way to communicate with the program participants, with each other, and with any justice personnel who might be involved in the case (e.g., probation, parole, specialty court personnel, correctional staff, etc.). Case Managers and Peer Support Specialists on the MISSION-CJ team utilize cell phones and email communication regularly (with appropriate confidentiality protections across email systems). All MISSION-CJ staff must have access to computers to maintain documentation and access program files and resources. MISSION-CJ staff must be able to successfully develop and maintain open communication with criminal justice authorities and representatives, both to facilitate referral and entry into MISSION-CJ services and to promote adherence to treatment.

Safety

Safety is the primary consideration associated with logistical aspects of the MISSION-CJ 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-CJ staff are encouraged to use their own judgment to determine whether they feel unsafe in certain areas or neighborhoods and are encouraged to conduct visits in teams when necessary. In circumstances in which team members feel unsafe and are worried about the safety of their clients, staff are reminded that they can always call 911. Regular discussion of safety issues in supervision is also recommended.

Emergencies

After-hours, on-call schedule policies vary by institution. While the authors believe that on-call mechanisms can be helpful, as the justice-involved clients served often have after-hour crises, an equitable arrangement should be made across staff with regard to coverage. This should also be considered in the context of the policies and procedures of the program employing the staff to deliver MISSION-CJ. It is critical to have a mechanism for immediate consultation between MISSION-CJ Case Managers or Peer Support Specialists and

their Clinical Supervisor when needed, as well as access to an emergency room for any medical or psychiatric emergencies. For systems that are unable to support an on-call mechanism, MISSION-CJ staff are encouraged to discuss an emergency plan and review contact information for local Emergency Rooms with staff as part of the introduction to the program. Staff are further encouraged to leave information on how to contact local agencies for emergency assistance on their telephone answering machines or voicemail message.

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IV. The MISSION-CJ Model of Care

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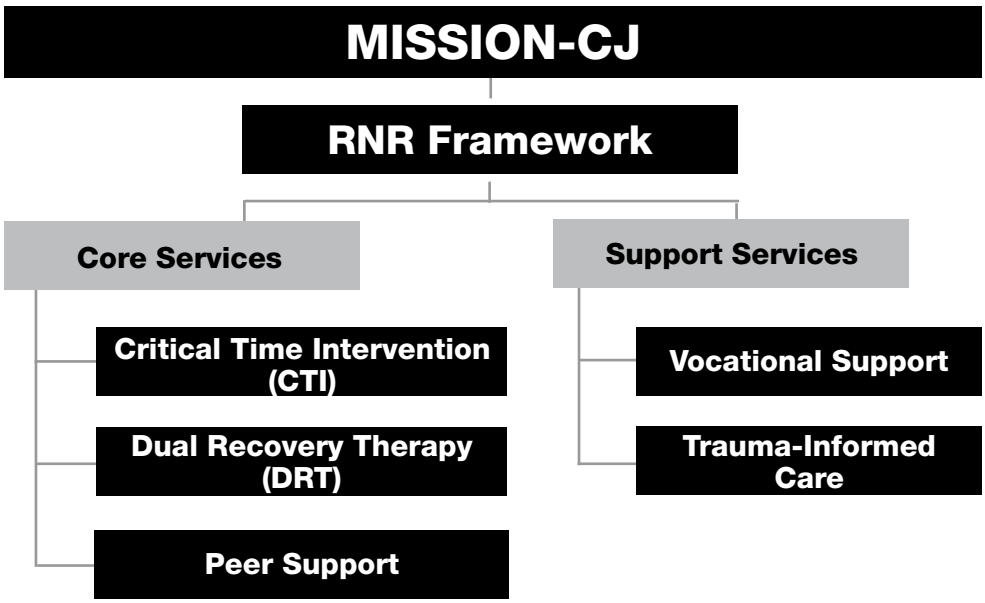
This chapter provides a basic overview of the MISSION-CJ model, including each of the components that have been systematically integrated into the treatment approach: Critical Time Intervention (CTI) case management, Dual Recovery Therapy (DRT), Peer Support, Vocational and Educational supports, and Trauma-Informed Care considerations. It explains how the tenets of each element of MISSION-CJ have been incorporated into the model and how each component works together to meet the needs of clients involved in the criminal justice system with a co-occurring psychiatric and substance use disorder to help them live fulfilling lives in their community.

A. Key Components of the MISSION-CJ Program

Built on the theoretical framework of the Health Belief Model (Becker, 1974), MISSION-CJ is a hybrid approach in which case managers (CM) and peer support specialist (PSS) offer treatment as well as service linkages to meet the multi-faceted needs of criminal justice-involved clients 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. One of the additional key goals of MISSION- CJ is to work with individuals with co-occurring mental illness and substance use disorders who also have histories of criminal justice involvement, such that reduced recidivism, in addition to relapse prevention and recovery, become targeted outcomes. MISSION-CJ takes into account criminogenic factors that may contribute to recidivism. For example, MISSION-CJ teams deliver treatments to address mental illness and substance use to enhance responsivity to interventions, but also help support clients with positive community linkages, such as prosocial support development, attention to employment as a positive daytime activity, and helping reflect upon antisocial attitudes with a goal of reduced recidivism. The MISSION-CJ program addresses the multifaceted needs of clients by using an RNR framework in the delivery of the core and support services as illustrated in the figure below.



These treatment approaches and philosophies are systematically blended, creating an integrated approach that fosters and supports recovery and independent community living among justice-involved clients with co-occurring disorders.

The MISSION-CJ model uses CMs and PSSs who link participating clients to community resources such as outpatient mental health and substance use treatment programs, primary and specialty medical care, vocational rehabilitation and educational services, and providers trained to deliver Trauma-Informed treatment. However, as noted above the case managers and peers also provide structured individual and group sessions and use psychoeducational exercises in the workbook, which help exemplify recovery principles and provide modeling for positive peer influences and prosocial thinking. Overall, the goal of these sessions and exercises is to assist the MISSION-CJ clients' participation in services by increasing their motivation to do so and by empowering them to build and sustain their own positive, productive, healthy and satisfying lives in their communities. Each of the critical elements described below are essential in implementing the MISSION-CJ model.

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-CJ treatment approach. CTI is used to link clients 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-CJ utilizes and adapts the original design of CTI to include supporting clients who are under criminal justice supervision (e.g., probation or parole), who may be pretrial and facing criminal charges, or for clients transitioning to the community following a period of incarceration (i.e., those going through a re-entry process). Because lack of support and disrupted treatments during these critical times can lead to recidivism and symptomatic relapse, MISSION-CJ emphasizes the need for a continuum of care and flexibility in meeting clients' needs, recognizing that different clients require different levels of attention and services at different points in time. Further, MISSION-CJ recognizes that in addition to healthcare needs for co-occurring disorders and integrated medical services, clients may have additional stressors related to their criminal justice histories or current involvement, and all of these factors need to be addressed as a whole through a person-centered treatment planning approach.

A great deal of research has been done to support the use of CTI. 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).

The CTI approach is distinguished from traditional case management in several respects, as shown in the table below on the following page.

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 relapses and continuity of care (and in MISSION CJ focus on reducing risk of reincarceration/recidivism through connecting individuals to community supports)	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-CJ, CTI has five main areas of intervention:

Psychiatric treatment and medication management. While Mission-CJ CMs do provide DRT to address co-occurring mental illness and substance use (COD), their primary responsibility is to link clients to mental health services within the community. MISSION-CJ CMs and PSSs provide assistance to clients by accompanying them to initial mental health treatment visits, overseeing their participation in follow-up visits, monitoring psychotropic medication compliance, and/or helping those with service-connected disabilities. In addition, certain MISSION-CJ clients will be under court or criminal justice supervision, whether through participation in drug court, Veterans treatment or mental health courts (or other specialty dockets), or through probation or parole. In those instances, compliance with sobriety may be mandated with potential for sanctions for drug use. Often, the supervising authorities will require specific toxicology screening to ensure abstinence from substances. MISSION-CJ CM/PSS will be familiar with the client's requirements for testing, sobriety and the like as well as the requirements for communication with probation or other supervising entities to ensure a coordinated care delivery that works in conjunction with criminal justice authorities. At the same time, MISSION-CJ CMs/PSSs will work as treatment providers and local requirements related to disclosure of personal health and substance use treatment information will conform to treatment provider privacy practices, with necessary signed releases of information or court orders in place facilitating communication when needed.

Money management. The MISSION-CJ CM and PSS help the client establish a bank account and create a budget. The team also assists with collecting any documentation needed to obtain entitlements. Neither the MISSION-CJ CM or PSS, however, handles or receives the client's money. This can be done, when necessary, through the identification of appropriate means to handle money management, such as a

representative payee, to ensure that rent and all other essential bills are managed monthly, particularly in the early stages of recovery when there may be greater financial strain and difficulty with individuals managing money more independently. Criminal history related to finances and money management (e.g., history of illegal drug selling, false checks, etc) can be discussed with the client, and with individuals assisting with financial management. Communications across providers and support personnel will be done with appropriate releases of information.

Criminogenic Risk, Needs and Responsivity. The MISSION-CJ CM/PSS team monitors situations that can threaten the clients' stability and put them at risk of relapse and/or criminal recidivism, including lack of productive activities, loss of housing, potential eviction, unsafe living conditions, proximity to drug activity, family conflict, and psychiatric decompensation and substance use relapse. MISSION-CJ team members support clients by understanding their criminogenic needs and developing treatment plans that attend to those needs. Although participation in MISSION-CJ requires a client's agreement for voluntary participation, criminal justice oversight may mandate adherence with certain terms of participation, which may include no contact orders and sobriety. Client's participation in MISSION-CJ services therefore requires a client's informed consent so that they understand how criminal justice and service providers may need to communicate about a client's status.

Crisis management. MISSION-CJ CM/PSS teams can intervene if necessary in particular crises by referring program participants to the appropriate supports. Crises can be emergencies or sub-acute but critical issues that may impinge on recovery goals. For example, for a client who is at risk of homelessness, staff can assist in identifying alternate living arrangements and link the client to community supports. Team members can also play a key role in helping clients to resolve housing-related conflicts, by providing clients with instruction on healthy interpersonal skills and communication strategies and through modeling these behaviors. In those cases where client crisis may involve non-adherence to treatment or other behaviors of concern, when criminal justice mandates are part of the client's picture, communication to criminal justice personnel (e.g., a probation officer, a judge in drug court, etc.) of challenges the client is facing may be necessary.

Family interventions. With the client's permission, the MISSION-CJ CM/PSS team may involve his or her family members so that they can provide ongoing support as well as assistance during times of crisis. If family connections are disrupted, and this is an identified criminogenic needs, CM/PSSs will work with clients to determine if building bridges to family would be of help, and if not, what other positive social relationships might be built (e.g., with recovery coaches, AA sponsors, etc) to help bring positive connections back into the person's life. Additionally, the CM might provide emotional support to the family or provide psychoeducation about mental illness, substance use, and MISSION-CJ services. Family therapy, if needed, is accomplished through referral in the community. Outside referrals for support for family members may also be provided.

Phases

CTI includes three phases, with contact between the MISSION-CJ CM/PSS team and the client decreasing in each phase. These three phases, described in detail in the CTI manual (Felix, Herman, Susser, Conover, & Bloom, 2001), are:

Reintegration to and/or Stabilization within the community. In this first phase of the MISSION-CJ service delivery the program stresses skills and strategies needed for successful community living. For clients in inpatient/residential care, the authors suggest that MISSION-CJ CM/PSS teams contact existing service providers in order to become familiar with the community services that they will eventually need to coordinate and to seek input on the development of clients' treatment plans. Similarly, when working with a reentry population or a criminal justice population, it is important for the CM/PSS to begin as early as possible to identify the community resources, such as housing and treatment providers, to help establish a network of linkages to maximize chances for successful outcomes (Draine & Herman, 2007; Jarrett et al., 2012). Building relationships between clients and CMs/PSSs can be challenging, given some of the trauma issues clients may have faced as well as given their likely transient

connection to service providers historically. This, in combination with antisocial attitudes and criminal thinking, can make engagement strategies challenging but important. In MISSION-CJ, this beginning may take place prior to the release of an inmate or prior to the adjudication of a criminal matter, such that ongoing transition services can take place in the community and/or post-adjudication depending on the criminal justice transition point at which the referral for MISSION-CJ services has been made.

Within this phase, particular attention is paid to areas that the MISSION-CJ team and client feel are critical to community transition, with particular focus on the five core domains previously described. Thus, the focus may be upon such concerns as the identification of a community-based psychiatrist, the need for ongoing dialogue about the importance of medication adherence, 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 client adjust to current or future community life and to develop a support system that can be used as a foundation for community living.

Try-Out. The second phase of the CTI program is known as the *Try-Out.* At this point, the focus is on establishing links between the client and community resources. The MISSION-CJ CM meets with the client 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-CJ CM makes an in vivo (i.e., "within real life") needs assessment, and if necessary the MISSION-CJ PSS accompanies the client to counseling, medical, and other appointments in the community, identifying, first-hand, any holes in his/her support system and service plan. If gaps are identified, the MISSION-CJ CM/PSS team works to address and resolve those issues. As the frequency of visits decreases, MISSION-CJ team members act increasingly as a liaison between the client and community-based services and less as a direct provider of supports.

It is essential that relationships are established between the client and staff members of community resources that will be invaluable to the client's ongoing recovery. Examples of such resources include community mental health clinics, substance use treatment programs, and vocational/educational training programs. The linkages provided during this phase marks the true start of the transition from services primarily being obtained through the MISSION-CJ team to being secured mostly through treatment providers and other resources in the community.

Transfer of care. In this third and final phase of CTI, visits are used to fine-tune the connections established with community-based resources. The MISSION-CJ CM/PSS team and key community providers may meet to review the transfer of care and identify any existing gaps in services. The MISSION-CJ CM/PSS team and client reflect upon the work that they have done together, and the client is encouraged to view the termination as another step taken on the journey of recovery and as a positive development toward decreased recidivism.

Clinical Principles

The CTI intervention requires a specific clinical approach, necessitated by the short-term and focused nature of the intervention. The MISSION-CJ CM/PSS team should take a flexible approach to assessing the client's strengths and needs, including evaluating the client's long-term needs (even though CTI is a time-limited intervention). Additionally, the MISSION-CJ CM/PSS team will need to be patient and work with clients "where they are" in recovery to help facilitate a person-centered approach. Utilizing motivational interviewing techniques will further enhance person-centered planning to achieve a positive direction toward recovery (Miller & Rollnick, 2009). Helping clients to recognize and use their strengths is essential to help the client transition from reliance on MISSION-CJ services.

MISSION-CJ 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 clients in becoming self-sufficient and independent in their communities. The "Clinical Concepts and Techniques Used in CTI" table describes some of the most important concepts and techniques that MISSION-CJ staff will need to employ when

working with clients during their time in the MISSION-CJ 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 client, the person uses a "guiding" style that helps the client hear their 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://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Abuse-Treatment/SMA12-4212.

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://harmreduction.org

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 by Felix and colleagues (2001). The following table lists some of these techniques. For more information, please refer to the CTI training manual (Felix et al., 2001).

CTI Counseling Techniques

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

C. Dual Recovery Therapy (DRT)

MISSION-CJ addresses co-occurring mental illnesses and substance use disorders (COD) through the use of Dual Recovery Therapy (DRT) (Ziedonis & Trudeau, 1997). DRT is consistent with existing therapeutic models that manage both substance use and psychiatric conditions simultaneously (Bennet, Bellack, & Gearon, 2001; Drake, McFadden, Meuser, McHugo, & Bond, 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 use symptoms and that successful treatment will address the interrelationship of the two problems.

DRT structured weekly sessions begin immediately after the client enrolls in the MISSION-CJ program (see Appendix F for more information on DRT sessions and exercises). DRT sessions are designed to help clients recognize the nature and interrelationships of their COD and to choose supports and goals that will help them maintain healthy lives in recovery despite the presence of these disorders and the often complicated history that goes along with them. Therapeutic techniques that facilitate the delivery of the 13 structured psychoeducational sessions are also included and described at length later in this manual (see Appendix G). Delivered by a MISSION-CJ CM, DRT sessions teach clients skills that will support their recovery from both psychiatric and substance use disorders and in their adjustment to community living. Specifically, the topics covered in the DRT sessions will help the client 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 client's mental health and substance use problems and how the two are interrelated; and
- Understand that both mental health and substance use 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-CJ CM. It is intentionally delivered at the onset of enrollment in order to provide clients 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 clients enter the DRT groups at different times depending on their enrollment into the MISSION-CJ program. Consequently, each group may include clients who have attended several DRT sessions or none at all. DRT sessions can also be delivered more frequently if the MISSION-CJ intervention is delivered over a shorter period of time. However, as illustrated in the table "Content of DRT Sessions as used in MISSION-CJ Program" the content of the DRT sessions remains the same.

Content of DRT Sessions as used in MISSION-CJ Program

- Clients learn how mental health and substance use problems can affect one another.
- Problems in specific life domains are identified to determine the impact each of these problems has had on the client's life.
- Motivation, confidence, and readiness to address each problem area are assessed to help clients understand their willingness or reluctance to begin work on each identified issue.
- Treatment goals are reviewed and emphasis is placed on the importance of participating and remaining engaged in substance use and mental health treatment.
- Benefits and consequences of continuing undesirable behaviors are explored.
- Clients learn about the importance of developing effective communication skills.
- Orientation to or revisiting of the role 12-step programs play throughout recovery is discussed.
- Identification of situations that trigger anger and strategies to manage emotions during those situations are explored.
- Clients learn specific relapse prevention strategies to increase the likelihood of sobriety and decrease the chance for relapse. Special emphasis is placed on how the presence of mental health problems can lead to a relapse.
- Clients learn how relapse can also contribute to criminal justice involvement.
- Clients learn how unhealthy relationships can lead to substance use relapse, mental health symptom exacerbation (and with MISSION-CJ, a focus includes how unhealthy relationships can lead to further criminal justice problems).
- Clients learn how unhealthy thinking patterns can perpetuate emotional problems and result in substance use relapse. The interplay among thoughts, behaviors, and emotions is explored.
- Clients learn how to modify dysfunctional beliefs to maintain flexibility in thinking.

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

D. Peer Support

MISSION-CJ's peer support element complements and reinforces both CTI and DRT by inspiring clients to establish recovery goals, modeling a sober lifestyle, encouraging the development of a supportive social network, and helping clients establish linkages to community services. MISSION-CJ employs Peer Support Specialists (PSSs) who use their own recovery and employment success to inspire hope for recovery in clients enrolled in the MISSION-CJ program. PSSs work closely with MISSION-CJ CMs and play an important role in socialization and recovery support. As role models, PSSs demonstrate to clients the concrete steps necessary to achieve recovery from substance use, mental illness, and criminal activity. For example, they may help clients on their caseload monitor relapse triggers and criminal recidivism risks through discussion of daily activities, accompany them to 12-step meetings, help them avoid "people, places and things" that are triggers or risk factors, 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-CJ PSSs who serve as providers can empathize and provide unique support to the clients they serve because they know what it is like to suffer from mental illness, struggle with substance use, face unemployment, and in some cases, experience criminal justice involvement. For specific populations, such as Veterans or female offenders, peers may have additional experiences from which they can draw to help support client recovery (Davidson & Rowe, 2008; GAINS, 2012). Many MISSION-CJ PSSs have experienced first-hand what it feels like to be on psychiatric medication, to have negative consequences related to substance use, to be hospitalized, perhaps even what it feels like to be incarcerated. The PSSs can help put in perspective when one feels they have lost out on life – knowing also what it feels like to win back their lives. Because of these shared experiences, MISSION-CJ PSSs tend to help clients set personally meaningful and realistic goals. As role models, they share their recovery stories and wellness strategies, offering mutual support and practical guidance to their clients. Often, MISSION-CJ PSSs are able to develop a great sense of rapport and a very trusting relationship with their client, one that is special and intrinsically different from the client's relationship with other MISSION-CJ team members.

Perhaps the most important contribution of MISSION-CJ's peer support component is the role PSSs play in offering inspiration and positive, prosocial peer support and modeling. They provide the hope that clients can and do overcome the barriers and obstacles that confront them. They also show the benefits of prosocial thinking and behavior in achieving health, stability, financial security through employment and the like. MISSION-CJ PSSs convey that recovery is a self-directed process wherein clients 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 use. They focus on whole health, with attention to physical and mental well-being. As members of the treatment team, PSSs also enhance the client's voice in the formal treatment process, helping to ensure that professional services are individualized to the client's needs. This liaison/coach role has been shown to enhance the likelihood that clients will complete and/or stay engaged in treatment as needed.

Specific Services Offered to Clients by MISSION-CJ Peer Support Specialists

- Facilitate the use of the MISSION-CJ Participant Workbook
- Help clients maintain stability and avoid hospitalization
- Encourage attendance at 12-step and other supportive meetings and groups
- Further clients' acceptance of their problems
- Help clients rebuild relationships disrupted by substance use and mental illness
- Enhance clients' prosocial attitudes, decrease criminal thinking, improve prosocial connections, and community living skills

- Enhance clients' activities of daily living (ADL) skills
- Encourage client compliance with any requirements of criminal justice supervising entities (e.g., probation, parole)
- Help clients relieve stress or anxiety that could lead to relapse, criminal recidivism or loss of employment, housing, friends or supportive family relationships
- Monitor signs of relapse or decompensation
- Address stigma associated with substance use, mental illness, or a criminal record
- Communicate regularly with MISSION-CJ Case Manager regarding client's progress toward recovery

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

Additionally, MISSION-CJ PSSs arrange and participate in social activities suggested by their clients that provide an opportunity for positive social support and an alternative to substance use. Ideally, activities can be coordinated with the schedule of AA/NA meetings and work schedules to make them convenient for the maximum number of clients participating in the MISSION-CJ program. Examples of activities might include trips bowling, movies, sporting events, museums visits, or dinning out. As reinforced during DRT sessions, clients in MISSION-CJ 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 client. Additionally, activities can be simple at first, such as shooting baskets at the local gym. If that goes well, PSSs can make arrangements for full-court basketball games between clients. PSSs may even facilitate the formation of a MISSION-CJ basketball team if there is enough interest among participating clients.

E. Vocational and Educational Support

Another core need for clients enrolled in the MISSION-CJ program is vocational and educational support. If MISSION-CJ services are initiated while the client is under criminal justice supervision, vocational rehabilitation service linkages or educational programs may also be identified through probation or parole officers. However, MISSION-CJ CMs and PSSs take extra care to ensure that linkages to education or vocational specialists are provided and that vocational rehabilitation plans are developed, either in conjunction with criminal justice partners or as a part of the MISSION-CJ CM/PSS role. Once developed, the MISSION-CJ CM/PSS team further fosters the vocational rehabilitation plan and takes action based on changes in the client's employment status. Educational needs may also be addressed. For example, if the client loses his or her job, the MISSION-CJ CM/PSS team may assist in establishing or facilitating linkages with the Department of Labor (DOL)-funded One-Stop Career Centers, whose employment specialists can assist in the job search. If clients are struggling to maintain employment, the MISSION-CJ team provides support and helps the client to understand and follow operating procedures of the employment site, maintain peer and supervisor relationships, and manage job-related stresses. If the client wishes to obtain a GED, the CM/PSS team may assist the client by linking them to programs where GED acquisition can be a goal, and helping them schedule time to allow for learning and self-guided study.

The specific type of vocational or educational support offered by the MISSION-CJ CM/PSS team varies according to the client's needs. For example, for those clients who are employed, the MISSION-CJ 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-CJ CM may facilitate role plays to practice healthy communication

with co-workers and supervisors. Additionally, MISSION-CJ CMs/PSSs provide positive reinforcement for job successes and encouragement to deal with challenges.

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

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

Benefits of Vocational Support as Used in MISSION-CJ

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

Finally, it is essential for MISSION-CJ CMs/PSSs to link clients to community-based employment services, such as the local Vocational Rehabilitation agencies, and other local venues for vocational supports. These linkages are used on an ongoing basis and as needed throughout the length of the MISSION-CJ program. The goal regarding these community-based vocational resources is for clients to become familiar with the services offered and comfortable enough to use them on their own upon completion of the MISSION-CJ program. For more information on specific Vocational Supports please see Chapter 7. Vocational and Educational Supports for Individuals Involved in the Criminal Justice System.

F. Trauma-Informed Care Considerations

MISSION-CJ is not a Posttraumatic Stress Disorder (PTSD) intervention, nor is it designed to treat co-occurring PTSD. However, given the high rate of trauma present within the MISSION-CJ target population, the MISSION-CJ CM/PSS team must be prepared either to assist clients with these issues directly or, for those clients who are acutely symptomatic, through a referral to specialized clinical care. The MISSION-CJ CM/PSS team should be familiar with the fact that the criminal justice population of individuals with co-occurring mental health and substance use difficulties also have high frequencies of exposure to prior trauma (Miller & Najavits 2012; Wolff & Shi, 2012). Further the MISSION-CJ CM/PSS team is familiar with the complexities of criminal justice interactions and issues that may trigger trauma-related symptoms or behaviors.

With that in mind, the MISSION-CJ team must assist in identifying and monitoring any symptoms of trauma that may impact treatment and recovery. For example, clients may relate information regarding exacerbation of these symptoms to their MISSION-CJ PSS, and communication among team members during such instances is crucial. Remaining sensitive to fluctuations in symptoms will allow MISSION-CJ CMs, in concert with the Clinical Supervisor, to make informed decisions on whether or not clients 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-CJ program. The "Goals of Trauma-Informed Care as Used in MISSION-CJ" table illustrates how the role and importance of Trauma-Informed Care considerations have been incorporated into the MISSION-CJ approach.

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

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

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

Monitor trauma-related issues on an ongoing basis. MISSION-CJ CMs are encouraged to monitor and be aware of trauma–related issues throughout their work with clients. Assessment tools may be helpful in this regard (see helpful websites in Appendix L for further information). Weekly follow-up meetings with clients can help to ascertain decreases and increases in symptoms that may impact treatment. For optimal delivery of care, basic information acquired through these assessments should be shared with the MISSION-CJ PSS to help support the client as needed.

Develop a plan for increased safety when necessary. MISSION-CJ CMs and PSSs are encouraged to have a plan in place for situations involving exacerbation of symptoms, suicidality, homicidality or aggression, and drug/alcohol relapse. Clients who are suicidal or homicidal with a clear plan or intent should not be left unattended whenever possible and should be evaluated by a mental health professional immediately. Emergency services may need to be contacted in extreme cases. Law enforcement involvement in behavior that creates a public safety risk may be needed, though law enforcement may elect diversion to treatment in a given situation over arrest. Once emergency situations have been stabilized and the client (and any others involved) is safe, MISSION-CJ 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 client's care. Plans should be appropriately adjusted as the client continues to make progress. Anger management classes may be part of their court oversight, and MISSION-CJ CM/PSS teams can help support clients regarding these programs.

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

Chapter 8, *Trauma as a Critical Consideration in MISSION-Criminal Justice Service Delivery,* focuses on Trauma-Informed Care considerations and serves as a resource to help guide the MISSION-CJ treatment team regarding these issues. Additionally, Appendix L includes additional resources to help identify trauma-related symptoms. This appendix contains additional links to connect to useful trauma-related resources.

F. Risk-Need-Responsivity Considerations

MISSION-CJ CM/PSS work with individuals referred after or during interaction with the criminal justice system. Some of the clients will have criminal justice supervision as another component to their lives that will have to be integrated into their recovery planning. From the perspective of reduction of criminal recidivism, treatment planning is developed through a framework of Risk-Need-Responsivity (Andrews, Bonta, & Hoge, 1990; Andrews, 2012). As a start, clients may have risk assessments using evidence-based tools (e.g., Ohio Risk Assessment System [Latessa, Lemke, Makarios, Smith, & Lowenkamp, 2010], COMPAS, [information available at www.northpointeinc.com], etc). These may be completed by criminal justice authorities or, with appropriate training, by MISSION-CJ providers. In many cases MISSION-CJ teams can utilize results of the tools that are already in place through the criminal justice entities or through clinical service providers. In these cases, identification of higher risk clients will often inform the level of criminal justice supervision the individual may be required to receive. It can also inform treatment considerations, with higher risk individuals being prioritized for treatments together, rather than with lower risk clients (Osher et al., 2012).

Once risk levels are identified, client criminogenic needs are also taken into account to help inform treatment planning. Criminogenic needs can also be examined from a broader perspective, even in the absence of a formalized risk assessment (though the latter should be examined if available). For example, specific cognitive behavioral treatments may be used more commonly for higher risk offenders whose antisocial attitudes and behaviors may place them at higher risk for recidivism (e.g, Moral Reconation Therapy [Little & Robinson, 1988], Thinking for a Change, [Bush, Glick, Taymans, & Guevara, 2011]). In addition, vocational supports, work with families, identification of leisure time activities are identified with the help of MISSION-CJ CM/PSS teams, which further address criminogenic needs. The higher the risk, the higher the "dosing" of interventions that might be put in place.

Finally, especially because MISSION-CJ participants have co-occurring substance use combined with mental health conditions, and often will have trauma histories, individual and system responsivity to treatment interventions is considered as part of MISSION-CJ treatment planning. For example, if a MISSION-CJ client is actively using substances, responsivity to treatment will be limited until active use is curtailed. Thus, referral to detoxification services may be the most appropriate step prior to longer term planning. Similarly, if a client is experiencing significant hopelessness and helplessness related to depression, a focus on access to appropriate psychiatric services and supportive therapy will be important to raise the individual's responsivity to additional supports and community linkages. In addition, system level responsivity is another important considersation. The MISSION-CJ CM/PSS teams and community justice partners will be working across systems. The CM/PSS teams and the respective administrative program staff will ideally coordinate with stakeholders and engage in systems brokering, cross-training of criminal justice and treatment personnel, and referrals to service providers that have a capacity to work with a criminal justice involved population.

Risk-Needs-Responsivity Considerations

- Utilization of available risk assessment tools alongside criminal justice entities when feasible
- Identification of criminogenic needs that can be incorporated into treatment planning
- Examination of individual level and systems level responsivity to treatment plan

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V. Case Management

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This chapter describes the roles and responsibilities of the MISSION-CJ Case Manager (CM) in MISSION-CJ service delivery. The chapter begins with an overview of the MISSION-CJ CM's role and describes how his or her responsibilities vary depending on the setting in which Mission-CJ is initiated. The importance of teamwork with the Peer Support Specialist (PSS) is stressed, and the Case Manager's role is distinguished from that of the PSS. The Chapter then reviews each of the Case Manager's primary responsibilities, which include incorporating aspects of risk, needs, and responsivity into treatment planning, initiating services, using Critical Time Intervention case management, delivering Dual Recovery Therapy, providing vocational support, understanding Trauma-Informed Care considerations, and ultimately ending participant's enrollment in the Mission-CJ Program as clients transition to more independent treatments. Because specialized and structured case management is seen as the foundation of the MISSION-CJ model, this chapter refers to a number of appendices that are useful tools for the Case Manager to use as MISSION-CJ is implemented.

It should be noted that in some programs, MISSION-CJ case managers have been referred to with different, more criminal justice specific titles. For example, within one re-entry program for offenders, the case managers were called "Reentry Support Specialists." The use of different terms for this specific role may have local significance relevant to particular programs. However, for the purposes of role clarity we refer to this function as a MISSION-CJ Case Manager throughout this manual. The function of the MISSION-CJ Case Manager is a necessary and critical element of MISSION-CJ services, regardless of the specific name given in an individual program.

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

The MISSION-CJ Case Manager (CM) and Peer Support Specialist (PSS) work as a team to help criminal justice-involved clients with co-occurring mental health and substance use disorders (COD) make the successful transition and adjustment to independent community living. The MISSION-CJ CM ensures that supports are in place for the client to promote health, wellness and recovery, and to reduce criminal recidivism. This includes delivering Critical Time Intervention (CTI) case management, mental health and substance use intervention and providing additional linkages for these problems in the community, giving assistance with employment/educational needs, and securing referrals for the treatment of trauma-related symptoms as needed. All of these services within MISSION-CJ are guided by the Risk-Needs-Responsivity (RNR) framework (see Chapter 2, Section D for a description the RNR Model).

The first step is a formal assessment that is performed by the MISSION-CJ CM with support from the PSS. MISSION-CJ CM/PSS teams work together with the client to develop a comprehensive treatment plan that includes the client's treatment needs, individual goals, and identification of appropriate team responses to meet these needs. In addition, the MISSION-CJ CM/PSS incorporate criminogenic needs into treatment planning, and work in conjunction with criminal justice supervising entities when these are part of the client's overall life demands (e.g., participation in a specialty court, coordination with probation or parole). These criminogenic needs similarly encompass treatment needs related to substance use. In addition, they may include attention to positive social relationships, engagement in appropriate leisure time activities, positive family and relationship supports, and the like. A focus on mental health considerations can also enhance responsivity to other interventions and supervision. The overall treatment plan should be

reviewed on a monthly basis and adjustments are made as needed and in the context of recovery and reduced criminal recidivism as overarching goals. CM/PSS teams offer direct services and linkages to their clients over a stated period of time (e.g., 2 months, 6 months, or 12 months depending on the service delivery schedule the team decides to implement) in order to meet the goals within the treatment plan. Once the assessment and treatment planning is completed, CMs guide the delivery of the MISSION-CJ service components which are described below.

B. Working Effectively as a MISSION-CJ Treatment Team

The MISSION-CJ approach requires CMs and PSSs to work together on teams, with one PSS and one CM assigned to each client. CMs and PSSs are seen as equal members of the team, each of whom contributes their unique backgrounds and experiences to assist clients enrolled in the MISSION-CJ program. As shown in the table, *"Responsibilities of the MISSION-CJ Case Manager and Peer Support Specialist,"* some roles and responsibilities are specific to the CM, some to the PSS, and others are shared. For more information on the role of the MISSION-CJ PSS please see Chapter 6, *Peer Support.*

"Responsibilities of the MISSION-CJ 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
• Comprehensive assessment and treatment planning documentation related to mental illness, substance use, and criminogenic risk/needs • Orientation/introduction, mid-program progress check, transition to community, and discharge plans • Responsible for regular reporting to criminal justice authorities as per the treatment plan (e.g., monthly written reports to probation or parole for individuals on community supervision or weekly reviews if in specialty court, etc) • 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)	• Support client in meeting goals/offer guidance and roadmap for recovery activities outlined in informed treatment plan • Provide positive role modeling and prosocial support • Help clients advocate for themselves with providers and ensure effective two-way communications • Recreational planning and modeling healthy living using free or low-cost community resources • Linkage to community mental health and substance use recovery programs (NA/AA) • Accompany clients to clinical appointments, job interviews, recreational activities, and self-help group meetings • Increase motivation toward recovery goals • Assist clients with program workbook exercises and readings, discuss material, and reinforce insights	• Monthly meetings to monitor and revise treatment plan progress and make adjustments as needed, considering risk, needs and responsivity factors, with the guidance of program supervisors • Support client in adhering to any requirements of criminal justice supervision • Develop plan for coordination with criminal justice supervising authorities as needed • Weekly team meetings with staff providing care at inpatient/residential treatment facility if relevant • Discharge session from treatment facility when participant has needed inpatient/residential treatment • Linkage to needed community services, including outpatient, vocational 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 crises • Refer out as appropriate during exacerbation of symptoms

For the MISION-CJ CM/PSS team to work effectively, it is critical that both team members share information with one another about the contact they have with the client. These communications help team members support each other's work and track evolving issues that may require special intervention. For example, the PSS may tell the CM that the client has been seeing drug-using friends at their old hangouts and is spending time with criminal associates, or the CM may tell the PSS that a client has been shy and is nervous about going to AA meetings and ask the PSS to offer to attend a meeting with that client. At their regularly scheduled supervision meetings with the Clinical Supervisor, or earlier if necessary, the CM/PSS team should share any serious problems on which they would like guidance or assistance, ideally at the earliest stage possible to allow for prompt intervention. This may include communication with supervising authorities such as probation and/or parole, depending on the terms of the client's current criminal justice involvements.

Depending on the issues to be addressed and the preferences of each client, CMs and PSSs may meet with the client together or separately. At a minimum, in addition to other regular sessions, a monthly meeting with the client and CM is recommended to specifically review treatment plan goals and any barriers to progress. When the CM and PSS meet with the client separately, the authors suggest that the CM and PSS meet and discuss their observations and concerns regarding the client regularly. By working together smoothly, MISSION-CJ team members can enhance their effectiveness and ensure each client enrolled in the MISSION-CJ program is receiving consistent messages and support. Clients are informed at the outset of their participation that information is shared among MISSION-CJ team members to better facilitate their care.

MISSION-CJ Case Managers should have the appropriate level of judgment to make well-grounded decisions independently, but at the same time be open to receiving assistance and guidance from others, primarily the MISSION-CJ Clinical Supervisor. CMs must be willing to enhance their skills, follow institutional policies and procedures, and work within laws and regulations. Although it is preferable for the Case Manager to have some clinical training, we recognize that this may not always be feasible for all programs. At a minimum the CM and the PSS will require regular supervision by a Clinical Supervisor. 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-CJ Clinical Supervisor also coordinates vacation schedules and manages service interruptions due to illness, providing coverage to ensure that clients are not left unexpectedly without support.

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

The MISSION-CJ CM/PSS also work alongside criminal justice supervising authorities (e.g., probation, parole, the courts) when this is an aspect of the client's circumstances. In so doing, it is important to recognize the unique roles of the criminal justice system (following court-orders, attending to public safety), that may not be aligned fully with treatment provider roles, which tend to allow for more flexibility related to things such as substance use relapse. Nonetheless, because the CM/PSS are supporting client's goals toward achieving successful, healthy, and safe independent living, the CM/PSS must support the client while fostering and encouraging their compliance with any legal conditions imposed upon them. This may necessitate providing information to probation/parole/the courts as needed and as agreed to from the outset of the MISSION-CJ program. It may also mean that the MISSION-CJ service providers support clients through brief re-incarcerations, probation surrender hearings, and the like.

In some cases, again, depending on context, the CM/PSS will have relationships within correctional facilities (e.g, in programs that start with re-entry services and in-reach) such that a client may be further supported by the CM/PSS within the facility if reincarceration occurs. In other instances, brief visitations may be allowable to continue to support clients who are reincarcerated. If a client's relapse or recidivism results in longer term incarceration, MSSION-CJ services may need to be terminated. Together with the Clinical Supervisor, decisions should be made regarding keeping clients on the active caseloads during the pendency of any legal proceedings that may take the clients out of the community and into a setting of detention. In those cases, some communication with clients will be important so that they understand their status with MISSION-CJ services and the ability to re-engage upon release.

C. Initiating the Delivery of MISSION-CJ Services

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

D. Identifying and Orienting MISSION-CJ Participants

Identifying Program Participants

Program referrals will generally come from different criminal justice representatives depending on when in the judicial process the referral is made, and the Mission-CJ CM will have to establish close working relationships with each of these representatives. For example, in a pre- or post- booking context that comes before arraignment, referrals for the MISSION-CJ program may come directly from the police officers or social service agencies who work with police; probationers who are at risk of re-incarceration and facing probation surrenders may be referred by probation officers. When working directly at the point the individual is interfacing with the court, whether through pretrial services or in a post-adjudication model as part of an impending plea agreement, referrals may come from defense attorneys, judges, probation officers, family members, clinical providers, peers, or clients themselves.

Screening Prospective Participants for Eligibility

Regardless of whether MISSION-CJ services are commenced in a correctional setting or in the community, the MISSION-CJ CM screens prospective clients for program eligibility. In general, clients are eligible for MISSION-CJ services if they meet the five criteria listed below:

1. Active or prior criminal justice involvement
2. Diagnosed with both a substance use disorder and mental illness
3. Willing to take part in the program and receive services
4. Able and willing to live in the community (which may need to be approved by a judge after some input from defense and prosecution on public safety considerations)
5. Capable of consenting to services, usually without any active concerns about competence to stand trial (or if there is a concern about competence to stand trial, there should also be a protocol or procedure that assesses capacity to participate in MISSION-CJ programming)

After confirming eligibility, the MISSION-CJ CM describes how the program works, including what information will be shared with criminal justice entities. It is important to note that the CM who conducts this screening may not be the client's assigned CM once services are initiated, and the client should be made aware of this. Once the client is screened and eligibility is confirmed by the MISSION-CJ Clinical Supervisor, a CM from the MISSION-CJ team is assigned to work with the client, ideally for the duration of the client's involvement in the program.

E. Clinical Assessment

If the client expresses interest in participating, the next step is to conduct a thorough mental health, substance use, and psychosocial needs assessment. In addition, the CM should identify whether there has been a formalized risk/need assessment through the criminal justice referring parties (e.g., Level of Service Inventory-Revised [LSI-R; Andrews & Bonta, 2000], ORAS, [Latessa, Lemke, Makarios, Smith, & Lowenkamp, 2010], COMPAS, [information available at www.northpointeinc.com]). When available, these should be reviewed with the criminal justice personnel who have conducted or have access to these assessments to help the CM inform treatment planning. CMs may administer risk/need assessment tools themselves in circumstances where they are appropriately trained and authorized to do so. 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 and treatment needs. A comprehensive clinical assessment may also be useful in identifying issues pertaining to risk/needs.

Factors for Assessment

- o Timeline
- o Mental Health
- o Addiction
  - Periods of stability/sobriety
  - Periods of Exacerbations
  - Impact on life-self
  - Craving
  - Legal, Employment
  - Stages of Change
- o Risky Behaviors
- o Suicide/Violence
- o Physical Health
- o Spirituality
- o Criminogenic Needs

Criminogenic Needs (Andrews & Bonta, 2010)

- History of Antisocial Behavior
- Antisocial Personality Pattern
- Antisocial Cognition
- Antisocial Associates
- Family/Marital Circumstances
- School/Work
- Leisure/Recreation
- Substance Abuse

F. Orientation to the MISSION-CJ Program

Following completion of the clinical assessments (and incorporation of available risk/need assessments), the client is introduced to his/her designated MISSION-CJ CM (if they have not already met through the screening process), who schedules an introductory 45-minute meeting to begin to get to know the client. The PSS should participate in the meeting if possible, but if necessary the client can meet with the PSS on a separate occasion. This initial orientation meeting is an opportunity for the CM to learn about the client's strengths, supports, interests and goals as well as the client's challenges, triggers, and barriers. The CM also explains how the program can support and assist the client and distinguishes the roles of MISSION-CJ from that of the client's primary treatment provider, if they have one.

The orientation session lays the foundation for a healthy working relationship between the client and MISSION-CJ treatment staff, builds the client's understanding of the program, clarifies expectations, marks the beginning of MISSION-CJ treatment planning, encourages hope, and lets the client 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 client meets his or her recovery goals.

The orientation includes a conversation about the client and CM roles with probation, the potential types and frequency of monitoring that may be done, and the possible consequences of lack of participation

or poor program attendance. Different programs and different individual circumstances may include different requirements. For example, an individual who is participating in a specialty court may have regular contact with the judge involved in the case in addition to probation and treatment providers, along with the MISSION-CJ staff. In those situations, frequent conversations between MISSION staff and the court personnel would be anticipated. In other, more community based programs, where criminal justice supervision only requires reports of compliance with treatment on a monthly basis, communication between providers and probation may be less frequent, and parameters for when communication needs to occur may need to be spelled out from the beginning of the program.

At the point of orientation, releases of information are reviewed and confirmed in order to allow communication between the MISSION-CJ CM/PSS and any criminal justice supervising authorities, as well as communication across treatment providers.

G. Introducing the MISSION-CJ Participant Workbook

During the orientation session, a member of the CM and PSS team will give the client the *MISSION-CJ Participant* Workbook and will explain that the workbook has two 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 PSS led sessions.

The Workbook is seen as an essential component of program orientation and symbolically offers the client a "gift" of support materials that will assist in the journey of recovery and community independence. While PSSs have a more critical role in the client's use of exercises and readings contained in the *MISSION-CJ Participant Workbook* (other than those used in DRT), the CM will want to review any significant issues raised by these materials with the client. A more extended discussion of the Participant Workbook and its use can be found in Chapter 6. *Peer Support.*

H. Initiating Treatment Planning

Treatment planning is a critical component of the MISSION-CJ approach and serves as the foundation for future program goals. While it is unlikely that the treatment plan will be completed in the first session, it is suggested that the 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 of the client's goals, available support, personal strengths, potential obstacles to recovery, and criminogenic needs as well as factors that may help improve responsivity to treatments. When the program is initiated in a treatment setting with an existing treatment plan, the MISSION-CJ team reviews the existing plan and coordinates their MISSION-CJ treatment plan accordingly so the client sees his/her treatment goals as consistent. As noted above, the MISSION-CJ team also adds to their treatment planning the perspective of reduced criminal recidivism to the treatment goals, and thus incorporates information related to criminogenic risk, needs and responsivity factors.

In the MISSION-CJ approach, treatment plans are reviewed at least monthly with the client, and the treatment plan is fine-tuned when necessary to reflect both goals achieved and new goals and objectives needed for independent community living. As noted, in addition to focusing on recovery related to co-occurring disorders, MISSION-CJ treatment plans are developed in accordance with the Risk-Need-Responsivity (RNR) framework (Andrews & Bonta, 2007). Thus, it is important to identify all risks and needs, to consider the work that has already been accomplished and the next steps that are needed, and to work with the client to prioritize their treatment goals. MISSION-CJ treatment plans should have clear goals and objectives and clearly describe MISSION-CJ's responsibility in coordinating care across community providers. As treatment planning is an essential component of MISSION-CJ services, a blank copy of a treatment plan is included below. Please refer to Appendix H for an example of a completed MISSION-CJ treatment plan as well as Appendix C for an explanation of how RNR relates to treatment planning.

MISSION-CJ Treatment Plan

Primary Diagnosis

_____

Secondary Diagnosis

_____

Other Treatment Providers

_____

_____

Criminal Justice Supervising Entity if applicable:

Special requirements of criminal justice supervision (e.g., toxicology screens, no contact orders, frequency of probation visits, court appearances, etc):

Service Needs

MISSION-CJ

Residential substance use treatment

Non-residential substance use supports (AA meetings, etc)

Acute psychiatric care

Other needed services

Housing needs

Outpatient mental health/substance use treatment

Medical care

Medication management

Dental services

Benefit entitlements

Vocational support

Family supports

Positive recreational activities

Cognitive behavioral therapies related to criminogenic needs (e.g. criminal thinking)

Specific trauma therapies

Crisis plan for individuals with a history of risk of harm to themselves or others

MISSION-CJ Service Delivery (increased frequency for medium and high risk offenders)

Frequency (Weekly, Bi-weekly, Monthly)

Length (2 months, 6 months, 12 months, other)

Treatment Priority Goal & Objectives to support recovery, wellness and reduced recidivism:

Treatment Goal #1:_____

_____

Treatment Goal #2:_____

_____

Treatment Goal #3:_____

_____

Next appt: Mon Tue Wed Thu Fri Sat Sun

Time: ___:___ am/pm

Provider: _____

Location: _____

I. Using Critical Time Intervention (CTI) Case Management

CTI case management, the cornerstone of the MISSION-CJ 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. Draine and Herman (2007) tested CTI in a criminal justice population for its effectiveness for a population of prisoners reentering their communities after a period of incarceration. In this study, persons who received CTI were more likely to be connected to services, receiving medication, and connected to a treatment provider than those who engaged in routine reentry services. Persons who have been arrested or who are appearing in court, or who have had short stays awaiting trial on criminal charges may have disrupted services and thus be in need of a mechanism to systematically reconnect them to care. Community integration and sustainment of positive community engagement is often difficult for these individuals, as there are many challenges to maintaining oneself and/or re-establishing oneself in the community with appropriate linkages to mental health, substance use, vocational/educational supports, and trauma-informed care. Focused, time-limited assistance during critical transitions and adjustment periods has been shown to have positive impacts upon the process of integrating back into the community (Susser et al., 1997; Kasprow & Rosenheck, 2007; Dixon et al., 2009; Herman & Mandiberg, 2010). With this in mind, time-limited but coordinated assistance can be applied at various points where individuals touch the criminal justice system.

Within the MISSION-CJ model the length of CTI can be modified depending on the client's needs and the available resources of the treatment program. Appendix E shows adjustments that may be made to the MISSION-CJ program for 2, 6, and 12-month service delivery schedules. Regardless of the period of time available to deliver MISSION-CJ services, the basic tasks and considerations described here still apply in each of the three phases. The reader might also be interesting in going to the CTI website for more general information on CTI (www.criticaltime.org).

The table below summarizes the three phases of CTI. The table outlines the MISSION-CJ CM's responsibilities in the delivery of CTI and other components of MISSION-CJ and how components in Phase I vary depending on the context in which services were initiated.

"Overview of the MISSION-CJ Case Manager's Responsibilities"

CTI Phase 1: Transition (or Integration) to Community	
Program is Initiated in Criminal Justice Context such as during reentry phases after incarceration. Treatment plans and ongoing monitoring are based on goals of recovery, and reduced recidivism, utilizing treatment planning with an added RNR framework.	**MISSION-CJ CM:** • Meets with the client and criminal justice representatives to discuss program expectations and boundaries, including the responsibilities of the MISSION-CJ treatment team. Also develop personalized treatment plan examining criminogenic risks and needs, as well as taking into account responsivity to treatment. When criminal justice supervision will be part of the client's circumstances, the supervision plan is reviewed with the client. In addition, with or without formal criminal justice supervision, the MISSION-CJ providers consider the criminogenic needs to help guide the client toward minimized risk of recidivism. ***Note***: *When MISSION-CJ staff become involved prior to a client's release from jail or prison and while a client is incarcerated, they ideally begin by providing in-reach supports, and working with correctional staff to help foster linkages that need to be put in place upon release. Primary providers, however, remain the correctional staff.* • Meets with judge, lawyer, and/or probation or parole officer when applicable to review the client's treatment plan and understand the criminal justice supervision requirements that will be placed upon the client in order to facilitate the support of the client's compliance with any mandates upon release.

(Continued)

CTI Phase 1: Transition (or Integration) to Community *Continued*

	• Conducts 13 psychoeducational **DRT** co-occurring disorders treatment sessions. • Meets with client prior to the release into community to assist in identifying community resources essential for successful community reintegration. • Assists with executing the transition plans that will help client sustain stability by providing linkages to key community supports. May includes crisis planning as indicated in the event that client poses risk of harm to self or others or other crises emerge.

CTI Phase 2: Try-Out

MISSION-CJ CM:

- Ongoing monitoring of treatment plan progress and fine-tune supports, taking into account criminogenic risk and needs.
- Continues to facilitate linkages that have already been established either by bringing the client into treatment or other related programs assertively or by working with the client to attend sessions on their own (discuss barriers with the client and consider use of telephone reminder calls).
- Facilitates new service linkages for identified problem areas, including those that may impact responsivity to treatments.
- Identifies any gaps in support system, barriers in accessing services, or areas where the client needs more support.
- Conducts periodic reviews to understand the client's association with positive peer influences, family stressors, social activities, structured leisure activities, and avoidance of factors that can contribute to recidivism.

CTI Phase 3: Transfer of Care

MISSION-CJ CM:

- Continues to monitor treatment plan considering recovery goals as well as framework related to criminal justice recidivism risks while preparing for termination from MISSION-CJ. Criminal justice community supervision may or may not be terminating simultaneously, and this transition needs to also be reviewed if it is occurring. Necessary prosocial supports and ongoing treatment plans should be solidified.
- Fine-tunes connections with community-based resources and supports.
- Meets with community providers to review transfer of care and identify any gaps in service.
- Reflects with the client on work that has been accomplished thus far and acknowledges end of participation in MISSION-CJ program.
- Reminds client of supports that have been established, says goodbye, and wishes the client the best of luck in their recovery.
- Works with criminal justice supervising entities, as applicable, on transfer of care plans and termination issues.
- Include crisis planning to help client identify resources if they have newly emerging difficulties after the transfer of care has taken place.

CTI Phase 1: Transition to Community

MISSION-CJ services may be implemented while the client is in a correctional facility or is living in the community. The MISSION-CJ CM's role in Phase 1: Transition to Community will be somewhat different in each of these circumstances. In situations when the client is incarcerated, CMs are responsible for tracking the client as he or she prepares for release back into the community. Whenever possible the CMs meet with the staff in the correctional setting to gain a better understanding of the client and to begin to talk about the future transfer of care. The CM should begin services delivery in the prison system to become familiar with the client's needs and to develop a trusting relationship that will continue into the community. In the jail or prison setting, the MISSION-CJ CM always serves as a secondary support and works in cooperation with treatment staff from the correctional facility. As clients prepare for their transition back into community living, MISSION-CJ CMs take part in facilitating the client's discharge plan along with the correctional reentry service planning staff. Planning often includes arranging for the use of community resources, including substance use and mental health treatment programs and linkages to housing, vocational/educational, and trauma-related treatment services as needed. Often, transportation from a correctional facility to the first point of contact for treatment or residential services offers a critical moment for positive engagement with MISSION CM/PSS teams. This is a critical time in the recovery process, and one that requires a high-level of support from the CM. Following discharge, the CM is responsible for facilitating and coordinating the implementation of the treatment plan in the community.

If MISSION-CJ services commence when the client resides in the community, the MISSION-CJ CM may be either the primary or secondary provider of care. This depends on whether or not the client is enrolled in an outpatient treatment, rehabilitation, or case management program, such as an Intensive Outpatient Program (IOP). If the client is not enrolled in a structured outpatient program or does not have another treatment provider, then the MISSION-CJ CM serves as the primary provider of care and assumes responsibility for executing the treatment plan and making modifications as needed. If the client is enrolled in an outpatient program the Mission-CJ CM serves as the secondary provider of care and works in cooperation with treatment staff from the outpatient program. Regardless of the treatment setting that the client 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 the client and to facilitate the ongoing use of these resources when the client does live in the community. This phase may include the development of crisis planning as indicated in the event that the client poses a risk of harm to self or others or other crises emerge as the client transitions to community or transitions from criminal justice interactions that raise the need for MISSION-CJ, such as court proceedings. In CTI Phase I, CM's also provide Dual Recovery Therapy treatment sessions, which will be described in Section J of this Chapter.

CTI Phase 2: Try-Out

In CTI *Phase II: Trying-Out*, MISSION-CJ CMs fine-tune community resources that support the client in meeting his or her goals as outlined in the MISSION-CJ treatment plan. The client's risks and needs are monitored on an ongoing basis and adjustments are made accordingly to the treatment plan. The CM conducts periodic reviews to understand the client's association with positive peer influences, family stressors, social activities, structured leisure activities, and avoidance of factors that can contribute to recidivism. The CMs may also incorporate new goals that were considered too difficult for the client to achieve prior to the progress made during Phase 1. For example, once a client has made sufficient progress towards securing housing and stabilizing mental health symptoms, he or she can begin to focus on other factors that may aid in recovery, such as rebuilding relationships with loved ones.

The primary goal of the *Try-Out* phase is for clients to become more self-sufficient in the community. Thus, the CM offers guided support in the attainment of the client's goals, as they are documented in the MISSION-CJ treatment plan, while encouraging the client to begin tackling some of these issues independently. In this Phase, the CM helps the client to build strong relationships with community providers as opposed to relying on the CM. As the frequency of the visits

between the CM and the client decrease, it is important that, whenever possible, the CM acts as a liaison between the client and other treatment providers rather than as a direct provider of supports. In addition, the CM supports the client and encourages adherence to any court mandates or supervision requirements. For example, in Phase 1, the MISSION-CJ CM may make calls to community providers on the client's behalf, even scheduling appointments if necessary. However, in Phase 2, the CM may assist the client in identifying a suitable provider, but will encourage the client to call and schedule the appointment on his or her own. This reduces the amount of services provided by the MISSION-CJ 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-CJ CMs must be prepared to offer support and guidance to assist with the reestablishment of the client's stability and sobriety as needed. Additionally, client's goals often change, and new and unanticipated obstacles may present themselves. Clients may find they have taken on more than they can handle in their financial obligations, encounter difficulty managing relationships, or find themselves overwhelmed by other responsibilities. As these situations arise, the CM works with the PSS to play a steadying role and help the client move forward. While this is happening, the CM helps check in on whether any community supervision requirements are at risk of not being met, and helps encourage adherence to those requirements, providing support and hope to the client regarding this aspect of his or her life.

The continuity of the relationship between the MISSION-CJ CM and client during this phase provides encouragement to the client and increases the likelihood that he/she will stay on course long enough to stabilize and remain clean and sober and continue to adhere to any needed mental health treatment. The MISSION-CJ CM continues to monitor the client for signs of psychiatric symptom instability and substance use relapse, making referrals to community treatment programs and other supports as necessary. MISSION-CJ CMs should frame relapses as something that can occur on the road to recovery. Every relapse should be seen as an opportunity for the client's growth and for the facilitation of a deeper client/CM/PSS connection. It is important to note that relapses are complex and may be related to and/or impact the client's involvement in the criminal justice system.

Specifically, it may be necessary to support the client despite the need for the criminal justice system to sanction a client (up to and including re-incarcerating an individual) related to substance use. Although relapse from a treatment perspective may be seen as something that occurs as part of the recovery journey, the criminal justice system sees relapse as a major criminogenic risk and therefore must respond to substance use and handle it in accordance with legal mandates and provisions related to sentencing and public safety goals. This is a tension that is also part of reality for a client in the criminal justice system, and MISSION CJ CMs understand this and help support, educate, and continue to guide clients to help them address warning signs of relapse before relapse occurs.

When relapse occurs within a criminal justice supervision context, in some cases long-term incarceration can result and the MISSION-CJ might terminate services with a client. If this outcome occurs, such termination should be done with a hand-off to treatment providers within the place of detention. If incarceration is short, MISSION-CJ may continue upon release and there may need to be bridging prior to release.

Another key responsibility of the MISSION-CJ CM during the *Try-Out* phase is to provide increased linkages to community-based vocational/educational rehabilitation programs (e.g., the VA, state or county level services, etc.) and to track the client's participation and progress in these programs. Because a great deal of vocational rehabilitation is delivered by others, the MISSION-CJ CM's responsibility is to help facilitate the vocational/rehabilitation treatment plan, be sure that it is working well to help meet the client's goals, and be prepared to fill in gaps as needed.

Throughout this phase, the client's treatment plan and progress toward meeting stated goals is discussed in regular meetings with the MISSION-CJ Clinical Supervisor. The CM and PSS may discuss challenges to the client's recovery, including lack of treatment engagement, symptom exacerbation, and substance

use relapse. The MISSION-CJ Clinical Supervisor provides the CM with guidance and discusses various approaches to work around any barriers to the client's participation in community treatment programs. Again, communication with criminal justice supervising entities is clarified at the onset of treatment and occurs throughout all the phases of CTI.

CTI Phase 3: Transfer of Care

During Phase 3, the MISSION-CJ CM fine-tunes linkages to community supports that were established during Phases 1 and 2, and identifies any potential future risks or needs the client may have before MISSION-CJ services are discontinued. For example, the CM and client may meet with community providers to identify any existing gaps in service and ensure that a continuing care plan for the client has been established. As the date for client's discharge from MISSION-CJ approaches, the CM, PSS, and client reflect on the work that has been accomplished and acknowledge the client's upcoming termination from the program. Termination from the program may or may not be aligned with the ending of probation or other community supervision period. Transitions from community criminal justice supervision are also discussed in this Phase, even if the supervision will persist beyond the time of the MISSION-CJ program.

It is important for the MISSION-CJ CM/PSS team to recognize that for many clients, MISSION-CJ 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 client in a direct and forthright way. It may be helpful to review the skills that the client has developed through the DRT psychoeducational treatment sessions and the keyed exercises and readings contained in the *Participant Workbook,* as well as other skills and strategies the client has found helpful (for example, meditation exercises, physical exercise, or the pursuit of personal interests such as writing or carpentry).

During the latter meetings, the MISSION-CJ CM will want to review the key community supports that have been established and explain to the client that he or she will soon no longer be a part of the client's treatment team and that ongoing care must be provided by community providers. There should also be a review of any remaining terms of mandated supervision so that the client is clear that they will now be managing this without the additional MISSION-CJ supports in place. Crisis planning should be reviewed in the event that the client has significant difficulties through and after the termination period. Clients may appear to be 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 clients to reveal their insecurities, leading to a false impression of well-being. Previous MISSION-CJ CMs have the following advice on how to handle the transition of care:

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

In addition, for MISSION-CJ clients, risk of re-arrest or re-incarceration persists for several years until stability can be achieved, at which point this risk may be decreased. A review of triggers that contribute to recidivism (e.g., antisocial peer influences, attitudes, behaviors, lack of structured activity, etc) should be done with the client for further education.

J. Delivering Dual Recovery Therapy (DRT)

Shortly after the Program Orientation session, during the first phase of the program (Transition to Community), the MISSION-CJ CM begins a series of sessions with the client to help him or her make crucial life changes that will enable them to meet their recovery goals. These sessions are a major component of the Dual Recovery Therapy (DRT) approach and can be delivered in a group format (such as when the clients are in prision/jail or an inpatient treatment facility), but can also be delivered individually (such as when a client is at home in the community). DRT addresses the problems clients face in recovering from both mental health and substance use disorders, each of which may be a "trigger" for the other. DRT is particularly applicable to criminally justice-involved clients 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-CJ CMs should be trained to deliver the 13 psychoeducational DRT co-occurring disorder treatment sessions.

The Case Manager begins each DRT session by administering the Dual Recovery Status Exam, which is presented below. This status exam helps the CM ensure that both mental health and substance use problems are monitored equally. Because of the criminal justice issues among the clients, the CM should also check in to make sure that the client is adhering to the terms of their probation or parole, if applicable. The CM then reviews treatment goals and the client's work on the MISSION-CJ Workbook exercises before introducing the topic of the present session.

The Dual Recovery Status Exam with Criminal Justice Elements

- Set agenda for session (client and counselor)
- Check-in with regard to any substances used since last session
- Check in about adherence to terms of probation, parole, or specialty court, if applicable
- Assess substance use motivational level
- Track symptoms of depression or anxiety and other mental health challenges
- Explore compliance with medications prescribed as well as probation/parole attendance
- Discuss the primary agenda topic(s) for the sessions
- Ask about attendance at Twelve Step groups and other elements of the treatment plan
- Check in about leisure time activities
- Check in about any recent family conflict
- Check in about current peers and whether they create any antisocial influences.

As shown in the table, "*DRT* Session Topics in Mission-CJ," each session focuses on a particular task. For more detailed information on the DRT sessions and worksheets keyed to each session, please see Appendix F. Participating clients use the exercises and readings in the *MISSION-CJ Participant Workbook* to follow along with the material covered during DRT sessions and to record their answers to the exercises. Any questions related to the additional exercises and readings contained in the Participant Workbook (especially those not part of DRT) should be discussed with the MISSION-CJ PSS, but if questions are relevant during a particular DRT session, the client 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 client's life. As used in MISSION-CJ, 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-CJ services commence in an institutional or outpatient setting, the authors suggest that the 13 psychoeducational DRT co-occurring disorder treatment sessions always be delivered along with CTI case management and care coordination services, as this is critical to the successful implementation of the MISSION-CJ approach.

DRT Session Topics in MISSION-CJ

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

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

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

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 use and mental health resources necessary to meet treatment goals.

Decisional Balance. A "decisional balance" worksheet is used to help clients identify the benefits and negative consequences of maintaining problematic behaviors and weighing the costs and benefits of continuing a behavior (e.g., substance use, missing appointments).

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

Twelve-Step Orientation and Recollections. Emphasis is placed on orienting clients who have never attended 12-step meetings to the structure, culture, rules, and language of the program. Emphasis is also placed on improving attendance for those clients who have attended in the past, but who dropped out or attended inconsistently.

Anger Management and Prosocial Skills training. This session focuses on prosocial skills training, including moral reasoning and anger control training. The goal is to teach the client cognitive strategies to combat unhealthy thinking styles. Clients discuss problematic behaviors in relationship to values and goals. A model of decision-making is presented as an alternative to impulsive actions.

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

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

Changing Unhealthy Thinking Patterns. Clients learn how unhealthy thinking patterns can perpetuate emotional problems and result in substance use as a maladaptive coping mechanism. Basic cognitive behavioral principles are taught during this session, including the interplay among thoughts, behaviors, and emotions. Unhealthy thinking is not the same as antisocial thinking, but MISSION-CJ clients may be at risk of having antisocial attitudes and thoughts and CMs/PSSs should be trained to identify these distinctions and review them in the context of risk of recidivism.

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

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

Therapeutic Techniques

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

The extent to which MISSION-CJ CMs are knowledgeable about and successfully utilize various evidence-based therapeutic practices during these sessions will influence the effectiveness of service delivery of the sessions. 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 G.

Although DRT is delivered primarily through 13 sessions, DRT principles are reinforced outside of these sessions as well. For example, MISSION-CJ CMs will find the Dual Recovery Status Exam with Criminal Justice Elements, which was described earlier in this section, a useful tool for monitoring recovery in their meetings with clients even after the completion of the 13 psychoeducational DRT treatment sessions. Additionally, MISSION-CJ 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 clients frequently to promote compliance with other substance use treatment regiments, encourage clients to utilize identified community-based resources, and to become involved in community-based activities such as church groups and 12-step meetings to reinforce the use of recovery activities in the community.

K. Providing Vocational Support

Clients may be ready to discuss vocational issues at any phase in the MISSION-CJ program, and the MISSION-CJ CM should be prepared to respond appropriately. For example, employment problems may arise early in the delivery of the DRT sessions as a major area of concern, especially for clients whose work histories, disabilities, or criminal backgrounds make it difficult for them to obtain employment. Similarly, clients who are able to obtain employment may have difficulty keeping jobs. As a result, throughout the intervention period, MISSION-CJ CMs should carefully monitor and support their client's employment-related goals on the treatment plan. In addition, lack of positive leisure time activities can be a risk factor for recidivism. Thus, although MISSION-CJ CMs need to focus on vocational supports, interim and additional steps might include examining leisure time activities that can impact positive outcomes.

The MISSION-CJ CM helps the client to overcome barriers to obtaining employment by connecting clients to Supported Employment, Vocational Rehabilitation, and State Department of Labor resources as well as any additional resources within the setting in which the CMs are employed. The MISSION-CJ CM also provides practical assistance to the client and helps him or her maintain employment satisfaction and cope with "on the job" stress. Throughout the MISSION-CJ program the client and the CM/PSS team identify barriers to obtaining and maintaining employment as well as possible mechanisms for overcoming these barriers.

The "Vocational Support Provided by MISSION-CJ Case Managers" table illustrates the CM's major responsibilities in providing vocational support. More information and resources to help MISSION-CJ CMs meet clients' vocational needs can be found in *Chapter 7: Vocational and Educational Supports for Individuals Involved in the Criminal Justice System.*

Vocational Support Provided by MISSION-CJ Case Managers

- Help clients initiate job search, complete applications, and prepare for interviews.
- Help clients identify how to handle their CJ history on job applications and in interviews.
- Help clients learn to manage their time and develop a work ethic.
- Help clients establish a positive, viable work history by demonstrating longevity and dependability.
- Manage conflicts.
- Help clients understand benefits packages, including medical and dental coverage, as well as vacation, sick, and personal leave.
- Help clients plan for retirement.

L. Trauma-Informed Care Considerations

While MISSION-CJ is not a PTSD intervention or one designed to treat co-occurring PTSD and addiction, MISSION-CJ CMs must be prepared to appropriately address the high rate of trauma experienced by clients with co-occurring mental health and substance use disorders who have criminal justice-involvement. As such, MISSION-CJ CMs must identify and monitor any signs or symptoms of trauma that may impact treatment and recovery. Remaining sensitive to fluctuations in symptoms will allow MISSION-CJ CMs to make informed decisions on whether or not clients should be referred out to a specialized program to stabilize PTSD symptoms and develop need coping skills prior to admission or readmission into the MISSION-CJ program. Essential trauma considerations for MISSION-CJ CMs are listed in the "Considerations in Trauma-Informed Care: What CMs Need to Know" table below.

Communication with MISSION-CJ PSSs is vital, as clients may relate information regarding exacerbation of these symptoms to their assigned PSS. Chapter 8: *Trauma as a Critical Consideration in MISSION-Criminal Justice Service Delivery* will help guide MISSION-CJ CMs, as well as the rest of the MISSION-CJ treatment team (peer and supervisor), regarding these issues.

Additionally, Appendix L provides links to additional resources related to trauma and recovery.

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

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

M. Ending the MISSION-CJ Program

As services to the client taper off, the client should be gradually preparing for the day when he or she will rely on community resources to help maintain recovery. In some programs, such as when MISSION-CJ may be linked to specialty courts, there may be a formal graduation as recognition of successful completion of elements of the program. However, it is also possible for the MISSION services to end while the client is still participating in an alternative to incarceration program such as a specialty court. That said, ending MISSION-CJ services can be a complicated time for program participants, and the MISSION-CJ CM must approach this time with careful consideration. At the final meeting with the MISSION-CJ CM (or with the CM/PSS team), it is helpful to review the client's goals and accomplishments. This review can also be benchmarked with the RNR informed MISSION-CJ assessment and treatment plan, which will offer a nice snapshot of the client's accomplishments during program enrollment, areas still needing to be addressed, and potential future risks to stable and sober community living absent further arrests or criminal justice involvement. The CM will also do well to review next steps with the client, supporting his or her plans to maintain recovery. MISSION-CJ CMs may want

to encourage clients to share good news and stay in touch, but they also must reinforce with the client that once the program ends the CM is no longer formally available as their care provider. While these discussions may bring up separation issues for some clients, successful completion of the MISSION-CJ program should be seen as a step forward in recovery. The table below summarizes the topics to be discussed during the final Mission-CJ session.

Topics for Discussion During Final MISSION-CJ Session

- Review the client's progress throughout the program. How has it gone for you? What have been the highlights and difficulties?
- What are your goals now as you move forward beyond MISSION-CJ?
- 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 community resources?
- Do you have a list of your upcoming appointments?
- Say goodbye.

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

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VI. Peer Support

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

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

- MISSION-CJ Peer Support Specialist

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

MISSION-CJ PSS as Staff: Opportunities and Limitations

MISSION-CJ PSSs are full staff members on the MISSION-CJ treatment team. The importance of PSSs should not be understated as they have the real-life experience to personally understand what a client may be going through; as such, their role is central no matter where MISSION-CJ services are initiated. Peer supports have become a critical part of successful treatment across settings, and their integration in MISSION-CJ is critical to the MISSION-CJ services.

One of the great opportunities for the MISSION-CJ peers is to foster engagement with participants, and to help role model successful roads to recovery. The PSS often is the person to build an early relationship with the participant- whether it is at court with a new referral, or someone coming out of jail or prison. So, for example, if MISSION-CJ service delivery is initiated while the client is receiving treatment in an institutional or outpatient treatment setting, MISSION-CJ PSSs facilitate weekly Peer Support group sessions. For those still incarcerated, we recommend that peers also go into the correctional facility and run groups, once a week if possible, to engage identified program participants in MISSION peer services prior to release.

Peer backgrounds may differ, but to be a peer, they should share some common element of experience with program participants, whether it is as a fellow Veteran, someone with lived mental health or substance use history, or any combination of these factors. In some instances, peers may have criminal justice histories (Miller & Massaro, 2008) in addition to mental health and substance use backgrounds. Peers with a criminal justice background working within criminal justice settings and with clients involved in the justice system are increasingly common, and lessons learned in hiring these individuals are important to keep in mind. For example, peers with criminal backgrounds should be willing and able to disclose information regarding their own criminal histories. In certain settings, there may be specific protocols to review their criminal backgrounds in order for them to be approved to work in particular places or contexts (e.g, when seeking entry into correctional facilities), and if these protocols do not exist, there may need to be new protocols identified. There may additionally need to be specific stakeholder buy-in to the concept of hiring peers with these backgrounds, and criminal justice personnel may have justifiable differences in how these individuals may or may not fit in with justice-related programs and services.

Hiring of forensic PSSs can be complicated given employment laws that may restrict individuals with certain criminal backgrounds from working in particular settings (Miller & Massaro, 2008). Some jurisdiction hiring practices may vary (e.g., federal vs. state) in which case there may need to be a review across two

different systems. Also, the person's willingness and ability to disclose the criminal justice aspect of their background may be difficult and will require support. Some jurisdictions may specifically not allow persons convicted of particular prior crimes to interact with individuals under probation or parole supervision. If the peer himself/herself is under probation/parole supervision, there may be restrictions placed upon them that may result in limitations to their employment in these programs. Jurisdictions bringing "forensic peers" into their programs would do well to discuss these matters with stakeholders.

An additional factor to consider is where in the legal case process the PSS becomes involved. Because PSSs may begin work with a client facing criminal charges, the PSS must be aware of certain nuances of working with a criminal defendant. For example, it may be that at a particular phase of engagement, the PSS does not talk to the client about the alleged offense, but rather focuses on hope, recovery and treatment oriented needs. This may be important if the peer is not protected from having to testify about the content of conversations with pretrial participants (See Seligowski & Grudzinskas, 2009 for more information on confidentiality and privilege issues within the peer workforce). More open discussions about criminal behavior may be more appropriate at later stages of a criminal case (post-adjudication), though it may be raised later if clients reveal illegal behavior in the course of conversation with the PSS. It is important to offer training and support related to these issues so that all are aware of the opportunities and potential challenges involved in the role in this context.

MISSION-CJ Peers: Working with Clients

During the often lengthy and difficult process of rebuilding a life in the community, clients receiving MISSION-CJ services can benefit greatly from the support of someone with similar experiences — someone who can offer advice and empathy when the client faces challenges along the way. In addition to being a client themselves in the past or even still actively receiving some services, each Peer Support Specialist (PSS) on the MISSION-CJ treatment team has recovered from challenges (criminal justice problems, substance use, mental illness, and/or unemployment) similar to those faced by the clients with whom they are working and has received training specific to serving as a PSS. MISSION PSSs advocate for the clients on their caseload, share wellness and relapse prevention strategies, and provide practical support. The unique mix of camaraderie and leadership empowers clients to self-determine their own recovery goals, which may be affected by criminal justice supervision.

Peer-led 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-CJ PSSs who have not facilitated groups before should look to the MISSION-CJ 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 client has transitioned to the community, the MISSION-CJ PSS will address the same topics as they become relevant to the client in one-to-one conversations. Peers meet with the client, often in the client's place of residence, ensuring that the client is utilizing the appropriate supports including community mental health and substance use treatment programs, 12-step meetings, and vocational rehabilitation services. If the client is not using these supports, MISSION-CJ PSSs facilitate the process by accompanying clients to 12-step meetings or by assertively bringing them to their appointments. Furthermore, utilizing "check in" sessions with clients, MISSION-CJ PSSs can reinforce both the work clients have done in Dual Recovery Therapy (DRT) sessions led by a MISSION-CJ CM, as well as the work clients have done on the Self-Guided Exercises contained in the MISSION-CJ Participant Workbook. These check-ins also allow a chance to make observations related to criminogenic risks and needs that may require education and guidance. Peers also may need to communicate concerns with probation or parole officers depending on the terms of the community supervision that the client is required to adhere to.

Implications of the "Critical Time Intervention" Model

The MISSION-CJ approach employs the tested model of "Critical Time Intervention" (CTI) case management and thus both the case managers and peers use this phased approach when delivering services. By

using this approach, the PSS offers different types of support to the client in different phases of the transition to community life. The three distinct phases of care are: (1) *Transition to community* (the initial phase of intense support), (2) *Try-Out* (in which the client accepts increasing responsibility for maintaining a healthy approach to life), and (3) *Transfer of care* (in which the client relies increasingly on community supports rather than the MISSION-CJ team, and the program comes to an end). Consistent with the CTI approach, the team gradually reduces its frequency of contact with the client over the course of the intervention to reinforce the use of community supports and independent living. Therefore, Peer Support must be provided in a way that fosters independence and focuses on helping the client learn self-advocacy skills and establish connections in the community that he/she can maintain independently upon completion of the MISSION-CJ program. In order to accomplish this, the MISSION-CJ PSS works in close collaboration with the MISSION-CJ CM. Both the PSS and CM have the mutual goal of ensuring that clients assigned to their team have the resources and skills they need to achieve the goals they have set for themselves as well as for continued growth in their recovery and in their efforts to avoid re-arrest and/or re-incarceration. Please see the table below which summarizes the role of the PSS in MISSION-CJ's CTI care component.

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

CTI Phase 1: Transition to the Community

The MISSION-CJ PSS:

- Meets with the client periodically to establish rapport and encourage the client in the changes he or she is making.
- Provides input on the MISSION-CJ treatment plan.
- Conducts group or individual Peer Support sessions on topics related to the transition to healthy living in a community setting and the importance of positive peer influences and prosocial thinking and behavior.
- Discusses exercises and readings in the MISSION-CJ Participant Workbook with the client.
- Works with the MISSION-CJ CM to identify community resources essential for successful community integration and community involvement in positive leisure time activities.
- Assists with executing the treatment plan and helps the client overcome barriers that arise in using key community supports, including accompanying the client to appointments and meetings when helpful. PSSs may also accompany clients to court appearances or meetings with community criminal justice supervising personnel.

CTI Phase 2: Try-Out

The MISSION-CJ PSS:

- Continues to facilitate linkages that have already been established, helping the client think through and resolve obstacles and challenges that arise through positive and prosocial behaviors. Provide positive peer role modeling.
- Redirects the client's attention to exercises in the MISSION-CJ Participant Workbook as needed, helping the client recommit to goals and strategies or, when needed, express new ones.
- Identifies any gaps in support system, barriers in accessing services, or areas where the client needs more support and works with the CM and other providers to address these gaps.

(Continued)

CTI Phase 3: Transfer of Care

The MISSION-CJ PSS:

- Celebrates the client's ability to maintain goals in healthy living and puts relapses or slips in perspective.
- Reflects on work that has been accomplished thus far and acknowledges end of participation in MISSION-CJ program.
- Reminds client of supports that have been established, says goodbye, and wishes the client the best of luck in their recovery and in their ability to avoid re-arrest or re-incarceration.

B. Working Effectively as a MISSION-CJ Treatment Team

MISSION-CJ PSSs and CMs are paired into permanent teams and share primary responsibility for the clients assigned to each pair. Other members of the MISSION-CJ team might provide back-up services; however, respecting the assignment of clients to particular teams is important to well-coordinated care. PSSs sometimes have contact with clients assigned to another MISSION-CJ PSS/CM team; this may occur through a chance meeting in the residential or inpatient treatment center, in the community, or if a client seeks out a particular PSS. Such contact is acceptable, but when a PSS discusses issues of clinical significance (i.e., issues that relate to the client's mental health or substance use recovery) with clients who are assigned to another team, the PSS must encourage the client to relay any relevant information to the PSS/CM team to whom that client 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 client. These communications help team members support each other's work and track evolving issues that may require special intervention. The PSS may tell the CM that the client has been seeing drug-using or criminally-involved friends at their old hangouts, or a CM may tell the PSS that a client has been shy and nervous about going to AA meetings and asks the PSS to offer to attend a meeting with that client or help him/her obtain a sponsor. 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, ideally at the earliest stage possible to allow for prompt intervention and potential problem solving with criminal justice supervising personnel.

Depending on the issues to be addressed and the preferences of each client, PSSs and CMs may meet with the client together or separately. When the PSS and CM meet with the client separately, the PSS and CM also meet and discuss their observations and concerns regarding the client regularly. More frequent contacts may be useful especially with higher risk individuals who may be more vulnerable to re-engaging with negative social influences. With greater contacts in the community, these individuals can be frequently engaged in positive activities and monitored for any increase risk of re-arrest. By working together smoothly, team members can enhance their effectiveness and ensure each client enrolled in the MISSION-CJ program is receiving consistent messages and support. Clients are informed at the outset of their participation that information is shared among MISSION-CJ team members to better facilitate their care.

Within individual teams, the PSS and the CM coordinate care in order to promote consistency in service delivery. Many roles and responsibilities are shared, with each member offering his or her skills and perspectives to assist the client in achieving important goals. Each team member, however, also has areas of primary responsibility (see the table, "Responsibilities/Roles of the MISSION-CJ Peer Support Specialist and Case Manager"). The MISSION-CJ CM takes the lead in the developing Risk-Need-Responsivity (RNR) informed treatment plans (see chapter 1 and Appendix C for more details about RNR). However, the treatment plans should reflect the PSS's

input. When one team member assumes a primary role in a certain area, the other team member provides assistance and serves in the primary or lead capacity when the primary team member is temporarily unable to fulfill that duty (for example, due to absence or sickness). While both PSSs and CMs share responsibility for assisting clients with use of the MISSION-CJ Participant Workbook, it is really the PSS who checks in with the client regularly; while CMs ensure that the appropriate 12-step supports are in place, it is the PSS who actually accompany clients to meetings if necessary. Because of their very hands on roll, the PSS will spend the majority of his or her time on the road and making phone calls.

Responsibilities/Roles of MISSION-CJ 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 clients advocate for themselves with providers and ensure effective two-way communications • Recreational planning and modeling healthy living and prosocial engagement and activities using free or low-cost community resources • Linkage to community mental health and substance use recovery programs (NA/AA) • Accompany clients to clinical appointments, job interviews, recreational activities, and self-help group meetings as well as court appearances and meetings with probation or parole • Increase motivation toward recovery goals and reduced recidivism • Provide positive peer support and role modeling of prosocial attitudes and thinking • Assist clients with *Participant Workbook* exercises and readings, discuss material, and reinforce insights	• Comprehensive assessment and treatment planning documentation related to mental illness, substance use, and criminogenic risk/needs • 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 supports as needed: interview skills training, resume building, linkages to education and training programs • Facilitate linkage to other clinical services • Support adherence to mandated terms imposed through the criminal justice system • Communicate with clinical service providers and criminal justice supervising entities • 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 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 • Coordinate responses and communication with probation, parole, and/or the courts depending on parameters of any community supervision term • Coordinate entry into a correctional facility to begin and/or continue to engage with the client

C. Initiating Relationships with Clients

Orientation to the MISSION-CJ Program

The initial MISSION-CJ session occurs after the intake conducted by staff. Before the MISSION-CJ CM and PSS meet the client, the MISSION-CJ Clinical Supervisor (or if necessary the CM) performs a diagnostic assessment and screens the client to determine his or her clinical eligibility for the program. Parties in the criminal case (e.g., Judges, Prosecution and Defense Attorneys) will also need to review the client's criminal case to determine whether, from a public safety perspective, the client is appropriate for MISSION-CJ as an alternative to incarceration or as an appropriate community reentry plan.

Once the client has been determined eligible and has agreed to participate in the MISSION-CJ program, the client is introduced to his/her permanent MISSION-CJ CM and PSS, and either the CM or PSS schedules an introductory meeting to begin the process of getting to know the client and determining his or her needs. Both the MISSION-CJ CM and PSS should participate in the introductory meeting if possible, but if necessary the client can meet with CM and PSS separately. This initial 45-minute orientation meeting is an opportunity for the MISSION-CJ treatment team to learn about the client's strengths, supports, interests and goals as well as the client's challenges, triggers, and barriers. The MSSION-CJ treatment team also must become familiar with any court-imposed or parole-related mandates on the client.

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

During the initial meeting with the participant, the MISSION-CJ 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-CJ that the client might not understand after meeting with the MISSION-CJ Clinical Supervisor or CM. In general, clients appear to be relatively comfortable with the informal nature of the relationship with the PSS. Sometimes, however, establishing rapport with a client enrolled in the MISSION-CJ program will take some extra work. The PSS should try and find a common bond or interest with the client to put the client at ease and help start the process of building a trusting relationship.

Furnishing the Client with a MISSION-CJ Participant Workbook

During the orientation session, the CM and/or PSS give the client the *MISSION-CJ Participant Workbook.* The materials in the Workbook are like "homework assignments" and designed for the client to have many of the needed resources at their fingertips to facilitate recovery and prevent criminal recidivism. The *MISSION CJ Participant Workbook* contains two important components:

1. Tools that will be used as part of DRT sessions led by the CM.
2. Exercises on recovery that are reviewed in peer-led sessions.

While the Workbook is essential to the MISSION-CJ program orientation and symbolically offers the client a "gift" of support materials, it is our experience that clients 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 Workbook is not seen as overwhelming, but rather as a critical resource that can be used throughout the duration of MISSION-CJ services and as a set of tools for recovery beyond the client's time in the MISSION-CJ program.

While MISSION-CJ PSSs have the lead role in facilitating the client's use of exercises and readings contained in the *MISSION-CJ Participant Workbook* (other than those used in DRT), the CM should be made aware of, and review with the client, any significant issues raised by these materials. More details about the PSSs role in ongoing facilitation of the Workbook with their clients are described below.

Working with Clients in a Treatment Setting

For clients who reside in an institutional setting such as a jail or prison, MISSION-CJ PSSs get to know their assigned clients both directly, through peer-led group discussions when possible, and/or indirectly, through meetings with care coordinators, re-entry planners and the like. Along with the MISSION-CJ CM, the PSS may attend treatment team or planning meetings held by the staff of a given facility or may be provided updates on the results of these meetings. The ability for PSSs and CMs to do in-reach prior to a re-entry initiative may vary across settings and across jurisdictions. When possible, participation in the institutional reentry planning meetings can be helpful for the MISSION-CJ team to learn more about a client's clinical course, risk needs, findings on risk assessments, and also provides opportunities to build relationships with institutional care staff, which is helpful for care coordination around the time of release. CMs/PSSs can also be helpful in arranging transportation and other forms of support for the actual planned date of release. Additionally, by building trust and camaraderie with clients and institutional staff during their incarceration the MISSION-CJ team can deliver targeted and informed treatment upon release. Similarly, when clients begin MISSION-CJ through community-based referrals, such as a court-based program, they can begin to build rapport from the outset. If clients require a period of residential or inpatient treatment at the beginning of the program, they have a bridger through MISSION-CJ teams that can assist them in transitioning back to community settings.

Opportunities for Contact in a Correctional Facility with Clients Receiving MISSION-CJ Services

- An initial meeting orienting the client to the MISSION-CJ program
- Informal contacts
- A transitional session close to the end of a criminal sentence and anticipated release
- Weekly in-reach group sessions led by the Peer Support Specialist for a specified time period prior to anticipated release
- Check in meetings to help with reentry planning

Tips For Peers Working in Correctional or Court Settings

- Vetting and approval may be required for peers to enter correctional facilities or work with currently court-involved defendants if peer has a criminal justice background
- Peers and other staff benefit from support, supervision, and guidance when working within correctional and/or court-based settings
- Training should include understanding legal terminology (see Appendix R) and some orientation to protocols, dress, items that may be allowable or not allowable (e.g., phones with cameras) for entering the institution

D. Using the MISSION-CJ Participant Workbook

As described earlier, the MISSION-CJ Participant Workbook is given to the client during the orientation session. The Workbook is divided into two main parts with additional exercises related to experiences in criminal justice settings. 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. Finally, there are some exercises focused on criminal justice experiences and the development of positive coping strategies. While the authors encourage clients to complete the self-guided exercises contained in Part 1 independently, the MISSION-CJ PSS plays a critical role in the completion of these exercises and in helping the client put new skills and discoveries into action.

Part 1 of the Workbook also contains DRT exercises, which are discussed during the DRT individual or group sessions led by the MISSION-CJ CM (the PSS works with the client to complete the worksheet in advance). The client's written responses to DRT exercises can be a helpful resource and a reminder of the client's commitment to achieving personal goals, the skills that help maintain recovery, and the essential concepts that will help the client stay focused on their recovery.

It is helpful for both MISSION-CJ PSSs and CMs to refer back to the client's "triggers" for substance use, vulnerabilities related to antisocial influences, family connections, his or her personal goals, and plans for recreational and leisure activities—either as a reminder, or as an opportunity to re-envision the path to recovery and decreased recidivism.

PSSs have a brief 10 minute weekly check-in session to review each exercise that the client has completed in the *MISSION-CJ Participant Workbook.* Although clients receiving MISSION-CJ services during incarceration or an inpatient/residential stay participate in DRT sessions and other structured sessions, MISSION-CJ peer-led sessions are unique because they offer the PSS's "been there, done that" perspective. The amount of time spent is variable, depending in part on whether a client needs to work through an issue raised by the DRT worksheets, the *MISSION-CJ Participant Workbook* Self-Guided Exercises, or the readings. While it is recommended that 10 minutes a week is set aside for this purpose, it could also be done in a longer individual session with the MISSION-CJ PSS. If many clients are having trouble using the workbook, or their motivation is wavering and the PSS is doing sessions in a group format, it could be brought into the PSS group session as an issue for everyone to discuss. More details about the peer-led sessions will follow.

For those clients leaving an institutional setting such as a jail, prison, or residential treatment facility, the readings in the latter part of the Workbook become particularly relevant, raising issues that may concern the client and creating 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 clients process these 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 client's progress regarding the readings in the Workbook and the issues that may be of concern to the client. The readings also provide an opportunity for PSSs to share their own stories about recovery, about exposure to the criminal justice system if applicable, or other common elements between the client and the peer. In this way, the PSS provides positive, prosocial role modeling that gives hope and helps meet the client where they are in their recovery journey.

Part 2 of the *MISSION-CJ Participant Workbook* includes a brief explanation of the most common mental health conditions of clients entering the MISSION-CJ program. This explanation is meant to serve as a resource for clients 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:

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

E. Peer Support Sessions

The PSS typically leads a weekly 60-90 minute group session (see Appendix I). These group sessions can be scheduled at different times and conducted by different PSSs in order to accommodate the varying schedules of clients; however, each MISSION-CJ PSS covers the same selected topic for the week. The 11 topics (see Peer-led Sessions table) have been identified by PSSs from past MISSION-based projects as having particular relevance to those clients who are either incarcerated or in inpatient/residential treatment settings, as they prepare themselves for independent community living. The group discussions serve several purposes. From the standpoint of the MISSION-CJ program, the primary purpose is to establish a sense of camaraderie among clients and the PSS. The work with the PSS and with the other clients allows for potential positive supports and prosocial connections for leisure time activities in the community. The weekly peer-led sessions offer clients a forum to air their concerns, fears, questions, and hopes in a safe environment, knowing that they will not be judged and that their peers (both the MISSION-

CJ PSS and their fellow clients) 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 throughout the program.

For clients who reside in institutional settings, when the institution will allow it, these groups may begin with in-reach sessions, so that after the client is discharged from the institutional setting, the client is already comfortable in seeking and accepting support and advice from the MISSION-CJ PSS. Incarcerated individuals may have difficulties with coping within the institutional setting. They may be in a situation where they have limited time out of their cell or they may have restrictions on contact with other inmates. Also, outside staff, including those within MISSION-CJ may not be permitted into a facility for a variety of reasons (though ideally MISSION-CJ work done with a re-entry focus would incorporate the opportunity for in-reach). If group sessions by the MISSION-CJ providers are not feasible as part of in-reach in a particular correctional setting, MISSION-CJ teams can identify alternative mechanisms for contact (e.g. visitation, individual visits). Work within a facility or institution allows for planning and connectivity upon discharge or release, but the MISSION-CJ team must also respect the boundaries and parameters of the correctional setting and thus can, if needed, begin treatment in the community (see below). Additionally, working with institutional staff can also allow for communication of support while a person is incarcerated.

For clients who are already living independently in the community, for example those who have been released or diverted from jail/prison, peer-led sessions often occur at the client's residence or in his or her surroundings. Thus, sessions may take place while taking a walk, sitting on nearby park bench, or in a coffee shop. 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. This approach may also be used in situations in which a client may have been incarcerated, but for whatever reason the MISSION-CJ team was unable to work with them prior to release. In some instances, work with clients might take place at a courthouse. When it does, the MISSION-CJ team should be sensitive to ensuring that participants feel comfortable speaking in such a setting.

In our experience, we have seen participants enjoy this format as they are coming to court to appear regularly before a judge for a specialty court session anyway. In other circumstances, we have seen clients feel that the court space provokes stress for them and they prefer meetings out in the community. Regardless, having meetings in spaces other than a traditional clinic office can be very helpful for clients.

The peer-led sessions allow the client to air any concerns they are having with their living arrangement or adjustment to the community; the MISSION-CJ PSS can then identify problems and relay information back to the treatment team. Additionally, these sessions allow the client to discuss concerns, ask additional questions, and express their future hopes in a comfortable, relaxed environment free of judgment and full of support.

Topic Addressed in Peer-led Sessions

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

Format

The design of the weekly peer-led session deliberately avoids excessive structure as clients receiving MISSION-CJ services participate in a number of structured activities either in the jail/prison, residential or outpatient programs, or in other program settings

relevant to their recovery. As a result, MISSION-CJ PSSs strive to present a more relaxed atmosphere.

Structure of Weekly Peer-led MISSION-CJ Meetings in the Treatment or Correctional Facility

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

When issues arise in peer-led sessions that involve safety or other critically important issues, the MISSION-CJ PSS's first step is to encourage the client to further discuss the issue with the rest of the treatment team, particularly the CM and an institutional or any other treatment provider, if applicable. The PSS shall also indicate to the client that he/she must share this information with the treatment team who in turn may need to share it with criminal justice personnel.

F. Providing Support in the Community Either Upon Release or if Client is Diverted

Providing Input into the Discharge Plan from a Correctional or Treatment Facility

If the client is re-entering the community following incarceration or inpatient/residential treatment, the MISSION-CJ team will not only have its own plan for helping the client, but will also play a key role in meeting the goals of the discharge plan of the agency from which the client was released. While staff from the jail/prison or treatment facility create discharge plans for each client re-entering the community, the MISSION-CJ team, including PSSs, have input into this plan. The MISSION-CJ PSS's input is coordinated through the CM assigned to the same client. This input reflects insights gained from informal contacts, contacts with current providers within a facility or in the community, observing the client's behavior in group sessions and from information learned from weekly treatment team meetings.

The MISSION-CJ PSS often offers their personal insights and observations about the client 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 client and could share this recommendation and the reasoning behind it. The client and his or her treatment team at the institutional facility may take these insights into account as they finalize the plan. When disagreements arise between the MISSION-CJ PSS and CM or between the PSS/CM and the correctional or inpatient/residential treatment staff regarding the care or planning for a client enrolled in the MISSION-CJ program, the MISSION-CJ team should raise the issue with the clinical supervisor, who works with each party, providing guidance and helping to resolve the conflict.

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

Providing Input into the Treatment Plan when MISSION-CJ is Initiated in a Community Setting including for those Diverted from Jail or Prison

MISSION-CJ services can be initiated when the client resides in the community, such as when it is implemented as part of a jail or prison diversion or after incarceration programs. In these circumstances, the PSS actively works with the MISSION-CJ CM and clinical supervisor to develop a MISSION-CJ treatment plan that provides a clear path to achieving the client's goals of recovery and reduced recidivism. In cases involving pre-trial defendants as potential participants, treatment planning may involve communication with

a participant's defense attorney, as well as providing support for the client during court proceedings. For clients involved in specialty court dockets, the PSS may play an integral role in ongoing support as the client prepares and organizes schedules around regular court appearances.

Types of Support Provided by Peer Support Specialist

MISSION-CJ PSSs offer individual support to the client in areas that overlap with the support provided by the MISSION-CJ CM. This includes offering support in getting and maintaining safe housing, sustaining recovery from substance use, managing mental health symptoms, obtaining gainful employment, maintaining positive leisure time activities, rebuilding positive family relationships, and achieving educational goals. The support also involves education and reminders regarding terms of supervision by criminal justice authorities.

The type of support that MISSION-CJ PSSs offer can be practical and/or emotional; for example, they might offer to accompany clients to initial mental health appointments, bring them to AA or NA meetings, bring them to court appearances or appointments with probation, tell them what to expect in a particular housing program, provide them information about local leisure time activities or volunteer opportunities, or offer advice and support as clients try to reconnect with their families. They also use specific tools and techniques, such as the "PICBA" tool for personal problem-solving (see the MISSION-CJ Participant Workbook), to empower clients to become more involved in treatment decisions. Like MISSION-CJ CMs, PSSs make ready use of the tools and narratives contained in the Workbook on an as-needed basis. Below are descriptions of experience-based competencies that PSSs have and select case examples of how PSSs applied those competencies.

Reducing Fear

Achieving life goals requires overcoming fear of failure and fear of the unknown. Having been homeless and through institutional treatment, clients might doubt their ability to succeed on their own, to remain sober, and to adjust to work and other aspects of community life with which they have become unfamiliar. Clients might also fear taking medications or being stigmatized in the community as a result of their substance use and mental health conditions or treatment. They may have difficulty with integration into their surroundings related to community supervision and oversight. Having been through some similar experiences, MISSION-CJ PSSs are able to provide emotional support and practical advice for facing these challenges. A client might call the MISSION PSS or CM because he or she had a "drug dream," had a fight with a spouse or partner, or is simply feeling the urge to use. In these circumstances, the PSS may be very helpful in identifying resources to help the client maintain successful sobriety in addition to providing an opportunity for the client to express feelings and have a supportive role model available to listen.

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 diverted from jail and into a residential substance use treatment program when he faced his first offense related to shoplifting. He did well initially and was transferred from his residential substance use treatment program to a new transitional housing program. While there, he began using alcohol again. Now, Isaac faced eviction from transitional housing, re-arrest related to his alcohol use, and in a panic he called his PSS for help.

By facilitating access to resources, the MISSION-CJ PSS was able to find Isaac a secure house located close to his community resources and services, where the MISSION-CJ 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 health-related business. The PSS was in touch with probation throughout these transitions and informed probation of the clinical changes in his program plan. Probation reviewed the case and did not file for any technical violations. Throughout this process his PSS provided encouragement, support, reassurance, and positive feedback to help Isaac overcome his paralyzing fear

and take the necessary steps back to a positive lifestyle.

Accompanying Clients

Another way in which MISSION-CJ PSSs can provide practical support to clients is to accompany them to their first few mental health appointments, to court hearings, as they learn unfamiliar public transportation systems, or when they need to buy groceries or shop for clothes. The PSS continues to accompany the client on these activities until they are comfortable doing such tasks on their own. For example, a PSS who has shopped for a child before might accompany a client who is trying to reunite with his family to help him buy clothes for his children. This support can be especially critical in times when the client stumbles on his or her recovery path. This type of support can also model positive leisuretime activities. The MISSION-CJ PSS can provide moral support when the client becomes homeless or begins using again by accompanying him/her to his probation officer, a shelter, detoxification facility, or the hospital.

Promoting a Healthy Lifestyle

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

Peer Support in Action: Example 2

"Ricardo" had recently received a housing placement upon prison release. 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 probation officer had him appear before the court, but advocated for increased treatment over incarceration. Shortly after a hearing on the matter, his MISSION-CJ 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 that allowed someone with Ricardo's criminal background, 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-CJ, 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 a local program.

Socializing

For clients 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-CJ 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-CJ PSS primarily relies on AA and NA social events because these events tend to be larger and better established, offering clients in the MISSION-CJ 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-CJ PSSs may also set up small, informal social events for clients on their caseload. For example, a PSS might get together with three or four clients to eat pizza and play pool, each chipping in if another client who attends does not have enough money to participate. Especially as clients return to work, social events are more likely to be successful on evening or weekend hours. Ideally, the work schedules of MISSION-CJ PSSs will include some evenings and weekends, since one of the hallmarks of peer support is that it is generally available when more traditional services are limited, and when clients are most in need of natural support and opportunities for social connectedness. Although MISSION-CJ PSSs have a working schedule that mostly follows "normal business hours," employing a mechanism that allows them to use "comp time" to shift their working hours, when necessary is useful. However, PSSs also tend to have natural contact with clients during nights and weekends since they often participate in the same type of activities as a part of their own personal lives (for example, going to AA or NA meetings/activities, church, and grocery shopping). MISSION-CJ teams should help educate clients and review projected plans in order to ensure that participation in any social events do not violate terms of their community supervision (this could include avoiding persons who have restraining orders against them, avoiding persons on parole if that is part of their own legal mandate, avoiding situations where illegal activities may be occurring).

Achieving Goals

As someone who has had experiences similar to those of the clients enrolled in the MISSION-CJ program, the PSS often has excellent insight into what can be considered realistic goals for clients to set and achieve. Those clients who are really struggling might have goals that seem trivial to an outsider, but are understood by those who have experienced similar struggles. For example, a person who is feeling extremely depressed might have as a goal to smile three times per day or to go out in public twice a week and talk to someone. Of course, MISSION-CJ PSSs should help set goals as high as the client wishes, with shorter-term objectives being developed in the interim. After goals are set, it is important for the MISSION-CJ 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-CJ 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 assist Earl to slowly pay off his fines and get his driver's license back. Even now that he has paid off his fines and has gotten his license back, he has decided to no longer smoke cigarettes. The PSS's sharing of his personal experiences showed Earl that the barrier he faced was not an insurmountable problem, and the PSS also helped to motivate Earl to seek a better paying job while also modeling healthy behavior (smoking cessation). Through perseverance, Earl got that job and was finally able to pay off his fines.

Working

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

Given that essentially all clients in MISSION-CJ have criminal histories (and some of them are extensive) and they may have limited work experience, they often have difficulty finding a job or have to start out working in less desirable positions. The role of the MISSION-CJ PSS is to review what correctional or treatment facility staff or others (e.g., probation) may have done in preparing clients for work and/or providing new instruction to them. One important topic to address with clients is responding to questions about their past difficulties on applications and during interviews. Other topics are the importance of punctuality and reliable attendance. The MISSION-CJ PSS may also take clients to a nearby career center to sign up for job skill classes or to get help drafting or editing a resume.

Peer Support in Action: Example 4

Marcus lost a well-paying job when he relapsed to cocaine use. Because of the terms of his community supervision and a positive toxicology screen with probation, he was sanctioned to a brief period of detention in a correctional facility. Some communication with the MISSION-CJ PSS was maintained while he was in jail. Upon release he asked for support from his MISSION-CJ 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 gardening store where he had previously worked. The pay for this job was much lower than Marcus's previous position, and Marcus was not sure he could get by on the reduced income. In fact, he did lose his apartment, but his MISSION-CJ PSS helped him locate alternative housing. Finding housing raised its own challenges given Marcus' criminal background. The PSS was able to sit with Marcus and review the official criminal record that Marcus had and was able to also support Marcus in getting a few default warrants resolved by going to court to explain that he had been in a treatment facility at the time the Court appearances were not addressed. Housing options then became more available.

Throughout the process, Marcus' PSS helped him to keep his head up, pointing out that the housing would be resolved and that the gardening job 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-CJ PSS drew from his own experience working at a nursing home for nine dollars an hour, explaining to Marcus the new perspective he had gained. He told Marcus, "you must have gratitude for your accomplishments now," rather than dwelling on the past. "You depleted your 401K to get high, and you're not going to get that back," he said. He helped Marcus realize that he would have to take things slowly in rebuilding his finances and helped him use his limited income to his advantage.

Addressing Stigma

While mental illness and substance use problems are not uncommon, stigma continues to be a prominent problem individuals face during recovery (Rodrigues et al., 2013; Corrigan, 2004; NAMI, n.d.) and has been linked to an increased risk for negative outcomes, which include reduced employability, imprisonment, and homelessness (Browne, 2007; Corrigan, Larson, & Kuwabara, 2007; McNiel, Binder, & Robinson, 2005). Therefore, stigma related to mental health and substance use may impede treatment and recovery goals integral to the MISSION-CJ program. In addition, stigma of criminal justice involvement creates a tertiary barrier that challenges maintenance of stability and may provoke recidivism.

Stigma 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 can be further broken down into two critical components: public and self-stigma. Public stigma occurs when there is a negative societal reaction that results in prejudice toward a group of individuals who share a negatively viewed trait (Corrigan, 2004), while self-stigma is an internalized negative reaction resulting in shame due to membership in a stigmatized group (Corrigan, 2004; Rüsch et al., 2006).

Self-stigma has been associated with decreases in self-esteem and self-efficacy, which may hinder motivation toward participation in activities that promote recovery (Corrigan, Watson, & Barr, 2006; Rodrigues et al., 2013), 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-CJ PSSs consider both, as each of these components often act together and build upon each other. For example, if a client with COD and a criminal justice history encounters a landlord who is reluctant to rent to the client due to his or her mental illness, substance use history, and/or criminal history (public stigma), the client may internalize this stigma (self-stigma), which may negatively impact perceptions of his/her own capabilities and decrease his/her motivation to approach another landlord with a new housing application. MISSION-CJ PSSs are encouraged to integrate two key stigma reduction strategies when

interacting with clients to help combat the negative consequences of public and self-stigma: contact and education (Corrigan, 2004).

Contact to Combat Stigma. 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-CJ model is the opportunity to combat self-stigma in clients struggling with recovery by providing regular contact with a positive role model. This kind of contact has two benefits. First, participating clients have an opportunity to witness that another person (the PSS) with a history of mental illness, substance use, and/or criminal involvement can be successful thus dispelling the myth that this group cannot succeed. Second, clients can learn concrete strategies from those who have faced and successfully overcome the challenges of stigma while working toward recovery.

Education to Combat Stigma. Having direct access to a contact, or role model, whom the client can turn to may not only serve to combat negative reactions toward the self, but may replace these same reactions with the installation of hope. Furthermore, MISSION-CJ PSSs can share the knowledge that they acquired through their own similar experiences with stigma to educate the client on how to best approach these and other similar situations in which the client feels stigmatized. In this way, MISSION-CJ PSSs can help divert otherwise potentially debilitating outcomes associated with stigma.

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

G. Helpful Training for the MISSION-CJ PSS

MISSION-CJ 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 9: *Core Competencies for MISSION-CJ Clinical Supervisors* for more information). The formal training in which MISSION-CJ PSSs participate includes internal training on program issues and operating procedures as well as training for participant-providers on the criminal justice system, mental health and COD provided by an outside agency. Additionally, MISSION-CJ PSSs have identified other areas in which training would be helpful, such as how to engage clients and improve motivation, and for which further training venues are being identified and/or developed. Peer certification type trainings available in particular jurisdictions may also be important to augment the skills of the PSS.

Internal Training

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

- Confidentiality policies
- Criminal case processing
- Issues related to court proceedings (roles and responsibilities of relevant parties to a matter, what to do if asked to testify, etc.)
- Research and documentation policies
- Crisis management
- Expectations of the position

Training for PSSs in the criminal system needs to include information related to how criminal cases are processed, the roles of courtroom participants, and mental health and substance use care considerations. The PSS should understand the strengths and limitations of treatments that may have been provided to the client. In addition, training should include the role of confidentiality and the client's right to be cautious regarding revealing self-incriminating information to others if a case is pre-trial. For a given jurisdiction

and program, there may need to be discussion about whether information the client shares with PSSs has privacy protections and whether PSSs could potentially be asked to testify in court. Communication between clients and PSSs may not be as protected as communication between therapist and patients (i.e, it may not be "privileged"; information is privileged if the client asserts it was provided in the context of a confidential relationship and therefore cannot be brought out in court- only certain confidential relationships are protected in this way, like those with a priest or a psychotherapist). See Appendix N for more information on PSSs and confidentiality issues.

External Training

Peers should ideally be afforded opportunities to take advantage of more general peer trainings or local seminars that are relevant to working with individuals with co-occurring disorders, and with criminal justice systems. In addition, where there are specific peer specialist trainings and certifications available, it can be very helpful to have the PSS participate in such trainings.

Example of a Systems Approach to Peer Training:

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 (see *http://www.gacps.org/Home.html* for more information). The Georgia program is a comprehensive, classroom-based, 40-hour, 30-module curriculum covering Peer Support, psychosocial rehabilitation and recovery, the impact of diagnosis on self-image, effective communication skills, and the basics of documentation. In addition, the Depression and Bipolar Support Alliance (DBSA), which works in collaboration with staff from the Georgia Peer Support Certification Program, provides an on-site, classroom-based, 40-hour training program. Both training programs include an exam that requires a minimum score of 80 percent in order to pass the course.

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

Training Topics for Peer Support Specialists in MISSION-CJ

- 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
- The Criminal Justice System: case processing, defendant rights, community supervision
- Risk-Need-Responsivity principles as they relate to recidivism
- Advocacy
- Crisis Intervention and Trauma
- Basic Principles of Case Management and Coordination
- Cultural Competency
- Entitlement Programs

- Ethical and General Legal Issues
- Professional Development
- Group Facilitation Skills
- Wellness Recovery Action Planning (WRAP)

Training on the Critical Time Intervention (CTI) Model

Training offered by the CTI Project at the Mailman School of Public Health of Columbia University may also be helpful for MISSION-CJ PSSs. CTI training is particularly helpful in ensuring that MISSION-CJ PSSs are able to work smoothly with CMs, with a common understanding of the foundations of this intervention for clients with COD and criminal justice-involvement.

Topics Covered in CTI Training

- Assessment and Prevention of Suicidal Behavior
- Counseling and Interviewing Skills
- Motivational Interviewing
- Harm Reduction
- Drug Craving
- Overview of Mental Disorders
- Trauma, PTSD and the Treatment of Clients
- 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-CJ 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-CJ PSSs and Clinical Supervisors

MISSION-CJ 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/*). SAMSHA and the Bureau of Justice Assistance additionally have developed webinars related to the role of peers in working in criminal justice related programs (Allen, 2013).

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VII. Vocational and Educational Support

for Individuals Involved in the Criminal Justice System

Jonathan Delman • Jennifer Harter

A. Introduction: The Importance of Work

Work, or goal-directed productive activity, is seen as central to anyone's wellbeing, including persons with COD and a criminal record. Employment can provide psychological, social and financial benefits for MISSION-CJ clients, including improved mental functioning, reduced use of illicit substances, and reduced re-incarceration rates. In MISSION-CJ, CMs and PSSs provide vocational support and link clients to community-based vocational services. The goal of their work is to assist clients in obtaining and sustaining employment. Similar to other areas targeted by MISSION-CJ, with vocational support CMs and PSSs work together as a team while at the same time having some specific tasks unique to their position. These overlapping and specific roles are described below in this chapter.

Although people with COD and a criminal record face formidable barriers to finding and maintaining employment, MISSION-CJ CMs and PSSs can use several strategies to help clients achieve employment success (Miller & Massaro, 2008). Along with the MISSION team, there is a network of programs, generally governmentally funded, that provide vocational assistance to people with disabilities and/or a criminal record (discussed below). CMs and PSSs should be trained on "supported employment" services, including how to access community resources for supported employment options as well as how to work with clients around their employment gaps. Some MISSION-CJ clients will require vocational programs designed specifically to meet the needs of people with serious mental illness (SMI) and substance use disorders outside the scope of MISSION-CJ. The most successful such intervention studied to date has been the Individual Placement and Support (IPS) model, a place and train approach driven by client preferences, and coordinated by an employment specialist who is a member of the client's integrated treatment team. MISSION-CJ teams that do not have embedded employment specialists may need to link clients to these individuals (Drake, Bond, & Becker, 2012). In addition, a client with a very complex criminal record may require the expertise of specialists in that area. This all is discussed in greater detail below.

Table 1. Roles and Responsibilities for CM, PSS and CM/PSS Team

Case Manager:

- Assistance in obtaining and evaluating criminal background check
- Assistance with filing for expungement of criminal charges or convictions or linkage to a legal professional for assistance
- Address employment-related Issues with probation and/or parole
- Linkage to potential employers
- Linkage to specialized vocational training programs

Note: Table continued on next page

Peer Support Specialist:

- Transportation training
- On the job support
- Assistance with professional appearance, punctuality, reliability in schedules

Both Case Manager and Peer Support Specialist:

- Job and career goal setting
- Address factors associated with client's motivation to obtain and maintain employment
- Cultivate the patience and determination to find employment
- Help to develop realistic employment goals
- Assist in the identification of potential employers
- Help secure documentation (e.g. resume, transcripts, references)
- Assist in the filing of applications
- Assist in interview preparation (e.g. conduct mock job interviews)
- Provide instruction on how clients can best answer questions regarding criminal background
- Help clients make face-to-face contact with employers
- Provide guidance on how to follow-up on applications/interviews
- Advise clients on how to handle symptom exacerbation on the job
- Provide clients with strategies for organizing and tracking workload
- Help clients to manage conflict with co-workers and supervisor

B. Barriers/Challenges to Employment Success

MISSION-CJ clients frequently lack the resources and basic skills to find and retain a job. Job search barriers include weak social networks (for learning about job openings), poor social skills (for making a positive presentation during an interview), and spotty or remote work histories (Epperson et al., 2011). Because of new and unfamiliar workplace technologies, MISSION-CJ clients often leave prison without work skills that are marketable to large-scale industries (e.g. software) (Swanson, Langfitt-Reese, & Bond, 2012). Even when a job is obtained, the job tenure for clients with COD and/or prior criminal justice problems is especially low. Clients may struggle on the job due to symptoms, relapses and frustration with employment expectations (Epperson et al., 2011). Female clients in particular struggle with family care issues that may interfere with their ability to be consistent at work.

While these individualized barriers to employment are significant, the most serious barriers tend to be external and environmental, such as workplace stigma, strong job competition, and employment and governmental policies that discourage the hiring of ex-offenders. For example, despite advances made by the Americans with Disabilities Act, employers may be ignorant about or cautious in providing reasonable accommodations on the job. In addition, ex-offenders tend to move to areas with high concentrations of ex-offenders, limiting the pool of available jobs and keeping wages low. Table 2 summarizes these barriers.

Table 2. Major Job Search and Retention Barriers	
Individualized	• Social skills • Social networks • Symptoms/relapses • Job histories • Motivation • Low socioeconomic status
Systemic	• Employer/Government ex-offender hiring/criminal record policies • Stigma • Job competition • New and unfamiliar workplace technologies

A client's criminal record is perhaps the most significant problem in helping clients obtain employment. Many professions are not available to people with criminal records because of licensure requirements and/or legal mandates. Certain employers routinely screen out applicants with a history of drug or sex offender charges for jobs as caregivers, particularly with children and the elderly (Thompson & Cummings, 2010). Clients with felony convictions are often likely to be restricted from obtaining jobs that require bonding, licensing, or working in the criminal justice system. In addition, the stigma of a criminal record impacts employers, many of whom have policies which specifically restrict the employment of persons with a criminal history. Because checking for a criminal background is routine practice for many employers, MISSION-CJ clients should be prepared to be asked to give permission for prospective employers to access a copy their criminal record (Swanson et al., 2012).

Because of these impediments, clients may be disinclined to look for employment because of shame, resentment, or a belief that they are "a lost cause." In addition, the loss of disability income or health care benefits because of increased job income has been shown to be a deterrent to maximizing one's potential to work.

Nevertheless, a key precept in the MISSION-CJ program philosophy is that with proper support, guidance, preparation, and dedication, clients can be successful in obtaining and sustaining employment. To achieve this goal, MISSION-CJ clinical teams will need to actively engage clients in taking the necessary steps to pursue employment while using a number of strategies to assist clients in overcoming the very real challenges they face to successfully gaining employment (Whitley, Kostick, & Bush, 2009).

C. Assessment and Expungement of Criminal Record and Addressing Outstanding Matters

The first step to developing effective job search strategies is to have a complete understanding of the individual's criminal background, and to assist the client understand what is recorded as their criminal background. This process should begin with the

MISSION-CJ clinical team helping the client request his or her own criminal background check and going over this record with the client. Clients often have limited knowledge of what is in their record and may be upset or surprised to learn the type and number of charges. As examples, individuals under probation or parole supervision may be required to meet with officers on a regular schedule, subject to curfews, and/or restricted from leaving a county or state. When reviewing the criminal record, MISSION-CJ clinical teams need to evaluate several factors related to job eligibility:

- The types of conviction(s): misdemeanor, felony, drug-related and/or violent offenses
- Involvement of probation or parole
- Prior involvement in diversion programs (e.g. mental health or drug court)
- Pending court dates or outstanding charges
- Whether charges place restrictions on driver's license, living arrangement, contact with other persons, or child custody

Upon reviewing the record, the team may want to consider working with the client and the client's attorney to petition the court for "expungement" of one or more convictions. When an offense is expunged, all records of the case are sealed and removed from the person's official court record, as if it never occurred. In addition, the client is not required to disclose expunged convictions to potential employers. While the requirements for expungement vary by state, in general only misdemeanor offenses can be expunged. In most jurisdictions, persons must also have been conviction-free for a certain amount of time before and/or after the case that is to be expunged.

Of note, past charges that did not result in convictions may possibly be expunged from a person's record with only a few restrictions; this may apply to a felony or a misdemeanor providing the person is not subject to future prosecution for the crime.

In addition to expungement, trying to resolve any outstanding issues (e.g., default warrants, open charges, etc.) can help resolve issues that may arise when a potential employer reviews a criminal record. Take, for example, a case where a charge remains open because a person's record reflects an outstanding default on a warrant of apprehension. The person may have been in a treatment facility on the date that a court appearance was required, and may have thought the issue with the court was attended to, only to learn that a charge is unresolved. By seeking legal counsel and going into court with proper documentation of why the court date was missed, this matter may be able to be reviewed and recorded as a closed issue with no outstanding charge noted. The MISSION-CJ CM/PSS team can work with the client to help acquire any necessary documentation and access to legal services as needed.

D. Assisting with the Job Search

Once the client is ready to begin a job search, there are several places where the MISSION-CJ CM/PSS can be of assistance. Even MISSION-CJ clients with prior job experience or work-related qualifications are likely to need considerable support and assistance with searching for a job. Clients with co-occurring mental illness and substance use disorders (CODs) and criminal records may need assistance in a variety of areas when looking for work, including obtaining necessary documents (e.g., social security cards, school transcripts), assembling documents (including resumes and references forms), completing employment applications, following up on applications or interviews, deciding how to best respond when asked about criminal background, checking in with probation/parole about the appropriateness of a particular job, and cultivating the patience and determination to find work. Below are steps for helping a MISSION-CJ client find a job.

Table 3. Steps to Assisting in Job Search

- Assess criminal record, consider expungement
- Develop an employment goal
- Identify potential employers
- Obtain references from trusted sources
- Prepare for job interviews and related interactions
- Help clients make face-to-face contact with employers

1) Assess criminal record (above, C)

2) Develop an employment goal: The CM/PSS help the client develop and formalize an employment goal that is in line with his or her life situation. It is important to coach the client on the realities of the job market, including the availability of jobs and related educational and licensure requirements (Thompson & Cummings, 2010). MISSION-CJ CMs/PSSs can help clients figure out what their preferences and aptitudes are for a job, including job setting and the number hours worked per week. For example, an outdoor job may be better suited to a client who is unprepared to work in a formal business setting. A sample "job profile" is included in Appendix K.

3) Identify potential employers: In general, CMs/PSSs should develop relationships with employers to learn more about their businesses while assessing the potential for hiring a person with a criminal record. Probation and parole officers can be a useful source of information here. Since most employers make such decisions on a case by-case basis, a CM generally need not ask the employer directly if s/he would hire a person with a criminal record, but instead ask about their willingness to meet a skilled person with COD. CMs should be ready to share with employers information about the incentives and protections involved in hiring formerly convicted individuals, including tax credits and the federal bonding programs. This information can be found at: *http://csgjusticecenter.org/nrrc/projects/mythbusters.*

In order to maintain a client's motivation to work, the job search should begin as soon as possible. Job leads can also be found through personal and family contacts, previous employers, and standard job search mechanisms such as the Internet and local advertisements. CMs/PSSs can also help the client to identify job leads, prepare and send out resumes, and prepare for interviews, utilizing governmental and community resources, such as state Department of Labor (DOL) Career Centers, state Vocational Rehabilitation (VR) agencies, the Disabled Clients Outreach Program (DCOP), and the local chamber of commerce. In addition, MISSION-CJ teams can assist clients in understanding the requirements/restrictions for particular positions. Geographic job location is relevant as well, primarily to avoid competing with an overabundance of people with criminal records for similar jobs. In addition, identifying transportation challenges to getting to and from a work site would be important to do in anticipation of whether a job is realistic for the individual.

4) Obtain references from trusted sources: Leading up to the job search, it is very helpful if the MISSION-CJ client has made a positive impression on people s/he has worked for in some way in the past (e.g. volunteered) who know him or her well (Swanson et al., 2012). CMs/PSSs can help the client consider who might be the best references, perhaps depending on the job being sought. Such potential references include probation or parole officers, clergy, former employers, volunteer coordinators, and employment specialists.

5) Prepare for job interviews and related interactions: MISSION-CJ clients are more likely to be hired if they develop strong job interview skills (LePage, Washington, Lewis, Johnson, & Garcia-Rea, 2011). Clients will be more successful when during the interview they can:

- present their job skills and strengths clearly;
- demonstrate a professional and positive demeanor;
- express enthusiasm for the job;
- be appropriately dressed;
- be timely to all interviews; and
- talk about their criminal history and their plan to avoid future legal problems.

In general, an employer is more likely to hire an applicant who is direct and honest about their criminal history (Swanson et al., 2012). In addition, the applicant should accept responsibility for past mistakes and explain how s/he has become a law-abiding citizen. Clients can explain how they have been helped by treatment, by involvement in church or volunteer activities, and by positive mentors. Applicants should also know how to handle the employer's expressed knowledge of arrests. Clients should be prepared to explain the circumstances of the arrest, and can emphasize that an arrest is not a conviction nor evidence of a criminal act.

The most effective way to prepare clients for job interviews is help them practice (Swanson et al., 2012). MISSION-CJ CM/PSSs can offer to play the

role of a prospective employer by conducting "mock" interviews . This gives the client a chance to get safe but direct feedback on areas in which the client needs to improve. It may be useful for the mock interviews to take place in groups, since the client can learn how other clients effectively handle questions (LePage et al., 2011). To boost the client's confidence, CMs/PSSs can explain to them that employers often hire the most qualified person for the job, regardless of legal system involvement.

6) **Help clients make face-to-face contact with employers:** Candidates with criminal histories may be screened out if they don't have a chance to make a personal connection with the employer. Thus, prior to clients formally applying for a job, CMs/PSSs should consider helping them meet with employers in order to introduce themselves as competent people with solid job skills. This can be done through informal informational interviewing, attending job fairs, and volunteering.

CMs/PSSs can accompany clients to informational or job interviews, and even offer to meet with employers to vouch for clients' motivations and work ethic. CMs/PSSs will however need to find out to what degree the client is comfortable with someone else searching for a job on his/her behalf. MISSION-CJ CMs and PSSs 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 client guidance and support as they go forward with the job application and interview phase. Vocational rehabilitation programs (see below) can help in this regard as well. Another excellent resource is the Department of Labor's website: *www.careeronestop.org.*

E. Consideration of COD

In addition to carefully reviewing a client's criminal justice record, CMs should have a good understanding of the client's mental health and substance use difficulties and the nature of the client's recovery supports. It is vital to understand the triggers that lead to psychiatric difficulties and/or substance use. It is also important to choose jobs that support recovery (e.g., jobs in drug stores or restaurants may provide greater temptation to use).

Additionally, random urine testing may be required by criminal justice supervising authorities for individuals with substance use difficulties. There also may be a need for attendance at structured appointments with mental health providers. MISSION-CJ clients who are enrolled in drug courts or other specialty court programs may be required to attend court sessions that could impact job schedules. MISSION CJ CMs/PSSs can support clients to adjust schedules at work to accommodate these programs or supervision requirements that might require them to miss work. The MISSION CJ team can also help clients communicate with employers and criminal justice personnel about scheduling challenges to help address potential problems before they arise.

Communication among various treatment team members will also be essential in arranging sufficient support and implementing interventions to prevent relapses. Ongoing supports may require special attention to prevent and attend to relapse issues. As always, when treating anyone with COD, it is helpful to take setbacks in stride while continuing to take note of any accomplishments or gains.

F. Vocational Rehabilitation Programs

MISSION-CJ clients may benefit from more formal job assistance for people with disabilities through a state government vocational rehabilitation (VR) program. The VR program provides and contracts for direct services to help people develop skills needed to find and maintain jobs. Typically, a VR counselor works with the client to develop an Individual Plan for Employment (IPE), which is organized around a specific employment outcome chosen by the client.VR programs offer a range of employment services including training for certain types of work, job screening, background checks, application follow-up, job training supports, and job performance supports. Work transition programs can also be helpful since employers are likely to positively view a client's success in a transition program as an indication of successful rehabilitation.

Table 4. Example Services of Vocational Rehabilitation Programs
• Medical and Psychological Assessment
• Vocational Evaluation and Planning
• Career Counseling and Guidance
• Training and Education After High School
• Job-Site Assessment and Accommodations
• Job Placement
• Job Coaching
• On-the-Job Training
• Supported Employment
• Assistive Technology and Devices
• Time-Limited Medical and/or Psychological Treatment

G. Integrated Placement and Support (IPS)

The aim of IPS is to help people with psychiatric conditions achieve competitive employment based largely on their job preferences. Competitive employment is defined as jobs in the open job market at prevailing wages, side-by-side with nondisabled employees, with supervision provided by personnel employed by the business (not sheltered work or segregated placements for people with disabilities). IPS emphasizes the avoidance of "lengthy" pre-employment preparation or training and does not screen people for work "readiness" or "employability". It is a systemic and manualized approach *(http://sites.dartmouth.edu/ips/fidelity/fidelity-review-manual/)* based on eight supported employment principles:

Table 5. IPS Principles
• Zero exclusion
• Focus on competitive employment
• Integration of vocational and treatment services
• Attention to client preferences
• Work incentives/benefits planning
• Rapid job search
• Continuous job supports
• Systemic employer relationships

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

Focus on competitive employment. Discussed above.

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

Client preferences. Key tenets of IPS are recovery, choice, and self-determination. Client preferences are the primary value with regard to job seeking decisions, hours worked, how IPS services are provided, and whether or not to disclose one's disability on the job.

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

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

Continuous job supports. MISSION-CJ clients may need varying intensities of support for a long time in order to succeed, and cases can remain open indefinitely. Intensive supports typically include face-to-face contact on a weekly basis for at least the first month of employment. Additional supports might include meetings with employers, help managing anxiety, and on-the-job coaching to learn new duties.

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

Within the IPS framework, CMs/PSSs can utilize job search strategies previously described in section D, which highlighted the need to become familiar with the clients' criminal record and expungement possibilities, to establish job references, and to prepare the client for job interviews.

H. Practitioner Skills and Training for Providing Job Supports

The manner in which CMs/PSSs "interview" clients about their person centered employment goals and ideas is critical. Interviews with clients 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 client are use of open-ended questions, active listening, and paraphrasing techniques. Always convey respect, hope and a positive attitude, while being careful to not convey judgment or paternalism, or to argue with the client (Whitley et al., 2009). Motivational interviewing (MI) techniques (see Appendix G) 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 to move clients past resistance to work and toward a willingness to try working. MISSION-CJ CMs are encouraged to seek more information on MI at: *http://www.motivationalinterview.org.*

While MISSION-CJ CMs and PSSs are not trained as employment specialists, they can apply a range of employment principles and practices to promote the employment of the clients on their caseload. Putting these principles into practice requires a special set of skills, some of which will be novel to MISSION-CJ CMs/PSSs. This will likely require additional training. Important training precepts can be found in the SAMHSA Toolkit *Supported Employment: Training Frontline Staff* (SAMHSA, 2009b) and in Supported Employment, A Practical Guide for Practitioners and Supervisors (Swanson, Becker, Drake, & Merrens, 2008).

CMs will also need training to provide a wide variety of follow-along job supports that are highly individualized, flexible, and creative. CMs should be trained in employment opportunities and protections of the Americans with Disabilities Act (ADA). Through the ADA, an employee with a disability can request a "reasonable accommodation," a change in the work environment, policy or practice that enables the individual to perform the essential job functions. Employers however do not have to provide an accommodation if it would cause an "undue hardship", meaning a significant difficulty or expense. The ADA thus presents an excellent and mandated framework for negotiating job decisions that can satisfy both clients and employers. Several federally funded agencies provide free technical ADA assistance and training, including the Job Accommodation Network, which has published a guide on the ADA and Mental Health Impairments (Job Accommodation Network, 2013).

MISSION-CJ CMs and PSSs can also advise clients on how to handle symptom exacerbations on the job, organize work assignments, and manage disagreements or problematic interactions with co-workers or supervisors. In addition, PSSs can also help clients to develop successful transportation plans and provide hands-on job support (possibly at the job site).There are many resources available for MISSION-CJ CMs and PSSs to utilize when these problems arise, including the client's clinical team, and via the following helpful websites.

Table 6: 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.pacer.org/tatra/resources/vr.asp*
- General employment supports and state Departments of Labor: *http://www.careeronestop.org/*

I. Supported Education

While education and training are often critical for job and career success, many MISSION-CJ clients have not completed college or technical trainings (Contardo & Tolbert, 2008). Some may not have received high school diplomas or equivalent certification. Mental health problems and criminal justice involvement often begin to occur in late adolescence and early adulthood, interrupting a person's educational, and thus career, trajectory. In addition, this population has relatively high rates of learning disabilities, which when not diagnosed or treated properly leads to poor school performance and lower educational attainment.

The barriers for MISSION-CJ clients to attaining the appropriate education, college in particular, can seem daunting (Brazzell, Crayton, Mukamal, Solomon, & Lindahl, 2009). Barriers to getting into college include difficulty in deciding which college best meets their needs, trouble with negotiating the admission and enrollment processes, and not knowing about the available public and private financial aid resources. Some colleges have started conducting background checks and taking into account applicants' criminal histories in making admissions decisions. Even when admitted, many MISSION-CJ clients will have difficulties keeping up with course demands, lack the necessary study skills, and/or feel isolated or stigmatized on campus.

"Supported Education" (SEd) is an approach that CMs and PSSs can use to assist MISSION-CJ clients choose, attend and succeed in schools in accordance with their individual educational and career goals (Delman & Ellison, 2013). Because the principles of IPS and SEd are similar, programs addressing the needs of young adults who are experiencing an early episode of psychosis have already begun to use them in concert.

SEd is a promising evidentiary practice based on principles (Table 7) that are consistent with the IPS approach.

Table 7. Supported Education Principles

- Access to an education program in which positive, forward progress is the goal.
- Eligibility is based on personal choice.
- Supported Education services begin soon after consumers express interest.
- Supported Education is integrated with treatment.
- Individualized educational services are offered for as long as they are needed.
- Consumer preferences guide services.
- Supported Education is strengths-based and promotes growth and hope.
- Recovery is an ongoing process facilitated by meaningful roles.

While there are a number of different SEd models, most offer the following core services:

1) Career planning,

2) Academic survival skills,

3) Direct hands on assistance, and

4) Outreach to campus resources.

CMs and PSSs with appropriate training and available time can use many of these SEd principles and practices to enhance clients' educational experience (Delman & Ellison, 2013). Referral to higher capacity SEd programs may make sense for some clients with more intensive needs. Regardless, CMs and PSSs should familiarize themselves with SAMHSA's SEd implementation and training toolkit and supporting documents (SAMHSA, 2009a).

The SEd model, with some minor modifications, can address the needs of people with a criminal justice history. MISSION-CJ clients leaving or having recently left prison will often need help with basic needs, such as finding a living place that allows them to study and access transportation (Brazzell, Crayton, Mukamal, Solomon, & Lindahl, 2009). A majority of colleges now consider an applicant's criminal record when

making admissions decisions; CMs should become familiar with this emerging concern and the related policies of colleges clients' show interest in (*http://www.communityalternatives.org/pdf/publications/Criminal-History-Screening-in-College-Admissions-AttorneyGuide-CCA-1-2013.pdf*). In addition, CMs and PSSs should ensure academic institutions and training programs (as well as employers) recognize the validity of certifications, course credits, and other credentials their clients earned during their incarceration. CMs and PSSs can help support a smooth transition from incarceration to community education by working with existing partnerships among prisons/jails, probation and parole supervisors, and schools (Brazzell, Crayton, Mukamal, Solomon, & Lindahl, 2009). The CM should familiarize and work with receptive schools and training programs and prepare them for MISSION-CJ client placements.

Based on the literature, we provide below an approach for utilizing SEd with people with COD and a criminal justice history, while helping them understand the issues at hand.

- **Career planning:** including career exploration and intermediate and long term goal setting;
- **Credits earned while in prison:** identify the client's certifications, course credits, and other credentials earned during and prior to incarceration (Contardo & Tolbert, 2008);
- **Academic skills assessment:** conduct a baseline assessment of academic skills, including the presence and relevance of learning disabilities;
- **Academic and social survival skills:** utilize college preparation programs, individualized tutoring and mentoring, time and stress management courses, peer support (e.g., current or former students), financial aid counseling, disability rights resources, social supports, connection to other reentry services, and peer support (Delman & Ellison, 2013);
- **Choosing where to apply:** based on the client's preferences and needs, with special attention to a college's use of criminal background information and acceptance of credits earned during a person's incarceration. Provide clients with information about college and training programs, and work with existing partnerships among prisons/jails, probation and parole supervisors and schools. Community Colleges can often be a natural place for MISSION-CJ clients because of their diverse populations, familiarity with students that have not had a typical educational trajectory, greater course flexibility and lower cost (Contardo & Tolbert, 2008);
- **Direct assistance:** aid with enrollment, as well as online admissions applications, online registration, financial aid, consideration of pre-enrollment college readiness classes, decisions on whether to be a part-time or full-time student and number of classes, course selection, and advocacy regarding the effects of the client's criminal record;
- **Basic needs:** finding a living place that allows clients to study and access transportation;
- **Outreach:** with campus resources, such as the Disability office and student mental health clinic;
- **Follow up:** with "academic survival skills".

Like supported employment, ongoing support is recommended to help the MISSION-CJ client stay in school and succeed (Delman & Ellison, 2013). Regular and periodic "check-ins" are useful to find out how the client is doing and to be proactive about identifying emerging problems. Peer mentors or tutors can play a role here.

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.

In some cases, it will make sense for the PSS or a vocational specialist to accompany the client to the first week of classes, a key period when insecurities and concerns can easily lead to poor performance. 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 (Delman & Ellison, 2013). Educational accommodations can include a note-taker in class, being allowed to record classes, being provided both written and verbal instructions, extended time for test taking, access to quiet spaces, or small groups for test taking and for classes. It may become necessary to make contact with specific instructors or professors to negotiate accommodations or to problem solve if the client is having trouble in a particular class. It is also valuable to attempt to identify an advocate or support person on campus. Establishing a link for the MISSION-CJ client to a person who can provide support and advocacy onsite will be important and helpful.

Some MISSION-CJ clients will want to share their mental health history and/or criminal justice background with students, teachers, and others. This is of course their right, but by no means their obligation. When asking for accommodations, some level of disclosure is required, but that can be done confidentially through the instructor and the disability office. General disclosure of one's mental health difficulties or criminal background to teachers and other students is a very personal choice based on many factors, and CMs and PSSs should be available to discuss the pros and cons of doing so, while respecting the clients' decisions.

Table 8: Helpful Education Support Websites

- Building Pathways from Criminal Justice to College: *http://www.changecenter.org/projects/long-term-research-collaborations/from-criminal-justice-to-college*
- SAMHSA's Supported Education implementation toolkit and supporting documents: *http://store.samhsa.gov/product/Supported-Education-Evidence-Based-Practices-EBP-Kit/SMA11-4654CD-ROM*
- Dealing with colleges that assess criminal histories in their admissions process: *http://www.communityalternatives.org/pdf/Reconsidered-criminal-hist-recs-in-college-admissions.pdf*
- Federal Interagency Reentry Council: *Education: http://csgjusticecenter.org/wp-content/uploads/2013/06/SnapShot_Education.pdf*

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VIII. Trauma as a Critical Consideration In MISSION-Criminal Justice Service Delivery

Matthew Stimmel • Andrea Finlay • Debra A. Pinals

A. Incidents and Impact of Trauma: Considerations for MISSION-Criminal Justice

Individuals in the criminal justice system experience significantly greater exposure to traumatic events over their lives compared to the general population (Bloom, Owen, & Covington, 2003; Weeks & Widom, 1999), and have higher rates of mental health and substance use disorders, often co-occurring (Abram, Teplin, & McClelland, 2003; Diamond, Wang, Holzer, Thomas, & des Anges, 2001; Fazel & Seewald, 2012). Estimates of lifetime physical or sexual abuse experienced by men in the criminal justice system range from 25% to 68% (James & Glaze, 2006; Weeks & Widom, 1999) with estimates of PTSD diagnoses among incarcerated men ranging from 20% (Trestman, Ford, Zhang, & Wiesbrock, 2007) to 54.6% (Proctor & Hoffmann, 2012).

For a general criminal justice population, exposure to traumatic events within criminal justice settings is also high, with rates of physical victimization or sexual victimization (by either inmates or staff) as high as 36% of male inmates and 30% of female inmates (Wolff & Shi, 2010). As with trauma exposure in the general population, justice-involved men experience higher rates of physical assault, while justice-involved women experience higher rates of sexual victimization (Beck & Harrison, 2008; Wolff, Blitz, Shi, Bachman, & Siegel, 2006; Wolff & Shi, 2010). In addition, almost half (48% of men and 42% of women) of incarcerated individuals with mental health histories experience interpersonal violence, either sexual or physical, while in a correctional setting (Wolff & Shi, 2010). Many of the individuals who have experienced interpersonal violence while incarcerated require subsequent mental health services due to the trauma.

Among justice-involved individuals with trauma histories and/or PTSD, co-occurring substance use disorders as well as difficulty engaging in substance use treatment are common (Kubiak, 2004). For example, research suggests that incarcerated men with PTSD are more likely to either recidivate or require aftercare treatment post-release (Kubiak, 2004). Incarcerated women with trauma histories are more likely to report substance use difficulties as adults, to relapse post-release, and to be introduced to the criminal justice system through substance-related crimes compared to their male cohorts, although these men do report higher levels of alcohol abuse (McClellan, Farabee, & Crouch, 1997).

Specific populations within the criminal justice context may also have unique trauma-related issues. The rate of trauma exposure among special populations within the criminal justice setting, including women and Veterans, is often higher (Harner, Budescu, Gillihan, Riley, & Foa, 2013; Saxon et al., 2001). As many as 55% of incarcerated women have experienced physical or sexual abuse in their lifetime and 41% have been diagnosed with lifetime post-traumatic stress disorder (PTSD; Osher & Steadman, 2007).

For Veterans returning from service, PTSD presents a specific risk for involvement in the criminal justice system (Elbogen et al., 2012). An estimated 87% of Veterans incarcerated in jails have exposure to traumatic events (including events in their homes and communities as well as during their service), whereas 31% have been diagnosed with PTSD (Saxon et al., 2001). Although there is a dearth of research on women Veterans in the criminal justice system, these Veterans represent a particularly vulnerable population; 83-91% of these women report at least one lifetime traumatic event (Zinzow, Grubaugh, Monnier, Suffoletta-Maierle, &

Frueh, 2007) and 27% have been diagnosed with PTSD in their lifetime. However, prevalence rates for PTSD among women Veterans varies greatly depending on type of trauma and has been reported to be as high as 60% among women Veterans who experienced sexual assault (Yaeger, Himmelfarb, Cammack, & Mintz, 2006).

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

B. Enhancing Trauma Awareness

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

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

Trauma awareness begins with a program's initial decision at the leadership level, extended down to all program and services offered to become trauma-informed. Where possible, MISSION-CJ brings trauma awareness to stakeholders beyond the service team involved in MISSION-CJ care. These may include a range of justice personnel such as probation, parole, judiciary, local police, and corrections. Essential features of trauma awareness include: staff education, training and consultation; using best practices to screen and/or assess for trauma; awareness of what trauma-specific services are offered by community service providers; recognition of the impact that hearing about trauma may have on providers within the program itself; and highlighting the need for staff to participate in self-care when necessary (Hopper et al., 2010). Although certain settings (e.g. correctional institutions) may appear to have specific barriers to implementing trauma-informed care, this kind of training and education can be extended and adapted to these settings (see Miller & Najavits, 2012 for further information about trauma-informed correctional care).

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

Trauma-Informed Care and its Components

1. Safety
2. Trustworthiness and transparency
3. Collaboration and mutuality
4. Empowerment
5. Voice and choice
6. Peer support and mutual self-help
7. Resilience and strengths based

8. Inclusiveness and shared purpose
9. Cultural, historical, and gender issues
10. Change process

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

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

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

Although the clients' challenges are discussed, it is important to maintain a position with clients that is strength-based and focused on their resilience. MISSION-CJ enables clients to feel a sense of control over their treatment and a sense of mastery in working towards their goals. By focusing on an individual's strengths, trauma-informed programs teach skills that maximize effective coping highlighting clients' resilience and recovery potential (Hopper et al., 2010). Finally, MISSION-CJ staff remain culturally-sensitive and inclusive, as clients are assisted in their individual change process toward recovery.

B.I. Trauma-Informed Care and MISSION-CJ: Criminal Justice Considerations

Role of Providers within TIC Approach in MISSION-CJ

1. Screen for and identify trauma related symptoms and disorders
2. Ensure that clients who need specialized treatment are referred to resources that are qualified to treat Posttraumatic Stress Disorder (PTSD) and other trauma-related disorders
3. Serve clients with trauma histories who do not require specialized trauma-related treatment
4. Provide ongoing support for those participants receiving treatment from a specialized PTSD provider
5. Coordinate care with specialized PTSD providers
6. Coordinate trainings to court personnel and community supervising agencies (e.g., probation, parole) and others on trauma-informed service delivery models and the issues related to trauma for MISSION-CJ clients

MISSION-CJ is a flexible, time-limited, and comprehensive treatment intervention designed to meet the mental health, substance use and other psychosocial treatment needs of clients identified through a criminal justice setting. Although MISSION-CJ provides comprehensive services to its clients, it is not an intervention that is specifically aimed at targeted treatment of trauma-related conditions such as PTSD. These treatments, such as Cognitive Behavioral Therapies, may be required in addition to MISSION-CJ services to assist the client in her/his recovery. However, as many justice-involved persons have experienced trauma (prior to or during incarceration), trauma-informed care considerations have been incorporated into the overall MISSION-CJ treatment model. MISSION-CJ case managers (CMs) and peer support specialists (PSSs) receive training on how to screen clients for trauma and how to coordinate care with specialized trauma clinicians, when needed, until trauma-related symptoms stabilize. MISSION-CJ CMs and PSSs can provide support to clients with elevated trauma symptoms; however, they are not expected to serve as primary providers of care for trauma-related disorders.

Trauma-informed approaches can help address recidivism when delivered within a Risk-Needs-Responsivity Framework (RNR). This framework guides treatment planning by benchmarking progress and making treatment adjustments to reinforce use of prosocial community supports, positive activities and peer influences, and improved cognition and attitudes to prevent criminal justice recidivism. MISSION-CJ focuses on responsivity to treatment, which means maximizing each participant's ability to learn from treatment by providing cognitive behavioral interventions and tailoring those interventions to the unique learning style, motivation, abilities and strengths of the offender (Rotter & Massaro, 2011). When trauma-related symptoms and/or co-occurring disorders are a core part of the risk/need presentation for a given participant, addressing these issues further enables participants to engage and be "responsive" to treatment.

In order to be fully trauma-informed, MISSION-CJ providers must understand that their clients are at a high risk for trauma exposure while incarcerated. Furthermore, though recent efforts have been made to encourage reporting of sexual trauma and other abuses in prison (e.g. Prison Rape Elimination Act of 2003), there may still be secrecy and non-reported events amongst inmates and officers. Therefore, even though trauma may be rampant in these settings, individuals, even when in the community, may be reluctant to divulge traumatic experiences out of fear, guilt, shame or avoidance. It is important for MISSION-CJ CMs and PSSs to understand that clients may be reluctant to discuss these more recent traumatic experiences though they can be a factor in their clients' presentations and need to be considered as a responsivity factor in treatment planning.

Another frame of reference for thinking about early trauma is the consideration of early development, and whether criminally involved individuals also had a history of juvenile delinquency and childhood trauma. Adverse childhood experiences (ACEs) include verbal, physical, and sexual abuse as well as complex family dynamics such as having an incarcerated parent, having a parent or family member with mental illness or substance abuse issues, witnessing domestic violence in the home, or absence of a parent. In the general population, adolescents endorse a median of 1 ACE in their lifetime (Centers for Disease Control and Prevention, 2010). However, one state's juvenile court system found that the median number of ACEs endorsed by juvenile offenders was 5 (Massachusetts Alliance of Juvenile Court Clinics, 2013). Youth with trauma histories (especially violence, victimization, or both) are at higher risk of engaging in delinquent behavior and recidivating more often than those without trauma histories (Eitle & Turner, 2002; Ford, Steinberg, Hawke, Levine, & Zhang, 2012). Juvenile offenders who are victims of violence are also at risk for continued offending behavior in adulthood (Teague, Mazerolle, Legosz, & Sanderson, 2008; Widom, 1989).

When working with MISSION-CJ clients, staff should recognize links between past trauma and present difficulties and be informed about pathways that appear to be gender specific. For example, female inmates are more likely to have experienced sexual abuse, emotional abuse, and deprivation growing up, while also being more likely to have been raised in single parent homes and to have relatives with mental health and/or substance abuse histories compared to male inmates (McClellan et al., 1997). Furthermore,

upon reaching adulthood, while men tend to report experiencing fewer instances of interpersonal violence or maltreatment, incarcerated females are more likely to report an increase in victimization, with a large proportion of these women experiencing abuse at the hands of their partners, as well as having partners with significant mental health or substance use disorders (McClellan et al., 1997). Data has also emerged to demonstrate the complexities of interpersonal violence and the role of gender for perpetrators and victims (Cho, 2012). Therefore, MISSION-CJ providers need to be aware of and assess for the potential impact of interpersonal violence and continued maltreatment of female and male clients. This pattern of abuse history can lead to mental health problems such as depression, which can then result in substance abuse and subsequent adult intimate relationship problems (Chesney-Lind & Sheldon, 2004; Salisbury & Van Voorhis, 2009). For both male and female clients, the impact of their trauma and criminal justice involvement may contribute to further difficulties in their children, and where domestic violence is an issue, there can be complex dynamics among partners. MISSION-CJ therefore considers intimate relationships and whether clients also have parental responsibilities, in order to best support participants toward positive family well-being.

C. Assessment and Treatment

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

C.I. Assessment

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

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

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

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

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

The purpose of the work of MISSION-CJ is to recognize that trauma symptoms are real and impact a person in very significant ways, and the treatment manual and workbook exercises recognize that trauma may be at the root of some of the issues program participants are having. In addition, referral to trauma-specific treatment may be necessary.

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

MISSION-CJ CMs and PSSs need to be aware of the kinds of symptoms with which individuals with trauma histories present, separate from a formal diagnosis that may be given to the individual served. Effects of trauma can both be directly related to problems

associated with previous traumatic experiences, such as hypervigilance to one's surroundings, and indirectly related through maladaptive coping responses, such as substance use (i.e., self-medication; Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005). Some of the more prominent symptoms associated with trauma in criminal justice populations include substance use, anger, social isolation, and self-injury. Sensitivity to these symptoms and their impact on treatment and recovery are important aspects of providing trauma-informed care. Providing this care can be difficult at times when individuals also have antisocial attitudes and negative thinking that makes treatment engagement difficult. Presented below is a table of the trauma symptoms in the treatment setting and description of each element.

Trauma Symptoms in the Treatment Setting

1. Substance Use Disorders

Clients present with relapse behaviors or an increase in on-going use

2. Avoidance

Clients avoid people, places or things that remind them of traumatic events

3. Negative Thoughts and Feelings (Internalizing)

Clients present with negative emotions such as depression, anger, anxiety; and negative thoughts such as self-blame

4. Acting out (Externalizing)

Clients present with increased irritability, anger, aggression and risk taking behavior

5. Dissociation

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

Substance Use Disorders. Given the emphasis on dual recovery therapy in the MISSION-CJ model and that substance use and trauma are so closely related, understanding the origins of substance use as well as the current function it serves in our clients' lives is an important part of assessing clients' treatment needs. For clients presenting with relapse behaviors or an increase in on-going use, CMs and PSSs should continue to screen for/ask about trauma-related symptoms because of their likely links with substance use behaviors. *For example, if a client discloses that they have had a lapse and used substances recently, MISSION-CJ providers should inquire about the events (both internal and external) that led up the behavior and the function of the substance use (e.g., was it in response to triggers related to trauma experiences, a way of coping with distress, or a pleasure-seeking experience with substance abusing peers?).*

Avoidance. One common behavior of individuals with trauma is avoidance, avoiding people, places or things that remind an individual of a traumatic event is a hallmark of individuals with trauma-related distress. This may manifest itself in missed appointments, refusal to engage in activities related to one's treatment plan, or increased anxiety and agitation within sessions. While generally speaking this may look like treatment interfering behavior or the actions of a "difficult client", it may in fact be related to the client's fears of being reminded of previously traumatic experiences. *For example, a client who has experienced trauma as part of a prison or jail sentence, may be reluctant to show up to court for mandated appearances because it is a reminder of having been incarcerated. While the behavior may be unacceptable, understanding when and how avoidance relates to trauma experiences allow the MISSION-CJ CM and PSS to address these issues in their care planning and support.*

Thoughts and Feelings ("Internalizing"). Affect dysregulation is characterized in part by high intensity negative emotional reactions, such as depression, intense anger, overwhelming anxiety, and emotional numbing, and may be a factor that compromises treatment outcomes of individuals with trauma related distress. Other negative emotions including guilt, shame, disgust and sadness are also experienced by individuals with trauma histories, and these negative

emotions may also impede treatment benefits or are associated with increased drop out rates (Cloitre et al., 2011; Dalgleish, 2004; Pitman et al., 1991). Clients may also present with negative thinking patterns, including increased thoughts related to self-blame for their traumatic experiences or negative beliefs about the world (e.g., "I am not safe anywhere"). *For example, a client who is missing sessions with his PSS or CM may be avoiding treatment, or may instead be disengaging because they are depressed and isolating and then blaming themselves for not showing up to sessions. Missing sessions in a criminal justice treatment program may create additional obstacles and further interpersonal challenges if a person is sanctioned by supervising authorities as a result. Assessing for negative mood and associated behaviors is important so as to further understand treatment planning and target specific trauma-related symptoms to help the client re-engage in treatment.*

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

Dissociation. There is a small group of individuals who experience trauma, develop PTSD, and subsequently demonstrate dissociative symptoms. These symptoms are considered distinct from intrusive memories, or impairments in trauma-related memories that are psychogenic in nature. Individuals with dissociative symptoms usually present with a lack of awareness of current circumstances, sometimes through actual flashbacks in which they believe they are actually re-experiencing the traumatic event of the past and lose track of their current circumstances and surroundings. Additionally, dissociation can take the form of derealization (i.e., feeling as if the world is not real or that current circumstances are not real) and/or depersonalization (i.e., feeling as if oneself is not real) (U.S. Department of Veterans Affairs, 2014b). Dissociation, though not fully understood from a biological perspective, can be one avenue by which an individual facing significant or repeated trauma separates their consciousness from what is happening to them at the moment. Individuals with derealization may present with decreases in emotional intensity, especially when discussing otherwise activating experiences (U.S. Department of Veterans Affairs, 2014a). Individuals who present with depersonalization may describe having "out of body experiences" in which they see themselves observing their own body from above (U.S. Department of Veterans Affairs, 2014a). *For example, when discussing difficult emotional events in session, a client may appear to be "somewhere else", not focusing on his/her CM or PSS, not responding to direct questions, or not demonstrating expected emotional expression despite describing emotional events. This client may need to use "grounding" tools (described below) and may describe feeling "disconnected" from the present moment.*

C.I.b. Differential Diagnostic Concerns Related to a Criminal Justice Population

Several symptoms described above that are associated with trauma history are also associated with personality disorders and anti-social behavior. CMs and PSSs should be careful to tease apart symptoms of trauma from antisocial personality and/or borderline personality disorder. This does NOT mean that all antisocial thoughts and behavior can be explained as related to trauma as there can be a co-existence of antisocial patterns that are separate and distinct from trauma. Also, although there is a high prevalence of trauma in a population of criminal justice involved individuals with co-occurring disorders there may be some individuals who did not experience or do not manifest trauma-related sequelae. Thus, there may be overlap between trauma behavior and antisocial traits that requires attention. On the following page is a table highlighting how some components of criminogenic risks overlap with potential trauma-related symptoms.

Overlapping Components of Criminogenic Risk and Trauma-related Symptoms

Risk Factor	Behavioral Manifestation	TRAUMA INFORMED PERSPECTIVE
History of antisocial (criminal) behavior	Criminal record	Self-destructive or reckless behavior
Antisocial personality pattern	Impulsive; Aggressive; Irritable	Irritability or aggressive behavior; persistent negative trauma-related emotions (anger)
Antisocial cognitions	Rationalize criminal activity; Negative attitudes towards the law	Persistent distorted blame of others for causing the traumatic event or resulting consequences
Antisocial associates	Lack of pro-social supports	Detachment or estrangement from others
Family support	Interpersonal difficulty with primary family members including parents, spouses, siblings, etc.	Feeling alienated from others (detached or estranged)
Leisure Activities	Lack of participation in pro-social recreation	Markedly diminished interest in (pre-traumatic) important recreational activities
Education and Employment	Lack of success, enjoyment or opportunity in school or work settings	Markedly diminished interest in (pre-traumatic) important school or work activities; Problems in concentration; Sleep disturbance; Avoidance of trauma-related cues
Substance Abuse	Substance use disorder (abuse or dependency)	Substance use

(Adapted from Bonta & Andrews, 2007; see also Chapter 2)

If individuals with a trauma history present with these kinds of behavioral manifestations it is important to understand them in the context of the trauma. It is important to consider the following two questions: (1) When did these behaviors begin (i.e., prior to or subsequent to trauma exposure)? (2) What function do these behaviors serve in an individual's life (e.g., pleasure seeking vs. coping with painful emotions/self-medication)?

Understanding and targeting criminogenic needs as well as non-criminogenic needs, can help ensure that the treatment provided does not serve to retraumatize clients, and/or reinforce problematic behaviors that are a result of traumatic histories rather than or in addition to antisocial and criminogenic risk factors.

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

Women. Women involved in the criminal justice system often endorse more frequent and persistent experiences of childhood sexual abuse, which is often associated with complex PTSD (cPTSD) and severe affect dysregulation (Ford, Chang, Levine, & Zhang, 2013). Affect dysregulation, dissociation, and interpersonal difficulties are core features of cPTSD

as well as borderline personality disorder (BPD; van Dijke, 2012). However, although many individuals with BPD have a history of poly-victimization in childhood, not all individuals with BPD meet criteria for cPTSD and likewise not all individuals with cPTSD develop BPD (van Dijke, 2012). The core distinction between cPTSD and BPD are that individuals with BPD are more likely to present with increased lack of self-identity, fear of abandonment, and suicidal and non-suicidal self-injurious behaviors. It is important for MISSION-CJ providers to understand the nature and complexity of the impairment in self-regulation processes that clients may present with, and resist the urge to label or classify clients, particularly female clients, as "borderline" without more fully understanding the nature of their traumatic histories and the role they play in current functioning and symptomatology.

Veterans. Veterans in the criminal justice system experience higher rates of exposure to traumatic events compared to non-military criminal justice populations. Veterans with mental illness and/or substance use disorders present with additional challenges stemming from their exposure to combat trauma as well as vulnerability to traumatic brain injury (TBI). Veterans exposed to trauma and/or TBI while in the military may have elevated risk for criminal justice problems (CMHS National GAINS Center, 2008). They are likely to exhibit greater externalizing and hyperarousal symptoms such as increased aggression and self-destructive behavior that may increase their risk for criminal justice contact. Furthermore, once arrested, Veterans with criminal records are also likely to have limited social supports and are at greater risk for homelessness (McGuire & Rosenheck, 2004). Of Veterans screened for Military Sexual Trauma (MST), 22% of women Veterans and 1% of men Veterans screened positive (Kimerling, Gima, Smith, Street, & Frayne, 2007), and women Veterans with sexual assault histories were at greater risk for developing PTSD (Yaeger et al., 2006). Complicating these clinical and social risks is the fact that many Veterans returning from service do not seek out appropriate treatment for their psychosocial needs. Although some studies have suggested that 80% of Veterans with PTSD who served in the Iraq and Afghanistan wars had at least one mental health visit at a VA treatment facility, less than 10% of these Veterans received the recommended amount of treatment within one year of their diagnoses (Seal, Bertenthal, Miner, Sen, & Marmar, 2007; Seal et al., 2010). Limited engagement in mental health treatment may increase the risk for criminal justice involvement through untreated mental health symptoms that are manifested as destructive or aggressive behavior.

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

In addition to considering specific issues relevant to the populations discussed above, it is important to be sensitive to the roles culture and gender play in the client's understanding of the trauma and in his/ her comfort level in addressing it. There may be cultural restrictions on discussing personal histories; cultural differences in how an individual expresses trauma symptoms (as examples, individuals from some cultures tend to express psychological distress through physical symptoms versus emotional symptoms and men more often "externalize" symptoms, while women are more likely to "internalize" them); cultural differences that influence the role substance use plays in an individual's coping style; and cultural differences that affect treatment response. The treatment provider's

awareness of cultural and gender issues may influence the level of engagement on the part of the client. Thus, MISSION-CJ CMs and PSSs are encouraged to seek training in cultural diversity and gender-based issues in order to provide the most compassionate and effective care possible to MISSION-CJ clients.

C.II. Treatment issues

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

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

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

If a client is particularly distressed during a meeting and is experiencing trauma-related symptoms, he or she must be assessed for safety risk. If the CM is a licensed mental health provider, he/she should assess the client for symptom exacerbation, suicidality, homicidality or aggression, and drug/alcohol relapse. If the CM is not a licensed professional he/she should ensure that the client is assessed for safety by a trained professional. If the client is not in immediate risk the client's safety plan should be reviewed with him/her and coping strategies for managing the distress should be discussed. **Clients who are suicidal or homicidal with a clear plan or intent should not be left unattended whenever possible and should be evaluated by a mental health professional immediately. Public safety personnel (e.g., police) should be contacted in an emergency where safety cannot be maintained.**

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

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

Trauma-related Symptoms and MISSION-CJ Case Manager and Peer Support Specialist Interventions

Symptom	Intervention (with corresponding exercises from MISSION-CJ Participant Workbook)
Intrusive memories or thoughts	Remind clients that they are only memories; that it's natural for them to occur; and that they are not in acute danger
Flashbacks and other types of dissociation	Have clients keep their eyes open and describe where they are and what they are seeing Keep clients engaged and talking Have clients stand up if necessary and move around Have clients splash water on their face Use grounding tools (e.g., describing the environment, counting, reading aloud, repeating a saying, touching objects around you, jumping up and down, stretching, breathing)
Sudden onset of intense emotional reactions	Allow clients space to express naturally occurring emotions Remind clients that these emotions are not dangerous Ask clients if they are also having scary thoughts and work with clients to help challenge those thoughts if appropriate (based on content and where clients are in their treatment) Practice deep breathing (MISSION-CJ Participant Workbook 2.18-19) Progressive muscle relaxation (two exercises which are included in the MISSION-CJ Workbook; 2.17-18)

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

C.III. MISSION-CJ Specific Tools

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

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

- Relapse Prevention Plans
- Preventing and coping with stress worksheets
- Moving through the fear worksheets
- Creating the life that you want worksheets
- Developing strong communication skills
- Anger management
- Relationship related triggers
- Changing unhealthy thinking patterns
- Changing irrational beliefs
- Scheduling activities early in recovery
- Understanding PTSD
- Coping skills focusing on planning, self-esteem, relaxation, and anger management skills

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

C.IV. Linkage and Treatment Options

Although MISSION-CJ is a trauma-informed program and there are ample opportunities for CMs and PSSs to help clients cope with trauma-related symptoms through the workbook and skills building, MISSION-CJ is not a specialized trauma program. Several authors have identified the importance of providers recognizing trauma prevalence in a justice population and that

referrals for further treatment can be helpful in these settings (Osher & Steadman, 2007). Therefore, as previously mentioned, it is important for MISSION-CJ providers to be aware of when symptoms are present that necessitate making a referral for specialized trauma-related treatment and consult with clinical supervisors if further treatment is warranted. Furthermore, when working with clients involved in the criminal justice system, there may be times when criminal justice personnel (e.g., probation officers, correctional officers, correctional program staff, etc.) also become aware of trauma-related symptoms and how they are having an impact on a client's responsivity to supervision. In these cases, these criminal justice personnel may suggest that MISSION-CJ providers further screen for trauma. MISSION-CJ providers should consult with supervisors as needed about appropriate referral options.

Referral options will vary based on the network of service providers available in a particular client's community, and what is permissible given the individual's criminal justice status (e.g, an incarcerated offender or an offender who is restricted via GPS monitoring or curfews may need permission to travel for such treatment). Additional considerations are: (1) whether the client should be referred to a residential or outpatient treatment program, (2) whether a client should be referred to a trauma-focused treatment program (e.g., where specific trauma memories are processed) or a trauma-informed treatment program (e.g., where coping skills related to trauma symptoms are learned), and (3) how to coordinate care between outside providers and MISSION-CJ providers and criminal justice supervising entities.

Residential vs. outpatient. Residential programs typically offer higher levels of care and are for clients who are suffering from more severe trauma-related symptoms. These programs are fewer in number and in most cases should only be considered if outpatient treatment has not been successful, and/or clients need a higher level of supervision and greater intensity of skills building. Outpatient trauma treatment is available in many communities and should be considered a first line option. There are several empirically supported treatments for trauma and stress related disorders.

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

It is important to note that in addition to trauma-specific psychotherapies, psychopharmacological approaches to trauma symptoms can be a critical component of treatment (see Nisenoff, 2008 and Ravindran & Stein, 2010). Medications themselves can have side effects and clients may express concerns about their medications. It is important that these issues get discussed with clients' psychiatrists or other prescribers. It may be useful to have clients write down their concerns so that at the time of their appointments they will have a tool that can assist them in articulating their questions. Going to a treatment provider can be stressful so strategies to help patients get their needs met can be helpful. Medications used to treat PTSD symptoms can include anti-anxiety medications, anti-depressant medications, and even what is called "anti-psychotic" medications that can be helpful with intrusive thoughts or some associated sounds or voices

that people with PTSD sometimes hear. Also, some of the treatments that are used to treat anxiety symptoms can have addictive properties and where there are co-occurring substance use disorders, clients may need careful education about staying within the guidelines of a prescription.

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

C.V. How to Resume Treatment

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

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

D. Summary

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

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

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IX. Core Competencies for MISSION-CJ Clinical Supervisors

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A. Introduction and Overview

The MISSION-Criminal Justice (CJ) Program is based on a community-integrated, professional, paraprofessional and peer support model for a client population affected by a multifaceted set of criminal justice, mental health, substance-related, psychosocial, educational, family, and often economic problems. The role of the Clinical Supervisor (CS) is to ensure that supervisees (Case Managers/Peer Support Specialists) understand and properly execute clinically appropriate, ethical and effective clinical principles in their work with MISSION clients, with adherence to the MISSION-CJ protocol.

This chapter presents information and strategies for the CS to provide on-going clinical supervision to the MISSION CJ Case Manager (CM) and Peer Support Specialist (PSS) team as they implement the MISSION-CJ protocol. This chapter will address: selection of clinical supervisors; understanding the target populations; responsibilities and tasks of the clinical supervisor; supervisory stance and structure; working effectively as a team, helping supervisees to make the most of supervision; assisting supervisees with caseload management strategies; general clinical issues relevant for CMs and PSSs; specific clinical issues relevant to CMs; and specific clinical issues relevant to PSSs.

B. Selection of Clinical Supervisors (CS)

Ideally, a MISSION-CJ CS should have an advanced degree, license in mental health care (e.g., licensed clinical social worker, psychologist, psychiatrist) and supervisory experience, with expertise in case management, assessment and treatment of psychiatric disorders, substance use disorders (SUDs), and/or serving criminal justice (CJ) involved populations. Since a central role of the CS is to ensure that the clinical care provided is consistent with the model, he/she should have training in and an understanding of MISSION-CJ protocol, the Motivational Enhancement Therapy (MET) approach, the 13 Dual Recovery Therapy (DRT) sessions, Cognitive Behavioral Therapy (CBT), and the 11 peer-led sessions. The CS should also be familiar with available community-level vocational, educational, health, social services, criminal justice, as well as housing resources to help CMs and PSSs link clients to available services.

C. Understanding the Target Populations

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

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

In general, the CS can expect that each team member has received the training for MISSION-CJ in the following areas: a general overview of the MISSON-CJ model, its key components and how to use the MISSION-CJ Treatment Manual and MISSION-CJ Participant Workbook. This includes information on the model's theoretical framework and the application of all MISSION-CJ's service components (e.g., CTI, DRT, peer support, vocational/educational supports, trauma-informed care considerations, and risk-needs-responsivity), the respective roles of all staff in the delivery of these key components, and how the MISSION-CJ team functions as a whole to support clients. If this has not been done, we recommend that the CS assist team members in obtaining these basic trainings. For supplemental training in these areas, CSs can contact the MISSION developers via the MISSION website (http://missionmodel.org) to schedule staff training. In addition, we would expect that

the CMs and PSSs have been trained and have developed a basic understanding of confidentiality, documentation, reporting, criminal justice supervision requirements, and crisis management policies and procedures of the clinical partner organization/ service provider agency.

However, each team member brings his/her own unique life experience, formal training and/ or previous work experience to his/her role on the MISSION-CJ team. Moreover, the CS should obtain a clear understanding of each MISSION-CJ team member's previous training and work experience. The CS should also assess each team member's knowledge of the MISSION model and understanding of his/her roles and responsibilities on the team, as well as the supervisee's strengths and weaknesses, role-specific learning needs and professional development level (e.g. beginner, intermediate, experienced). Assessment of a supervisee's skills and training should be an interactive and collaborative process that can include: asking the supervisee about his/her own strengths/weakness (self-assessment); having the supervisee provide responses to hypothetical clinical situations; and/or observing the supervisee in a real clinical situation such as during an intake or DRT session. This process can help streamline training and supervision by enhancing the supervisor's understanding of the supervisee's starting points in terms of knowledge, skills, and values or attitudes. The CS can then address gaps during on-going supervision/training, and adjust supervision sessions accordingly to meet the professional needs of novice to advanced team members.

a. Case Managers (CM) are either licensed clinical social workers (L.C.S.W.) or licensed professional counselors (LPC) who have experience working with clients with a history of mental health and substance abuse problems, and demonstrated expertise delivering case management services. They should have training in MET, CBT, and vocational/ educational support and community outreach with criminal justice involved individuals. They should be comfortable (or trained to develop familiarity) with court systems, criminal justice settings, and/or probation or parole services. They may be asked to speak in open court about a client's progress.

b. Peer Support Specialists (PSS) are individuals who have faced their own addiction and/or mental illness, they may have interacted with the criminal justice system, and they have demonstrated successful recovery with the ability to navigate complex public health systems. PSSs bring a valuable set of skills in advocacy and engagement and received training specific to the role of participant (i.e. peer) provider. This type of training is increasingly popular and available, and enables them to provide an array of practical/social supports to clients and implement the 11 peer-led sessions. PSSs should be knowledgeable of community, social, and health service systems, as well as criminal justice systems and their related mandates and requirements, and have significant abilities to link, advocate, and help criminal justice involved individuals with co-occurring disorders (COD) navigate these systems.

2. MISSION-CJ Clients

MISSION-CJ serves ethnically and racially diverse criminal justice involved adults with CODs. Clients may also include male and female offenders of various risk levels. They may include specific populations with targeted additional needs such as persons who are homeless or Veterans who meet criteria for the MISSION-CJ program. Overall, many MISSION-CJ clients have experienced high rates of unemployment and victimization themselves, putting them at increased risk for homelessness and related psychosocial problems such as substance abuse, mental illness, and exposure to violence. Due to multifaceted and complex client backgrounds and needs, CSs should be skilled in addressing their diversity of presenting problems (e.g. CODs, legal, housing, employment issues, etc.).

D. Responsibilities and Tasks of the Clinical Supervisor

1. Caseload

Treatment team members work together, under the supervision of the CS, to implement MISSION-CJ protocols. CMs and PSSs are equal members on

the MISSION-CJ treatment team and both report to the CS. The number of CM/PSS treatment teams is dictated by the needs of the agencies implementing MISSION-CJ, but on average most agencies have 1-2 CMs, 1-2 PSSs and 1 CS. Each CM/PSS/CS team will typical have caseloads of up to approximately 20 clients at any given time. These numbers may vary depending on the length of time individuals are receiving MISSION-CJ.

2. Tasks

CSs engage in both administrative and clinical supervision activities. The CS may be responsible for recruiting and hiring full-time qualified staff (CMs and PSSs) and for ensuring that program-specific training and on-going supervision is comprehensive and timely. CSs play a role in organizing and overseeing initial training, and orienting new team members to the clinical organization, the MISSION-CJ model, the clinical population and the agency's policies/practices. Supervisors may also train CMs to complete, write up, and present assessment intakes. Supervisors meet weekly with the full CM/PSS team to coordinate case management and peer support activities, and also ideally meet individually every week with team members, providing clinical direction and overseeing that each team member complies with applicable policies and legal requirements. Each supervision meeting with the CM/PSS team lasts approximately 1-1.5 hours. In addition, CSs may meet with consultants and specialists to ensure a smooth interface between MISSION-CJ and linkage services. For example, seeking consultation from experts in forensic psychology, forensic social work, or forensic psychiatry may be helpful if legal issues interface with clinical concerns. Consultation with lawyers, general psychiatrists, addictions specialists, trauma experts, etc., may also be useful at times. Since many MISSION-CJ clients will be parents, there may be a need to consult with a variety of child service agencies at times.

3. What is the Difference between Training and Supervision?

The CSs' responsibilities include both training and clinical supervision. Training refers to activities to impart acquisition of a new skill set and knowledge base needed to begin a particular type of work. Supervisors play a role in providing that foundation by reviewing confidentiality, documentation, reporting, and crisis management policies and procedures with all team members. CSs also train new staff in the theory and application of all service components in the MISSION-CJ program (e.g., CITI, DRT, peer support, vocational/educational supports, Risk-Needs-Responsivity (RNR), and trauma-informed care considerations), the respective roles of all staff in the delivery of these essential MISSION-CJ components, and how the MISSION-CJ team functions as a whole to support clients. Additional training activities can include reviewing organizational policies with staff, having staffs member re-read the MISSION-CJ treatment manual, having staff attend peer support training and/or obtain a peer specialist certification, and training the CM on administering the assessment battery, etc.

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

E. Supervisory Stance and Structure

1. Collaborative

The MISSION-CJ model emphasizes a collaborative relationship with the client, and thus, the CS should model this type of collaborative relationship with the CM and PSS, thereby facilitating a strong supervisory alliance with CM and PSS team members. A strong sense of shared tasks, goals,

and bonds among treatment team members is important to be able to work in tandem to help each client on the MISSION-CJ caseload. Thus, each member's input, contribution, and ideas are welcomed and discussed and the team works in a collaborative manner to provide support and services to all MISSION-CJ clients.

2. Motivational Interviewing Style

Use of a Motivational Interviewing style (MI, Houck et al., 2012), incorporating global dimensions of acceptance, empathy, and MI Spirit (collaboration, evocation, and autonomy/support) (Vader et al., 2010), further facilitates alliance between the CS and his/her team members, as well as provides a model for the CM/PSS/client relationship. CSs can teach team members to use an MI spirit approach with clients, by assigning readings, providing examples, discussing the approach, and using MI in supervisory communications. The approach prohibits a communication style that is critical or confrontational. For instance, CSs provide feedback using a positive and affirming style, first identifying what the supervisee has done well, and then giving specific guidance on what could be done differently. The supervisor can also provide a range of options for possible interventions with clients to foster collaboration and the CM's/PSS's autonomy and involvement in decision-making. The CS uses empathy and validation to foster support for the team members, by being respectful and non-judgmental of supervisee's questions and decisions, and attempts to evoke the supervisee's perception and thoughts rather than dictating what to do.

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

PSS: I am not happy with the way this case is going. I feel like I'm the only one on the team who is helping this guy find a job. I know how important having a job is to help reduce his risk for recidivism.

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

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

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

PSS: I looked into vocational training options and identified ones that he would be eligible for; I talked to the client about pursing these training options. He has never had traditional vocational training or a career, so we talked about the pros and cons of each option to help with his motivation to apply for a job, but the client is still not taking action. When I try to bounce these ideas off the team, no one says anything.

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

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

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

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

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

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

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

PSS: I guess I could have something ready for our meeting this week.

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

3. Observing Supervisees

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

F. Working Effectively as a Team

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

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

a. Parallel Process: Use the Same Good Communication Skills that We Teach the Client.

CSs model and train CMs and PSSs to recognize effective and problematic communication styles and to use the "elements of good communication" (see box) outlined in the DRT approach. CSs can set the tone of team communication by reviewing DRT communication skills with their team, modeling these skills in supervision and giving positive or corrective feedback regarding the team's communication. In other words, team members should strive to use the same good communication skills that they teach the clients to use in daily living.

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

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

- *Be polite and considerate.* Treat your team member with respect; don't judge.
- *Stop and think* before commenting on things that bother you. Don't bring up issues unless they are really important.
- Decide not to "kitchen sink" or bring up other problems when discussing one problem. Try to resolve one issue at a time.
- Make sure to express positive feelings and to reward your team member rather than taking for granted things that are going well.
- Avoid destructive criticism or complaining. Phrase change requests in a positive way. *Use good listening skill*s: Look at your team member when he/she speaks to you. *Don't interrupt! Take turns talking and listening.* Validate what your team members say even if you don't agree (e.g. "I can understand why you're upset about the client asking me to attend this meeting and not

including you. Maybe we can decide together how we should approach this issue in the future").

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

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

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

3. Information Sharing Between Team and Others

In the MISSION-CJ model there will be times when a number of providers (probation officer, vocational counselor, psychiatrist, CM, PSS, housing support counselor, etc.) are involved in the provision of integrated care. Confidentiality is important to consider in communication with these outside providers. First, the client should be asked to sign a consent form to release/provide information before any information regarding the client is shared with other providers or agencies outside the team. Teams should have explicit discussions with clients regarding what will and will not be shared with other providers. After consent is received, team members should be mindful to release only information that is directly relevant to the client's care. For example, if the client has provided consent, it would be appropriate for a team member to inform the client's vocational counselor of client interest in a prospective job, but not inform them that the client has recently been divorced. For justice system-involved clientele, the team must also request clear direction from other agencies and providers on what the limits of confidentiality are, for instance, whether the Probation Officer needs the CM to report if the client is positive on a drug screen, or whether they engaged in what might have been problematic or illegal behavior from the court/public safety supervisory agency's perspective (e.g., meeting up with girlfriend despite an active no-contact/ restraining order from the court).

4. Maintaining Clear Team Member Roles and Responsibilities

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

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

*See also tables in Chapter 5: Case Management and Chapter 6: Peer Support

5. Supervisory Intensity is Tapered Over Time

Similar to the tapered dependence of clients on CMs and PSSs over time in the CITI model, this supervision model assumes increasing independence of CM and PSS as their level of competence, knowledge, and confidence increase over time. Thus, it is expected, but not required, that as each CM and PSS gains experience and on the job training, intensity of needed supervision tapers over time (or should, if CMs and PSSs are learning and implementing MISSION-CJ appropriately). For instance, clinical supervision is more intense for new MISSION-CJ CMs and PSSs, (i.e. observe intake assessment, attend first DRT group session, etc.); the supervisee is expected to seek help and assistance often in addition to weekly supervision meetings, and the CS's interventions should be very structured, providing significant directive feedback and support. With accumulated experience and increased expertise, supervisees should acquire strong skills, be stable in their delivery of the key MISSON-CJ components and reach a level of proficiency where they have some level of autonomy in their work. They can nicely focus and integrate all aspects of the work including the client, the process, the CM/PSS team and their own contributions. They are aware of their own and their team's strengths and weaknesses and understand when to seek help. Supervisory interventions should be balanced so that autonomy and independence are fostered while support and structure are still available at all levels of supervisee experience and expertise. CSs can use the following methods to monitor supervisees' progress in learning the MISSION-CJ materials and appropriately implementing it: observation, role play, skills training, modeling, assigning reading and discussing it, and providing opportunities for peer supervision. Similar to the way CMs and PSSs closely monitor clients and gradually encourage independence as clients develop their skills and build their confidence, supervisees become more independent from their CS's expertise as their own experience accumulates.

6. Evaluation of Supervisee Performance

Inherent in this supervision model is the continuous monitoring of CM and PSS performance. CSs can implement a quarterly evaluation of each CM and PSS to summarize and review progress and performance in expected areas. This should be a structured process, where the supervisor reviews the table of roles and responsibilities and provides direct feedback to each CM and PSS individually. Ideally, this feedback would be written and reviewed verbally. CSs can also integrate a self-assessment (completed by each CM and PSS evaluating their own performance) based on the table of roles/ responsibilities. In the evaluation process, CSs should solicit CMs and PSSs understanding of the evaluation and ask them to add their thoughts (i.e. clinical development goals). Supervisors can also use fidelity methods (described later in this chapter) to identify areas in which CMs/PSSs need improvement or additional support and provide feedback. If the CS identifies areas in which CMs/PSSs are especially deficient, the CS should institute a remedial plan and perform more frequent oversight of the CM's/PSS's performance

7. Preventing Splitting of Team by Client

The term "splitting" is used to denote the pitting of one entity against another. For example it can occur when a client expresses polarized views of their CM/ PSS team members, viewing the CM as "all bad" and the PSS as "all good". Team members play a role in preventing splitting. First, by communicating regularly about shared clients, so that all communications are transparent across all parties, CMs and PSSs can avoid intra-team conflict or miscommunication related to clients. Second, CMs and PSSs should never gossip about or "badmouth" the other team member to clients. Third, CMs and PSSs should not discuss or disclose dissatisfaction or resentments or conflicts among the client's team, to the client. If clients disclose polarized views regarding a team member, team members should acknowledge (not confirm or collude with) the client's concern, coach client on appropriate ways to handle and communicate their concerns directly (e.g. encourage the client to talk to the other team member), discuss this issue with the team member directly and/or discuss during clinical supervision. It

should be noted that splitting can also occur when working with providers outside of the team. The clients may have an "all good" view of CM/PSS team and all bad view of his/her probation officer, for instance. Teams should follow the steps outlined above to prevent splitting in these situations.

8. Managing CM and PSS Stress and "Burn out"

CMs and PSSs will encounter and listen to very distressing stories and the immensely difficult life situations of their clients. Given team members' exposure to potentially distressing situations, stories, and information on a day-to-day basis, it is important to identify the signs of burnout and compassion fatigue in team members. Burnout is a prolonged response to chronic emotional and interpersonal stressors on the job. Compassion fatigue is a form of burnout. It is a physical, emotional and spiritual exhaustion accompanied by emotional pain. Compassion-fatigued helpers often continue to give themselves fully to their clients, but find it increasingly difficult to maintain a healthy balance of empathy and objectivity. It can lead to serious issues for helpers and can compromise client care. Therefore it should be monitored and addressed by supervisors.

Additionally, in many service organizations there are often a significant number of helpers in recovery as well. Particular to MISSION-CJ, PSSs are generally all in recovery from substance use and/or mental health problems and/or have had experiences with criminal justice involvement, homelessness, unemployment, etc. Supervisors should be mindful and monitor substance use relapse warning signs and slips of team members. For PSSs in recovery, being exposed to high risk situations and familiar personal triggers (criminal behavior, active drug/alcohol users, street life, talking about client's triggers, depressing events, etc.) might put them at increased risk for relapse themselves. This should be attended to and discussed to generate a plan and a commitment to communicate with the clinical supervisor about slips and relapse.

CSs should provide space and create a safe atmosphere in their meetings where CMs and PSSs can feel comfortable to discuss these issues. To facilitate this atmosphere, CSs can start by alerting CMs and PSSs to the potential for burnout, highlighting the causes, signs and methods to prevent it, and its impact on client care.

Strategies for Preventing and Managing Burnout and Stress (Young, 2009)

- Engage in things that bring joy and relieve stress.
- Decide on a time of the day when not to engage in helping-related work and, instead, focus on leisure.
- Take time each day to relax, even if it is only for a couple minutes of deep breathing.
- Avoid taking on extra clients if your caseload is full. Just say "no" to yourself.
- Avoid taking on extra work-related responsibilities if you are feeling overwhelmed or spread too thin.
- Keep your supervision appointments and receive supervision regularly, discussing your concerns.
- Receive counseling of your own to manage any difficult feelings you are experiencing.
- Routinely assess where you stand in regard to burn out and compassion fatigue.
- Debrief with team members after a challenging experience/situation.
- Discuss burnout and stress in supervision meetings.

9. Dealing with Staff Turnover

Burnout and staff turnover go hand in hand. Helpers who are "burned out" are more likely to leave their positions. Therefore, prevention of burnout is key in preventing staff turnover. Identifying signs of burnout or burnout risk in team members, providing feedback about this in the weekly individual supervisee meeting, and collaborating on a plan to manage the variables contributing to the development of burnout can help avoid a negative outcome for team members and thus, help to prevent turnover. If turnover does occur, determine the cause by

asking the departing team member what led to their decision to leave, or by evaluating what system issues lead to having to terminate the team member.

G. Helping Supervisees to Make the Most of Supervision

1. Balancing Independent Work with Seeking Supervision when Necessary

It is important to define when a supervisee should work independently versus seek supervision. In general, supervisees can work more independently if they report during supervision and the client's objective progress indicates that the supervisee has a clear understanding of the presenting problem and is effectively implementing the MISSION-CJ treatment plan. No matter what level of expertise, supervisees need to seek immediate supervision in the event of emergent issues including: client suicidality or homicidality, concern about child, elder abuse and domestic violence, acute intoxication, and withdrawal risk issues. CSs should be available to respond to emergent issues and/or identify a "back-up" supervisor if they are not available.

2. Efficient Use of Supervision Time

Team and individual supervision meetings only occur once a week for about 1-1.5 hours each. This will not provide enough time for an in depth review of every case on the MISSION-CJ team's caseload. Therefore supervision meetings should be structured to optimize the time. Preparing for supervision and structuring the meeting can help optimize the time. Below are ways in which this can be accomplished.

Efficient Use of Supervision Time:

Supervisor Responsibilities

- Set an agenda at the start of each supervision meeting. Ask the supervisees what they would like to add. This models a core CBT skill for supervisees and keeps the meeting on task.
- Demonstrate time management in the supervision session. This is another skill that is good to model for supervisees. After collaboratively setting the agenda with the supervisees, divide the time among the items on the agenda.
- Discuss clients who are using and where there are clinical concerns first. Clinical concerns include: lack of taking care of daily care needs, lack of progress in the case, lack of cooperation, criminal activity or arrest, warning signs of relapse or recidivism, increasing symptoms of mental illness.
- Have template letters/documents that can be easily modified by clinicians (e.g. letter regarding treatment attendance to the court). Supervision time can be drained by spending time drafting documents from scratch.
- Keep a running list of re-occurring themes and responses to commonly occurring issues/ questions. This is helpful to prevent "recreating the wheel" during the meeting and providing consistent responses to your supervisees.

Supervisee Responsibilities

- Take notes during the week on important clinical issues to discuss in supervision.
- If there is a complex clinical concern, take a few minutes before supervision to conceptualize the issue concisely. Present key points only. Do not focus on unrelated details. Your presentation should be limited to about 5 minutes.
- Bring client session notes, updated use graph/ data, abstinence plan, and intake to supervision. It is important to present weekly updated accurate alcohol/drug use data at every session. This data is essential in developing appropriate abstinence plans and /or making decisions regarding need for higher level of care. The first two questions a good supervisor will ask are: "What did the client drink/ use this week?" (looking for frequency and quantity info, and patterns of drinking/use situations) and "What were the triggers for engaging in criminal activity this week?"
- Bring questions to supervision sessions, about a specific case, or more generally related to therapy skills (e.g. case formulation, or MET skills, etc.) or strategy (e.g., how does one motivate a clients to seek additional social support for recovery).

- Record what has been discussed in supervision in relation to your client and implement in the next session. You should refer back to these notes before supervision to address how you used feedback from prior supervision session.

H. Assisting the CM and PSS with Organizational Skills and Strategies to Manage Caseload

Organizational skills, including systems to promote accurate and timely case recordkeeping/clinical documentation, impact the quality of care. It is important for supervisees to receive training and supervision in how to keep track of each case's weekly activities, overall week by week treatment plan, contacts with clients, issues, etc. Each agency has its own unique clinical documentation system and supervisees should be trained in how to use these systems. CSs should continually assess supervisees' timely and accurate submission of clinical documentation and general competency in clinical organizational skills. CSs should model and reinforce organizational skills. For example, CSs can create a binder, which they bring to each supervision session. The binder contains agendas from each supervision session with notes on what was discussed and decided. Therefore as treatment progress and plans are reviewed the CS can easily track client progress and assess the supervisees' implementation of clinical recommendations from previous meetings. This models a system for tracking clients. CSs should explicitly advise CMs and PSSs on the use of best practices in tracking clients and supervision issues (e.g., keeping a supervision notebook with notes, noting supervision questions that come up in the field on a smart phone, etc.). In providing these tips, supervisors should also reinforce the importance of following all confidentiality policies.

In addition, it will be important for the CSs as well as the CMs and PSSs to gain familiarity with the criminal justice environments that their clients will have encountered or with whom clients will continue to intersect. For example, the team and CS may need to visit the jails and prisons that will be sending clients as part of re-entry services. The members of the team and the CS may attend court sessions and meet with probation and the judge prior to receiving clients. Some of these environments can be stressful to navigate and the CS should be mindful of providing and/or referring for any support that the CM/PSS may need.

I. Ensuring Fidelity to the MISSION-CJ Treatment Manual

While CSs are responsible for ensuring fidelity to the model, it is also possible that this is being done by the developers of MISSION-CJ if the program is being implemented as part of a federal study. This is particularly true for those research projects that involve testing on the implementation and efficacy of the MISSION-CJ model. In either case, fidelity is defined as the accuracy and consistency with which the MISSION-CJ model is delivered to ensure it is implemented as prescribed and that each component is delivered in a comparable manner to all clients over time and across all MISSION-CJ providers. Poor fidelity to the model can lead to poor client outcomes. Through ongoing assessment, monitoring, and corrective feedback, supervisors can impact fidelity. Some specific methods to assess and monitor protocol fidelity include: training and orientation, familiarity and consistent use of the treatment manual, direct observation of interactions between staff and clients, group and individual supervision meetings, and conceptualizing cases using CTI and DRT as described in the manual.

1. Tracking Fidelity

As an adjunct to the processes described above to track fidelity, the MISSION-CJ program utilizes the following standardized instruments to assist clinical supervisors in tracking the fidelity of clinical practice to the MISSION-CJ model (instruments can be found in Appendix M of the MISSION-CJ treatment manual) (Pinals, Smelson, Harter, & Sawh, 2014):

- *The MISSION Services Delivery Record:* a checklist which CMs and PSSs use to record each client contact along with the types of services they deliver during that contact. Each clinician's Services Delivery Record for each active client should be accessible to project management on a shared computer drive, allowing clinical supervisors to conduct quick spot checks on the

level and types of service delivery activity in which clinicians are engaging.

- *The MISSION Fidelity* Index is more often used in studies where the MISSION-CJ model is being tested to assess the extent, as well as the quality, of delivery of key MISSION-CJ service components and the quality of clinician record keeping. For example, the measure assesses the extent to which a CM or PSS follows up on identified client problem areas. The index is completed quarterly over the course of the project (often dictated by the research design of the study) by the MISSION development team and done on a random selection of patients on each CM and PSS caseload. If this is being done, it is important to note that the MISSION project staff will notify you that this is part of the project and that you should expect to have fidelity monitoring.
- *MISSION-CJ Services Delivered Tracking Sheet: Case Manager and Peer Support Specialist* is designed to document the delivery of MISSION services and should be completed by the CM and PSS following each treatment session with the client.

J. General Clinical Issues Relevant to Case Manager and Peer Support Personnel

1. Therapeutic Alliance with Client and Modeling Prosocial Connections

A collaborative and strong therapeutic relationship is the foundation of an effective treatment experience. Changing maladaptive behavior is quite difficult for clients to accomplish, and a positive therapeutic alliance helps to motivate the client to learn and practice the skills covered in the model. Some clients will come to treatment having had a disappointing experience (i.e. having violated probation or having been arrested for a minor offense, failed attempts at sobriety, etc). This may result in feelings of frustration, disappointment, and anger that may be expressed or projected onto the therapist. Following are some techniques to foster therapeutic alliance with the client.

Developing a Positive Therapeutic Stance and Alliance with Patients and Modeling Prosocial Connections

- Speak clearly and slowly. Use terms the client will understand.
- Ask the client what he/ she would like to be called when you first meet.
- Don't jump into the manualized material. Spend some time getting to know the client, developing a mental picture of his/her daily life.
- Integrate what you know about the client's case conceptualization into everything you choose to say. For instance, if a patient is generally passive and unassertive, and he/she reports saying no to someone during the week, say, "wow, that's great – that must have been really hard for you to say no! You did a great job! In your family, you never had all that much of a voice to say no, but you are doing much better with that now."
- Ask the client during agenda setting if there is anything he/she would like to add.
- Integrate client's experiences, triggers, and case conceptualization when providing intervention rationale to highlight how each intervention may be helpful to each particular client.
- Provide praise for change attempts.
- If the client tends to go off topic, re-direct the conversation by linking what they are saying to the skill at hand.
- Normalize clients' experience, validate, but don't collude with victimization, helplessness, etc.
- Utilize MI/MET/CBT concepts to motivate and teach skills to clients.
- Assess, encourage, and enhance self-sufficiency of the client.
- Identify service gaps. Be responsive by providing appropriate referrals.
- Together develop a vision of the potential each client can strive to reach, and map out a plan for him/her to achieve those goals.

2. CM and PSS Therapeutic Stance

In general, use a non-confrontational, non-judgmental therapeutic style, integrating a Motivational Interviewing "spirit". It is important that the CM and PSS convey warmth and empathy by acknowledging the difficulties clients have faced along the way, as well as ambivalence about change, acknowledging the client's strengths in the face of these challenges, and fostering hope and motivation for change.

a. Psycho-education. By having a sound foundation in addictions and mental illness, the CM can integrate psycho-education as a way to engage the client and possibly counter client's "negative self talk" about their addiction (e.g. I can't quit because I am lazy").

b. Taking a Collaborative, Coaching Stance. It is essential for MISSION-CJ team members to provide positive reinforcement for positive changes. Every session, the CM or PSS should provide some praise for positive movement toward behavior change and use this movement towards positive change as a motivational tool. Don't confuse positive reinforcement for behavior change with overuse of reassurance for lack of behavior change. Validate but don't collude.

c. Importance of Empathy, Validation, and Reflective Listening. Empathy, the ability to understand experiences from another person's point of view, is essential for establishing a strong and engaging therapeutic relationship. Empathy is an important part of building rapport and will help to facilitate feelings of trust and mutual respect between the client and MISSION-CJ team. Demonstrating empathy and understanding of a client's world helps to validate the client's experiences. Beginning CMs and PSSs often view making direct statements about the client's challenges as counterproductive to an empathetic stance. They fear being critical and rupturing the therapeutic relationship and thus may err on the side of caution and avoid direct discussion of important issues like continued drinking, and treatment non-adherence.

CMs and PSSs must be trained to use validating responses to show empathy towards a patient but not encourage unhealthy patterns/behaviors. For example, a client comes in very upset and says, "My husband is horrible. He made me steal for drug money this whole week". A novice helper may respond by saying "He sounds pretty mean. What did he do that made you steal and use?" This response reinforces to the client that it is OK to be reactive to her husband and also reinforces that her husband is in control of her stealing and use of drugs. The CS can suggest an alternative response, a reframe that helps the client learn to take responsibility for her own drinking behavior: "sounds like you had a rough week, and were really angry at your husband. Let's talk about the triggers related to your husband that led to your deciding to steal and use, and what you might do differently if the same situation comes up this week."

3. Case Conceptualization

Case conceptualization is key in understanding the client and their current problems; informing treatment and intervention techniques; assessing client progress; and helping to establishing rapport with clients. The case conceptualization should be based on the initial assessment, each team member's input about client, the client's needs and resources, pre-homeless highest functioning, and realistic, measurable goals for what each client might be able to achieve (i.e. highest potential expected). These components of the case conceptualize help in the development of clinical hypotheses that will guide the treatment planning process. These hypotheses may require adaptation as new information reveals itself during treatment.

Clinical hypotheses can be used by the team to guide case management and/or can be shared with clients. For example a CM could share the following clinical hypothesis for a person with depression and alcohol dependence: "Would it be helpful for me to share with you my observations? Since you moved to this area, it seems that you have experienced many life changes and some very upsetting losses. Your problems sort of accumulated over time. After a while, you realized that savings have been spent, and your relationship with your girlfriend ended

leaving you sad, lonely, and without a place to live. Understandably, your thoughts, which used to be pretty optimistic, are now very negative, especially about your future. In reaction to your low mood, you have stopped doing things you liked to do. Instead, you started to spend your time drinking, and stopped interacting with your family. What parts of these observations ring true to you and what don't? "It is important to note that prior to sharing a clinical hypothesis with a client, CMs and PSSs should get their supervisor and team member's input regarding the hypothesis. This minimizes the chance of inaccurate hypotheses and also keeps CM/PSS teams on the same page regarding their conceptualization of the client.

4. Treatment Planning

The case conceptualization leads to the development of the treatment plan. A sound treatment plan should be an integration of the presentation and causes of the patient's difficulties into a specific set of steps to address these issues. Specifics should include: length of treatment; need for initial level of care for substance use disorder (withdrawal risk); need for initial level of care for mental health problem (stability); triage of patient's needs (i.e. coordination with the client's probation officer, treatment and services needed, etc.); housing and vocational needs. In addition, treatment planning should look at risk-needs and related interventions that can decrease recidivism. Once the plan has been discussed and approved in supervision, it should be presented to the client. When presenting the plan, actively involve the client and incorporate his or her feedback.

In this population, withdrawal risk is essential to consider to treatment planning. If not managed properly withdrawal from drugs and alcohol can be fatal. While the CM and PSS are not managing withdrawal risk themselves, they are often the eyes and ears of the physician who is also working with the client. For that reason we have included the following criteria that physicians and programs may use in deciding whether the client needs a higher level of care (inpatient detoxification or rehabilitation) and are based on the American Society of Addiction Medicine guidelines (ASAM, 2013):

- Clients at particularly high risk for complicated withdrawal (i.e. 3 prior withdrawal episodes, history of severe withdrawal symptom);
- Clients at high risk for biomedical complications: Presence of biomedical problem(s) requiring inpatient diagnosis and treatment, such as impending hepatic decompensation, acute pancreatitis or other condition requiring parenteral therapy, active gastrointestinal bleeding, cardiovascular disorder requiring monitoring, etc. Chemical use gravely complicating existing biomedical condition, or worsening of a condition making immediate abstinence critical to avoid severe morbidity or mortality.
- Clients at high risk for psychiatric or behavioral complications: Uncontrolled behavior endangering self or others. Impairment of cognitive function, mental confusion or fluctuating orientation, or extreme depression such that activities of daily living are impeded. Evidence of disorientation to self, alcoholic hallucinosis, or toxic psychosis within the past 24 hours or currently. Chemical use complicating existing psychiatric condition, or worsening of a condition making immediate abstinence critical to avoid severe morbidity or mortality.

Withdrawal Symptoms (Center for Substance Abuse Treatment, 2006)

Drug	Onset	Duration	Symptoms
Alcohol	24–48 hours after blood alcohol level drops	5–7 days	Irritability, restlessness, anxiety, depression, insomnia, tremor, increase in blood pressure, heart rate, temperature, nausea/vomiting/diarrhea, seizures, delirium, death
Benzodiazepines	1 -7 days after ceasing use	2-8 weeks (depends on type: long vs short acting)	Anxiety, depression, diarrhea, constipation, bloating, insomnia, irritability, muscle aches, poor concentration and memory, restlessness, perceptual disturbances, panic attacks (less common), seizures, psychosis
Cocaine	Depends on type of cocaine used: for crack will begin within hours of last use	3-4 days	Sleeplessness or excessive restless sleep, appetite increase, depression, paranoia, decreased energy, stroke, cardiovascular collapse, violence
Cannabis	3-4 days	Up to several weeks	Irritability, appetite disturbance, sleep disturbance, nausea, concentration problems, involuntary eye movement, diarrhea
Methamphetamine	4- 12 hours after last use	1-2 weeks	Depression, anxiety, fatigue, paranoia, aggression
Opiates/Heroin	Within 24 hours of last use	4-7 days	Depression, anxiety, irritability, muscle aches (particularly in the back and legs), sensitivity to pain, overproduction of bodily fluids, such as sweat, tears, and a runny nose, diarrhea, nausea/vomiting

5. Handling Clinical Emergencies

One can't always predict and prevent crises in this work, but when crises do occur, there should be a plan in place for how to handle them. CSs must review plans for handling emergent issues with all CMs and PSSs before they meet with their first client. Plans should be reviewed in orientation, training and supervision throughout the MISSION-CJ program period.

a. Suicide Risk. This manual does not provide a comprehensive model for suicide or violence risk assessment and management. It is expected that teams work with their CSs around these issues to develop crisis planning procedures and to discuss individual staff safety and safety of others. If a CM or PSS believes a client might be suicidal, and there is time to plan, they should discuss their concerns and options with the client. Assessment of suicidality should follow this format: assess thoughts, means, plans, and history of attempts. However, fully trained clinicians may follow other formats depending on the clinical scenario. If the client presents as a suicide risk (a clear plan or definite intent), the

MISSION-CJ CS should be notified immediately. The client's CM or PSS should escort the client to meet with the CS for additional assessment. If the CS decides the client needs emergency psychiatric services or is unavailable, the client should be escorted to the closest walk-in emergency psychiatric services. Clients should not be left alone during this time unless there are risks to the clinicians or others. It may be necessary to call first responders (e.g., police, ambulance) to maximize safety for all. MISSION CMs and PSSs who are able should stay with the client until they are able to see an emergency psychiatric services clinician for evaluation and/or until there is back up (e.g., police, if needed) for safety concerns. MISSION-CJ CMs and PSSs should also remind clients of emergency contact options throughout the course of treatment as well as during emergent situations. Examples of emergency contact options include: emergency psychiatric services, 911, and the 24-hour national suicide prevention lifeline, 1-800-273-8255 (TALK).

Signs of Intoxication (Center for Substance Abuse Treatment, 2006)

Drug	Signs
Alcohol	Slurred speech, unstable movement and walking, smell of alcohol on breath or skin, glazed or bloodshot eyes, flushed skin
Benzodiazepines	Drowsiness, double vision, impaired balance, impaired motor function, anterograde amnesia, and slurred speech
Cocaine	Anxiety and agitation, chest pain or pressure, increased energy, paranoia, decreased appetite, fatigue, enlarged pupils, sweating, tremors, confusion, hyperactivity, hyperthermia (elevated body temperature)
Cannabis	Lower blood pressure, increased heart rate, pressure around the eyes, reddening of the eyes, bleary/ shiny eyes, talkative, giggling
Methamphetamine	Increased heart rate, increased blood pressure, large wide pupils, jaws grinding
Opiates/Heroin	Pupillary constriction, drowsiness, nodding off, slurred speech, impairment of attention, goosebumps

b. Intoxication During Sessions with MISSION Team. Clients may show up to sessions intoxicated. Therefore there should be a plan in place to handle an intoxicated client. The organization may have a method for assessing intoxication such as a breathalyzer or drug screen at the beginning of each session. Others may subjectively assess by observing signs of intoxication.

If the client appears intoxicated, the CM or PSS should not proceed with the session. There may be instances when the client is clearly intoxicated but denies being under the influence. Do not engage the client in confrontational interchanges around whether he or she used alcohol/drugs or not. Simply inform the client that the policy is to reschedule the session. If the client is intoxicated and could possibly be driving impaired, work with the client to make arrangements to get him or her home or to an ER safely without operating a vehicle. Organizations should create a form outlining these procedures to follow in this situation and the MISSION-CJ CM and PSS should keep this form readily available. If the client's level of intoxication could be potentially dangerous there are additional considerations. At these levels, the client may need medical attention. Depending on acuity and safety considerations, one option is to have the client call a friend or family member to come pick him/her up and take him/ her to the nearest emergency room (ER). Or, the client can take a taxi to the nearest ER. In some cases, if the client agrees to go directly to a detox or inpatient rehabilitation unit, CMs and PSSs can help in making arrangements to transport the client to the treatment facility through a friend, family member or taxi. Some treatment facilities provide pick up service.

c. Serious Psychiatric Symptoms. If a CM or PSS believe a client might be presenting with serious mental health symptoms (active psychosis, mania, severe depression), the CM should thoroughly assess these symptoms. If there are imminent concerns, the CM or PSS should notify their CS immediately. If the PSS observes these symptoms, they should consult with the CM and then based on the CM's interpretation notify the CS or refer the patient immediately to a higher level of care. If the CS is unavailable and the client is reporting symptoms that could pose a risk to self or others, the client should be escorted to the closest walk-in emergency psychiatric services, or the CM/PSS should call 911 or an available acute psychiatric call-line. Clients should not be left alone during this time. MISSION CMs and PSSs should stay with the client until they are able to see an emergency psychiatric services clinician for evaluation. If the client's symptoms are not posing an imminent risk, the CM or PSS should discuss concerns with the client, develop a safety plan (including emergency contact options and information), inform client's family of the concerns and emergency plan (if the client's provides consent), and inform the CS of the concerns and plans immediately after the session.

d. Homicidality or Threats to Hurt Another. As noted, this manual does not provide a comprehensive model for violence risk assessment and management. It is expected that teams work with their CSs around these issues to develop crisis planning procedures and to discuss individual staff safety and safety of others, managing them as one might for other clinical situations. MISSION-CJ clients may manifest violent intentions toward an individual or a potential group of individuals, and CMs and PSSs are obligated to assess. Assessment of violence risk should follow this format: assess thoughts, means, plans, and history of attempts to harm others. This format is not etched in stone and clinical teams may consider other approaches in accordance with their own professional judgment. CMs and PSSs should follow procedures dictated by their licensing/certifying organizations and their agency regarding duty to warn or protect. CSs should be aware of their and their team's duties to warn/protect. CSs and other team members should be informed immediately or as soon as practicable of any concerns of this nature. First and foremost, safety of all should be paramount. If needed, first responders (such as law enforcement) can be contacted.

e. Violence History. If a CM or PSS becomes aware that the client has been involved in violence outside of the meetings, gather details about the incident from the client (e.g. initiation of violence, victim and perpetrator injuries, etc.). If the client is the victim of violence (e.g. domestic violence), create a safety plan and connect the client to appropriate services. If the client is the perpetrator of the violence, when clinically appropriate, utilize tools from the MISSION-CJ treatment manual appendices to reinforce anger management skills to prevent future violence, review the limits of confidentiality (staff member may need to report), and/or report immediately to the police if violence led to serious bodily harm or fatal injuries. MISSION-CJ CS and CM/PSS team members should be informed immediately.

f. De-escalating Anger or Violence During Sessions with MISSION Team Member. Anger and violence may occur during MISSION-CJ sessions. It's important that CMs and PSSs are trained in de-escalation strategies. De-escalation strategies aim to facilitate the gradual resolution of a potentially violent and/or aggressive situation through the use of verbal and physical expressions of empathy, alliance and non-confrontational limit setting. De-escalation techniques include: observing for signs and symptoms of anger and agitation; approaching the person with caution in a calm and controlled manner; using distraction; using verbal techniques to calm the person down (using clear, calm and respectful language; using open-ended sentences; avoiding challenges and promises). In these types of situations, CMs and PSSs should make note of exits in the vicinity should they need to leave immediately, avoid vulnerable positions, such as turning one's back to the client or positioning the client between the team member and the door (Skolnik-Acker, 2008).

g. Arrest, Incarceration, and Other Interactions with the Criminal Justice System. CMs and PSSs should gather details about new arrests (e.g. offense, terms of release, pending court dates, etc.). An arrest indicates a need to revise the treatment plan. Any new charges or interactions with the legal system should be shared with the CS and other team member. These may need to be discussed with relevant criminal justice parties (e.g., Specialty Court sessions, probation, etc.).

6. Dealing with Family Members

With the client's permission and signed consent, the CM/PSS team may involve the client's family members in providing support and responding to crises. Additionally, the CM might provide emotional support to the family or engage in psycho-education about mental illness, substance abuse, criminal recidivism, and MISSION services. Family therapy, if needed, is accomplished by referral.

Positive family engagement/involvement can boost treatment outcomes. CMs and PSSs may need to motivate the client to consider involving family members. Prior to talking with family members, team members should acquire the client's signed consent. The treatment team's contact with family members can range from practical, crisis and/or legal reasons or they may engage the family by explaining to families how to handle the needs of the client; identifying gross family dysfunction and making a referral; and identifying family members who might be helpful to incorporate into treatment planning. CMs and PSSs who are actively engaging families should: ask questions that elicit family members' expressions of concern and feelings related to the client's condition and its effect on the family; empathically listen to family members' concerns and feelings and, where appropriate, normalizing them; form a preliminary assessment of the family's level of functioning as it relates to the client's problem; and encourage family members to seek support in their efforts to cope with their situation as a family (Center for Substance Abuse Treatment , 2004).

7. Trauma-Informed Care

CMs and PSSs should be trained to screen and/or further evaluate clients for symptoms of trauma and refer them as needed to specialized trauma treatment providers who are trained to deliver evidence-based treatments for trauma. MISSION-CJ CMs and PSSs should also be trained to provide ongoing support for clients while clients are receiving treatment from a specialized trauma program and to serve clients who are not acutely symptomatic and do not require specialized trauma services.

a. What Is PTSD? CMs and PSSs should be trained in the diagnostic criteria for PTSD. Post-traumatic stress disorder (PTSD) can develop following a traumatic event that threatens the client's safety or makes them feel helpless. Usually these events are outside the realm of normal human experience. More recently people often associate PTSD with Veterans but any overwhelming life experience can trigger PTSD (i.e. sexual assault, witnessing or being the victim of a violent crime, etc.), especially if the event feels unpredictable and uncontrollable. In addition to having a history of exposure to a traumatic event, the following four groups of symptom criteria are required to assign the diagnosis of PTSD (American Psychiatric Association, 2013; see also Chapter 8 for more information related to trauma):

- Intrusion: Recurrent re-experiencing of the trauma (i.e. dreams, nightmares, or flashbacks)
- Avoidance: Avoidance of places, people, and experiences and/or a memories, thoughts, and feelings that remind the client of the trauma
- Negative alterations in cognitions and mood: A variety of mood states and cognitions, including a persistent and distorted sense of blame of self or others to markedly diminished interest in activities
- Arousal and reactivity: Chronic physical signs of hyper-arousal, including sleep disturbances, poor concentration, increased tendency and reaction to being startled, and hyper-vigilance (excessive watchfulness) to threat

b. How to Assess PTSD Symptoms (Warning Signs). The severity of trauma symptoms can change over time, and therefore, it is important for CMs and PSSs to recognize PTSD early warning signs that may be an indication that symptoms are getting worse. Trauma symptoms do not usually just pop up out of the blue; they are usually preceded by some warning signs. These warning signs can range from the experience of certain emotions, changes in thoughts, or changes in behavior. Below are some common warning thoughts.

Common Trauma Symptom Warning Thoughts (Marlatt & Gordon, 1985)

Changes in Thinking

"I am in danger"

"I am thinking about it (the traumatic event) all the time."

Changes in Mood

"I am beginning to feel really jumpy and on edge."

"My mood keeps changing rapidly. In minutes, I can go from feeling really happy to really terrified."

Changes in Behavior

"I don't want to be around people anymore. I've been isolating myself."

"I've been drinking more, but just to take the edge off of my feelings a little."

c. When Is It Time to Refer? If the CM and/or PSS suspect that the client has PTSD and these symptoms are impacting social, emotional and vocational functioning, it's important to refer the client for treatment right away. For example, if the client is engaging in unhelpful thought processes and behaviors to avoid painful memories and feelings (i.e. avoiding social events), it is time to refer. The sooner PTSD is addressed, the easier it is to treat.

d. Discussing Trauma with Clients. The goal of screening clients for trauma is to connect the client with the proper treatment provider who will conduct a thorough evaluation. The treatment team should not attempt to identify, in as much detail as possible, the traumatic events that occurred. Asking the client to go into exhaustive detail about the trauma can intensify trauma symptoms/re-traumatize the client and vicariously traumatize the CM and PSS. Once the client has been referred, they will have an opportunity to complete a trauma-related assessment with a qualified trauma specialist who can systematically and effectively assess the details and context of the trauma. Therefore, the CM and PSS should be trained to leave the "heavy lifting" of assessing and exploring the trauma to the experts.

8. Ethical and Legal Considerations

a. Confidentiality. CMs and PSSs should be trained in the organization's confidentiality policies. Clients should be informed that their confidentiality is protected but it is not absolute. There are some exceptions under the law when the CS or CM is required to share information about the client. Exceptions to confidentiality include the following: (1) Imminent Harm to Self - If a team member has reason to believe that the client is in danger of physically harming himself or herself, the staff member may have to report this to the appropriate agency and may have to make an involuntary referral to a hospital. (2) Imminent Harm to Others - If a team member has reason to believe that the client is seriously threatening physical violence against another person, or if the client has a history of physically violent behavior, and the team member believes that the client is an actual threat to the safety of another person, the team member may be required to take some action (such as contacting the police, notifying the person against whom threat has been made, seek involuntary hospitalization, or some combination of these actions) to ensure that others are protected. (3) Child Abuse or Elder Abuse - If the client reports anything about a child under the age of 18 being abused or neglected, or a vulnerable adult being abused or neglected, present or past, CMs and CSs may be required to make a report to Child Protective Services or Adult Protective Services. Supervisors should thoroughly review reporting requirements with PSSs, as reporting requirements for PSSs may vary per organization/state.

b. Consent. As mentioned all client's information should be kept confidential. Client information can only be released with the client's permission, unless there is an active court order that authorizes such release. CMs and PSSs should be trained to request verbal and written consent from the client to release and receive client information to/from other providers and family members. In releasing information, team members should be clear with the client what information will and will not be released. MISSION-CJ team members should also be mindful to not release information to providers that is irrelevant to the treatment of the client.

c. Working with Vulnerable Populations. Female offenders and women who have offended in the past present unique challenges, not the least of which is pregnancy. Pregnant woman who are incarcerated or involved with the criminal justice system may also be eligible for MISSION-CJ. CMs and PSSs should receive supervision and training that: explicitly explores team member's perceptions and values regarding women who use substances during pregnancy; reviews the effects of substance use during pregnancy, and their effect on infant and child development; and increases knowledge of community resources and services for pregnant women. Teams working with clients who have been incarcerated should keep in mind knowledge regarding the legal system and process.

9. Diversity Issues

One goal of clinical supervision is to increase team members' cultural competence, their sensitivity and responsiveness to diversity issues among staff, with clients, and between staff and clients. Cultural competence is an on-going interactive and reflective process experience through education and training, supervision, and ongoing working with diverse populations. Supervisor's should initiate discussions of differences in race, ethnicity, gender, religion, socioeconomic status, sexual orientation, or disability regarding both clinical work with clients and supervisory and team relationships. These discussions can promote awareness of diversity and cultural issues and affords the supervisor the opportunity to model culturally competent behaviors. Some areas to explore in these discussions include:

- Unintentional racism, sexism, ageism, homophobia, etc. Well-intentioned CMs and PSSs who are unaware of how their own racial, gender, and sexual identity affects their relationships with clients may avoid talking about race, gender, age, and sexuality.
- Communication issues. Differing communication styles among cultural groups can result in misunderstandings between team members and clients and among team members.
- Cultural Differences. Attitudes toward mental illness/addictions vary among individuals, families, ethnicities, cultures, and countries. Cultural and religious teachings often influence beliefs about the origins, nature of, and treatment of mental illness/addictions. These differences should be considered in the case conceptualization and treatment (Center for Substance Abuse Treatment, 2009).

Gender differences should be included in diversity training and supervision. Men and women differ in their development and maintenance of mental illness and substance use disorders. MISSION-CJ CMs and PSSs should be trained on these gender-specific differences and on how to implement interventions in a way that effectively incorporates gender specific issues.

K. Specific Clinical Issues Relevant to Case Managers

1. Intake Assessment and On-Going Within-Protocol Assessment

Assessment is an important part of this treatment, for case conceptualization, level of care determination, abstinence planning, and treatment planning. Assessment also provides a baseline of functioning and use against which to measure progress throughout treatment via continuous within-treatment assessment of target behaviors. Clinical supervisors are responsible for performing comprehensive assessments. The supervisor evaluates substance abuse, severity of psychiatric

symptoms, and functioning in other life domains (e.g., physical health, family, social, and legal). In some programs, the MISSION-CJ CM may also conduct intakes under close supervision by the CS. Assessment is an on-going process and all staff should be trained in assessment activities. Conducting an unbiased and accurate assessment is critical in making an accurate diagnosis.

a. Ongoing Assessment: Monitoring Client's Progress. Ultimately, effective clinical supervision ensures that clients are competently served and progressing towards their treatment goals. MISSION-CJ CSs should monitor each client on the team's caseload consistently. CSs should ask supervisees' for verbal reports of their impressions of client progress; utilize objective data (e.g. drug screen results, client's use of other services, etc.) to confirm accuracy of supervisee's report; assist supervisees to identify clients not making progress; and engage in regular discussion of clients' progress towards the established goals of the MISSION-CJ treatment plan. As part of the ongoing assessment of the client's progress, there also should be a review of data related to criminal justice compliance (e.g., reports on how the individual is doing with probation, with reentry planning and the like).

b. Assessment Stance. It is not easy to walk the balance of empathic interviewing/ good assessment-rapport, so training must include ongoing monitoring and supervision in this area. This can include observing a CM conducting an intake, having a CM observe the supervisor conducting an intake, and providing feedback during and/or after the observation or in supervision.

c. How to Write Up a Clinical Intake Summary. After completing the assessment, an intake report should be written. It should concisely summarize the patient's current and past use, relevant current/ past mental health, withdrawal profile, medical and treatment history, family history, and diagnoses. CMs should present their clinical intake reports at supervision. As the CM presents the intake, the supervisor should provide feedback on the accuracy and quality of assessment (e.g., *Did the CM get adequate quantity/frequency information?*) and provide initial thoughts on the client's abstinence plan and case conceptualization.

Suggested Format for Intake Reports

Demographic Information:

Client's name: AR Date: 5/17/2012 Clinician: Jen Connelly, LCSW

Age: 40 Marital Status: Divorced Ethnicity: Caucasian Spouse's Occupation: n/a

Address (Town, State): Metro Boston Area, Staying with various friends and family members (currently residing with Mother in Boston)

Occupation: Unemployed, line cook when available Prior Occupation: Cook

Children (ages): 21, 19(bio)

Weight: 140 lbs. Height: 5'5"

Breathalyzer: BAL=0.0

Oral Drug Test: Negative

Annual income: $5,000.00 Insurance: Uninsured

Legal Status: On probation

Presenting Problems:

AR is a 40-year-old divorced man. He is concerned that his drug use and depression are adversely impacting his ability to maintain stable housing, employment and contributing to his multiple arrests. He reported that he stays with friends and families in the Metro Boston Area, moving around every couple of weeks. He is currently living with his mother. He is currently on probation for possession with the intent to distribute charges and is concerned that if he doesn't address his issues, he may be arrested again.

Mental Status:

AR arrived on time for the assessment session. The client appeared his stated age. He was dressed in a disheveled way and personal hygiene was poor. Eye contact, speech, mood/affect were appropriate. He did not present with cognitive or memory disturbances. Orientation was intact for person, time and place. He appeared somewhat anxious and fidgety. No thought disorder, no psychotic symptoms, no suicidality or homicidality were evident.

Current Legal Involvement and Lifetime History of Legal Involvement:

AR reported a long history of involvement with the criminal justice system dating back to his early teens. The client reported "minor" involvement with the police in his early-mid teens. He reported being "arrested" a couple of times for public intoxication but did not receive any charges for these arrests. His first arrest with charges was at age 20 for possession of marijuana. As his drug use escalated he was arrested a couple of times on possession and petty theft charges and served brief jail sentences. He was most recently incarcerated for 5 years for drug possession with the intent to distribute a class B drug. He is currently on probation.

Current Psychiatric Symptoms and Lifetime History of Psychiatric Problems:

AR reported a history of bipolar disorder. He believes his condition has worsened as he faced chronic housing, employment and drug problems. He reports being hospitalized once for depression in high school. He reported that his counselor at school believed that he was so depressed he would kill himself. He was involuntarily admitted to an inpatient psychiatric hospital. He stayed for 3 days and was released. He was diagnosed with bipolar disorder at this time. He adamantly denied past and current suicidal ideation. He reported that he "distrusts" counselors because of this "forced" hospitalization.

Current Drinking and Drug Use Pattern and Consequences:

AR is a daily drinker. He generally drinks 5 shots of whiskey (Standard Drinks (SD=5) from 6-10 pm (Blood Alcohol Level (BAL=.10). He has been drinking in this pattern for the last couple of months. The client had his last drink less than 24 hours before the interview, 5 shots of whiskey (5.12) SD from 5-8 pm (BAL=.11). He is currently a daily smoker and smokes a pack of cigarettes per day. He also reported struggling with marijuana use. He experienced a slip since his release and has been smoking 1 joint per day. He reported the following negative consequences related to use: his children refuse to speak to him because of his use, arrests, overdoses, feeling out of control (unable to control his use), spending substantial time each week using or being high, withdrawal, giving up other activities in order to use, having to borrow, or steal money or sell drugs to pay for drugs.

He presents with moderate depression and mild anxiety.

- Beck Depression Inventory II: 30. He didn't endorse suicidality.
- Beck Anxiety Inventory: 13

Alcohol and Drug History:

AR began drinking at age 13. He reported a history of binge drinking from age 13-35 years old, drinking about 7 standard drinks on each drinking occasion 3-4 days per week. He met criteria for current alcohol dependence with physiological dependence starting at age 15. The client began smoking marijuana at age 13 as well. He quickly progressed to a daily use of marijuana. He has only been abstinent from marijuana when incarcerated and for brief periods to "pass" court related drug testing. The client reported experimenting with cocaine in his late teens. He reported that he would only use it on weekends to stay up to party and sell drugs. His use of cocaine escalated in his 20s, increasing to daily use for about 1-2 years. He reported that he supported this expensive habit by working, selling drugs, and stealing. The client reported that he was then introduced to speed balling heroin and cocaine. He eventually switched to primarily using heroin in his mid-late 20s. He quickly developed a daily heroin habit. The client could not recall any periods of abstinence from all substances outside of his periods of incarceration. He reported that he has received alcohol/drug treatment: he attended AA/NA inconsistently for the last 15 years and attended substance abuse groups in jail.

Family/Personal/Relationship History:

AR was married for 4 years. His marriage ended due to his drug/alcohol use and untreated mental health problems. He reported a distant relationship with his ex-wife and his adult children. He reported that they are angry with him because of his string of arrests, broken promises and bad behavior (i.e. stealing from them, becoming emotionally abusive during manic episodes, etc.). The client reported feeling like a loser in life. He is able to find temporary housing with friends, family, and shelters throughout the Metro Boston area. When he is unable to find temporary

housing, he sleeps under the bridge by Main Street. He reported that his depression is at its lowest when he doesn't have stable housing or employment.

He has a positive family history of addictions: father and 2 brothers. His mother has a history of bipolar disorder.

Medication/Health:

The client was diagnosed with hypertension in jail. While he was in inpatient treatment for depression, he reported that the doctor prescribed him medications for bipolar disorder. He could not recall the name of the medication and never took it.

Current Need for Detoxification:

The client was abstinent from all substances while incarcerated (5 years). He is currently a daily drinker and smokes marijuana. He has been treated in general hospital emergency rooms several times for acute withdrawal from drugs and alcohol. Due to the client's high blood pressure and history of acute withdrawal, detox should be considered. Additionally since his last drink was less than 48 hours ago, there is concern about withdrawal risk, since he could still have a seizure within 72 hours after last drink.

Provisional DSM-V Diagnoses:

Axis I:

- Alcohol Use Disorder, Severe, with Physiological Dependence (DSM-5)
- Cannabis Use Disorder, Severe, with Physiological Dependence (DSM-5)
- Tobacco Use Disorder, Severe, with Physiological Dependence (DSM-5)
- Opioid Use Disorder Severe, with Physiological Dependence, In full sustained remission, (DSM-5)
- Cocaine Use Disorder Severe, with Physiological Dependence, In full sustained remission (DSM-5)
- Bipolar Disorder

Axis II: Deferred

Axis III: Hypertension

Axis IV: Problems with Primary Support Group, Chronic Homelessness, Arrest/Incarceration, Unemployment

Axis V: 50

d. How to Present a Clinical Intake in Group Supervision. Intake presentations should be no longer than 10 minutes of presentation and discussion. The CM should review the clinical intake summary in the order written, read at a steady efficient but not rushed pace, be open to feedback and questions from the supervisor and the group. Discussion and feedback should focus on withdrawal profile risk, psychiatric symptoms, level of care determination, level of housing need urgency, case conceptualization, and case management plan. The CS can write notes on the intake, indicate changes the CM will need to make to the intake before it is finalized (e.g., including more detail about DUI history).

e. Providing Supervision on Dual Recovery Therapy Protocol. CSs should be familiar with and if possible experienced and proficient with DRT implementation with justice-involved populations. Supervisors should thus read the DRT manual and use it with some clients to achieve proficiency.

f. Integrating the Risk-Need-Responsivity (RNR) Model. The RNR models aims to reduce risk of recividism by matching interventions to the client's level of risk, needs and responsivity. It provides treatment teams guidance on how to tailor interventions to "meet the client where they are at" on these dimensions. CSs should have a clear understanding of the RNR model (refer to the RNR chapter in this manual for an in-depth discussion of the model) (Pinals, Smelson, Harter, & Sawh, 2014). CSs should be experienced and proficient in formal and informal ways of integrating the RNR model into assessment. CSs should provide CMs and PSSs with concrete strategies to integrate RNR strategies, continually assess their efforts in this area and provide feedback. CSs should encourage frequent communication with criminal justice authorities to ensure that all parties are working in collaboration.

L. Specific Clinical Issues Relevant to Peer Support Specialist and Peer Navigators

1. Setting and Maintaining Boundaries around Relationship with Clients

Setting and maintaining boundaries with clients is essential to effective and ethical treatment. This can be an issue for both CMs and PSSs. This may be a more pressing issue for PSSs because they have more exposure to the client outside the traditional therapeutic setting and relationship. PSSs act as an advocate, a mentor, a "one way friend" to clients but not a friend in the sense of two people on the same level of power and at same level of personal disclosure with each other. PSSs are para-professionals and should conduct themselves accordingly. CSs should provide training on boundary issues. Training should include the rationale for boundaries in relationships with clients, disclosure (what is appropriate and not appropriate to disclose), discussion of clear boundaries violations (e.g., intimate relationships with clients), and discussion and role-plays of how to handle less clear boundary issues. Less clear boundaries may need to be negotiated in supervision. For example, can a PSS receive or give a small gift to or from the client. Different teams may come to different decisions about these kinds of questions, depending on the treatment setting and other factors. Recognizing and discussing these less clear-cut boundary issues is an important part of supervision.

Appropriate and Inappropriate PSS/ Client Disclosures and Behaviors

	Appropriate	Inappropriate
Disclosures/ Behaviors	• Disclosing detailed information regarding substance use history, mental health history, struggles to overcome problems, dealing with the system, life experience • Attending a recovery meeting with a client • Ride the bus with the client to educate them on the city's transportation system	• Disclosing home address • Bringing the client to a team member's home • Introducing team member's family members to client • Intimate relationships • Business relationships • Borrowing from or lending money to a client

2. Providing Supervision for the 11 Peer-Led Sessions

CSs should be familiar with and if possible experienced and proficient with implementation of the 11 peer-led sessions with this population. Supervisors should thus read the manual for the 11 sessions, the client workbook and attend any related training on the 11 topic sessions to achieve proficiency.

3. Providing Supervision for the DRT Sessions

CSs should be familiar with and if possible experienced and proficient with implementation of the DRT sessions with this population. Supervisors should thus read the manual for the DRT sessions and have a clear understanding of the theoretical framework underlying DRT.

Conclusions

In supervising CM/PSS teams in MISSION-CJ, the Clinical Supervisor must continually have in mind the goals of helping clients achieve sustainable recovery, which includes reduction of recidivism. With strong supervision and support of the CM/PSS teams, participants can benefit from the full potential of the component parts of MISSION-CJ.

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Dr. Debra A. Pinals currently serves as the Assistant Commissioner of Forensic Mental Health Services for the Department of Mental Health, and is an Associate Professor of Psychiatry and Director of Forensic Education at the University of Massachusetts Medical School. She is a forensic psychiatrist who, over the past 15 years, has worked in inpatient psychiatric hospitals, correctional facilities, court clinic, outpatient, and emergency mental health settings as an attending psychiatrist and conducting forensic evaluations. In her current role she oversees management of adult and juvenile court clinic services, reentry services for individuals with serious mental illness, police diversion programs, specialized risk management services as well as standards for forensic clinical assessments. She has directed several federal grants related to reentry and court-diversion, including four grants that have helped inform the development of MISSION- CJ services. Dr. Pinals has served as a member of the Council on Psychiatry and the Law for the American Psychiatric Association and as President of the American Academy of Psychiatry and the Law (AAPL). She has received awards and recognition for her work in Public Sector Psychiatry, Jail Diversion, and the establishment of the Plymouth Mental Health Court in Plymouth, Massachusetts. Dr. Pinals has developed training materials for police who encounter persons with mental illness, and has authored or co-authored numerous publications on topics related to mental health, justice, and forensic assessment. Dr. Pinals extends her appreciation and gratitude to the individuals she has treated, the students she has taught, and the countless colleagues who have worked with her across various agencies and institutions and who strive to provide better services for court-involved individuals with co-occurring disorders as they work toward personal recovery.

David Smelson, PsyD

Dr. David Smelson is a Professor and Vice-Chair of Clinical Research in the Department of Psychiatry at the University of Massachusetts Medical School. He is also the Director of Translational Research in Mental Health at Edith Nourse Rogers Memorial Veterans Hospital and Director of the Bedford Node of the National Center for Homelessness Among Veterans. He has devoted his career to studying treatments for addiction and mental health problems and received grants from such agencies as the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment and Center for Mental Health Services, the National Institute of Health/National Institute of Drug Abuse, and the National Center for Complementary and Alternative Medicine, along with numerous other foundations. The majority of the work on the initial MISSION Service Delivery project and MISSION Manual Development Fidelity Project was done while Dr. Smelson was at the Department of Veterans Affairs, New Jersey Health Care System; the University of Medicine and Dentistry, Robert Wood Johnson Medical School; and the University of Medicine and Dentistry School of Health-Related Professions. He remains indebted to these institutions for their ongoing support and assistance with these projects.

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Dr. Jennifer Harter is a Licensed Clinical Psychologist in Massachusetts where she specializes in treating children and adults. She received her PhD in Clinical Psychology from Fordham University. She is affiliated with the UMASS Medical School Department of Psychiatry. Her early clinical and research interests primarily focused on underserved populations, including individuals with HIV/AIDS and substance abuse disorders.

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Daniel M. Blonigen PhD, is a Career Development Awardee (Clinical Sciences Research & Development) at the HSR&D Center for Innovation to Implementation, VA Palo Alto Health Care System. He received masters and doctoral degrees in clinical psychology from the University of Minnesota – Twin Cities, and completed his predoctoral clinical internship at the Palo Alto VA. His interests and expertise lie at the intersection of psychological assessment, personality, and disorders of substance use and antisocial behavior. Dr. Blonigen has received funding to study homelessness, treatment engagement, and treatment outcomes among Veterans with substance use disorders (SUD) and other mental health problems. His current work entails development of a personality-assessment feedback intervention to increase Veterans' engagement in SUD treatment, and qualitative research to examine the implementation of Risk-Need-Responsivity (RNR) principles into the practices of VHA Justice Program Outreach Specialists. He has published over 40 peer-reviewed manuscripts and book chapters, and serves on the editorial boards of Personality Disorders: Theory, Research, & Treatment, and Journal of Psychopathology and Behavioral Assessment. He is also a member of the Department of Veterans Affairs, Quality Enhancement Research Initiatives for SUD and Mental Health (forensic emphasis).

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Jonathan Delman, PhD, JD, MPH

Jonathan Delman, PhD, JD, MPH is a principal at Reservoir Consulting Group and Research Faculty at the University of Massachusetts Medical School, Department of Psychiatry. At UMass, Dr. Delman is the Director of the Program for Recovery Research and the Associate Director for Participatory Action Research at The Learning & Working during the Transition to Adulthood Rehabilitation Research & Training Center. Dr. Delman's vocational research and development projects focus on the needs of particularly vulnerable populations of people with mental illness, such as transition age youth, people who are homeless, and those who are court-involved. He also studies the workplace conditions that lead to employment and career success for people with mental illness, and in particular peer specialists. Dr. Delman also develops and leads projects on recovery-oriented care, consumer outcomes measurement, and activating consumer participation in both treatment decisions and policy development. Dr. Delman has regularly advised SAMHSA (Substance Abuse Mental Health Services Administration) and NIMH on these matters, and most recently was appointed to the Institute of Medicine's Committee on Developing Evidence-Based Standards for Psychosocial Interventions for Mental Disorders.

Dr. Delman is a mental health consumer researcher and a 2008 recipient of a Robert Wood Johnson Community Health Leader award, one of ten awarded nationally, for "individuals who overcome daunting obstacles to improve health and health care in their communities." He has received several awards from DMH for "Distinguished Service", and is a member of the editorial board of the Psychiatric Rehabilitation Journal.

Elizabeth E. Epstein, PhD

Elizabeth Epstein, PhD is a Research Professor and Director of the Clinical Division at the Center of Alcohol Studies (CAS), Rutgers University, is on the Contributing Faculty, Graduate School of Applied and Professional Psychology (GSAPP) and The Department of Psychology at Rutgers University, and is an adjunct Clinical Associate Professor in the Department of Psychiatry, Rutgers Medical School. Dr. Epstein teaches graduate level courses on the assessment and treatment of alcohol use disorders as well as on Cognitive Behavioral Therapy (CBT) for adult psychopathology. She is formerly Director of the Program for Addictions, Consultation, and Treatment (PACT) at CAS and GSAPP, Rutgers University. In addition, she is a Senior Clinical Associate with the Freehold Psychology Group. Dr. Epstein received her PhD in Clinical Psychology at the University of Connecticut and is a licensed psychologist in the state of New Jersey. She is Principal Investigator and/or co-investigator on several past and current clinical research grants funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and National Institute on Drug Abuse (NIDA). Her primary research activities involve development and testing of CBT models and mechanisms of change for substance use disorders, and in individual differences among substance abusers and impact on treatment response. She has published and lectured widely on the treatment of substance use disorders.

Andrea Finlay, PhD

Dr. Finlay is a Special Advanced Fellow in Health Services Research & Development at VA Palo Alto Health Care System, an Implementation Research Coordinator for the VA Substance Use Disorder Quality Enhancement Research Initiative, and a Postdoctoral Fellow at Stanford University School of Medicine. She received her PhD in Human Development & Family Studies from the Pennsylvania State University. Her research focuses on justice-involved Veterans with mental illness, with an emphasis on identifying and addressing gaps in access and engagement in mental health treatment.

Ayorkor Gaba, PsyD

Dr. Gaba is the Project Manager of the Women's Treatment Project at the Center of Alcohol Studies (CAS) at Rutgers University and a Clinical Supervisor at the Rutgers Psychological Clinic at the Graduate School of Applied and Professional Psychology (GSAPP), Rutgers University. She is formerly Co-Director of the Program for Addictions, Consultation, and Treatment (PACT) at CAS and GSAPP, Rutgers University. In addition, she is a licensed clinical psychologist with a private practice in Highland Park, NJ. Dr. Gaba received her Psy.D. in Clinical Psychology at Rutgers University. She completed her doctoral internship at the University of Medicine and Dentistry of New Jersey (UMDNJ) and is a licensed psychologist in the states of New Jersey and New York. Dr. Gaba has provided clinical training and supervision to mental health trainees, professionals, and para-professionals, and has conducted research in addictions and public health. She has presented on a wide range of topics related to addictions, cultural issues in psychology, and cognitive behavioral therapy. She is a member of the American Psychological Association (APA) and served on the board of the New Jersey Psychological Association Foundation. She is also an APA appointed representative to the United Nations.

Stan Goldman, JD

Stan Goldman practices law in Reading, Massachusetts. In January 2012, he retired from the Committee for Public Counsel Services, Massachusetts' Public Defender agency. At CPCS, Attorney Goldman created and served as Director of the Mental Health Litigation Division. In this capacity, he trained and supervised all attorneys assigned to represent indigent persons in mental health proceedings, and trained and consulted with defense counsel in respect to forensic mental health issues in criminal proceedings. He also has served as Executive Director of the Mental Health Legal Advisors Committee of the Massachusetts Supreme Judicial Court, as Director of Litigation and Assistant General Counsel of the Massachusetts Department of Mental Health, and as Assistant Legislative Counsel to former Governor Michael Dukakis. Mr. Goldman has served on the Mental Health Committees of the Massachusetts District Court Department and the

Boston Municipal Court Department, the Advisory Board of the Massachusetts Protection and Advocacy Project, the Human Rights Advisory Committees of the Massachusetts Departments of Mental Health and Mental Retardation, and the National Policy Board of the National Legal Aid and Defender Association. He is the author of many books and articles on mental health law, a frequent speaker at legal conferences, and an adjunct professor at the Massachusetts School of Law.

Albert J. Grudzinskas, Jr., JD

Albert J. Grudzinskas, Jr., J.D. received his undergraduate degree at Northeastern University and his law degree at Syracuse University. After 12 years of private legal practice Attorney Grudzinskas served as Assistant General Counsel to the Department of Mental Health of the Commonwealth of Massachusetts for eight years. Currently Attorney Grudzinskas is a Clinical Associate Professor of Psychiatry at the University of Massachusetts Medical School and Coordinator of Legal Studies in the Law and Psychiatry Program. Attorney Grudzinskas is active in the National Association of Counsel for Children, the American Psychology – Law Society, the National Association of Criminal Defense Attorneys, the American Society of Adolescent Psychiatry and the American Academy of Psychiatry and the Law. He has presented at national and international conferences. Attorney Grudzinskas consults widely to state governments and court systems. He has lectured on and authored more than 50 book chapters, peer reviewed articles, law review articles, and papers on such topics as sex offender commitment and offender registries, police training for encounters with persons in crisis, protection of vulnerable populations in research, ethics in medical practice, involuntary outpatient commitment, diminished capacity, substance abuse, the presentation of expert testimony, and trial tactics. In 2009 he co-edited and contributed chapters to: F.M. Saleh, A.J. Grudzinskas, Jr., J.M. Bradford & D. J. Brodsky (eds.) (2009) Sex Offenders: Identification, Risk Assessment, Treatment, and Legal Issues, New York, NY: Oxford University Press.

John Kuhn, MSW, MPH

Mr. Kuhn is the VA National CHALENG Coordinator and the newly appointed National Director of VA Homeless Prevention Services. As the co-author of the CHALENG report, Mr. Kuhn is responsible for developing and assessing the VA national assessment on the needs of homeless Veterans. As a Center Investigator, Mr. Kuhn will be involved in efforts to develop strategies to meet these needs. Mr. Kuhn has a BA in Psychology from Brown University, a MSW from Columbia University, and an MPH from Rutgers University. He has been working with the homeless for over 20 years and has developed a broad range of services addressing housing, vocational, legal, health, and mental health needs, including the use of “positive” addictions in the treatment of substance use disorders. Mr. Kuhn has made extensive use of community partnerships to create Veteran run businesses, peer services, and housing programs.

Stephanie Rodrigues, PhD

Dr. Rodrigues is an Assistant Professor and Clinical Psychologist in the Department of Psychiatry’s Division of Addiction at the University of Massachusetts Medical School with research and clinical experience in the treatment of severe mental illness, addiction, and co-occurring disorders among general, Veteran, and homeless populations. Dr. Rodrigues received her doctorate from the Combined Clinical/School Psychology Program at Hofstra University. After completing a Department of Veterans Affairs Advanced Post-Doctoral Fellowship Program in Health Services Research at the Center for Health Quality Outcomes and Economic Research at the Edith Nourse Rogers Memorial Veterans Hospital, Dr. Rodrigues transitioned to the University of Massachusetts Medical School as a Faculty Diversity Scholars Program award recipient, sponsored by the Office of Faculty Affairs, to further pursue her research interests related to stigma. In particular, Dr. Rodrigues is interested in efforts to improve stigma reduction and the role of stigma in the treatment engagement of marginalized populations. To date, Dr. Rodrigues’ research has addressed stigma related to co-occurring mental health and substance abuse disorders, depression, homelessness,

and obesity. Dr. Rodrigues is also interested in the development, implementation, and evaluation of programs that target stigma reduction in order to promote recovery among individuals with mental health, addiction, and other stigmatizing conditions.

Merrill Rotter, MD

Merrill Rotter is a forensic psychiatrist working at Albert Einstein College of Medicine where he is Associate Clinical Professor of Psychiatry and Director of the Division of Law and Psychiatry for the Department of Psychiatry. Dr. Rotter received his B.A./M.D. from the Boston University Six-Year Combined Liberal Arts Medical Education Program. Trained in clinical psychiatry at Columbia and in forensic psychiatry at Yale, Dr. Rotter leads a program of teaching, research and clinical service for Einstein as well as the New York State Office of Mental Health. In his OMH role, Dr. Rotter is Director of the Division of Forensic Services at Bronx Psychiatric Center and Senior Consultant to the Division of Forensic Services. In addition, Dr. Rotter is the Medical Director of the EAC, including its NYC TASC Mental Health Programs, which provide the clinical arms of the Queens, Bronx, and Staten Island Mental Health Courts, as well as diversion and re-entry services in Brooklyn. Dr. Rotter is Project Director of SPECTRM, a research, training and treatment program aimed at helping to meet the needs individuals with mental illness who have a history of incarceration. His primary research interests include risk assessment, mental health diversion, forensic psychiatry education, and evaluation and treatment of mentally ill offenders. In 2009 Dr. Rotter received the award for Best Teacher in a Forensic Psychiatry Fellowship from the American Academy of Psychiatry and the Law.

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Ms. Singer is a master's candidate at Drexel University in the Department of Psychology and a research coordinator at the University of Massachusetts Medical School in the Department of Psychiatry. She is also affiliated with the Edith Nourse Rogers Memorial Veterans Hospital. Ms. Singer's research and clinical interests are in the treatment and assessment of juvenile and adult offenders as well as the treatment of Veterans with co-occurring disorders.

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Dr. Stimmel is a Clinical Psychology Postdoctoral Fellow in PTSD at the VA Palo Alto Health Care System. He received his PhD in Clinical Psychology from Fordham University. He specializes in evidence-based treatment for trauma-related disorders working in both residential and outpatient settings at the VAPAHCS. His research interests include forensic assessment, understanding mechanisms of change in treatment of PTSD, the relationship between PTSD and affect regulation, and providing trauma-informed care within criminal justice settings.

Douglas Ziedonis, MD, MPH

Dr. Ziedonis is Professor and Chair of the Department of Psychiatry at the University of Massachusetts Medical School and UMass Memorial Health Care. Dr. Ziedonis has dedicated his career to better understanding and treating individuals with co-occurring mental illness and substance use disorders, including research in mental health, addiction, and primary care settings. He is an internationally recognized leader in co-occurring mental illness and addiction, including recovery and wellness. He has received many NIH, SAMHSA, and Foundation research grants, including support to develop and evaluate behavioral therapy approaches such as Dual Recovery Therapy (DRT) and organizational change studies to help agencies better address co-occurring disorders, including tobacco. He has been active in Veterans Affairs related initiatives, including serving on the Institute of Medicine's (IOM) Committee on Gulf War and Health: Smoking Cessation in Military and Veteran Populations. Dr. Ziedonis has served as an advisor to President Bush's New Freedom Commission on Mental Health and SAMHSA on numerous Co-Occurring Disorder activities, including the Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders and TIP 42, Substance Abuse Treatment for Persons with Co-Occurring Disorders. He served as Senior Fellow for the SAMHSA Co-Occurring Disorder Center for Excellence. He served on the American Society of Addiction Medicine's Patient Placement Criteria Co-occurring Disorder Workgroup that developed the Dual Diagnosis Capable/Enhanced concepts. He has written over 150 peer reviewed and other publications,

including co-edited 3 books and 5 behavioral therapy manuals for co-occurring disorders. He serves on the Editorial Boards of The Journal of Groups in Addiction & Recovery and The Scientific World Journal.

Mason Ziedonis

Mason Ziedonis is the founder and owner of Peloton Web Design. He provides consultation on website design and development, Google advertising, and search engine optimization, including the use of social media. He is also a research assistant for the Center of Homelessness at the Department of Veteran Affairs. He is the website designer for the MISSION Model website (missionmodel.org).

Glossary Acrynyms and Terms

AA: Alcoholics Anonymous

ACT: Assertive Community Treatment

ADL: Activities of Daily Living

APIC: Assess, Plan, Identify, Coordinate, a model for release planning.

BJA: Bureau of Justice Assistance, a component of the U.S. Department of Justice that administers grants and disseminates research and practices related to the criminal justice system.

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

CHALENG: Community Homeless Assessment, a local education and networking group.

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

CJ: Criminal Justice

CM: Case Manager

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

COD: Co-occurring psychiatric and substance use disorders

CS: Clinical Supervisor

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

CTI: Critical Time Intervention, a time-limited intervention designed to facilitate linkages with social supports and community resources for people with mental illness who have moved from a shelter, the streets, a psychiatric hospital, or the criminal justice system to the community.

CWT: Compensated Work Therapy Program

DOL: Department of Labor

DOM: Domiciliary Residential Program, a program in the Department of Veterans Affairs that provides approximately 14 weeks of housing and associated services to homeless Veterans.

DRT: Dual Recovery Therapy, the integrated mental health and substance abuse treatment model of care used in the MISSION and MISSION-VET programs.

DSM-V: the Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition, a classification manual to quantify symptoms in order to diagnose a mental health condition.

EMDR: Eye Movement Desensitization and Reprocessing

GDP: Grant and Per-diem Program

HBM: Health Belief Model

HCRV: Health Care for Re-entry Veterans

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

HOC: House of Correction

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

IOP: Intensive Outpatient Program

IPS: Individual Placement and Support

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

MI: Motivational Interviewing

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

MISSION-CREW: Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking – Community Reentry for Women

MISSION-DIRECT VET: Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking – Diversion and Recovery for Traumatized Veterans

MISSION-RAPS: Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking – Reentry and Peer Support

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

NA: Narcotics Anonymous

NAPS: National Association of Peer Specialists

PE: Prolonged Exposure

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

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

PHA: Public Housing Authority

President's New Freedom Commission: a commission appointed by President Bush to evaluate the mental health treatment system in the United States and offer suggestions regarding areas to improve the health care system.

PTSD: Post-Traumatic Stress Disorder, a DSM-V diagnosis that refers to a set of specific symptoms that develop in response to experiencing an unusual traumatic event such as a car accident or seeing someone injured in combat.

RAP: Reentry After Prison program

RNR: Risk-Need-Responsivity Model, a framework for treatment planning that provides the client and CM/PSS team a more objective way of determining client needs, identifying risks, and monitoring ongoing progress and responsivity to interventions.

RSS: Re-entry support specialist, an alternative name given to Peer Support Specialists.

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

SE: Supported Employment

SIM: Sequential Intercept Model

SMI: Serious Mental Illness

SPECTRM: Sensitizing Providers to the Effects of Incarceration on Treatment and Risk Management, program that trains providers how to deal with individuals who have previously been incarcerated.

TIC: Trauma-Informed Care

TLC: Time-Limited Case Management, 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.

VR: Vocational Rehabilitation

Appendices

APPENDIX A: Key Clinical Outcomes for Early MISSION Studies and Preliminary Data on MISSION-Criminal Justice

Debra A. Pinals
Stephanie Hartwell

MISSION services have developed over the last two decades, beginning with a homeless Veteran population transitioning from residential services to alternative settings and now evolving to address and support a more general criminal justice-involved population. The following information is useful to understand the early outcomes, and how those initial outcomes have helped inform the conceptualization of MISSION-CJ and the use of similar modeling for an expanded population.

Data from Early MISSION Studies:

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 clients address their co-occurring substance use and non-psychotic mental illness and other psychosocial issues, including problems with housing, employment, family, and the criminal justice system. The model has been an ideal service delivery platform for helping these clients 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 earlier MISSION studies and participants receiving Treatment as Usual (TAU) in residential treatment at 12 months post-baseline showed that both groups made significant improvements as a result of treatment. However, individuals who received MISSION treatment services achieved better outcomes in a number of key domains including treatment engagement, behavioral outcomes such as substance use and mental health symptoms, housing stability, and satisfaction of services received during the 12-month evaluation period.

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

- Reduced use of illicit drugs (71% to 13%)
- Reduced use of alcohol to intoxication (19% to 8%)
- Reduced symptoms of depression (66% to 34%), symptoms of anxiety (72% to 35%), and any mental health symptoms (88% to 57%)
- Fewer hospitalizations for psychiatric reasons (6.5 days prior to enrollment to 2.7 days 12-months post baseline)
- Fewer problems controlling violent behavior (15% to 7%)

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

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

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

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

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

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

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

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

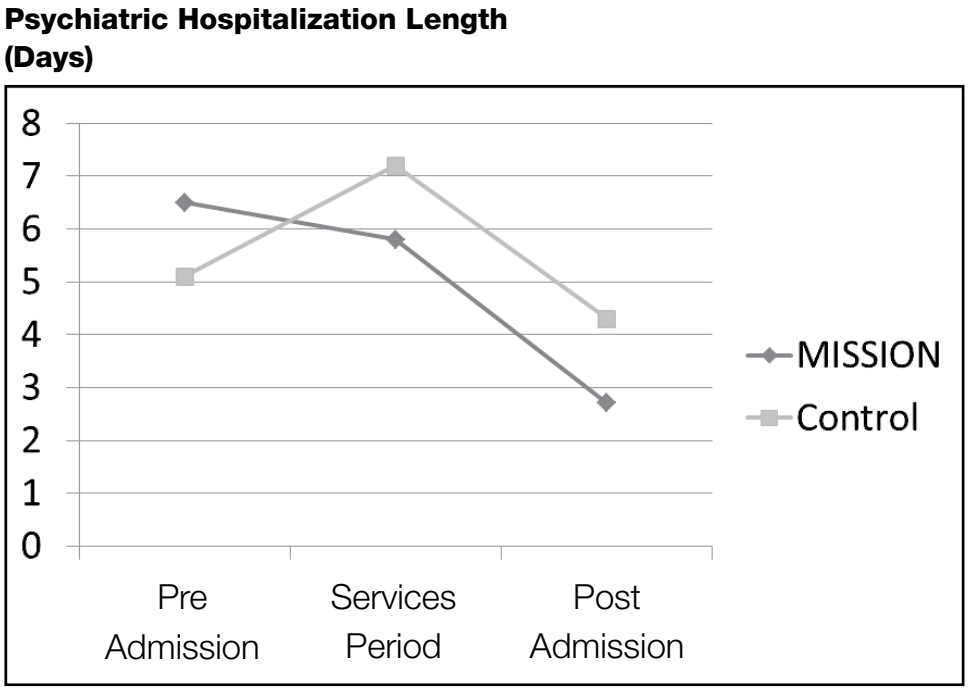


Figure 1 illustrates the significant reduction in hospitalization days among the MISSION group as compared to those receiving TAU.

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

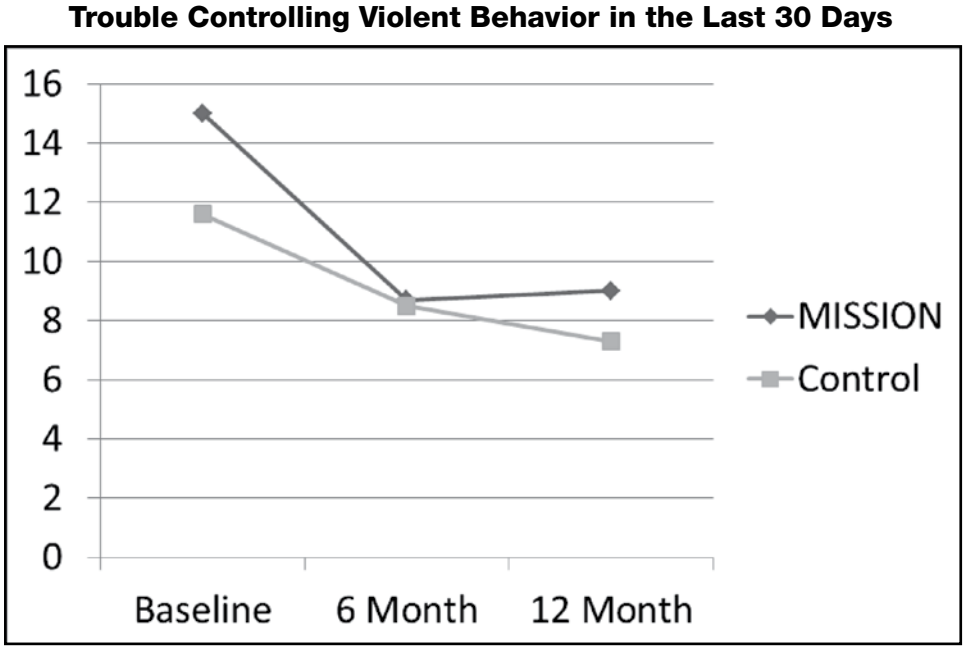


Figure 2 shows the significant improvement among individuals receiving MISSION services in controlling violent behavior at the end of the study compared to those receiving TAU.

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

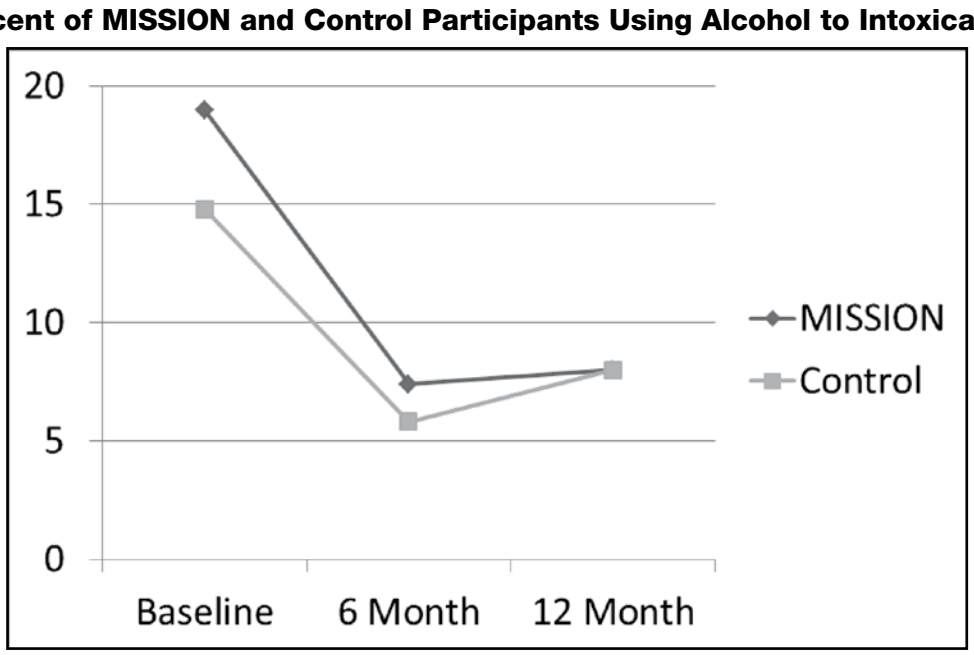


Figure 3 illustrates the reduction in drinking to intoxication in the MISSION group as compared to those receiving TAU.

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

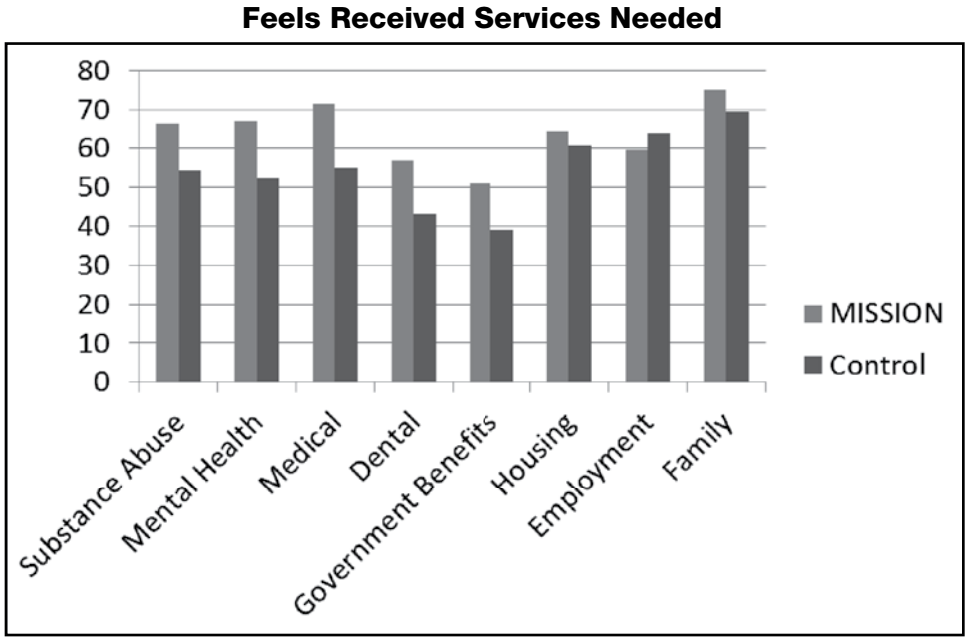


Figure 4 illustrates that compared to TAU, those in MISSION felt more satisfied with receiving key services that reflected their baseline treatment plan requests on the majority of the domains.

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

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 early 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.

MISSION-Criminal Justice Edition: Early Outcome Findings

The first effort at adapting MISSION services to a justice-involved population involved the use of this model for a Veterans court-based alternative to incarceration program. In this program, Veterans were identified in courts and referred to Case Managers and Peers who functioned to provide MISSION services. These services were delivered in a post-adjudication framework and as part of probation. As such, efforts at reducing recidivism and enhancing community tenure were primary targeted goals of the program and services.

Early outcomes from that study, known as MISSION-DIRECT VET (funded by SAMHSA grant # SM-58804) showed promise along similar domains as prior MISSION studies.

Figure 5. Shows basic preliminary outcomes from the MISSION-DIRECT VET program and services. (From: Hartwell, S. MISSION DIRECT VET Evaluation Report, Year 5, Quarters 3 & 4; September 2013, with acknowledgement also to J. Siegfriedt, F. Parsa, and T. Hall, unpublished data)

Figure 5. Preliminary Outcomes: MISSION DIRECT VET Alternative to Incarceration Program[5]

Variables	Baseline	6 Months	12 Months
Employed	29 (28.2%)	17 (27.5)	22 (52.4%)
Benefits	48 (46.6%)	35 (56.5%)	28 (66.7%)
3 Nights Homeless	14 (15.2%)	4 (6.5%)	2 (4.8%)
Outpatient (MH)	32 (31.1%)	28 (45.2%)	19 (45.2%)
Outpatient (SA)	17 (16.5%)	20 (32.3%)	13 (31%)
Arrested (1+)	90 (88.2%)	3 (4.8%)	2 (4.8%)
Restraining Order	26 (46.4%)	11 (18%)	7 (16.7%)
Strongly Agree (Deal with Problems)	11 (10.7%)	8 (12.9%)	7 (16.7%)
Strongly Agree (Deal with Crisis)	14 (13.6%)	3 (4.8%)	8 (19.0%)
Nervous None of the Time	6 (6.5%)	6 (9.7%)	9 (21.4%)
Depressed None of the Time	33 (35.9%)	29 (46.8%)	23 (54.8%)
Have People to Turn To	88 (86.3%)	54 (88.5%)	36 (85.7%)
Belong in My Community	48 (46.6%)	33 (53.2%)	24 (57.2%)
Support of My Family	75 (72.8%)	45 (72.6%)	28 (66.7%)
No Stress About the Past	24 (23.8%)	22 (35.5%)	19 (45.2%)
Psych Symptoms under Control	65 (63.7%)	44 (77.2%)	28 (66.7%)
Learning New Things	81 (79.4%)	59 (95.2%)	32 (76.2%)

The findings in Figure 5 demonstrate that for Veterans involved in MISSION-DIRECT VET Services, there were positive improvements in employment, homelessness, engagement in treatment, sense of stress, nervousness, depression and belonging to one's community. Interestingly, some items such as feeling supported by family and feeling symptoms were under control showed improvements initially, but as services were closer to ending, some of these symptoms seemed to return. These findings marked important lessons for future programs to consider on how to best transition people out of MISSION-CJ services, as they are increasingly independent.

Criminal Justice Outcomes are also a critical component to consider with regard to MISSION-CJ. Data is still emerging and being refined as of this writing. However, preliminary findings showed some relief from arrests and restraining order involvement (see Figure 5). In addition, the following Figure 6 shows early recidivism findings and is explained further below.

Figure 6. Preliminary Recidivism Data and Comparison Populations

Population*	One Year Re-Arrest**	One Year Re-incarceration**
MISSION-DIRECT VET (n=61)	32.9%	7.9%
General Mental Health Re-entry population (n=137)***	28.5%	14.6%
SMI Re-entry population (n=138)***	46%	25.5%

(Personal Communication, Hartwell, S, March 23, 2014)

*Populations identified should be compared with caution. The MISSION-DIRECT VET sample consisted of Veterans (primarily males) with co-occurring mental health and substance use conditions who were eligible for a diversion/alternative to incarceration, and thus may not have penetrated as deeply into the justice system. The General Mental Health Re-entry population included a group of male and females identified by correctional facilities as having mental health needs. The SMI Re-entry population included individuals with serious mental illness who were leaving particular correctional settings upon re-entry.

**Re-arrest and reincarceration information was only counted for those whose baseline interview occurred at least a year before the official criminal offender record information data could be pulled.

***Data based on preliminary analyses from Hartwell, NIMH 1RC1MH088716-01

It should be noted that recidivism is a complex concept, and definitions of recidivism can vary greatly across studies, ranging from excluding technical violations, excluding or including arrests that lead to dismissals, and re-incarceration that includes pre-trial detention and bail holds. However, the data above was analyzed using similar definitions of recidivism across different populations of study.

A subsequent early study of female offenders (Bureau of Justice Assistance Second Chance Act Grant # 2011-RW-BX-0010), MISSION-Re-entry and Peer Support, utilized MISSION services for a re-entry population of individuals that were considered to have mental health needs by the correctional facility. In

that study, early findings for 18 women who received 3 months of in-reach and 6 months of MISSION community-based re-entry services showed the women were better able to manage daily life and cope with life problems, had fewer problems with alcohol and drugs, less trauma exposure and significantly reduced drug and alcohol use. In addition, early data showed decrease incarceration rates compared to prior to enrollment.

Implications of Early Findings

Findings for MISSION in general provide evidence that a low-intensity intervention (2.5 to 5 additional hours of services delivered by a case manager and peer specialist per week) to augment treatment as usual in homeless service programs can improve treatment engagement, patient satisfaction, and behavioral outcomes among those individuals receiving homeless services who suffer from co-occurring substance use problems and non-psychotic mental illness. For a criminal justice population, similar benefits appear to emerge, though over time ongoing data testing will be conducted across subpopulations (e.g., general offenders, Veterans, drug court participants, female offenders) as comparisons of needs and outcomes across populations may need further refinement. That said, data that has been analyzed suggests that augmentation with MISSION treatment services can improve treatment engagement, patient satisfaction, and other behavioral outcomes, providing evidence that the enhanced MISSION approach might offer unique programming opportunities within existing mental health and substance use clinical services, and with MISSION-CJ might have additional benefits of reducing recidivism for justice-involved individuals with co-occurring mental health and substance use disorders.

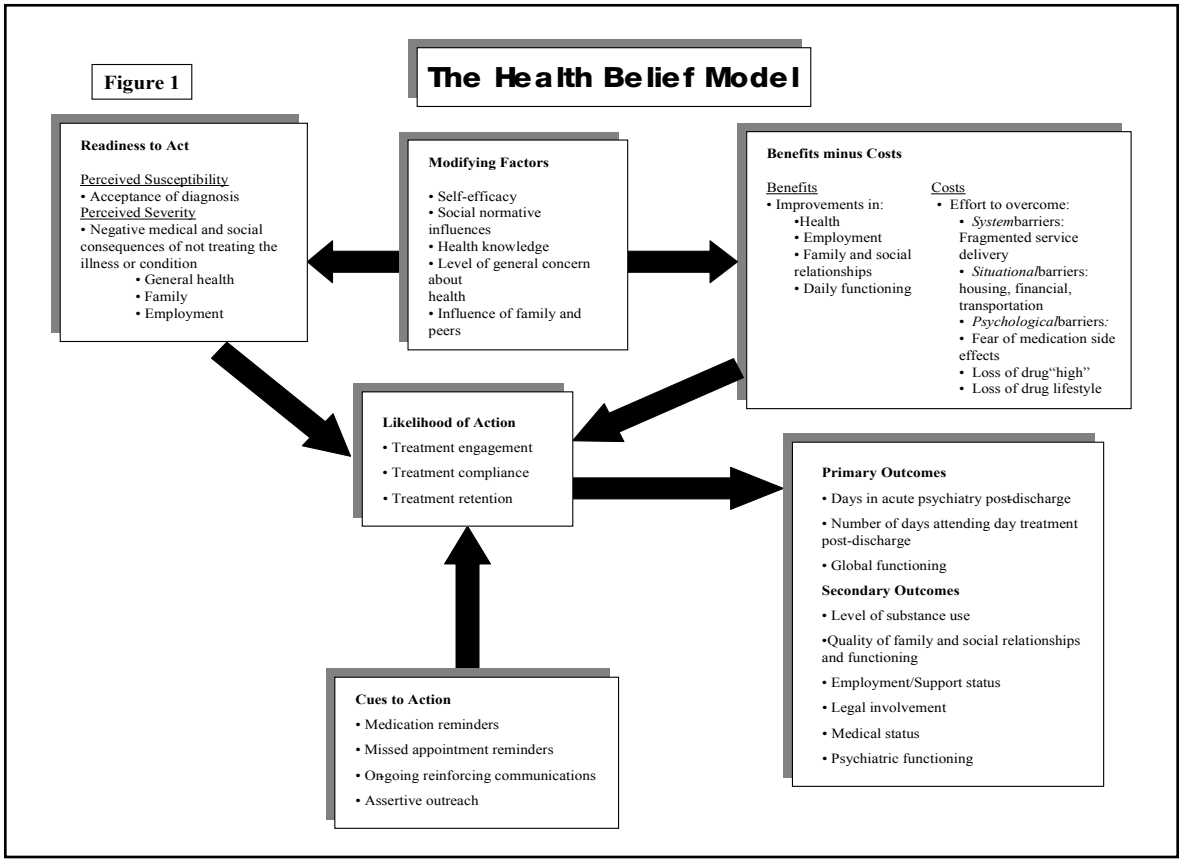
APPENDIX B: Theoretical Framework Underlying the MISSION-CJ Modeel

Stephanie C. Singer
Debra A. Pinals

The theoretical framework of the MISSION model is derived from the Health Belief Model (HBM) (Rosenstock, 1966; Becker & Maiman, 1975; Janz & Becker, 1984), which presents a broad structure for understanding the major components of the health decision-making process. Originally proposed to explain preventive health behavior, the HBM has been found to predict compliance with treatment regimens as well as utilization of services for preventive and therapeutic purposes (Janz & Becker, 1984). The HBM has provided a valuable framework for understanding treatment compliance among the severe and persistent mentally ill (Budd, Hughes, & Smith, 1996; Nageotte, Sullivan, Duan, & Camp, 1997; Perkins, 1999; Adams & Scott, 2000; Perkins, 2002) as well as those with co-occurring psychiatric and substance use disorders [COD] (Mulaik, 1992; Fenton, Blyler, & Heinssen, 1997). Researchers have also applied the model to outpatient psychiatric attendance for people with bipolar disorder (Connelly, 1984), compliance with discharge plans after psychiatric ER visits (Porter-Tibbetts, 1986), decisions to abuse drugs (Lindsay & Rainey, 1997; Minugh, Rice, & Young, 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 & 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 & Becker, 1984). The combination of DRT, CTI, and Peer Support in the MISSION-CJ 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-CJ 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 individuals acknowledge their substance use and mental health problems and understand the severe health and social consequences of leaving these problems untreated. Mediating factors include the feelings of self-efficacy in refraining from substance use and following treatment regimens, the influence of peers and others in reinforcing beliefs that such actions are not only desirable, but possible, and access to sufficient information about the disease to promote informed decision-making. We expect individuals to identify improvements in health and social functioning as possible benefits of treatment and to identify a

variety of potentially limiting barriers, or costs, including fears about medication side-effects, relinquishing the desirable physical and psychological feelings associated with substance use and the difficulty of negotiating possible institutional and situational barriers to treatment. Finally, we identify cues to action, in the form of communications from providers to encourage compliance.

DRT, CTI, and Peer Support, as used in MISSION-CJ, 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-CJ Components

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

Health Belief Model Constructs	MISSION 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

Health Belief Model Constructs		MISSION Component
	Institutional Barriers	CTI • Identification of and Linkage with Community Resources • Early and Consistent Involvement with the Patient • Patient Advocacy
	Personal and Practical Barriers	CTI • Assertive Outreach • Transportation Assistance • Money Management • Housing Assistance • Facilitation of Family Involvement • Patient Advocacy • Vocational and Educational Assistance
Cues to Action	**Follow-up on Missed Appointments**	CTI • Assertive Outreach
	Medication Checks	CTI • Professional Support • Facilitating Linkages Among Patient, Physician, and Pharmacy DRT • Psychoeducation • Medication Management
	Ongoing Reinforcing Communications	DRT • 12-Step Therapy to Provide Support and Feedback CTI • Professional Support and Feedback • Peer counseling • Peer-to-Peer Support and Feedback

DRT, through its use of Motivational Enhancement Therapy (MET), psychoeducation, 12-step facilitation, relapse analysis, and medication management, will enhance beliefs about disease severity and susceptibility, will increase self-efficacy and health knowledge and will promote a more favorable analysis of the costs and benefits of treatment. DRT, for example, includes a Dual Recovery Status Exam, which monitors medication compliance and provides individuals with support and feedback regarding their medication management. CTI will affect perceived treatment costs/benefits by enhancing treatment accessibility and reducing fragmented service delivery through coordinated treatment planning. CTI will also address situational barriers to treatment and will provide cues to action in the form of additional medication monitoring, follow-up phone calls for missed visits, and ongoing encouragement and positive reinforcement. Peer Support will affect social normative attitudes by providing social reinforcement for continued abstinence and compliance with treatment protocols. Interaction with Peer Support Specialists [PSS] who have had

similar problems yet achieved a successful recovery will reinforce the normative value of maintaining sobriety and add to the client's sense of self-efficacy in being able to achieve comparable goals. The PSS will also assist clients in accepting and understanding the severity of their addiction problems and understanding the benefits of treatment. Finally, PSS provide cues to action through frequent communication with participants around treatment compliance issues.

The MISSION-CJ model is also based on the Sequential Intercept Model (Munetz & Griffin, 2006), which provides a framework from which to view various interception points between the criminal justice and mental health systems. The model mirrors the typical path that individuals follow through the criminal justice system: pre-arrest, post-arrest, post-initial hearings, re-entry from prisons/jails, and community corrections (see Figure 3 below).

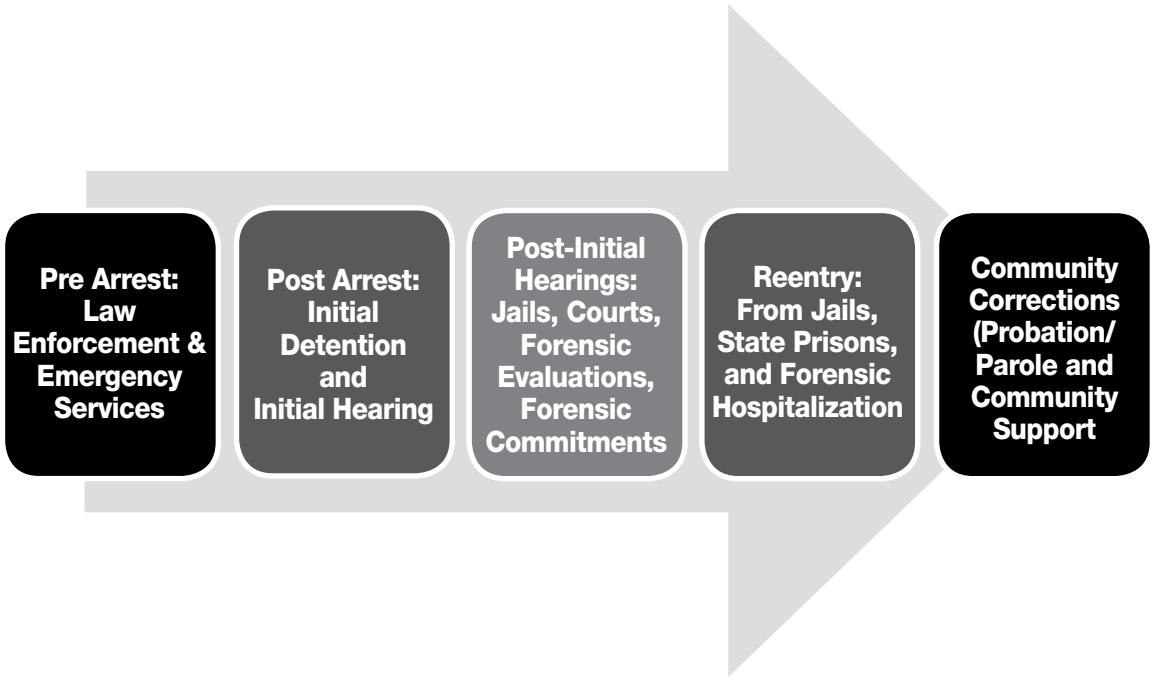


Figure 3. Sequential Intercept Model (adapted from Munetz & Griffin, 2006)

At the core of the model is the idea that identification of individuals with mental illness at particular intercept points and delivery of appropriate services will prevent individuals from entering or repeatedly cycling through the criminal justice system (see Figure 3). Ideally, individuals will be targeted at the earlier points of interception; however, interventions at all timeframes are useful. The model is also designed to decrease jail admissions and link and engage individuals to services as soon as possible. Moreover, its design allows for easy identification of key stakeholders whose participation in the design and implementation of programs at a particular intercept point is crucial.

As described in Chapter 1, the MISSION-CJ program can be applied at any of these intercept points though it was first used in the MISSION-DIRECT VET (SAMHSA Grant #SM-58804) program at the post-initial hearing point, with a court-order to MISSION services following an adjudication of either a new offense or a probation violation. Based on our experience, a court-based agreement to have an individual "diverted" from incarceration to community-based MISSION-CJ services, will typically follow the procedure outlined on the following page:

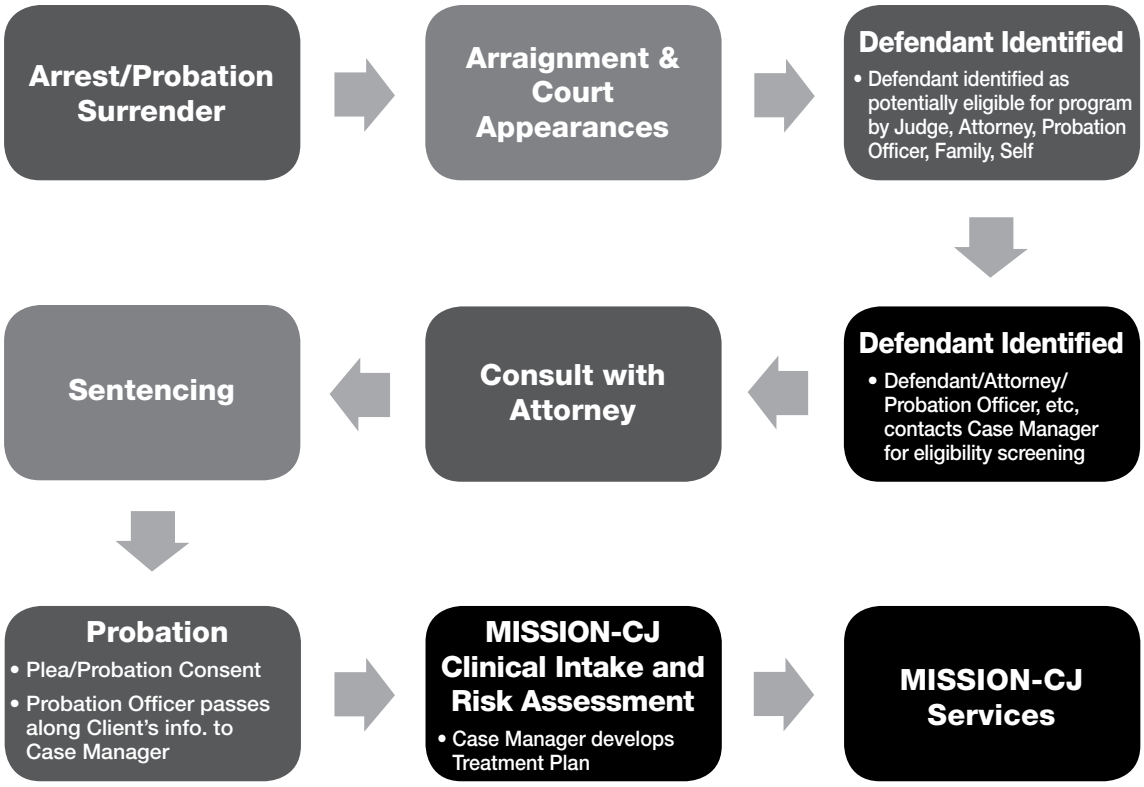


Figure 4. Case Flow Diagram of MISSION-CJ from a Court-Based Program where MISSION-CJ Services are court-ordered in lieu of incarceration

First, an individual is arrested or charged with a violation of probation. Next, the individual is arraigned in court. Typically referral to a community based program as an alternative to incarceration occurs after arraignment and before sentencing, though the ultimate court order into the program may occur at sentencing. This can be done through a specialty court docket or through a regular docket with a community based program and use of MISSION-CJ services. The referral can come from a variety of sources (e.g. judge, probation officer, attorney, treatment provider, peer, family member, self) and an eligibility screening, both from a clinical perspective (i.e., does the person have a co-occurring disorder that could benefit from MISSION-CJ), and a criminal justice perspective (i.e., is this person's current alleged offense, risk of recidivism, and criminal background such that MISSION-CJ in a community setting is appropriate and reasonable from a public safety and criminal justice standpoint) is required to determine whether or not the individual is eligible for the particular program. If the individual does screen eligible, he/she will consult with his/her attorney prior to sentencing to determine the best course of action. Should the individual be identified as appropriate for diversion from jail or a court-ordered term of MISSION-CJ services in lieu of incarceration, the program will be listed on his/her terms of probation and so the probation officer, an attorney, or the client him/herself will reach out to the case manager to do a more thorough intake and treatment planning process in order to begin services.

In another version of MISSION adaptation in a re-entry program for female offenders (DOJ Grant # 2011-RW-BX-0010), the following flow chart for service delivery and evaluation was established:

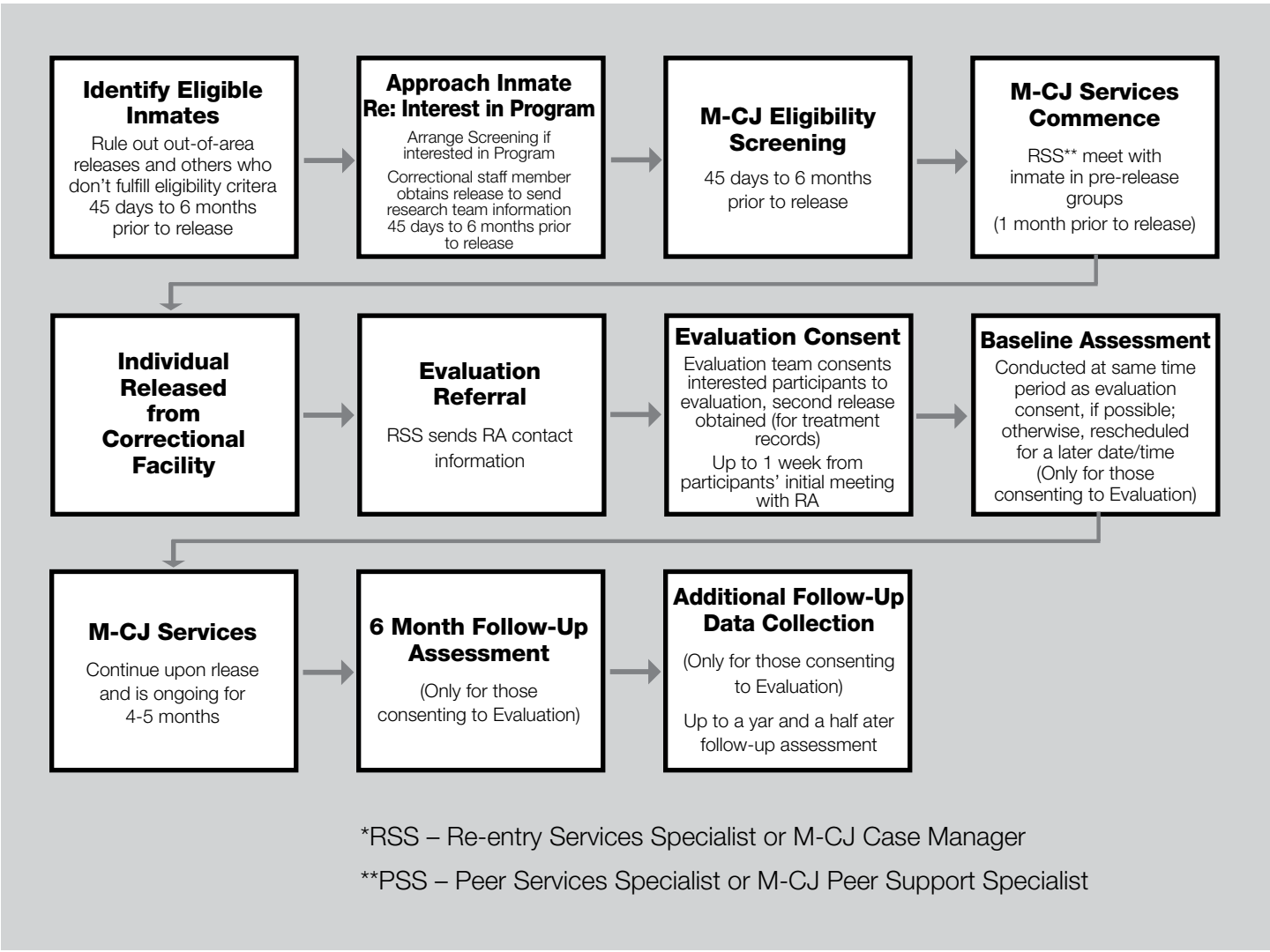


Figure 5. Case Flow Diagram of MISSION-CJ from Re-entry Services Perspective

In each of these case flow diagrams, one sees the importance of early identification of individuals with co-occurring mental illness and substance use conditions, as well as the need for early engagement of criminal justice partners. As the Health Belief Model focuses on wellness and recovery, recidivism reduction also becomes an important part of the conversation. Case flow processing will allow the delineation of individualized treatment planning within the broader systems in which MISSION-CJ participants find themselves.

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APPENDIX C: Integrating RNR Principles into the MISSION-CJ Model: A Concrete Guide for Case Managers, Peer Support Specialists, and Administrators

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I. Appendix Goal and Outline

The goal of this appendix is to (a) operationalize principles of the Risk-Need-Responsivity (RNR) model from the standpoint of specific assessment and treatment practices, and (b) integrate these practices into the MISSION-CJ manual for use by case managers, peer support specialists, and administrators for the purposes of treatment planning, outcomes monitoring, and maintaining the integrity of the intervention. To demonstrate these practices, a case example is given along with the central assessment features that are relevant to each of the RNR principles.

II. Overview of RNR

The RNR model is a broad framework that outlines the principles that facilitate successful community readjustment of justice-involved individuals, particularly in terms of reducing their risk of recidivism (Andrews & Bonta, 2010a, 2010b). The Risk principle states that the level of care should be matched to the risk-level of the individual, such that intensive services (e.g., residential treatment) should be directed toward higher-risk, and minimized for lower-risk, individuals. The Need principle states that the targets of an intervention should be the dynamic risk factors (i.e., "criminogenic needs") for poor community adjustment that are most highly predictive of recidivism. In contrast to static risk factors (e.g., age of first offense), dynamic risk factors (e.g., substance abuse; lack of employment/skills or stable housing; family dysfunction; antisocial tendencies; pro-criminal associates) are amenable to change and should guide the treatment planning and referral process for re-entry populations. The Responsivity principle states that interventions should be delivered in a manner that is appropriate to the learning styles of offenders. In practice, structured cognitive-behavioral interventions are most efficacious in terms of facilitating the community readjustment of high-risk individuals and reducing their risk of recidivism (Milkman & Wanberg, 2007).

In terms of specific practices for individuals in MISSION-CJ services, per the RNR model, this would entail: (a) using structured and validated risk assessments when available to assist with case management planning and delivery; (b) reserving intensive services for moderate- and high-risk individuals and those whose treatment needs warrant these services; (c) focusing treatment planning on the dynamic risk factors of recidivism that are relevant for the individual; and (d) employing structured, cognitive-behavioral interventions with moderate- and high-risk individuals.

III. RNR Principles and Corresponding Practices

A. Risk principle (Who should be treated?)

The Risk principle specifies who should be treated. The key components of this principle are (1) use of structured assessments, rather than clinical judgment alone, in order to differentiate reliably between high- and low-risk offenders, and (2) matching level of service and attention to the client's risk level. Regarding the first component, the history of risk assessments has seen four generations. The first generation of risk assessment models focuses solely on the use of professional judgment through unstructured interviews and observations of clients. The second generation of risk assessments includes structured assessments that are largely atheoretical and rely primarily on (a) criminal history items that are routinely collected by correctional systems, and/or (b) non-criminal history items that are static – e.g., a history of substance use disorder (SUD) – rather than dynamic predictors of criminal recidivism. The third generation of risk assessments is also structured and largely atheoretical, but includes both static and dynamic elements. An example is the revised version of the Level of Services Inventory (LSI-R; Andrews & Bonta, 1995).

The fourth and most current generation of risk assessment tools, which adhere more strongly to RNR and other well-validated conceptual models from the risk assessment literature, incorporate elements of previous generations, but also includes components for assessment and monitoring of a broader range of factors that could influence treatment planning (e.g., LS/CMI; Andrews, Bonta, & Wormith, 2004). Use of fourth generation risk

assessment tools by providers of MISSION-CJ can be particularly useful in terms of offering specific, informed recommendations on a client's disposition to a court or parole board. Such recommendations include the frequency and intensity of meetings between the client and the MISSION-CJ Case Managers (CM) and Peer Support Specialists (PSS). For example, if a client's risk level for criminal recidivism is determined to be in the low range, the frequency of meetings with MISSION-CJ providers may be limited to once per month, whereas a risk level in the high range may warrant weekly meetings with these providers. Similarly, for low-risk clients, the intensity of services outlined in the client's treatment plan may be limited to self-help or outpatient groups, whereas high-risk clients may warrant inpatient services.

i. Concrete steps and recommendations relevant to the Risk principle

Table 1 and the following sections outline the concrete steps and recommendations that providers of MISSION-CJ should follow, which are relevant to the Risk principle of the RNR model.

Table 1. Concrete steps and recommendations relevant to the Risk principle

- Request permission from the client, court, and/or correctional agency to review the client's legal records.
- If information on risk level is not available, or was based largely on clinical judgment, conduct a structured risk assessment that is based on the client's length and breadth of criminal history.
- Match clients to the appropriate MISSION-CJ protocol based on the results of the risk assessment, and liaise with programs that match the client's risk level.

1. Request permission from the client, court, and/or correctional agency to review the client's legal records.

Information relevant to a client's risk level is typically available in their institutional files and court records. The CM should attempt to obtain the appropriate permissions as early as possible and to look for results of structured risk assessments that were previously completed. If multiple assessments are available, it is recommended that the CM focus on the results of the most recent testing. However, given the static nature of many criminal history items and their salience in predicting risk level, no risk assessment results should not be ignored or dismissed even if they are dated (i.e., over a year).

2. If information on risk level is not available, or was based largely on clinical judgment, conduct a structured risk assessment that is based on the client's length and breadth of criminal history.

In instances when the CM cannot find or obtain any recent information on risk level in the client's records, it is recommended that they use at least a 2nd generation risk assessment to determine this. The 8-item screening version of the Level of Services Inventory-Revised (LSI-R SV; Andrews & Bonta, 1998) can be used as a standalone index of risk, or as a means of determining whether a more comprehensive, fourth generation assessment of risk and need such as the LS/CMI (Andrews, Bonta, & Wormith, 2004), the Ohio Risk Assessment System (ORAS; Latessa et al., 2010), and the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS; Brennan & Oliver, 2002) should be administered.

Alternatively, if these tools are not available, information on criminal history, which can provide a static measure of risk level, can be obtained from the Legal Status section of Addiction Severity Index (ASI; Fureman et al., 1990). In this regard, the key information to obtain is (a) current age (i.e., younger = higher risk), (b) age of first offense (i.e., earlier-onset = higher risk), (c) number of prior offenses, (d) variety of prior offenses (e.g., property and violent crimes), and (e) rule violations while on conditional release. In addition, it is recommended that the CM give minimal weight to the "seriousness" of the current offense when estimating level of risk. For example, although a violent offense may have warranted a longer prison sentence, a history of committing such acts does not necessarily equate to a high level of recidivism risk.

3. Match clients to the appropriate MISSION-CJ treatment plan based on the results of the risk assessment, and liaise with programs that match the client's risk level.

Once the CM has determined the risk level of the client, s/he can plan the intensity of that client's treatment services. For example, for clients that are determined to be at low risk of recidivism, the 2-month MISSION-CJ protocol may be recommended. By contrast, for clients at moderate- and high-risk, the 6- and 12-month protocols, respectively, are recommended. In terms of specific types of treatment services, referrals to intensive services such as residential programs might be reserved for moderate- and high-risk participants, though the level of treatment need should also be determined by clinical factors related to their current substance use and co-occurring mental illness. In other words, inpatient level of care or residential services can require a clinical determination that is separate from criminal justice risk and needs and will be important in order to address co-occurring substance use, mental health and recidivism factors together, rather than separately.

Participants determined to be at low-risk of recidivism should generally not be assigned to these intensive services, and attempts should be made to not mix low-risk with high-risk clients in MISSION-CJ groups (e.g., DRT, SPECTRUM). In addition, it is recommended that the CM and other relevant parties do not confuse high risk of recidivism with being untreatable. Even among clients with a history of treatment non-compliance, as well as clients who have been given the formal designation as having strong "psychopathic" traits (e.g., score of 30 or above on the Psychopathy Checklist-Revised [PCL-R]; Hare, 2003), intensive services and residential programming may be appropriate.

B. Need principle (What should be treated?)

The Need principle specifies what should be treated. Specifically, the "criminogenic needs" (i.e., risk factors that have been identified in the literature as robust predictors of recidivism) from the "Central Eight" (Andrews & Bonta, 2010a) should be featured prominently in the assessments that are administered to clients, as well as the design of the client's treatment plan. The Central Eight is divided into the Big Four and Moderate Four. The Big Four (i.e., factors with the strongest association with recidivism risk) comprise indicators of antisociality: (1) history of antisocial behavior; (2) antisocial personality pattern (e.g., impulsivity, aggression/poor behavioral controls, sensation seeking), (3) antisocial cognitions (e.g., criminal identity, rationalization of crime), and (4) antisocial associates (e.g., close relationships with those who provide social support for crime). The Moderate Four (i.e., risk factors that are significantly, but less strongly, associated with recidivism) include (1) negative family/marital circumstances; (2) lack of positive school/work involvement, (3) limited opportunities for, or involvement in, prosocial activities (e.g., recreation/leisure), and (4) substance abuse. With the exception of history of antisocial behavior, the Central Eight may be conceptualized as malleable risk factors that can serve as intermediate targets of change (Andrews, Bonta, & Hoge, 1990).

ii. Concrete steps and recommendations relevant to the Need principle

Table 2 and the following sections outline the concrete steps and recommendations for providers of MISSION-CJ, which are relevant to the Need principle of the RNR model.

Table 2. Concrete steps and recommendations relevant to the Need principle

- Conduct a clinical evaluation that primarily covers the dynamic criminogenic needs from the Central Eight.
- When possible, use a structured and validated instrument that considers strengths, special responsivity factors, and case management planning.
- Cover the same domains of a needs assessment for all clients, regardless of sociodemographics.

1. Conduct a clinical evaluation that primarily covers the dynamic criminogenic needs of the Central Eight.

Regardless of whether the results of risk assessment are available in the client's institutional files, it is recommended that a needs assessment be conducted. History of antisocial behavior is a static risk factor that informs prediction of risk level, so it can be omitted here. However, the remaining seven domains from the Central Eight should be assessed in some fashion. Although a formal assessment tool is recommended, there may be times when a structured assessment is not feasible to administer. Accordingly, information regarding criminogenic needs may be obtained from a full clinical evaluation. Specifically, the CM should evaluate whether or not the client (a) exhibits an antisocial personality pattern (i.e., tends to be impulsive, aggressive, risk-taking, narcissistic, and/or callous) or antisocial cognitions (i.e., tends to externalize blame, has problems with authority, and/or unrealistic long-term plans and goals); (b) has a peer network of individuals who are involved in criminal activities; (c) has significantly strained relationships with, or is estranged from, family members; (d) has limited education or job skills and limited employment prospects; (e) has limited avocational interests or pastimes; and (f) has ongoing substance use problems or is at high risk for relapse to alcohol and illicit drug use (Andrews & Bonta, 2010a, 2010b). This step could be omitted if a needs assessment was done within the past month and the CM has an opportunity to consult with the individual who conducted the assessment.

2. When possible, use a structured and validated instrument that considers strengths, special responsivity factors, and case management planning.

In contrast to assessment of risk level, which may be accomplished with a 2nd generation or an ad hoc risk assessment tool, assessment of criminogenic needs is increasingly accomplished with 4th generation instruments such as the LS/CMI (Andrews, Bonta, & Wormith, 2004), the ORAS (Latessa et al., 2010), or the COMPAS (Brennan & Oliver, 2002), which include consideration of the client's strengths, special responsivity factors, and guidance for treatment planning. When these more comprehensive assessments are not feasible, it is recommended that the CM use brief, yet structured, risk assessments that have been validated in at least one study. Examples of these include the Risks and Needs Triage (RANT; Marlowe et al., 2011) or the Short-term Assessment of Risk and Treatability (START; Desmarais et al., 2012). Given the evolving nature of the field, it should be noted that these assessment tools may change over time and others may emerge. In addition, tools that focus on one domain of risk (e.g., sex offending, violence) may not be as helpful to determine risk of general recidivism. However, if information about specific factors related to violence or other types of offending is available, it may be important to seek consultation to understand how it should be interpreted and incorporated into treatment planning.

3. Cover the same domains of a needs assessment for all clients, regardless of sociodemographics.

Although there are gender differences in the prevalence or mean levels of many of the criminogenic needs of the Central Eight (e.g., indicators of antisociality; substance abuse), the predictive validity of these in regards to recidivism risk is comparable between men and women (Andrews & Bonta, 2010a). Further, there is no evidence that the Central Eight vary based on other sociodemographics such as race or ethnicity (Andrews & Bonta, 2010a). Therefore, it is recommended that the Central Eight domains are included in a needs assessment with all clients.

C. Responsivity principle (How clients should be treated?)

Once the risk level and criminogenic needs of a given client are determined, the Responsivity principle specifies how these clients should be treated. There are two prongs to responsivity: General and Specific. General responsivity states that all treatment options should adhere, more or less, to cognitive-social learning methods. Such methods have been shown to be effective regardless of offender type (e.g., violent vs. non-violent offender) or level of antisociality (Landenberger &

Lipsey, 2005). The key components of effective cognitive-social learning strategies include (1) use of structured interventions that reinforce behavioral change such as modeling; differential reinforcement; skills training; and reinforced practice of behavioral skills (e.g., drink refusal), and (2) delivery of all intervention in the context of a warm, respectful, collaborative relationship with the client (Bonta & Andrews, 2007). Specific responsivity serves to "fine tune" the cognitive-social learning strategies that are recommended for the client; that is, it outlines how a treatment plan should be tailored to the criminogenic needs of a given individual. In this regard, the above-mentioned needs assessment can be supplemented with assessments of non-criminogenic factors that can help identify specific treatment recommendations for the client and if/how these treatment services should be delivered.

iii. Concrete steps and recommendations relevant to the Responsivity principle

Table 3 and the following sections outline the concrete steps and recommendations that providers of MISSION-CJ should follow, which are relevant to the Responsivity principle of the RNR model.

Table 3. Concrete steps and recommendations relevant to the Responsivity principle

- Either formally or informally assess clients (or review with treating clinicians their assessments) for the following information and revise the MISSION-CJ treatment plan accordingly:
- *Cognitive impairment/concrete thinking/poor verbal skills*
- *Motivation for change/readiness for treatment*
- *Personal strengths*
- *Practical barriers to treatment attendance*
- *Sociodemographics*
- Administer, and/or work with clinicians who can administer, an assessment of global personality functioning to obtain information on (a) antisocial personality patterns and cognitions, and (b) personal strengths.
- Ask clients for their personal goals regarding (a) treatment in general, and (b) the personality assessment they received.
- Provide feedback to clients using a collaborative approach to assessment.
- Discuss with clients which traits would be most beneficial to monitor over time, and conduct periodic assessments based on level of risk.
- Jointly develop an individualized treatment plan with clients, which is based on assessments of (a) criminogenic needs, (b) specific responsivity factors, and (c) global personality functioning.
- For clients in which antisocial personality patterns and cognitions are identified as criminogenic needs, a structured CBT group for recidivism risk could be offered.

1. Either formally or informally assess clients (or review with treating clinicians their assessments) for the following information and revise the MISSION-CJ treatment plan accordingly:

a. Cognitive impairment/concrete thinking poor verbal skills: Based on the client's institutional files or a brief neuropsychological screen, determine if the client has cognitive impairments that could limit their ability to comprehend abstract concepts. Potential cognitive screeners may include the Neurobehavioral Cognitive Status Examination (NCSE; Kiernan et al., 1987) or the Mini-Mental status Exam (MMSE; Folstein, Folstein, & McHugh, 1975). The client's treatment provider may have conducted these, and as such a conversation with that provider can be helpful for the CM. If there is indication of such issues, it is recommended that CMs and PSSs divert such clients from programs that demand at least an average level of cognitive functioning or verbal skills. CM's should consult with the directors of any programs they are considering for referral, and over time begin to rank such programs and services based on their required level of cognitive functioning. In addition, it is recommended that CMs and PSSs spend more time on behavioral practice of concrete skills with such clients, rather than processing their thoughts and emotions. More significant mental illness, such as depression and anxiety symptoms should also be examined, and referred to further treatment, to enhance the client's ability to respond to and adhere to the services being offered.

b. Motivation for change /readiness for treatment: Ongoing assessment of motivation and treatment readiness can be very important throughout MISSION-CJ services. Because MISSION-CJ focuses on persons with co-occurring mental health conditions, motivation and readiness may also be related to ongoing signs and symptoms of mental illness (e.g., depression, hopelessness, anxiety, fear). MISSION-CJ teams should routinely be referring the clients to appropriate mental health services to address these issues. In addition, motivation can be examined through a variety of lenses. For example, the URICA (DiClemente & Hughes, 1990) is useful to assess motivation to change problematic behaviors more generally, whereas the SOCRATES (e.g., 19-item SOCRATES 8D; Miller & Tonigan, 1996) is useful for specifically assessing motivation to change and treatment readiness for substance use problems. If time is limited, the Readiness Ruler (Zimmerman et al., 2000) is a brief index of treatment readiness. If a given client's motivation for change or readiness for treatment is found to be low, or if s/he has a history of dropping out of treatment more than once, the CM should engage in brief motivational interviewing to discuss the pros and cons of treatment and ask the client to complete a decisional balance sheet (Hettema et al., 2005; Rubak et al., 2005).

c. Personal strengths: Based on assessments of the Central Eight criminogenic needs (e.g., quality of relations with family members; housing status), broadband personality questionnaires (e.g., scores on indices of impulse control or sociability), and/or clinical impressions, the CM should emphasize potential strengths during meetings with the client and adjust the treatment plan accordingly. For example, a client with a safe and supportive family network and stable residence could be diverted from residential programming, and a client who scores above average scores on a scale of self-control may require less oversight on the part of the CM to manage and structure the client's schedule.

d. Practical barriers to treatment attendance: Lack of transportation or childcare, ineligibility for benefits, and other practical barriers may hinder the ability of clients to access and engage in needed services. In designing the client's treatment plan, the CM should consider if such issues may adversely impact the client's treatment attendance, and modify the plan accordingly or work with a social worker to determine solutions to these barriers.

e. Sociodemographics: Issues such as age, gender, and race do not impact what domains are covered in a needs assessment, but they may impact the type of services that are recommended for a client. For example, the CM should consider if there are any cultural barriers to a client being able to engage in and align with a given treatment program, as well as whether any cultural differences between the therapist and the client could impact the therapeutic alliance (Vasquez, 2007). In addition,

consideration should be given to the impact of age. For example, treatments that focus on antisocial thinking and long-term planning may be less beneficial for an older offender.

2. Administer, and/or work with clinicians who can administer, an assessment of global personality functioning to obtain information on (a) antisocial personality patterns and cognitions, and (b) personal strengths.

Given that the RNR model has been contextualized within a general personality-social learning theory of criminal conduct, assessment and feedback of personality test data fits within the conceptual framework of this model. Such assessments are particularly useful to quantify the degree to which a client exhibits antisocial tendencies. Antisocial tendencies exist on a continuum and are relevant criminogenic needs or responsivity factors regardless of whether a client meets the diagnosis of antisocial personality disorder from the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) or psychopathy based on the PCL-R (Hare, 2003). Personality models and questionnaires that are well validated and commonly used include the Big 5 (e.g., NEO-PI R or Big Five Inventory; Costa & McCrae, 1992) and the Big 3 (e.g., the Multidimensional Personality Questionnaire; MPQ; Patrick, Curtin, & Tellegen, 2002). The following traits from these models are robust predictors of antisocial behavior and should be given special attention when reviewing the test results (Andrews & Bonta, 2010a; Miller & Lynam, 2001):

- Low agreeableness/high negative affect (e.g., anger, hostility, or aggression; antagonism; alienation; distrust).
- Low conscientiousness/constraint (e.g., impulsivity; sensation-seeking; negative or positive urgency).
- High self-centeredness/narcissism (NOTE: These traits are not as strong predictors of antisocial behavior as the preceding trait domains; Miller & Lynam, 2001).

3. Ask clients for their personal goals regarding (a) treatment in general, and (b) the personality assessment they received.

During early sessions between the CM and the client, it is important to review with clients what their goals are for treatment and, in particular, what behaviors they wish to change. To facilitate this process, the CM can inquire about the client's "ideal" personality to clarify which behavioral tendencies they perceive to be the most problematic. This discussion will help the CM when reviewing the results of the personality assessment and in knowing which information is more important to provide feedback to the client.

4. Provide feedback to clients using a collaborative approach to assessment.

In the treatment planning process, CMs should use a collaborative approach to assessment (Finn & Tonsager, 1997) to provide feedback to clients, including assessments related to personality traits, and work together to see whether the client agrees or disagrees with these assessments. From there, it can also be helpful to work with the client to identify which aspects of their own thinking may be problematic and contributing to their criminal recidivism.

5. Discuss with clients which traits would be most beneficial to monitor over time, and conduct periodic assessments based on level of risk.

After reviewing the results of the assessments with the client, the CM and the client should engage in a collaborative discussion regarding which traits would be most beneficial to monitor over time. The CM should encourage the client to keep of log of the frequency of behaviors that are indicators of the trait (e.g., traits of aggression or anger/hostility could be monitored based on the frequency of arguments with family members). At subsequent sessions, the CM and client should review changes in these key behaviors since the initial session to help monitor the progress in these areas. In addition, personality questionnaires or assessments could be re-administered to clients periodically throughout the course of the MISSION-CJ protocol. For example, clients who are high risk could be reassessed every 1-2 months, clients who are moderate risk could be reassessed every 3-6 months, and clients at low risk could be reassessed at the end of the treatment period.

6. Jointly develop an individualized treatment plan with clients, which is based on assessments of (a) criminogenic needs, (b) specific responsivity factors, and (c) global personality functioning.

Inevitably the CM and other relevant parties will have recommendations and preferences regarding which needs to prioritize in a client's treatment plan. However, considerable weight should be given to the needs that are most important to the client and, when feasible, deliver on these needs early and often during the treatment. Further, the CM should review the specific exercises and services within the MISSION-CJ model and determine how they align with the dynamic criminogenic needs that are relevant to the client. For example, to address antisocial personality patterns and cognitions, self-guided exercises from the MISSION-CJ workbook could be selected and customized so that they are directly responsive to the client's problematic behavioral tendencies. Other criminogenic needs such as antisocial peers and lack of family support can be addressed through modeling on the part of the PSS; lack of education/ employment skills can be addressed through the supportive employment resources; and substance abuse can be addressed through DRT sessions.

7. For clients in which antisocial personality patterns and cognitions are identified as criminogenic needs, a structured CBT group for recidivism risk could be offered.

Moral Reconation Therapy (MRT; Little & Robinson, 1988), Thinking 4 a Change (T4C; Bush, Glick, & Taymans, 2011), and Reasoning & Rehabilitation (R&R; Ross, Fabiano, & Ross, 1983) are cognitive-behavioral interventions with empirical support that were designed to modify antisocial personality patterns and cognitions. New therapies along these lines may also be emerging. Participation in these groups as an adjunctive component to the MISSION-CJ protocol may be warranted for high-risk clients with those criminogenic needs. If such groups are not available to the client, other cognitive-behavioral interventions that aim to reduce impulsive decision-making (e.g., Dialectical Behavior Therapy; Kliem, Kröger, & Kossfelder, 2010) may be recommended. Alternatively, during the individual sessions with clients, the CM could also engage clients in thought restructuring exercises to modify antisocial thinking patterns and generate alternative responses to situations and triggers that increase the client's risk for recidivism.

IV. The Role of Managers and Administrators

A final, critical component to ensure that RNR principles are integrated into the MISSION-CJ protocol relates to the actions of managers and administrators of this intervention. In order to properly implement RNR principles in any context, *managers and administrators must attend to the relationship and structuring skills of service delivery staff and provide support and training when necessary.* Having a sound organizational structure in place to support an intervention and maintain its integrity is essential to the effectiveness of such interventions in terms of reducing risk of recidivism (Lowenkamp, Latessa, & Smith, 2006). In terms of concrete steps, managers and administrators should consider the following:

- Selection of staff that have high interpersonal skills, as well as knowledge and training in structured cognitive-behavioral approaches.
- Consideration of the need to properly train staff in the concrete steps of RNR, particularly assessment practices.
- Development of supervision models for staff to identify non-adherence or drift from RNR principles.

To facilitate supervision and provide flexibility in this regard, it may behoove managers and administrators to use technology (e.g., telehealth) to provide routine monitoring of CM and PSS staff during their interactions with clients. In addition, formal assessments may be used to monitor providers' adherence to RNR principles and provide corrective feedback. The Correctional Program Assessment Inventory (CPAI; Gendreau & Andrews, 1989) is one example of such a measure that has been used previously by administrators in correctional settings. Scores are positively and significantly associated with reduced rates of recidivism (Goggin & Gendreau, 2006).

V. Case Example

Jeff P. is a 36-year-old Caucasian male US Veteran who was recently arrested for possession with intent to distribute. During his arraignment, he was diverted to a Veterans Treatment Court, and the court members (judge, prosecutor), and liaisons from the local VA including a Veterans Justice Outreach Program (VJOP) Specialist are discussing the terms of his probationary release. Jeff has a history of alcohol, cocaine, and marijuana abuse, as well as comorbid posttraumatic stress disorder (PTSD) from his combat experience during a brief tour in Iraq.

During initial meetings with the court members and the VJOP Specialist, the MISSION-CJ Case Manager (CM) obtains permission to review Jeff's court records. The records do not include any formal or informal evaluation of Jeff's risk level. However, there is detailed information on his criminal history, which indicates that he was first arrested as a juvenile (age 16) for breaking and entering, has half a dozen prior arrests for offenses ranging from drug possession and theft to assault and battery, and had previously violated the conditions of his parole after failing multiple toxicology screens. Based on this extensive and diverse criminal history, the CM decides that further screening of risk using the Level of Services Inventory-Revised Screening Version (LSI-R SV; Andrews & Bonta, 1998) is not necessary at this time and concludes that Jeff is at high risk to reoffend. Given this risk level, the CM recommends that Jeff complete the 12-month protocol of MISSION-CJ. In addition, the CM initiates discussions with the intake staff from a local VA residential substance use disorder (SUD) treatment program to evaluate whether Jeff would be appropriate for that program.

During the CM's initial meeting with Jeff, the CM takes time to build rapport and then conducts an unstructured clinical interview to obtain background information on Jeff's past and current mental health functioning. Following this, the CM completes the Risks and Needs Triage (RANT; Marlowe et al., 2011) and integrates the results with the findings from the interview to determine Jeff's criminogenic needs. Based on the results of the RANT, Jeff's needs appear to include (a) antisocial personality patterns and cognitions, (b) associates with antisocial peers, (c) few prosocial leisure activities, (d) poor relationships with his wife and 12-year old daughter, and (c) ongoing substance use problems. By contrast, Jeff has over 10 years of experience in construction with specific skills as a heavy machine operator, and has been given the option to return to his old job once the terms of his probation are complete.

During the next meeting between Jeff and the CM, the CM administers the NEO Personality Inventory-Revised (NEO PI-R; Costa & McCrae, 1992) and the SOCRATES (Miller & Tonigan, 1996) to obtain more detailed information on Jeff's behavioral tendencies and motivation to reduce drug and alcohol use and engage in SUD treatment. Based on Jeff's education level (Bachelor's degree), the CM's behavioral observations (e.g., Jeff is very articulate), and the absence of a traumatic brain injury in Jeff's medical records, there appears to be no overt signs of cognitive impairment and therefore no need to conduct a cognitive screener. After completing the NEO PI-R and SOCRATES, the CM asks Jeff what his goals are for treatment, and what information he hopes to learn about his personality from the assessment. Jeff indicates that he wishes to rebuild his relationships with his family. Regarding the testing, he is interested in learning about his anger problems.

When asked what would be his ideal personality, Jeff indicates that he wishes he could let things slide off his back and have more patience in general. Further discussions with Jeff indicate that he has a history of aggressive behavior and a tendency to act on the "spur of the moment" (e.g., leaving jobs and ending relationships with minimal forethought). Before the next session, the CM scores the NEO PI-R and SOCRATES. The results of the NEO PI-R indicate that, relative to others his age, Jeff is in the very high range on a scale of assertiveness, and in the very low range on scales of trust and impulse control. The results of the SOCRATES indicate that Jeff is highly ambivalent about his substance use.

During the next meeting, the CM provides Jeff with a written summary of his personality profile and solicits Jeff's input regarding (a) whether the findings seem accurate and match his experience, and (b) how these behavioral tendencies have helped him and hurt him in the past. Jeff agrees that the testing is accurate and gives a number of examples how it has been difficult to get close to others because he is always waiting for

them to "disappoint" him. In addition, he indicates that his assertiveness has generally served him well, though acknowledged he has to learn when to hold his tongue. The CM reflects Jeff's belief that his willingness to stand up for himself can be a strength, but encouraged Jeff to keep a log of times when he has asserted himself and what the reactions of others has been.

After reviewing these results, Jeff and the CM work together to draft the key components of Jeff's treatment plan. Jeff agrees to monitor his levels of trust and impulsivity over time. To this end, the CM encourages Jeff to keep a weekly log that details incidents in which he had concerns about the intentions of another person and how he acted in those situations. In addition, the CM encourages Jeff to consider past spur-of-the-moment decisions, and to maintain a weekly log of times when he acted without thinking and what the consequences were. Jeff agrees to meet weekly with the CM and the PSS to review these logs and complete other components of the MISSION-CJ protocol, and to retake the personality questionnaire every 2 months until the intervention is complete. The CM and Jeff also review the MISSION-CJ Participant Workbook to identify specific exercises that would help Jeff work on his self-control. Finally, the CM solicited Jeff's interest in attending a Moral Reconation Therapy (MRT) group that is run by a VJOP Specialist at the local VA. The CM notes that these groups may further help Jeff deal with his substance use problems, as well as give him tools to increase his trust of others and his impulsive tendencies. To address his ambivalence about SUD treatment, the CM asks Jeff to complete a decisional balance sheet regarding the pros and cons of cutting down or quitting his substance use and to review this during their weekly sessions. Jeff agrees to complete the decisional balance exercise and to try out the MRT group, but expresses a desire to not enter into a residential SUD treatment program at this time.

Table 4. Assessment features relevant to RNR principles

- **Risk:**
  - o Review institutional/court records.
  - o Consider available formal risk screening tools.
- **Need:**
  - o Consider available tools that measure criminogenic needs in a structured format.
  - o When structured tools are unavailable, supplement measurement of criminogenic needs with information gathered during clinical interviews.
  - o Integrate risk and needs findings.
- **Responsivity:**
  - o Consider mental status testing and basic cognitive screens.
  - o Examine motivation for change/readiness for treatment.
  - o Examine personality domains that can impact readiness for change and other responsivity factors.

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APPENDIX D: MISSION-CJ Sample Position Descriptions

Generic Case Manager Position Description

Major Duties and Responsibilities

- Case management and community outreach with criminal justice-involved or formerly criminal justice-involved individuals with co-occurring substance use and mental health problems in the MISSION-CJ (Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking – Criminal Justice Edition) program. This will consist of meetings with clients to discuss their needs in the community (e.g., connecting them with mental health and substance use services, recreational opportunities, self-help groups, transportation resources, etc.). The incumbent will also provide vocational/educational support to help clients maintain employment and find new employment/educational opportunities. The incumbent will be required to work with criminal justice entities (e.g., probation, parole, courts) to support clients in reducing recidivism over time.

Factor 1: Scope and Effect

- The objective of this position is to provide case management and outreach services to criminal justice-involved individuals with co-occurring mental health and substance use problems for the MISSION-CJ program under the direction of a Clinical Supervisor. These tasks will contribute to the overall effectiveness of the MISSION-CJ program.

Factor 2: Knowledge Required for the Position

- The incumbent will have experience working with people with a history of mental health and substance use problems.
- The incumbent must have experience providing case management services.
- The incumbent's preferred qualifications include knowledge and experience working with criminal justice involved individuals.

Factor 3: Supervisory Controls

- The incumbent works under the supervision of a Clinical Supervisor. The incumbent is required to function independently, but he/or she also meets regularly with his/her Clinical Supervisor to provide regular updates and status reports regarding contact with clients in the MISSION-CJ 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 client's problem or situation.

Factor 5: Complexity

- Working with criminal justice-involved or formerly criminal justice-involved individuals with co-occurring mental health and substance use 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 clients with co-occurring mental health and substance use problems. He/she may also contact the family members/friends/clinicians/employer of clients (with the permission of the client). He/she will also have direct contact with the staff of the MISSION-CJ program and other treatment providers. He/she will also likely have direct contact with criminal justice authorities (e.g., probation, parole, court personnel, lawyers, police) and must be comfortable negotiating these contacts.

Factor 7: Purpose of Contacts

- The incumbent will contact clients to help them engage in treatment services, and locate/maintain employment in the community, reduce their

likelihood of further criminal justice involvement, and maintain stable housing. He/she will contact the family members/friends/clinicians/employer/criminal justice supervisors of clients to promote the tenure of the client in the community and in their job. The incumbent will contact other treatment providers to promote the smooth integration of MISSION-CJ services with other providers.

Factor 8: Physical Demands

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

Factor 9: Work Environment

- The incumbent will have a designated workspace. However, he/she will spend the majority of his/her time in the community meeting with clients and members of various community programs or criminal justice authorities to which the client is responsible for reporting.

Generic Peer Support Specialist Position Description

Major Duties and Responsibilities

- The Peer Support Specialist (PSS) is a full member of the MISSION-CJ program treatment team and provides peer support services to clients with co-occurring mental health and substance use disorders. Under supervision of the MISSION-CJ Clinical Supervisor, the Peer Support Specialist functions as a role model to clients; provides positive social attitudes and linkages to activities; exhibits competency in personal recovery and use of coping skills; and serves as a participant advocate, providing participant information and peer support for clients in both the residential and community settings. The PSS performs a wide range of tasks to help clients regain independence within the community and mastery over their own recovery process. The Peer Support Specialist in the provision of services utilizes recovery resources such as the Participant Workbook, tapes, pamphlets, and other written materials. Peer Support Specialists also focus on goals related to reduced criminal re-arrests and offending as part of outcome goals for clients.

The PSS assists the client's recovery by…

- Using a formal goal-setting process to help him or her articulate personal goals for recovery. By conducting one-on-one and group sessions, the PSS supports clients and helps them identify objectives, create goals, and develop recovery plans. The PSS and the client will discuss the skills, strengths, supports, and resources that are necessary to help achieve these goals. In addition to recovery and wellness, the PSS supports clients to reduce criminal recidivism.
- Encouraging and facilitating an effective working and treatment relationship with the client's MISSION-CJ Case Manager.
- Prioritizing the formation of new and/or sustainment of existing self-help (mutual support) groups. The PSS works to help the client locate and join existing support groups, and will attend initial meetings with the client if desired, therefore stressing the importance of joining and regularly attending these groups.
- Using tools such as the MISSION-CJ Participant Workbook and other appropriate tools, to assist clients in achieving their own recovery and treatment goals and reduced criminal justice recidivism.
- Independently, or with periodic assistance from the MISSION-CJ Case Manager or other providers, teach, through instruction and/or example, problem solving skills to both individuals and groups. The PSS also leads discussions that encourage clients to share common problems of daily living and methods they have employed to manage and cope with these problems. As individuals who can relate to the clients through their own experiences, PSSs highlight the skills, strengths, supports, and resources they share and/or have used. As much as is helpful, the PSSs will share their own recovery stories and, as facilitators of these sessions,

demonstrate how they have directed their own recoveries.

- Use ongoing individual and group sessions to teach clients how to identify and combat negative self-talk. By using identified literature, DVDs, etc., PSSs help clients gain hope, learn to identify their strengths, and combat negative self-talk. Through this process, the PSS will help clients identify their fears, insecurities, and underlying barriers to success, and develop action plans to counter these.
- Supporting clients' vocational choices and assisting them in developing educational experiences and job acquisition skills, and in choosing a job that matches their strengths. Recognizing the likely presence of job-related anxiety, the PSS will help the client by reviewing job applications, locating resume-building volunteer and/or temporary job opportunities, coaching the client through an interview process, and 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.
- Assisting clients in prosocial thinking, attitudes and behaviors, role modeling hopefulness and positive attitudes and supports.
- Keeping records that document the client's treatment/recovery plan, including:
- Identified person-centered strengths, needs, abilities, and recovery goals;
- Interventions to assist the client with reaching his/her goals for recovery and reduced recidivism;
- Progress made toward goals;
- Maintaining a working knowledge of current trends and developments in the mental health field and criminal justice recidivism reduction programs 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 client in his/her choice of activities and housing that is in the most integrated, independent, and least intrusive or restrictive environment possible. The PSS will facilitate this by accompanying the client either by driving the client or riding with them on public transportation to attend activities, search for housing and other building blocks.
- Serve as a recovery agent by providing and advocating for any effective recovery-based services that will aid the client in daily living. The PSS's role is critical as he or she models effective coping techniques and self-help strategies.
- Assist in obtaining services that advance the client's recovery needs. By providing points of contact and relevant information for community resources, self-help groups, and other useful services, the PSS serves as an information conduit, relaying information about community and natural supports and how these can be used in the recovery process. These may include, but are not limited to, connections with federal government agencies, such as Social Security offices; state and local programs, such as child welfare and social services agencies; local community organizations such as the YMCA or JCC, public libraries; neighborhood and community associations; and other relative organizations and community resources.
- Assist clients in meeting demands of community supervision (e.g., probation, parole, courts) where applicable by helping clients with schedules, reminders of punctuality, supports related to sobriety, and the like.
- Empower clients to combat stigma through self-advocacy. By attending regular group and individual meetings with clients, and employing role-play and modeling techniques, Peer Support Specialists create an environment that is conducive to sharing how they, and other clients have handled difficult recovery situations. As the PSS models respect for each client's individual recovery experience, s/he demonstrates appropriate social interactions, problem-solving skills, and techniques for managing interpersonal relationships.

Factor 1: Knowledge Required by the Position

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

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

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

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

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

f. Awareness of the requirements of any criminal justice authority that has conditions that apply to the client, in order to best support the client in meeting those mandates.

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

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

i. The PSS must be willing to share their own criminal justice background, if any, with clients and provider communities. In some instances, hiring will require a review and approval of the PSS based on the criminal justice history of the PSS. Because MISSION-CJ may be offered across systems (treatment services, public safety services, criminal justice services), it may be necessary to receive multiple levels of approval for hiring and entrance into certain criminal justice facilities.

Factor 2: Supervisory Controls

The Peer Support Specialist is administratively assigned to the MISSION-CJ program and will receive supervision from the MISSION-CJ Clinical Supervisor. While the supervisor provides regular supervision and generally helps guide the treatment team 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. The supervisor does not review assignments that are routine and repetitive unless there are problems. The incumbent will follow all legal, medical, and organizational policies as mandated by the program.

Factor 3: Guidelines

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

Factor 4: Complexity

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

Factor 5: Scope and Effect

The PSS assists and guides clients toward the identification and achievement of specific goals as defined by the client and specified in the Individual Treatment Plan (ITP). The work involves a variety of routine, standardized tasks that facilitate work performed by higher-level providers. Work performed by the incumbent will promote sobriety, community socialization, recovery, self-advocacy, self-help, and development of natural supports.

Factor 6: Personal Contacts

Personal contacts include clients, family members and significant others, treatment team members and other clinical staff, to include all disciplines. Contacts may also be with criminal justice authorities such as probation, parole, court personnel, attorneys, etc. In addition, contacts may be with private citizens, landlords, community leaders, and staff of community, federal and state agencies. Contacts may be in person, by telephone, or by written communication.

Factor 7: Purpose of Contacts

Personal contacts are made to give or exchange information; resolve issues; provide services; and to motivate, influence, and advocate on behalf of the client. Contacts with clients are for the purpose of assisting them in managing their sobriety and emotional and behavioral symptoms, teaching them independent living skills, and identifying and achieving their individual recovery goals.

Factor 8: Physical Demands

The work generally involves some sitting, walking, standing, bending, carrying of light items such as books and papers, accessing transportation, and driving. Driving program participants may also be required.

Factor 9: Work Environment

Work will be performed in a wide range of settings, including a medical center; in a client's place of residence (both inpatient and in the community); group or family homes; in community-based outpatient settings and/or community agencies; in government transport vehicles (public or government), and elsewhere. Work areas are often noisy, irregular, and unpredictable and can be stressful at times. Work may include visitation in correctional settings as well as in courts. As participating clients demonstrate varying levels of recovery and symptoms, and may have many environmental triggers, the MISSION-CJ 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" (MISSION-CJ clients, visitors, volunteers, criminal justice personnel, medical staff) in a courteous, tactful, and respectful manner. Provides the customer with consistent information according to established policies and procedures. Handles conflict and problems in dealing with the customer constructively and appropriately.

ADP Security

Protects printed and electronic files containing sensitive data in accordance with the provisions of the Privacy Act of 1974 and other applicable laws, federal regulations, and agency statutes and policy. Protects the data from unauthorized release or from loss, alteration, or unauthorized deletion. Follows applicable regulations and instructions regarding access to computerized files, release of access codes, etc. Comprehension is indicated and compliance is pledged with the employee's signature on a standard agreement.

Age-Related Competency Statement

Provides care and/or services appropriate to the age of the clients being served. Assesses data reflective of the client's status and interprets the information needed to identify each client's requirements relative to their age-specific needs and to provide care needed as described in the policies and procedures.

Computer Knowledge - Word Processor

Uses MS-Word or comparable word processing software to execute several office automation functions such as storing and retrieving electronic documents and files; activating printers; inserting and deleting text; formatting letters, reports, and memoranda; and transmitting and receiving e-mail.

APPENDIX E: MISSION-CJ Sample Service Delivery Schedules

Schedule for MISSION-CJ Service Delivery:

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

Screening and Orientation to MISSION-CJ

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

Groundwork and Relationship Building

- Clients participate in DRT psychoeducational co-occurring disorders treatment sessions. If initiated in an inpatient/residential treatment setting, it is important to note that clients may participate in DRT sessions while receiving inpatient/residential treatment services. DRT sessions are designed so clients can begin at any time, so if delivered in a group setting he/she does not have to wait for a new group of other clients to enroll in MISSION to begin DRT sessions.
- Clients participate in Peer-led sessions with Peer Support Specialist (PSS).
- Clients participate in regular "check-in" sessions with PSS regarding Participant Workbook exercises.
- If client is receiving inpatient/residential treatment services, MISSION-CJ staff attends treatment team meetings with inpatient/residential staff and provides input on the client's treatment plan and discharge plan from the facility.
- PSS has an "open door policy" for informal discussions with clients on caseload.
- MISSION-CJ staff ensures individuals are linked to appropriate addiction, mental health, vocational/educational, and trauma-informed care treatment services via referrals to community programs.
- MISSION-CJ staff review any legal terms of compliance with MISSION-CJ clients to ensure that all are familiar with the terms of community supervision such as those of probation, parole, etc. MISSION-CJ staff work with client to develop treatment plan to maximize adherence to these plans and decrease recidivism.

Further Defining Relationship with MISSION-CJ Treatment Team

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

MISSION-CJ staff review of the timing of any criminal justice community conditions or mandates, which may extend beyond MISSION-CJ services, may be briefer than MISSION-CJ services, or may end at the same time as MISSION-CJ.

Transitioning to Community-based Services

- The MISSION-CJ Case Manager and Peer Support Specialist 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 and reduced recidivism. Modifications to treatment plans are made as new needs arise.
- The MISSION-CJ PSS participates in community activities with the client (going to 12-step meetings, social events, recreational activities, etc.)
- The MISSION-CJ Case Manager and PSS conduct outreach weekly to every other week as needed by the client. These meetings can also be supplemented by telephone contacts if necessary. MISSION-CJ 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.
- Planning for the ending of criminal justice community supervision requires careful examination and discussion with client about building ongoing positive community supports.

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

Transfer of Care

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

Note: Termination is often difficult for those receiving treatment services and brings up such core issues as loss, dependency, etc. The CTI manual can serve as an additional resource for this component of treatment and is seen as a critical component of the treatment process. Furthermore, should a client begin to show exacerbation in their mental health and substance use problems, sessions could be increased, but with a focus on helping clients to engage with their new community supports and providers and empowering the client to identify additional support as needed. Again, it must remain clear to the client, Case Manager, and PSS that the goal in the transitional phase in this stage of treatment is to empower clients to believe that they can live independently in the community, without the assistance they have been receiving from the MISSION-CJ Case Manager and PSS.

Discharge from MISSION-CJ

- The MISSION-CJ case manager and PSS review progress and goals; discuss the client's strength, resiliency, and available resources; review any ongoing criminal justice system requirements or follow up appearances; and reinforce the use of community supports. Then MISSION-CJ staff say goodbye to the individual.

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

MISSION CJ 2 - MONTH PROGRAM TIMELINE

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

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

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

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

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

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

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

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

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

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

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

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

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

Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8

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

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

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

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

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

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

CTI: Try Out
-Identification of gaps in support and additional needs
-Assertive outreach

Peer Support Group
-One Session: Self-monitoring of substance abuse triggers and craving levels

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

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

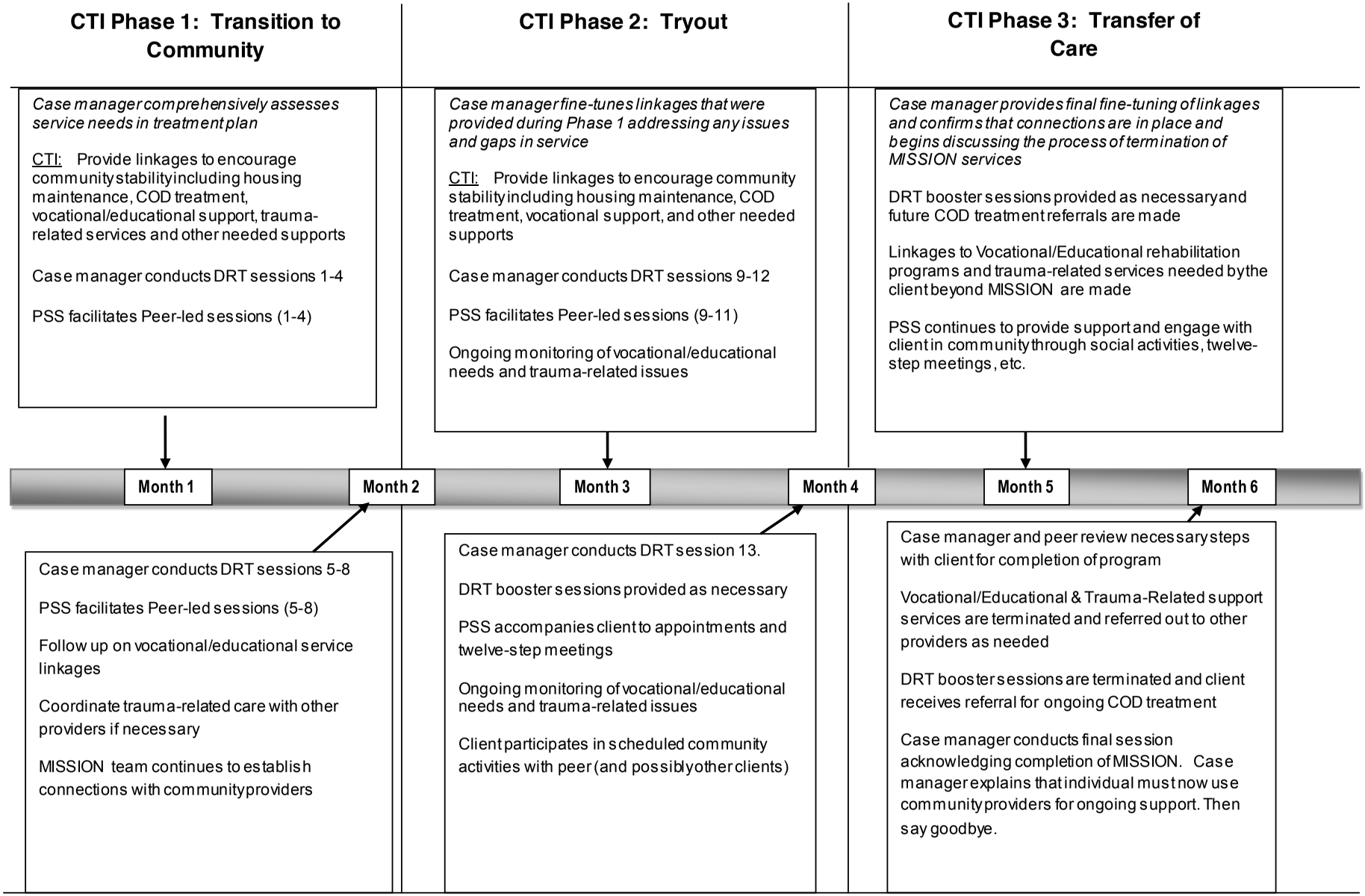
Peer-led session focuses on reinforcing completion of exercises in MISSION Participant Workbook

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

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

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

MISSION CJ 6 - MONTH PROGRAM TIMELINE



MISSION CJ 12 - MONTH PROGRAM TIMELINE

CTI Phase 1: Transition to Community

CMs and PSSs should have weekly contact with client

(Note CTI begins immediately if services initiated in community)

Case manager comprehensively assesses service needs in treatment plan

Case Manager orients client to MISSION and provides Consumer Workbook

Case Manager conducts DRT sessions 1-12

PSS conducts peer-led sessions 1-11 and works with client on Consumer Workbook

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

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

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

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

CTI Phase 2: Tryout

CMs and PSSs should have biweekly contact with client

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

Care coordination continues with decreased frequency of contact between MISSION staff and client

Attend to any crises/issues that arise

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

Resolve identified issues

Adjust systems of support as needed

Conduct final DRT Session 13

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

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

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

CTI Phase 3: Transfer of Care

CMs and PSSs should have monthly contact with client

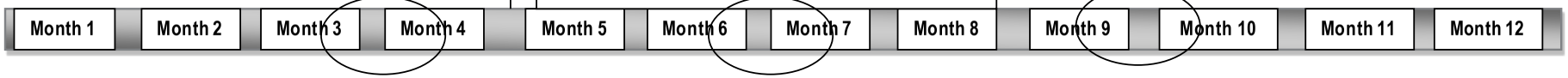
Case manager provides final fine-tuning of linkages and confirms that connections are in place

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

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

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

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



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

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

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

APPENDIX F: Leading Exercises in Dual Recovery Therapy

The following section presents exercises as they appear in the Participant 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 use 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 use. When were you using or drinking?

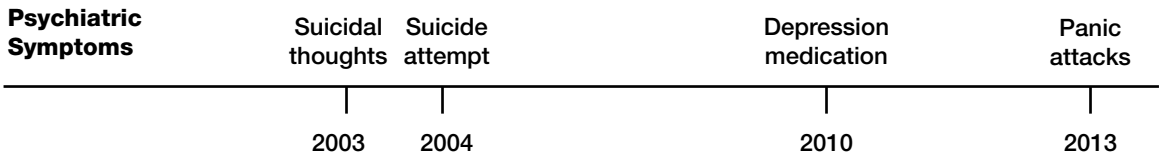
Once you have all three timelines, you can use them to explore what was happening at the same time in your life. What triggered what? Did you start using to control psychiatric symptoms? Did something in your personal life stress you out, causing symptoms to flare up? Once you can name these patterns,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

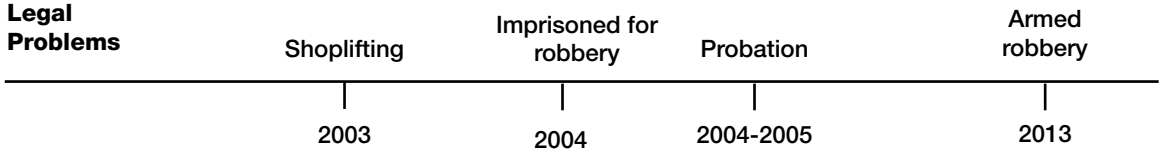
Notes for the Session Facilitator:

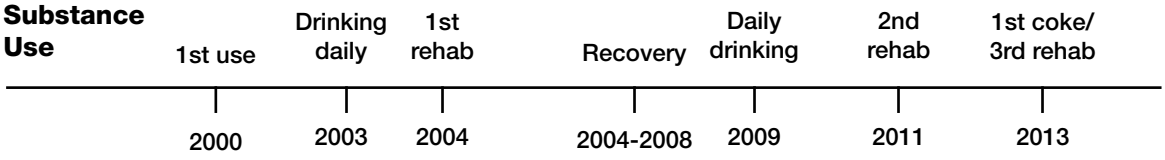
Explain to client that there is usually a pattern to when symptoms begin and that symptoms for substance use and mental health problems are often interrelated.

After showing the client how to fill out the timelines and going over the example, give participants time to fill out their own timelines. If completed in a group environment, you can ask the client to share his or her insights, leading to a discussion of common patterns and useful discoveries.

MY TIMELINES WORKSHEET *(SAMPLE)*







MY TIMELINES WORKSHEET

Psychiatric Symptoms

Interpersonal Problems

Substance Use

2. Life Problem Areas

What's it for?

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

Why does it work?

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

When to use it:

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

How to use it:

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

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

Notes for the Session Facilitator:

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

PERSONAL LIFE PROBLEM AREAS WORKSHEET *(SAMPLE)*

LIFE AREAS	PROBLEMS
Substance Use	*Use cocaine every weekend for 2 months; must stop* *Drink heavily every day*
Family	*Arguments with spouse – frequent!* *Very angry with my spouse* *Don't get along with Ben (15 year old stepson)*
Financial	*Last job was 5 months ago due to frequent coke use – so money is very tight* *Spouse is working but tough to pay bills*
Psychological	*Angry a lot*
Social	*Not very many friends*
Legal	*Possession charge*
Employment	*Unemployed – looking for work*
Health	*High cholesterol*
Spiritual/Religious	*Anger at higher power* *Lack of meaning in life*

PERSONAL LIFE PROBLEM AREAS WORKSHEET

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

3. Motivation, Confidence, and Readiness to Change

What's it for?

To help you look at something you want to change in your life and see whether you have the motivation, confidence, and readiness to make something different happen. This can include changes in substance use, 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?

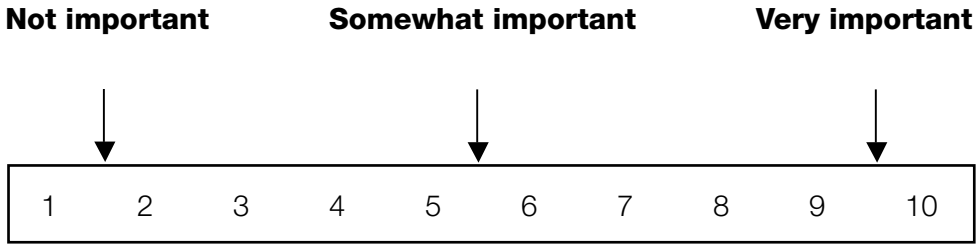
Notes for the Session Facilitator:

Explain to the client that a sense of importance, confidence, and readiness are all different aspects of motivation. Encourage the client to answer honestly for each area they choose to address. You may want to have extra copies of the following page or extra notepaper so they can easily use the rulers to explore different areas in which change is needed in their lives. The problem areas discussed in the previous session will be helpful as participants fill these out. If in a group environment, consider encouraging sharing around some of the problems explored, the motivation participants find to address them, and implications for recovery.

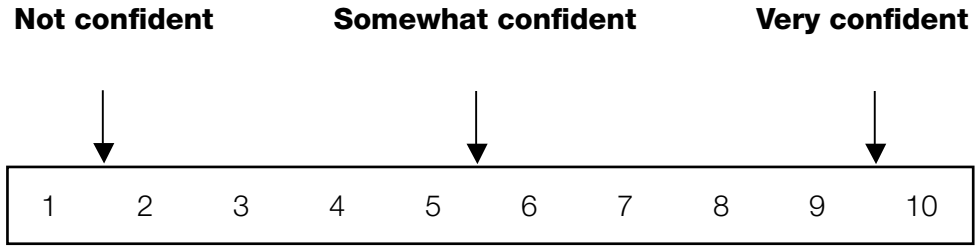
IMPORTANCE, CONFIDENCE, READINESS RULER WORKSHEET

First identify the change that you would like to make in your life. Then, using the ruler below, please indicate with a line HOW IMPORTANT it is for you to make a change in this area. Marking #1 means it is not at all important to make a change, #5 means it is somewhat important, and #10 means it is very important. Please feel free to use any of the numbers in between.

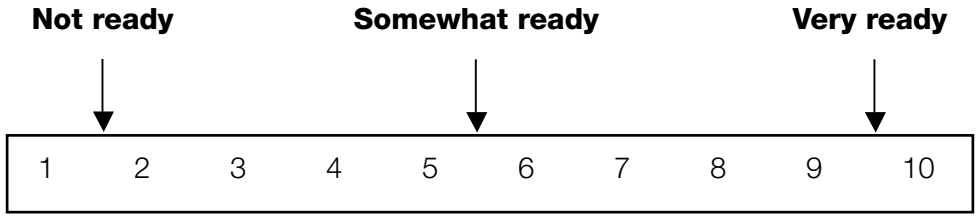
Change:



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



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



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 use 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 clients to refer back to their answers and identify positive steps they can take to address the problem. Encourage them to share their thoughts with their peer support specialists, their primary case managers in the residence, and others who play a key role in their hopes for recovery. Provide an opportunity for sharing around various strategies participants have suggested for themselves in each area.

RECOVERY PLAN WORKSHEET *(SAMPLE)*

LIFE AREAS	PROBLEMS	RECOVERY PLAN (How willl the problem be addressed?)
Substance Use	*Use cocaine every weekend for 2 months; must stop* *Drink heavily every day*	*Stop using drugs and alcohol* *Attend NA/AA groups* *Learn new ways of coping with problems*
Family	*Arguments with spouse– frequent!* *Very angry with my spouse* *Don't get along with Ben (15 year old step-son)*	*Enter family counseling* *Improve communication skills*
Financial	*Last job was 5 months ago due to frequent coke use – so money is very tight* *Wife is working, but paying the bills is tough*	*Learn money management skills* *Look for part-time work to help with bills*
Psychological/Psychiatric	*Angry a lot* *Feel Depressed*	*Work on developing anger management skills* *Get a psychiatric evaluation to find out if an antidepressant would help me feel better*
Social	*Not very many friends*	*Make an effort to talk to more people at NA/AA groups*
Legal	*Possession charge*	*Make sure to be present for court date and listen to advice from my lawyer about situation* *Continue to attend NA/AA groups and individual counseling sessions for ongoing support*
Employment	*Unemployed – looking for work*	*Get a stable and satisfying job* *Enter vocational rehabilitation program*
Health	*High cholesterol*	*Go to community health center for check -up* *Start eating healthier foods*
Spiritual/Religious	*Anger at higher power* *Lack of meaning in life*	*Speak with pastor about anger at higher power* *Increase participation in meaningful activities and relationships*

RECOVERY PLAN WORKSHEET

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

5. Decisional Balance

What's it for?

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

Why does it work?

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

When to use it:

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

How to use it:

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

Notes for the Session Facilitator:

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

SHOULD I STAY THE SAME OR CHANGE MY BEHAVIOR? WORKSHEET *(SAMPLE)*

Descripton of the Behavior: ***Snorting cocaine.***

	Maintaining My Current Behavior	Changing My Current Behavior
BENEFITS	*I can keep the same friends and enjoy hanging out with them.* *I can escape the bad feelings and memories I have about my past crimes.*	*I could probably hold down a job.* *I wouldn't lose my temper and hurt people.* *I could avoid being arrested.*
NEGATIVE CONSEQUENCES	*I keep getting fired.* *I will keep getting really angry. I recently punched my friend and broke his nose.* *I could get arrested a third time if I rob again to get money for cocaine.*	*I couldn't hang out with the same friends or at the same places because I'd want to use cocaine.* *I'd have to find some other way to cope with the bad feelings and memories about my past crimes.*

SHOULD I STAY THE SAME OR CHANGE MY BEHAVIOR? WORKSHEET

Descripton of the Behavior:

	Maintaining My Current Behavior	Changing My Current Behavior
BENEFITS		
NEGATIVE CONSEQUENCES		

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

ELEMENTS OF GOOD COMMUNICATION

- **Be polite and considerate:** Treat your partner with the same basic respect you show acquaintances!

- **Stop and think:** Before commenting on things that bother you: decide not to bring up issues unless they are really important.

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

- **Express positive emotions:** Make sure to convey lots of positive feelings and to reward your partner rather than taking things for granted when they are going well.

- **Decide on fun activities together.**

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

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

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

- **Try to be assertive - not aggressive:** Think about what you want before you speak. Start with a positive statement and then use "I" statements. For example, instead of, "You are 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

- **Not listening:** Not looking at your partner when he/she is speaking, or ignoring what he/she said.

- **Mindreading:** Assuming you know what the other person is thinking, and basing your response on that rather than checking out what they are really thinking or what they mean.

- **Cross-complaining:** Complaining in response to your partner's complaint. "I hate it when you do not come home when you say you will." "Well, I hate it when you complain all the time."

- **Drifting away from the point of the conversation:** Bringing up another issue before resolving the first one.

- **Interrupting:** Talking over your partner or not letting him or her finish a sentence.

- **"Yes butting":** Agreeing yet avoiding the issue. "Yes, but what about when you embarrassed me that day" or "yes, but you've embarrassed me lots of times…"

- **Heavy silence (standoff routine):** Trying to punish the other person by ignoring him/her.

- **Escalating arguments:** Becoming louder and louder and more and more vicious.

- **Never calling a time out or asking for feedback:** Forgetting to stop the conversation if it is getting too heated. Forgetting to ask your partner what he/she really meant.

- **Insulting each other (character assassination):** Name calling, such as, "you always…you never…you're a….")

- **Not validating:** Saying 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."

- **"Kitchen sinking":** Throwing in more and more accusations and topics until you do not know what it is you're arguing about.

- **Not taking responsibility:** Always talking about what your partner is doing wrong instead of what you may be doing wrong.

7. Orientation to 12-Step Programs

What's it for?

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

Why does it work?

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

When to use it:

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

How to use it:

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

Notes for the group leader:

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

ALCOHOLICS AND NARCOTICS ANONYMOUS (AA / NA)

AA and NA emphasize complete abstinence from substances of abuse through a combination of mutual support, spiritual practices, and a personal dedication to a structured program of recovery known as the Twelve Steps. Most individuals recovering from alcohol and drug addiction 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 Step One 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.

Over the decades, we have witnessed an explosive proliferation of twelve-step offshoots. Emotions Anonymous, Nicotine Anonymous, Cocaine Anonymous, Al-Anon and Alateen 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 are a few commonly encountered twelve-step terms and concepts:

- ***Dry Drunk*** – A state of mind characterized by abstinence without spiritual and emotional growth.
- ***Earth People*** – Those not involved in twelve-step recovery.
- ***Friend of Bill*** – Fellow twelve-step program member.
- ***HALT*** – Hungry, angry, lonely, and tired. A quick checklist of mood states that can act as triggers. It is often said in AA that "alcoholics can't afford to get angry."
- ***On the Tracks*** – Flirting with disaster by spending too much time around people, places and things.
- ***Pigeon*** – A newcomer who is working with a sponsor.
- ***People, Places, and Things*** – Stimuli associated with using drugs and alcohol.
- ***Serenity Prayer*** – "God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference." Recited at every meeting, this prayer is used frequently by members as a meditation.
- ***Slogans*** – Phrases commonly heard or prominently posted in AA/NA meetings.
- ***Bring the Body and the Mind Will Follow*** – Advice to the newcomer who may be 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, and 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 programs 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 twelve-step recovery; however, there are different roads to recovery, and recently participants with a mental illness have adopted this word to describe their journey. This trend has been accelerated by the involvement of those with co-occurring disorders participating 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 others or ourselves, 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.

What are some of the negative consequences that could occur if a person becomes angry and out of control?

After they fill out the worksheet that follows on things that anger them, share some techniques for "cooling down." How can they hit the "pause" button?

ANGER MANAGEMENT WORKSHEET

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

I am likely to get very angry when:

_____ I think that I am being treated unfairly

_____ People criticize me

_____ I remember times that others have mistreated me in the past

_____ I feel insulted

_____ People disobey or disagree with me

_____ I do not get credit for something I have done

_____ I feel embarrassed

_____ People lie to me

_____ People tell me what to do

_____ I feel that I have failed at something

_____ People are late or waste my time

_____ People ignore me

_____ I have to wait

_____ There is a lot of noise or confusion around me

_____ I see others being mistreated

_____ I feel helpless or out of control

_____ My chronic pain worsens

_____ I am reminded of the death of a loved one or close friend

_____ I feel angry that I was in prison and lost my freedom for a period of time

_____ I am reminded of a time that I have mistreated others in the past

_____ I feel at fault for a real incident involving harm to others

_____ People do not let me live down mistakes that I have made in the past

_____ Other: _____

_____ Other: _____

_____ Other: _____

_____ Other: _____

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!

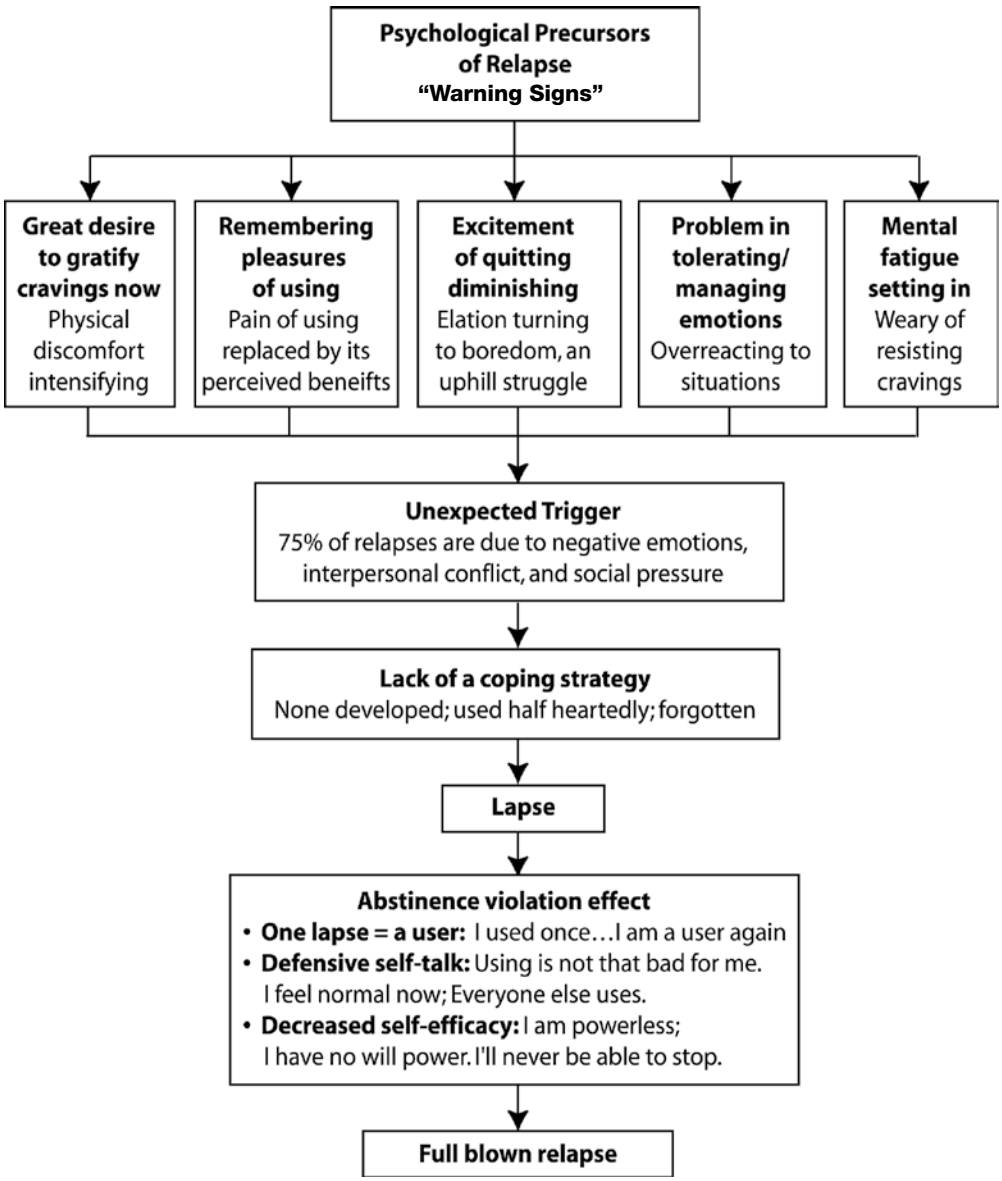
Notes for the Session Facilitator:

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 client to get started practicing some of the good coping strategies in the weeks to come.

WARNING SIGNS FOR RELAPSE

Preventing relapse is different from helping someone to stop using initially. The action stage of quitting involves helping an individual to formulate a positive action plan 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 psysiological withdrawal symptoms, depending on the substance of abuse. As physiological 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 and your overall health – eat well, sleep on a normal schedule if possible each night, and exercise regularly.
- Take a bath – warm water can be relaxing and calming.
- Set limits – say "no" when necessary.
- Speak kindly – to yourself and others.
- Avoid extremes – move towards the opposite if you find yourself overdoing anything.
- Seek healthy control – look for things you can change, and let go of things you can't.
- Stay in the moment – avoid anticipating disaster.
- Breathe – regularly, deeply. Focus on your breathing to shut out overwhelming thoughts and feelings.
- Remember your values – avoid actions that will bring regret later.
- Do not give up – keep trying, even when discouraged.
- Choose courage – be willing to make hard choices.

DUAL RECOVERY THERAPY CHANGE PLAN WORKSHEET *(SAMPLE)*

The changes I want to make are:

When I feel afraid of relapsing or something brings back strong memories of using, I don't want to give in. I want to have something else to do. I could call Jake or Carmen from my MISSION-CJ DRT groups, as they are further along in the program, or my NA sponsor. I could make plans to go to a Twelve-Step group that day. I could also read over my goals and what I want to achieve. It will also help if I exercise every day at the gym.

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

I want to share custody of my children.

I want to have a steady job and a stable home.

I want to respect myself.

I don't want to go to jail.

The steps I plan to take in changing are:

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

I will avoid my favorite drinking spot and try out new hobbies like church groups or book clubs at the library, where I can form sober relationships with others who share similar interests.

The ways other people can help me to change are:

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

I will know that my change plan is working if:

My children really enjoy hanging out with me again.

I can keep a job.

I begin to develop new friendships outside of my addiction.

I receive positive feedback from my probation officer.

Some things that could interfere with my change plan are:

I could get a call from some of my drinking buddies. I would have to tell them I don't drink any more. That will be hard. I will role-play that with Jed, my MISSION-CJ Peer Support Specialist, so I know what I want to say. I will also ask Jed how he handled similar situations.

DUAL RECOVERY THERAPY CHANGE PLAN WORKSHEET

The changes I want to make are:

_____

_____

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

_____

_____

_____

_____

_____

_____

The steps I plan to take in changing are:

_____

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The ways other people can help me to change are:

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I will know that my change plan is working if:

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Some things that could interfere with my change plan are:

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10. Relationship-Related Triggers

What's it for?

To help identify some of the things that other people do that can trigger your substance use 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 client time to finish the reading that comes just before the worksheet. Elicit some additional examples of "chain" reactions. Then ask the client to answer the first two questions. If in a group environment, encourage clients to share their answers.

RELATIONSHIP-RELATED TRIGGERS WORKSHEET *(SAMPLE)*

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

1. *My girlfriend Aliyah won't lend me money when I really need it.*

2. *My brother Malik keeps trying to get me to go back to school ever since I got released from prison.*

3. *My children keep asking me to buy them things that I can't afford.*

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

1. *I get furious when I can't get money. Also, I feel frustrated, helpless and alone.*

2. *I get stressed out when I think about school. Maybe it would help me get a better job, but I wasn't a good student before. I don't want to be humiliated. I feel jealous of Malik, I guess – things always seemed so much easier for him.*

3. *I feel guilty and ashamed that I can't buy my kids what they want. Sure, they have the necessities, but sometimes I feel like they just keep paying for my mistakes.*

What might you typically have done then?

1. *I usually yell at Aliyah and leave the house angry.*

2. *I told Malik to just shut up and leave me alone.*

3. *I eventually give in to the kids, then get even more stressed out about whether or not we'll have enough money to make it through the rest of the month.*

To Spouse, Family Member, or Friend:

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

1. *I shared this page with Aliyah and asked her why she doesn't want to lend me money when I need it. She told me she couldn't lend me money and have me drink it away. But she says after I've been sober at least 6 months, she could help me out a little if I need it sometimes, just as long as I get a job and pay it back.*

2. *I explained to Malik that I'm just not ready to think about school right now, and he agreed to stop asking me about it.*

3. *I spoke to my kids about our need to budget and encouraged them to get a paper route or mow lawns in the neighborhood. This can be a good opportunity to teach them about the value of a dollar.*

RELATIONSHIP-RELATED TRIGGERS WORKSHEET

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

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

Remember:

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

BUT:

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

Example: Partner-related Chain

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

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

RELATIONSHIP-RELATED TRIGGERS WORKSHEET

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

1_____

2_____

3_____

4_____

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

1_____

2_____

3_____

4_____

5_____

What might you typically have done then?

1_____

2_____

3_____

4_____

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 client time to write at least one example on the worksheet. Review these, and 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 should not do, and you feel guilty if you do not live up to your standard. You may also feel angry, resentful, and frustrated with others if they do not 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 or 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 individuals with substance abuse or past criminal activity may use:

- **ALL OR NOTHING THINKING:** "My partner is being good, or he's being bad."

- **OVERGENERALIZATION:** "If he has one urge to use, or has one bad day in which he uses, he's hopeless (or unmotivated)."

- **"SHOULD" STATEMENTS:** "I should be able to keep him from going back to prison."

- **PERSONALIZATION:** "His drug use problem is all my fault."

IDENTIFYING "STINKING THINKING" WORKSHEET *(SAMPLE)*

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

Black and White Thinking: Does everything seem absolutely true or false? Right or wrong? Great or awful?

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

Examples from my experience: *Last time I was in treatment, just before I went to jail for possession.*

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

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

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

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

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

Examples from my experience: *When I went through my divorce. After I got out of prison the first time and was ashamed to face my family.*

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

Example: *"I just know that things aren't going to work…I can feel it."*

Examples from my experience: *When I first started my new job and things seemed to be going so well.*

IDENTIFYING "STINKING THINKING" WORKSHEET

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

Examples from my experience:

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

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

Examples from my experience:

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

Example: *"I just know things aren't going to work out…I can feel it."*

Examples from my experience:

COMBATING "STINKING THINKING" WORKSHEET *(SAMPLE)*

Black and White Thinking

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

Healthier Response: *"Relapse is serious, but it doesn't mean I am a total failure."*

OR

"I have a choice about whether I use drugs today."

Projecting

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

Healthier Response: *"Why do I care so much what other people think of me? I am here to help myself, not to keep them happy."*

OR

"Everyone makes mistakes sometimes when they talk. People won't hate me for it."

OR

"I don't need to be so hard on myself. People probably aren't judging me that harshly."

I-can't-take-it!

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

Healthier Response: *"I can deal with this. I am stronger than I think I am."*

OR

"I may feel bad, but that doesn't mean I have to use. I have a choice."

OR

"Relapsing will feel worse than getting mad."

Emotional Reasoning

Example: *"I just know things aren't going to work out…I can feel it."*

Healthier Response: *"Just because things feel bad doesn't mean they are bad."*

OR

"I can control my behavior, but not the results."

OR

"I need to live in today. Most things I worry about will never happen."

COMBATING "STINKING THINKING" WORKSHEET

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

Black and White Thinking

My Example:

My Healthier Response:

Projecting

My Example:

My Healthier Response:

I-can't-take-it!

My Example:

My Healthier Response:

Emotional Reasoning

My Example:

My Healthier Response:

PRACTICING NEW WAYS OF THINKING WORKSHEET *(SAMPLE)*

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

PRACTICING NEW WAYS OF THINKING WORKSHEET

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Describe the situation or event that was upsetting.	What were you thinking at the time of the event?	What emotion(s) did you feel at the time?	How did you react to the situation?	What are some other ways of thinking about the event?	What emotion(s) might be associated with this new way of thinking?	How would this new way of thinking and feeling affect how you might react to a similar event in the future?

12. Changing Irrational Beliefs

What's it for?

To help notice and change things that we believe that get in the way of recovery.

Why does it work?

Human beings are pretty smart, but we're also smart enough to lie to ourselves and get away with it sometimes. We just have to catch ourselves at it and say, "no way!"

When to use it:

This is good to do whenever we just did something self-destructive or hurtful to someone else. That's usually when we tell ourselves something that isn't true to justify what we did, or to make sense of an action that really just wasn't a good or fair choice.

How to use it:

Read through the list of irrational beliefs and you'll get the idea. Think about which of them ring true and put them in your own words, or think of other things you tell yourself. Write them down, just the way you think them sometimes. Then write down a true statement, one that will be healthy and help you recover.

Notes for the Session Facilitator:

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

TEN POPULAR IRRATIONAL BELIEFS

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

Here are ten irrational beliefs:

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, and feels like 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 is easier to put off something difficult or unpleasant than it is to face up to it.

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

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

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

PERSONAL IRRATIONAL BELIEFS WORKSHEET *(SAMPLE)*

Irrational Belief	Possible Modification of Belief
I will never get out of the punishment/ criminal cycle given my background. I will always end up with the cop, the lawyer and/or the judge looking to lock me up and not help me.	*It is hard to convince the authorities that a guy with my kind of rap sheet can turn his life around. I have taken some steps in the right direction though. My probation officer has noticed how hard I am working on my recovery and is pretty helpful now. Maybe the cops in my neighborhood will notice as well and ease up on me.*

PERSONAL IRRATIONAL BELIEFS WORKSHEET

Irrational Belief	Possible Modification of Belief

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

SCHEDULING ACTIVITIES IN EARLY RECOVERY WORKSHEET *(SAMPLE)*

Many people in early recovery find they need help structuring their time. In the past, life may have been organized around drugs, alcohol, and criminal activity. Staying sober and law abiding involves developing a new lifestyle structured around more healthy activities. This worksheet is designed to help you begin to think about ways to organize your day.

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

Drink more water and cut out the soda. Run or work out.

What recovery-related activities can I do every day?

Write in my journal.

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

What are some activities that I can do by myself?

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

What are some activities I can do with others?

I can play basketball sometimes.

What are some activities that I will enjoy?

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

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

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

SCHEDULING ACTIVITIES IN EARLY RECOVERY WORKSHEET

Many people in early recovery find they need help structuring their time. In the past, life may have been organized around drugs, alcohol, and criminal activity. Staying sober and law abiding involves developing a new lifestyle structured around more healthy activities. This worksheet is designed to help you begin to think about ways to organize your day.

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

What recovery-related activities can I do every day?

What are some activities that I can do by myself?

What are some activities I can do with others?

What are some activities that I will enjoy?

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

APPENDIX G: Helpful Therapeutic Techniques Underlying MISSION-CJ Components

MISSION-CJ Case Managers (CMs) will need to employ several core therapeutic techniques to appropriately facilitate sessions. MISSION-CJ Peer Support Specialists (PSSs) should be familiar with these techniques as well. Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, and Behavioral Role Play 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
- Relapse Prevention
- 12-step Facilitation

Core mental health therapy approaches included in DRT are:

- Cognitive Behavioral Therapy
- Skills Training

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

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

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

Motivation

Motivating clients over the duration of DRT involves the following considerations:

- Motivation changes over time.
- Motivation is affected by therapist behavior.
- Motivation is not “all or nothing.” Clients may have different levels of motivation to address mental health and substance use issues.
- Motivation is influenced by the treatment setting.
- Treatment strategies should be based on the client’s stage of readiness to change.

Given this, modifications to MET could increase its efficacy for clients who have been diagnosed with co-occurring disorders. The client, faced with the complex challenges of dual recovery, may

- Have more problems to address.
- Have a longer engagement period.
- Experience lower self-efficacy/confidence.
- Need modified feedback and Change Plans.
- Be limited by cognitive abilities.
- Experience higher therapist activity.
- Need brief, simple, and repetitive statements.
- Need integrated mental health and substance use treatments.
- Be aided by assessing motivation to change for each issue on the problem list.
- Engage the patient in selecting and sequencing Change Plan interventions.
- Maintain MET spirit when making transition to other modes of treatment.

Dimensions of Assessment

- Substance use
- Mental health symptoms
- Symptom interaction
- Personality factors, especially antisocial personality traits
- Motivation
- Spirituality

Assessment Strategies

- Time-line (prior history of both)
- Onset
- Periods of stability/sobriety
- Periods of exacerbations
- Impact on life-self, others, legal, employment
- Prior treatment (each, integrated care)
- Information from significant others
- Family history
- Symptom scales and diagnostic tools
- Stages of Change Assessment
  - ***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 of Treatment Plan in MISSION-CJ and Other Providers

- ***Address type of treatment provided*** (e.g., individual therapy, group therapy, medication management)
- ***Address amount of treatment provided*** - how often will treatment be provided? How long will treatment last? How long does each treatment session last? In what Program?
- ***Describe the focus of treatment.*** What will the treatment address? Treatment cannot and should not attempt to address all problems simultaneously.
- ***Define goals and objectives of treatment.*** It is important here to distinguish between goals and objectives. Goals are desired ends…what is it important for the client to achieve? Objectives are means towards these ends, the strategies by which goals will be achieved.

Dual Recovery Therapy Sessions

- 13 structured sessions
- Front loaded in treatment for early skills development
- Provided as adjunct to residential program
- Booster sessions delivered as needed by case managers in the community
- Peers reinforce skills of sobriety, use of 12-step therapy and offer hope

The Dual Recovery Status Exam - Framework for Each Session

- Set agenda for session (client and counselor).
- Check-in with regard to any substances used since last session.
- Assess substance use motivational level.
- Track symptoms of depression or anxiety etc.
- Explore compliance with medications prescribed.
- Ask about attendance at Twelve Step groups, other treatment plan elements.
- Discuss the primary agenda topic (s) for the session.

Cognitive Schemes

- ***Catastrophization -*** turning relatively minor disappointments into major catastrophes.
- ***All-or-none thinking -*** viewing the world in absolute, mutually exclusive terms.
- ***Personalization -*** relating external events to oneself based on little or no evidence.

- ***Arbitrary inference -*** drawing inappropriate conclusions based upon faulty, insufficient, or contradictory information.
- ***Disqualifying the positive -*** rejecting positive experiences by interpreting them as trivial or undeserved.
- ***Emotional reasoning -*** assuming that negative emotions invariably reflect the true state of the world.
- ***Antisocial cognitions -*** attitudes that indicate lack of remorse related to rule violations, rights of others.

Relapse Prevention

- Identifying cues / triggers for substance use
- ID early warning signs of mental illness recurrence
- Goal to improve self-efficacy to handle specific people, places, things, moods
- *Examples:*
  - o Drug refusal skills
  - o Seemingly irrelevant decisions
  - o Managing moods / thoughts
  - o Stimulus control

Behavioral Role Plays

- *Stages of a Role Play*
  - o Discuss rationale and gain client commitment.
  - o Learn about others significant to the client.
  - o Discuss the goals, skills to be learned, and criteria for success.
  - o Do the role-play.
  - o Elicit and give feedback.

Role Plays Continued: The Clinician's Role

- Actively help the patient to set specific interpersonal goals.
- Promote favorable expectations and motivation before role-playing begins.
- Assist the patient in building possible scenes in terms of emotion and setting.
- Structure the role-play by setting the scene and assigning roles.
- Use the role-play to model alternative behaviors.
- Prompt and cue the patient during the role-play.
- Use an active style of training through coaching and support.
- Give positive feedback for specific verbal and nonverbal behavioral skills.
- Identify specific verbal and nonverbal behavioral deficits or excesses and suggest constructive alternatives.
- Shape behavioral improvements in small, attainable steps.
- Elicit or suggest alternative behaviors.
- Give specific and attainable "homework" assignments.

Modifying 12-Step for Co-occurring Disorders

- Recovery concepts supports increased sense of hope and connection to others
- Shared experience (experience, strength, and hope)
- Recovery is not cure, but rather a way of living a meaningful life
- Recovery is a process of restoring self-esteem and a personal commitment to growth, discovery, and transformation

The Role of Medications

- Medications are not a panacea. Substance abusing clients are accustomed to addressing complex problems with simple answers and to viewing pills as the ideal solution to a variety of problems.
- Medications can take time. Clients often have little ability or willingness to delay gratification and tend to "want what they want when they want it." Without considerable support and education, they are prone to lose patience.

- Illegal substances can make a medication ineffective. Clients often want the best of both worlds – the emotional stability or relief from anxiety or depression provided by a medication and the euphoria obtained through illicit drugs. It is important to realize that the therapeutic effects of a medication can be easily overwhelmed by simultaneously misusing other substances.
- Some types of dependence are healthy. For clients committed to abstinence, the idea of relying upon any substance may seem distasteful or even frightening. They may view all medications as "mind-altering" or "addictive" and need to be educated about the important differences about therapeutic medications and drugs of abuse.

General Treatment Issues

- Empathy and the therapeutic alliance
- Brief Interventions: Feedback, Advice, Choices, Optimism, Responsibility, and Follow-up
- Manage resistance
- Monitoring for relapse / relapse prevention
- Involve families/significant others
- Recovery Tools: treatment plan & contract, self-help groups, medications, & therapy

Personality Dimensions and Challenges

- Understanding that negative attitudes ("I don't care", lack of empathy toward others) may be part of the client's challenges that need work
- Impulsivity and irritability can also be a factor in recidivism and should be addressed
- Positive role modeling is critical to enhance prosocial activities and behaviors

APPENDIX H: Supplemental Materials for Case Managers

Developing Relationships with a Broad Network of Community Agencies

"Systems brokering" - building relationships with community agencies that provide the services clients need to adjust to community life - is the responsibility of the entire MISSION-CJ team, but MISSION-CJ Case Managers (CMs) are seen as being in a unique position to foster these relationships. Clients benefit from the connections that are established with community agencies already maintained by staff at the inpatient, residential, or outpatient treatment programs. For example, MISSION-CJ staff strive to refer each client to 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." In another example, clients may need additional coordination with criminal justice entities (e.g., attendance at probation appointments or court hearings, or communication with attorneys, re-entry coordinators in local jails, etc.). As such, networking skills are essential ingredients in successful implementation of the MISSION-CJ program.

Second, MISSION-CJ 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-CJ CMs joined the MISSION-CJ team with experience in vocational rehabilitation and connections that helped facilitate employment; she also had years of experience in vocational counseling. We encourage a team approach, in which MISSION-CJ 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-CJ CMs often build relationships "from scratch" through Internet searches or referrals from others in the field who know of useful resources. MISSION-CJ CMs divide the responsibility to research programs that address certain needs. Such teamwork has helped them identify resources that can help clients prepare resumes and acquire tools needed for work; nonprofit agencies that give furniture to clients free of

charge; contacts for employment and housing; a public program that provides half-price public transportation for persons with disabilities; and agencies that provide quality clothing free or inexpensively. MISSION-CJ CMs documents this shared knowledge and explain the process for applying for services or goods to clients.

Training Needs

Training is seen as essential for personal growth and development, and all staff are required to participate in MISSION-CJ training activities. MISSION-CJ CMs receive ongoing internal training through group sessions and individual sessions led by their clinical supervisor. In addition, they receive:

- Internal training, to help them implement the program in accordance with the organization's expectations.
- Supplementary training from outside sources, to help them build clinical skills and acquire the knowledge they need to help enrolled clients navigate health care systems and access community services. They may also receive training on pertinent techniques and subjects, such as Motivational Interviewing and employment issues for persons who have a criminal or legal history.

Internal Training

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

- Confidentiality policies
- Research integrity when applicable
- Documentation policies
- Crisis management
- Working with criminal justice entities
- Recidivism reduction strategies and goals
- Expectations of the position

Supplementary Training

In addition, it is recommended that MISSION-CJ CMs receive and retain certification from the Red Cross on cardiopulmonary resuscitation. Consistent with their own credentials and professional affiliations, MISSION-CJ CMs are encouraged to attend continuing education training events both within and outside of their employer. MISSION-CJ 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-5 Mental Disorders
- Trauma, PTSD and Related Issues
- Special Focus on Returning Veterans
- Unique Needs of Female Offenders
- Understanding Risk/Needs/Responsivity Approaches
- Cognitive Behavioral Approaches to Reducing Recidivism
- 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-CJ CMs may encounter in their work with clients. Each example presents a problem and is followed by strategies MISSION-CJ CMs might employ

to assist clients during different phases of the CTI model highlighted in Chapter 6: Case Management.

CTI Phase 1: *Transition to community*

Due to the flexibility of the MISSION-CJ program, clients may begin receiving services while in an institutional setting, such as a jail while awaiting trial or after serving a sentence, or a residential treatment facility, or after their transition into the community while trying to acquire stable housing. During the first phase of CTI, MISSION-CJ CMs follow clients in each of these settings closely. For example, MISSION-CJ CMs function as a secondary provider, collaborating with other staff by attending weekly meetings to discuss treatment progress. In doing so, the MISSION-CJ CM supports the client, by providing specialized co-occurring disorder treatment; assistance with regard to discharge planning; and identification of resources needed to facilitate a successful community transition. As clients prepare for engagement outside of these settings, they will need a lot of support from their MISSION-CJ CMs to ensure that their treatment plan links them to the community resources necessary for a successful recovery and that this plan is implemented once the client transitions into the community. Similarly, if MISSION-CJ services begin in the community, the MISSION-CJ CM may be either the primary or secondary provider of care, depending on whether the client is enrolled in a structured outpatient treatment program, such as an Intensive Outpatient Program (IOP). Ultimately, the common goal of the first phase of CTI is to identify and begin to implement additional and critical community resources that will help promote the successful recovery of each MISSION-CJ client in a supportive environment.

Example 1. A Veteran, who is about to transition to the community, voices concerns with her MISSION-CJ case manager 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 case manager contacts a vocational rehabilitation agency that is able to arrange transportation on a short-term basis. She also researches train schedules and finds an alternate way for the Veteran to get to work when needed, easing the Veteran's anxiety.

Example 2. As a client is developing a re-entry plan after serving an 18-month sentence at a local jail, he is not certain how he will receive a supply of anti-depressant medications after the two week supply provided by the jail finishes. The MISSION-CJ case manager realizes that the client will be in danger of starting to drink and use drugs again if there is a disruption in his treatment. The case manager works with the jail re-entry services coordinator to ensure that the client's Medicaid number is re-activated prior to release. Upon release they are able to go to a local mental health center for a first appointment, and prescriptions are able to be continued through the psychiatrist there. In this way, the CM assists the client in ensuring that medications will be able to continue seamlessly.

CTI Phase 2: Try Out Phase

As the client's recovery and work with MISSION-CJ becomes more securely grounded, MISSION-CJ CMs gradually decrease the frequency of their visits with the client. The client's goals often change, and new kinds of obstacles present themselves. Clients may find they have taken on more than they can handle in their financial obligations, especially rent. They may feel overwhelmed by responsibility or have difficulty managing relationships. Spouses and friends may seem nagging and unsupportive. They may re-encounter antisocial peers that put them at risk for recidivism.

The MISSION-CJ CM plays a steadying role in fostering independence, while helping clients see the way forward. For example, the MISSION-CJ CM may suggest that the client and his/her significant other enroll in couples counseling, help with money management, or suggest a way for the client to gain the skills that would qualify him or her for a higher-paying job. In addition, the CM plays a role in providing education and reminders about the importance of

socialization with positive social influences and staying focused on recidivism reduction goals. The CM might, for example, suggest alternative social activities that may help the client participate more with a pro-social group. The continuity of the relationship with the MISSION-CJ CM encourages the client and increases the likelihood that he/she will stay on course long enough to stabilize.

Example 3. During an early session with his case manager, a 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 case manager 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 client who has not seen his children or spoken to his former spouse since he was arrested wants to see the children again. The case manager helps this client work with the court to determine if visitation is possible. Working with probation, he learns that there was a no-contact order, but that this order was removed a few months prior. The CM works with the client to identify how to best approach visitation without re-exposing the client or the family to triggers. A local state agency office is willing to help to broker visitation. The CM works with the client to prepare him to stay calm, focus on the goal, and avoid antagonizing his ex-wife. The case manager reinforces the anger management skills this client learned in the DRT group sessions and in anger management groups that were mandated by the court. The visitation occurs under careful conditions, and the client is able to handle his frustration, keep focused on his goal, and enjoy a first successful meeting. He is now setting a new goal of having a second meeting with the idea that getting to know his children again might become a helpful and stabilizing motivating factor in his recovery and positive community tenure.

CTI Phase 3: *Transfer of Care to Community Supports*

In this phase, MISSION-CJ case management support continues to decrease in intensity and gradually "tapers off" as the client's supports within the community stabilize. Meetings stretch from weekly to every other week, for example. Towards the end of a client's participation in MISSION-CJ, meetings may be as infrequent as once a month. MISSION-CJ CMs should vary the frequency of their meetings according to the client's needs: some are reluctant to let go of the friendly hand, while some are self-determined and independent. For some, it may make sense to replace in-person contact with telephone contact on occasion. The goal is to have less frequent sessions with the client and to foster independence and reliance on available community supports that have been reviewed with the individual by their MISSION-CJ CM. This will also assist with his/her termination from MISSION-CJ, the process of which begins slowly as sessions become less frequent. In some cases there may be a relapse of symptoms, and the transition planning should expect this to occur and ensure appropriate alternative supports are put in place to help foster the client's stability during this transition.

The MISSION-CJ CM should first and foremost, make sure that he or she has the correct telephone numbers and addresses to contact the client (both at present and in the community) including numbers for family members or others likely to know where the client is if he or she moves. In their meetings with clients, the MISSION-CJ CM should also devote time towards the MISSION-CJ Participant Workbook readings that focus on transitioning to the community. Sessions that address the client's transition to routine support services in the community will allow MISSION-CJ CMs to contribute valuable input to their client's ongoing stability. For high-risk cases, the MISSION-CJ CM may meet with the primary care provider to ensure they are "on the same page" about how best to manage the client's critical transition away from MISSION-CJ supports and back to the community providers

themselves to ensure that needed supports are in place. In rare cases, the MISSION-CJ CM may need to provide additional support in locating housing, a job, or other resources needed for the client's transition at this stage; in this circumstance, assistance would be coordinated with the primary care provider.

Effective aftercare to ensure that functional community supports are in place is central to the MISSION-CJ program. The support provided by the MISSION-CJ CM changes to match the individual's status, usually evolving as the period of community living continues.

The MISSION-CJ CM may present a list of local resources and referrals for reference at the closing meeting, if the client has not received those before. Often, MISSION-CJ CMs send a positive, personalized closing note that thanks each client and expresses good wishes. In some programs that might have attached MISSION-CJ services, there are official "graduation" ceremonies (e.g., specialty court programs.) Depending on the institutional policy, one might even encourage these former clients to call and "check in" after three months. This offer has helped some individuals who have participated in MISSION-CJ, as it conveys the MISSION-CJ 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.

Attending to Relapses: In some cases, a client receiving MISSION-CJ 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-CJ program, it can be a reason for immediate discharge from some residential facilities and a reason for criminal justice sanctions. Thus, if this occurs, the MISSION-CJ CM begins immediately to provide supportive assistance, regardless of the setting the client may be in (e.g. the client may be held in jail awaiting a determination of a sanction). While this is obviously not an ideal situation, individuals can have setbacks and often can recover and have subsequent successes, such that hopefulness and re-focusing on treatment goals becomes an important aspect of the MISSION-CJ CM's role.

EXAMPLE OF COMPLETED MISSION-CJ TREATMENT PLAN

This completed example of a MISSION-CJ treatment plan is provided as a guide for MISSION-CJ CMs; however, each MISSION-CJ client will have unique considerations that will need to be accounted for by MISSION-CJ CMs.

Considerations for MISSION-CJ Treatment Planning

Primary Diagnosis

Major Depressive Disorder, severe, without psychotic symptoms

Secondary Diagnosis

Cocaine Dependence, Early Full Remission

Other Treatment Providers

Dr. Smith, Primary Care Provider

Dr. Jones, Psychiatrist

Service Needs

- MISSION-CJ
- Residential substance use treatment: currently participating
- Acute psychiatric care
- Other Needed Services
- Needs: currently receiving residential care; transition to community
- Outpatient mental health/substance use treatment: referral needed once discharged from residential substance use treatment
- Medical Care: diabetes management
- Medication Management: psychiatric/diabetes medication management
- Dental Services
- Benefit entitlements
- Vocational Support: increase job-related experience; link to services.
- Cognitive Behavioral treatments to address impulsivity and criminal thinking patterns
- Other

Considerations for MISSION-CJ Treatment Planning (cont'd)

MISSION-CJ Service Delivery

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

Treatment Goal & Objectives: Client is currently receiving care in a residential substance use treatment program. Client has identified the following treatment goals/objectives below:

Treatment Goal #1: maintain abstinence from drugs

Treatment Goal #2: gain job-related experience

Treatment Goal #3: transition to independent housing

Treatment Goal #4: Participate in community service activities

Next appt: Mon Tue Wed Thu Fri Sat Sun **Time: _11_:_00_ am/pm**

Provider:

Location:

EXAMPLE OF MISSION-CJ CASE MANAGER NOTE

The sample MISSION-CJ CM note provided below is based off of the sample MISSION-CJ treatment plan provided above to provide a fluid example of documentation during different stages of the MISSION-CJ program.

SAMPLE CASE MANAGER NOTE FROM MISSION ORIENTATION SESSION

Date: 5/1/2010

Individual Session: Orientation to the MISSION-CJ Program

The client attended an orientation session with this MISSION-CJ Case Manager to learn the goals, structure, and schedule of the MISSION-CJ program. The client was given the opportunity to ask questions about the program and these questions were answered to his satisfaction. The client's goals during his treatment in the 14-week MISSION-CJ program and following completion of the program were discussed. The client stated that his primary goals were to maintain his abstinence from drugs, gain job-related experience, and to transition to independent housing during his participation in the MISSION-CJ program. The client also recognized that excessive leisure time has contributed to criminal activities and agreed that community service projects may help focus on non-criminal thinking.

After completing the program, he hopes to get a part-time job while completing his GED. The client also agreed to continue his attendance at NA meetings, to continue his adherence to his psychiatric medication regimen, and to continue outpatient psychotherapy. His strengths are his stable work history and his commitment to his faith and sobriety. His barriers to success include his tendency to relapse during times of emotional stress and a lack of social support as well as certain peers that provide negative influences.

The client reported feeling hopeful about his future and less depressed than when he was initially admitted to the MISSION-CJ program. Despite this improvement, his affect continues to be somewhat sad and constricted. The client denied any suicidal/homicidal ideation*, as well as, any intent or plans to hurt himself or others. The client denied any current alcohol or drug use. His thought process was goal-directed and linear.

This MISSION-CJ case manager will contact the client's primary care provider and probation officer, the purpose of which is to communicate information gathered during the MISSION-CJ orientation session to aid in the development of his treatment plan. All releases of information for these communications were signed by the client.

**In the event that a client indicates that he/she is suicidal with a clear plan or definite intent, the client should be escorted to his/her current therapist, if possible. If his/her therapist is unavailable, the client should be escorted to the walk-in mental health clinic to be seen by the next available clinician. In these instances, whenever possible, the clients should not be left alone. Case managers should stay with clients until they are able to see a mental health clinician for evaluation. Case managers should also remind clients of emergency contact options such as, current therapists (during business hours)/walk-in mental health clinic, 911, and the 24-hour National Suicide Hotline, 1-800-273-8255 (TALK), Good Samaritans emergency hotlines and the like.*
In the event that a client indicates clear intent and a definite plan to harm a specific person, 911, police and/or the targeted person (local practices related to this may vary) may also need to be notified to ensure the safety of all involved. MISSION-CJ CMs should immediately alert supervisors of these emergency situations to identify how best to handle them. When in doubt, in an emergency where safety is concerned, 911 or police should be contacted.

EXAMPLE OF A TEMPLATE NOTE FOR DRT SESSION

TEMPLATE FOR NOTES ON INDIVIDUAL PARTICIPATION IN DRT

Group: Dual Recovery Therapy for MISSION-CJ Program

Date: 7/12/2013

Agenda: Relapse Prevention

GROUP BEHAVIOR RATING:	**LOW**	**MEDIUM**	**HIGH**
SEEMED INTERESTED IN THE GROUP	()	()	()
INITIATED POSITIVE INTERACTIONS	()	()	()
SHARED EMOTIONS	()	()	()
HELPFUL TO OTHERS	()	()	()
FOCUSED ON GROUP TASKS	()	()	()
DISCLOSED INFORMATION ABOUT SELF	()	()	()
UNDERSTOOD GROUP TOPICS	()	()	()
PARTICIPATED IN GROUP EXERCISES	()	()	()
SHOWED LISTENING SKILLS/EMPATHY	()	()	()
OFFERED OPINIONS/SUGGESTIONS/FEEDBACK	()	()	()
SEEMED TO BENEFIT FROM THE SESSION	()	()	()
TREATMENT CONSIDERATIONS ADDRESSED	()	()	()

COMMENTS: The client participated in the Dual Recovery Therapy group that is a component of the MISSION-CJ Program. Group members discussed methods of relapse prevention.

APPENDIX I: Topics for Peer-Led Sessions

The following sessions were designed based upon collaboration between previous MISSION-CJ Peer Support Specialists [PSS] and clients. The goal of these sessions is to focus on a different topic each week but impose a minimum amount of structure in order to promote free discussion and provide an alternative to the many structured activities in which these clients engage during time spent in their treatment programs.

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

Some of the descriptions below also include a short passage written by a client who has previously participated in that particular session. If desired, the PSS facilitating the session can read these passages as a way to spark discussion, asking the individual if they've had similar feelings or experiences.

1. Willingness

Description: A discussion of how willingness can be the key to recovery and maintaining a healthy lifestyle. The desired outcome is for clients to pursue a course of action leading to recovery through their own choice.

Learning goals: Clients will

(1) become informed that willingness is an important part of recovery;

(2) comprehend that willingness is necessary for change; and

(3) understand that willingness is the basis of maintaining a quality way of life.

How to introduce the topic: Make sure clients understand that the assistance people are offering them will be helpful only if they are willing to accept it. With willingness, the journey to a new life can begin, and change will come.

Questions to spark discussion:

- What are some things that you have been willing to change in your life? Unwilling to change?
- Would you agree that willingness is an important part of the recovery process?
- Have you acted on your willingness?
- What are some results from taking a course of action based on your will?

2. Self-Acceptance and Respect

Description: A discussion on how self-acceptance and respect are important in recovery from addiction and promotion of mental health.

Learning goals: Clients will

(1) understand that denial of one's illnesses and lack of respect for oneself inhibits recovery;

(2) become informed that self-acceptance of their addiction and mental health issues is needed in order to grow and maintain their recovery;

(3) grasp the idea that through self-respect they will become more comfortable with themselves and others;

(4) perceive that acceptance and respect of self can help them overcome stigma and prejudice in society; and

(5) understand that self-acceptance and respect can turn around someone's perception of them.

How to introduce the topic: Make sure that clients understand that denial and being down on oneself is common, but by gaining self-acceptance and respect, they begin their healing process.

Question to spark discussion:

- Are you having difficulty accepting the fact that you are living with addiction and mental health issues?
- Where are you on a scale of 1 to 10, 1 being the lowest and 10 being the highest, with self-acceptance and respect for yourself?
- Can you explain something that you have already accepted about yourself?

- Could you explain how you have increased your respect for yourself?

Here's what a client who previously participated in this session wrote:

It's taken me most of my life to admit the truth about myself, to be honest, and accept me as me. The moment I did that, it seemed like a switch went off in my head. It was like I could see things I could not see before my thinking changed. I was able to handle things better and make better decisions. Once I was able to be honest with myself and see myself for who and what I was, I could adjust and make changes to improve myself, my attitude, and my outlook on my life.

Self-respect is my ability to accept myself and to project a positive image, to hold my head up with pride and dignity, to treat myself as well as others as human beings. When things aren't going right I need to keep myself together, hold onto my composure, and remain humble. I've learned that I must respect myself, I must respect others, and I must respect my disease. If I don't I'm doomed to fail. I must have respect for myself or no one else will.

3. Gratitude

Description: In order to maintain motivation in recovery, clients should learn to recognize and be mindful of what they have to be thankful for.

Learning goals: Clients will

(1) grasp the meaning of gratitude;

(2) learn to identify how they react with others when they are not grateful;

(3) understand how their interactions when ungrateful affect them; and

(4) learn strategies for being more grateful in chaotic and stressful situations.

How to introduce the topic: Make sure that clients know that acknowledging others (or a higher power) is normal, and the goal is not to be overwhelmed but to help them become more comfortable with gratitude.

Questions to spark discussion:

- Have you experienced gratitude in situations pertaining to your recovery?
- Has being grateful brought about change for you?
- What can you say about your gratitude for recovery?

4. Humility

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

Learning goals: Clients will

(1) come to recognize situations in which humility can be helpful;

(2) learn to identify how they react with others when they are not humble;

(3) understand how their interactions when not humble affect them; and

(4) learn strategies for being humble in chaotic or stressful situations.

How to introduce the topic: Make sure the client understands that being humble is a positive thing. Do not portray being humble as being passive.

Questions to spark discussion:

- Who do you know who is humble, and how has it helped them?
- Can you think of a way to relate humility to personal growth?
- Has humility been a factor in your change?

5. Dealing with Frustration

Description: A discussion of methods of processing frustration and developing coping skills.

Learning goals: Clients will

(1) come to 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 clients are aware that frustration happens, it is normal, and the goal is to help people become more aware of their issues with frustration and improve their resolve when dealing with frustration.

Questions to spark discussion:

- Can you share a situation that was frustrating to you?
- How did you resolve it?
- How did you feel after resolving the situation?
- Have you dealt with frustration with emotion or with intellect?
- What was the result from dealing with the situation with emotional behavior?
- What resulted from use of a rational approach to the situation?
- Which resulted in a better outcome in dealing with frustration, the emotional or the rational approach?

6. Handling Painful Situations

Description: A discussion of how to handle circumstances, conditions, and surroundings that cause extreme uneasiness or pain.

Learning goals: Clients will

(1) identify types of situations that are particularly painful for them;

(2) learn to identify how they react when they are not aware of how they handle painful situations;

(3) understand how their interactions when handling painful situations affect them; and

(4) learn strategies for not becoming stressed while handling painful situations.

How to introduce the topic: Make sure that clients know that experiencing great discomfort, uneasiness, or anxiety in certain situations is normal, and the goal is not to surrender to the situation but to develop a way to acknowledge, cope, and deal with the issue or issues causing the situation.

Questions to spark discussion:

- How did you handle a circumstance that was painful?
- Would you say that processing 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: Clients will

(1) come to realize situations in which they need to be honest;

(2) learn to identify how they react when they are not honest;

(3) understand how their interactions when honest or dishonest affect them; and

(4) learn strategies for maintaining honesty in chaotic or stressful situations.

How to introduce the topic: Make sure that clients know that honesty is something that is not always rewarded or recognized, but it is placed in high value. Clients should not retreat from situations where honesty is needed.

Questions to spark discussion:

- When feeling cornered or trapped in a situation where honesty is needed, how do you handle it?
- When you use honesty in a trying circumstance, how do you feel?
- When you can be honest with yourself do you feel that you can be honest with others?
- Would you agree that being honest helps you grow in recovery?

Here's what one participant wrote:

Being honest with myself allows me to see me for who I really am, and sometimes it hurts. Also, hearing what

other people think or feel when I ask a question is not easy, but it is not as hard as using drugs every day, lying just to kill the pain, and seeing how I have screwed up my life, with so many years wasted. If I feel bad, I want to say I feel bad, and when I say no, I don't mean yes: I mean no.

Since my last relapse … I'm choosing to be honest about myself. I don't ever want to live that kind of life again, so I must remain true "to thine own self." I know there is going to be a whole lot of life's honesty coming at me, and this time I'm ready.

8. Courage

Description: An exploration of various types of courage—for example, courage needed to deal with life on its terms, cope with mental health and addiction issues, adjust to changes in life, and let go of the past.

Learning goals: Clients 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 clients know that the lack of courage may be normal in some situations. The goal is not to undermine people but to help them understand the need for courage.

Questions to spark discussion:

- Can you share a time when you needed to call on your courage?
- Would you agree that it takes courage to stand up for yourself?
- How is courage needed in your recovery process?

Here's what one participant wrote:

I *spent the latter part of high school just making it by a thread. Courage and eagerness to be the best got lost in transition, and not making the grade seemed to be a tool of defiance. Once I gave up my will to give the best attempt at success, then failure turned into the acceptable thing to do.*

After not fulfilling what should have been, it seemed the only thing to do was give up! The importance of being number one just wasn't there anymore, and like anything you practice well, I got good at being bad.

Courage now is thoroughly needed in my life, in order to change my way of being, in hopes of finding the spirituality so needed, and to have the self-confidence to turn around and make what's left of my life meaningful.

9. Patience

Description: A discussion of how patience can improve relationships and an exploration of ways to build patience.

Learning goals: Clients will

(1) come to 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 clients know that impatience is normal, but the goal here is to help them become more patient. Consider starting with an anecdote to which clients can relate - perhaps the desire for recovery to happen more quickly than it does.

Questions to spark discussion:

- How often do you wish your recovery was going faster?
- When has wanting something too fast interfered with getting it at all?
- What do other people say about you when you're impatient?
- Have you ever lost a job or ended a relationship because of impatience?
- What do you do to calm yourself when you're impatient?

Here's what one participant wrote:

Currently I try to practice patience because I find myself wanting to do too much in the course of the day. I do realize that if I did attempt to do everything in one day that I would be doing nothing more than bringing unnecessary stress upon myself and probably would make more mistakes than accomplishments due to this added stress. This exact behavior played a role in my relapse. So I am grateful to have learned something from that. In practicing patience I put forth effort, but I don't rush the results. I just gradually watch them fall into place at God's timing.

10. Medicine Maintenance

Description: Reinforcement of the urgent importance of maintaining a medicine schedule and discussion of how medicine relates to the recovery process.

Learning goals: Clients will

(1) come to realize that because of their diagnosis they need to maintain the medicine schedule prescribed for them;

(2) learn to identify how they react with others when they are not in compliance with their medicine regimen; and

(3) learn strategies for keeping up with their schedule on a day-to-day basis and managing chaotic or stressful situations.

How to introduce the topic: Make sure clients know that medicine maintenance is part of life for people living with co-occurring mental illness and substance use disorders, and the goal is not to cause alarm but to become more knowledgeable of the importance of using helpful medications as prescribed.

Questions to spark discussion:

- Would you say that you have difficulty keeping up with your medication maintenance sometimes?
- Is the reason why that you may not want to?
- How about the side effects? Do they turn you away from taking your dosage?
- Do you understand the importance of your medication and taking it regularly?
- What strategies do you use for remembering to take your medication or anything else you need to do regularly?

11. Making a Good Thing Last

Description: Discussion of how to develop a lifestyle that supports mental health and recovery from addiction, as well as the benefits of living clean. Clients should understand the importance of using the skills they have learned in the residential facility in order to keep what is good in their lives.

Learning goals: Clients will

(1) come to realize situations in which they will have better experiences because of maintaining their recovery;

(2) I earn to identify how they react with others when they stay the course of a good decision;

(3) understand how their interactions when they make the right decisions affect them; and

(4) reflect on how good things are evolved from living life on its terms even through chaotic and stressful times.

How to introduce the topic: Make sure clients know that wanting a good thing to last is normal, but making a good thing last requires work.

Questions to spark discussion:

- What good things in your life are you working to keep?
- Did anything good ever come easy for you?
- Would you say that keeping this good thing was difficult?
- Are there times when you have had to contribute more of yourself in order 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 J: Supplemental Materials for Initiating Peer Support

As stated in Chapter 3 of this manual, Replicating the *MISSION-CJ Program*: *Guidance for Program Managers and Administrators,* MISSION-CJ reflects an approach to providing services that has been developed over time, with many lessons learned. We hope this appendix serves as a valuable resource regarding 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 for initiating peer support in one's MISSION-CJ service delivery system.

At the outset, MISSION-CJ's program design, which began with the initiation of MISSION-Direct Vet (SAMHSA grant # SM-58804), a court-based Veterans program offered as an alternative to incarceration for court-involved Veterans, PSSs were recruited from a pool of individuals who had experience as Veterans and with VA services, rather than consumers who were already trained and experienced consumer-providers. While the value of this additional layer of shared experience appears to have obvious benefit it also may require the need for extensive on-the-job peer support training. It also means that until training was completed, some PSS activities were significantly curtailed.

The system in which the 12-month MISSION-CJ study was implemented was just beginning to embrace the role of peers as equal team members into a criminal justice-related program. Thus, the PSS initially did not have access to agency client record systems, which necessitated that the case manager be the conduit for all information collected by the PSS and required that the case manager be counted upon to relay any relevant medical record information to the PSS. The delay in access to client record systems impeded the PSS's ability to act as—and feel like—a full member of the treatment team. Similarly, the program elements evolved to recognize the importance of developing trainings that could enhance the PSS role as an equal member of the team. In addition, the value of formal peer certification trainings was recognized early on. It is recommended that in jurisdictions where those trainings are available that programs attempt to encourage, or even require, their peer staff to attend those certification trainings.

As such, MISSION-CJ on-the-job training program (including "shadowing assignments") should be implemented, so that PSSs have the requisite job-training to be able to ensure they are able to maximally support clients in a systematized manner consistent with their roles as members of the treatment team.

As stated above, the employment of PSSs 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, yet not all jurisdictions will have peer certification programs from which to draw, and as such there may need to be specific attention to the peer roles in delivering services.

The unique qualifications and roles associated with these positions often raise important questions and issues that are best addressed by specific training for PSSs as well as supervisors and other team members. Some questions do not have clear-cut answers that can be universally applied, since the size and culture of both the organization and the wider community often influence the development of local policies and practices. The answers to some frequently-asked questions, are much more straight-forward and are, in fact, a matter of law.

The following questions are among some of the most common we have heard. We offer our answers as a step towards guiding policy and practice development for those wishing to replicate the MISSION-CJ program in local jurisdictions.

1) Hiring criteria: What are appropriate hiring criteria for PSSs?

Peers may have experiences in a variety of areas that will be common to the clients being served, whether that be lived experience with mental illness, substance use, criminal justice experience, and/or experience with military. It is essential for Administrators to understand that the Americans with Disabilities Act prohibits employers from asking applicants about their medical/psychiatric conditions or histories. **Rather, the hiring criteria for PSSs should be based on the knowledge, skills, abilities, and personal characteristics required to perform the duties of the position. Position descriptions and recruitment announcements should describe the population served and the expectation that the PSS will utilize his or her own recovery experiences as a means of role-modeling successful community integration and providing peer support to foster achievement of clients' recovery goals.** Employment application forms and interview questions should be carefully designed to elicit the necessary information to determine if the applicant's training and personal experiences have afforded him or her 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-CJ PSS position description can be found at the end of this Appendix).

It is generally recommended that organizations recruit individuals who are not currently, or have not recently received mental health services from the same organization in which they would be employed. Most organizations do not strictly prohibit this, and the negative impacts of doing so are minimized in large organizations where PSS can be employed in a program that is remote from where they have recently received or currently receive their own mental health services. Should the selected candidate be one who currently receives services from the same organization, it is generally advised that he or she make every effort to distance his or her personal service providers from his or her supervisor and direct co-workers. Under no circumstances should a PSS employment supervisor also be that person's mental health services provider.

PSS training and certification programs may help make clear the legal parameters that must be followed in hiring individuals with disabilities as noted above.

Additionally, because PSSs in the MISSION-CJ program may have their own criminal justice backgrounds and will be expected to work with individuals with criminal justice issues, there may be a need for further vetting and policies related to their hiring. This may need to be developed and discussed with the correctional or criminal justice stakeholders involved in the program.

2) Confidentiality: Is there a different level of confidentiality for PSSs than for other service providers? Does everything that gets stated to a PSS by a client automatically get transmitted to the rest of the team?

As a general rule, information conveyed by participants in peer support groups is confidential. However, as a member of a client's treatment team, the PSS is expected to encourage and help the client share with the rest of the team information that is pertinent to the team's effort to support the client's treatment/recovery goals. In addition, the PSS may need to share information with his or her supervisor to ensure that appropriate attention is paid to matters that involve the health and safety of clients. How to handle these issues should be reviewed and discussed in supervision between the PSS and his/her supervisor.

Each client will have been informed at the commencement of his or her program enrollment that MISSION-CJ staff are legally obligated to take appropriate steps should they believe that the client poses a danger to him- or herself or others. Where a client divulges during a peer support group session information that suggests that such a danger may be present, the peer support specialist would generally raise discussion with the client outside of the peer support meeting as a means of processing with the client the value and importance of including the team in addressing the issue. However, should the client refuse to do so, the PSS would be expected to convey to other members of the treatment team information that the PSS considers vital to the client's or others' safety, after reminding the client of the PSS's obligation to do so; provided that the PSS believes that his or her safety is not compromised. In an emergency situation, crisis services, 911, or even police may need to be contacted to maximize safety.

3) Fraternization: Can PSSs spend time with their clients after hours? What are the boundaries of clients and PSSs giving money to each other? Can a PSS buy a client a cup of coffee or not?

PSS are staff of the treatment services system in which they are employed, and any organizational policies regarding financial transactions, intimate relationships, etc. that apply to other providers would also apply to the PSS. The fact that PSSs may more often live, socialize, attend meetings, etc. where clients are likely to be, does not change organizational policies designed to protect both the mental health system employee and the clients served by that system. PSSs should be familiar with, and employers should review, any policies or protocols relevant to these issues that exist within the organizational structure.

Most all friendships outside of the work environment have the potential to influence behaviors within the work setting and should therefore be avoided. PSSs are, however, likely to have more social contact with clients than traditional healthcare providers, and peers have a more mutual relationship with clients in the context of their work. It is therefore recommended that there be a safe environment for PSSs to discuss any questions and to review complex relational situations with their supervisor as they may arise, to include assistance with discussing healthy boundaries with clients.

Like all employees (and perhaps even more so), it is important that PSSs balance and have a healthy separation between their work and their personal lives. Where a strong personal friendship may have previously been established between a PSS and a new client coming into the program, the 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 client to a different case management/peer support specialist team. Where assignment to another team is not possible, the employee and their supervisor should discuss appropriate boundaries to minimize real or perceived conflicts of interest that could jeopardize the PSS/client relationship and goals of the program.

4) Supervision/performance appraisal: How does a supervisor appraise the performance of a PSS?

Performance standards for PSS should be developed based on the work of the position, as with any other staff member. In the case of the MISSION-CJ PSS, the supervisor's appraisal should focus on the PSS's effectiveness in developing supportive relationships with clients that foster successful personal and community integration skills and the development of natural supports.

5) Sick leave policy: One of the top concerns organizations may have about PSSs is what will happen if the PSS relapses. Should special sick leave policies be in place for them?

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 and to any provisions related to sick leave policies for the organization that apply to the PSS position. 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 in establishing parameters for employment

6) Disclosure of mental health status: To what extent is a PSS required to disclose his/her personal history of mental illness/addictions/ criminal justice experiences in the context of their work with clients?

Unlike more traditional mental health providers, such as social workers, psychologists, etc. who may also be (and disclose their personal experience as) consumers of mental health services, the unique role of the PSS requires them to do so. Their training as a PSS should comprehensively address how to utilize their own experiences effectively, so as to connect with, empathize with, and support clients. PSS training also generally includes learning to "tell one's story" from a recovery versus an illness perspective, and how to ensure that their self-disclosure is pertinent to the situation and does not dominate the conversation. Under no circumstances should a PSS feel compelled to disclose aspects of their personal experiences that they would be uncomfortable sharing.

Knowledge, Skills, and Abilities considered essential for the MISSION-CJ 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 work with individuals currently or formerly involved in the criminal justice system.
6. Ability to teach self-advocacy through role-playing, role-modeling techniques, to include role-modeling personal experiences to assist others in their recovery process.
7. 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, probation officers, lawyers, etc.)

Sample interview questions pertinent to the MISSION-CJ PSS position

1. The position you have applied for is a Peer Support Specialist. Please describe what you believe a peer support specialist's role should be and what you would envision yourself doing in this role. Give an example of how you have provided this type of service in the past.
2. Please share a couple of specific examples of progress you've made in personal and/or work life where you experienced a setback or challenge and then turned the situation around to a positive outcome.
3. Please provide specific examples of how you have provided informal or formal support to one or more of your peers.
4. Please discuss a specific time when you had to negotiate with a group of people to obtain their cooperation. Tell us specifically who you negotiated with and what the outcome was. What did you learn from the situation?

5. Think of a time when you had to communicate something that you knew the other person did not want to hear. How did you go about communicating it? What was the outcome?
6. Please describe a time when you assumed a leadership role (in any context). What sort of problems came up? What did you learn about yourself?
7. What was the most recent skill that you set out to learn? How did you go about it?
8. Give an example of an important goal that you have set for yourself in the past. What did you do to reach it? How did you measure your success in reaching that goal?
9. On a scale of 0 (lowest) to 10 (highest), please rate your personal knowledge in the following areas and give examples of how you have acquired and utilized this knowledge:

Knowledge of community resources_____

Knowledge about mental health and addiction problems_____

Knowledge of recovery issues and processes_____

Knowledge of the criminal justice system_____

10. How does being a peer support specialist in the MISSION-CJ program fit in with your overall life plan goals for yourself? Please be specific.

Appendix K: Vocational and Educational Support Materials

This appendix is meant to accompany *Chapter 7, Vocational and Educational Supports for Individuals Involved in the Criminal Justice System*. The supplementary material found in this appendix is intended to provide the MISSION-CJ team with a list of resources to help ensure that MISSION-CJ 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: _____

SIGNATURES/DATES: _____

ADAPTED WITH PERMISSION FROM:

Swanson, S. J., Becker, D. R., Drake, R. E., & Merrens, M. R. (2008). *Supported employment: A practical guide for practitioners and supervisors.* Kearney, NE: Morris Publishing.

JOB START FORM

CLIENT:

CASE MANAGER:

EMPLOYMENT SPECIALIST:

EMPLOYER:

EMPLOYER'S ADDRESS:

START DATE:

HOURS PER WEEK:

JOB TITLE:

JOB DUTIES:

PAY:

BENEFITS:

UNION POSITION: _____ YES _____ NO

DISCLOSURE: _____ YES. CLIENT HAS AGREED TO EMPLOYER CONTACT AND HAS SIGNED A RELEASE. HOWEVER, CLIENT DOES NOT WANT TO DISCLOSE THE FOLLOWING:

SUPERVISOR'S NAME:

_____ NO. CLIENT DOES NOT WISH EMPLOYMENT SPECIALIST TO HAVE CONTACT WITH EMPLOYER.

STAFF SIGNATURE DATE

ADAPTED WITH PERMISSION FROM:

Swanson, S. J., Becker, D. R., Drake, R. E., & Merrens, M. R. (2008). *Supported employment: A practical guide for practitioners and supervisors.* Kearney, NE: Morris Publishing.

SAMPLE LETTER TO EMPLOYER

October 29, 2010

Mr. John Smith

Sunnyside Bowling Lanes

One Employment Way

Bedford, MA 07130

Dear Mr. Smith,

Thank you very much for taking the time to meet with me today in regards to Henry Miller's application for a cashier position at Sunnyside Bowling Lanes. Although you do not have cashier openings at this time, I encourage you to consider Mr. Miller for future positions. He is very interested in working at Sunnyside Bowling Lanes in particular because he lives in the neighborhood and has had prior experience working in a similar position. I believe you will find him to be a reliable and responsible employee.

I will contact you again about future openings for him. Thank you for your time and consideration.

Sincerely,

Jane Taylor

Case Manager

444-4444

ADAPTED WITH PERMISSION FROM:

Swanson, S. J., Becker, D. R., Drake, R. E., & Merrens, M. R. (2008). *Supported employment: A practical guide for practitioners and supervisors.* Kearney, NE: Morris Publishing.

RECOVERY ASSESSMENT SCALE (RAS)

Name or ID Number_____ Date _____

PLEASE ANSWER THESE ITEMS ON AN AGREEMENT SCALE WHERE 1 IS "STRONGLY DISAGREE" AND 5 IS "STRONGLY AGREE."

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. I have a desire to succeed.	1	2	3	4	5
2. I have my own plan for how to stay or become well.	1	2	3	4	5
3. I have goals in life that I want to reach.	1	2	3	4	5
4. I believe I can meet my current personal goals.	1	2	3	4	5
5. I have a purpose in life.	1	2	3	4	5
6. Even when I don't care about myself, other people do.	1	2	3	4	5
7. Fear doesn't stop me from living the way I want to.	1	2	3	4	5
8. I can handle what happens in my life.	1	2	3	4	5
9. I like myself.	1	2	3	4	5
10. I have an idea of who I want to become.	1	2	3	4	5
11. Something good will eventually happen.	1	2	3	4	5
12. I'm hopeful about my future.	1	2	3	4	5

RECOVERY ASSESSMENT SCALE (RAS) (CON'T)

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
13. Coping with my mental illness is no longer the main focus of my life.	1	2	3	4	5
14. My symptoms interfere less and less with my life.	1	2	3	4	5
15. My symptoms seem to be a problem for shorter periods of time each time they occur.	1	2	3	4	5
16. I know when to ask for help.	1	2	3	4	5
17. I am willing to ask for help.	1	2	3	4	5
18. I ask for help, when I need it.	1	2	3	4	5
19. I can handle stress.	1	2	3	4	5
20. I have people I can count on.	1	2	3	4	5
21. Even when I don't believe in myself, other people do.	1	2	3	4	5
22. It is important to have a variety of friends.	1	2	3	4	5

`

The RAS Score Sheet

Name or ID Number_____ Date _____

Factor scores are obtained by adding up the parenthetical items which load into each factor.

_____ Personal Confidence and Hope (Sum of items 7, 8, 9, 10, 11, 12, & 19)

_____ Willingness to ask for Help (Sum of items 16, 17, & 18)

_____ Goal and Success Orientation (Sum of items 1, 2, 3, 4, & 5)

_____ Reliance on Others (Sum of items 6, 20, 21, & 22)

_____ Not Dominated by Symptoms (Sum of items 13, 14, & 15)

RECOVERY-PROMOTING RELATIONSHIPS SCALE (RPRS)

The following statements describe different aspects of the relationship people with psychiatric conditions might have with a mental health or rehabilitation provider.
Please think of the relationship you have with _____

Please circle the answer that best describes your relationship with this provider.

1. My provider helps me recognize my strengths.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

2. My provider tries to help me see the glass as "half-full" instead of "half-empty."

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

3. My provider helps me put things in perspective.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

4. My provider helps me feel I can have a meaningful life.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

5. I have a trusting relationship with my provider.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

6. My provider helps me not to feel ashamed about my psychiatric condition.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

7. My provider helps me recognize my limitations.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

8. My provider helps me find meaning in living with a psychiatric condition.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

9. My provider helps me learn how to stand up for myself.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

10. My provider accepts my down times.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

11. My provider encourages me to make changes and try things.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

12. My provider reminds me of my achievements.

DISAGREE SOMEWHAT DISAGREE SOMEWHAT AGREE AGREE NOT APPLICABLE

RECOVERY-PROMOTING RELATIONSHIPS SCALE (RPRS) CON'T

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 L: Trauma as a Critical Consideration in MISSION-Criminal Justice Service Delivery: Resources for Case Managers and Peer Support Specialists

Matthew Stimmel

Andrea Finlay

This appendix is meant to accompany ***Chapter 8: Trauma as a Critical Consideration in MISSION-Criminal Justice Service Delivery.*** *The material found in this appendix is meant to provide resources for MISSION-CJ teams and stakeholders involved in MISSION-CJ service delivery who are interested in learning more about trauma and how to access materials related to trauma-informed services*.

What is PTSD?

The PTSD diagnostic criteria include 20 symptoms that are broadly grouped according to intrusion of traumatic memories and reactions to environmental cues that remind the individual of the trauma, avoidance of traumatic stimuli, negative cognitive appraisals and negative mood symptoms associated with the trauma (such as guilt, fear, shame, confusion, sadness, or diminished interest in activities or social withdrawal), and alterations in arousal and activity (e.g., sleep difficulties, irritability, recklessness, high startle response, aggressive behavior or hypervigilance). Symptoms must be present for at least one month after the trauma, must have a significant impact on functioning, and must not be due to a co-occurring substance use disorder or medical condition (American Psychiatric Association, 2013).

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

What are resources that can provide further information about trauma?

To learn more about what PTSD is, how it develops, how to assess it, and how to treat it, the following resources are recommended:

- US Department of Veterans Affairs National Center for PTSD (www.ptsd.va.gov). This site provides comprehensive information for both the public and professionals on PTSD including psycho-education; training resources; treatment options; coping tools and other informative material (including assessments, videos, handouts, and online toolkits) regarding PTSD and trauma-related experiences and symptoms. It also has links to a comprehensive database of PTSD-related literature.
- *National Center for Trauma-Informed Care* (http://mentalhealth.samhsa.gov/nctic). This site is an online resource center that provides information on trauma-informed care and how to implement TIC practices in a variety of mental health and other public settings.
- International Society for Traumatic Stress Studies (www.istss.org). ISTSS is a professional society that provides a forum for an exchange of research, clinical interventions, theoretical explanations, and policy issues all relevant to trauma and PTSD.
- Witness Justice (www.witnessjustice.org). This is a website that was created by survivors of interpersonal violence (IPV) as a support center for other survivors of IPV. *The site provides information about trauma related to IPV and how to report, get support and advocate if you or someone you know has experienced IPV.*
- National Child Traumatic Stress Network (www.nctsn.org). This website provides information, psychoeducation, and other resources dedicated to increasing awareness and improving care for children and families that have been affected by trauma.
- International Society for the Study of Dissociation (www.issd.org). Professional society that provides

information for professionals, students, and the public, as well as opportunities for training regarding trauma and dissociation.

- Sidran Foundation (www.sidran.org). A non-profit organization that is geared towards raising awareness and understanding of how to address trauma and related problems including PTSD, dissociation, and co-occurring disorders.
- National Resource Center on Domestic Violence (www.vawnet.org). This site provides gender-specific resources geared to raise education and awareness of issues related to women who experience domestic violence, sexual assault, and other forms of oppression.

Many of the above websites also provide links to other resources and assessment tools. For a more specific list of what trauma-related assessments are available, what the research base is for those assessments, and tutorials on how to use them, please visit: http://www.ptsd.va.gov/PTSD/professional/assessment/overview/index.asp

As noted above, additional resources related to trauma may also be found at the National Center for Trauma Informed Care website (http://mentalhealth.samhsa.gov/nctic)

Reference

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.*). Arlington, VA: American Psychiatric Publishing.

APPENDIX M: MISSION-CJ Fidelity Index

This fidelity index is designed to document services delivered as indicated by the MISSION-CJ approach. This fidelity index should be completed based on ONLY the documentation contained in the participant's treatment or court record.

***If an individual is incarcerated or is in inpatient treatment during a particular time period, or if no service was needed or necessary, mark 'N/A' for relevant questions.*

1. Comprehensive Assessment

A) Did the Participant have an orientation session to the MISSION-CJ program? Yes Somewhat No

B) If Yes or Somewhat ⇨ What components were included?

C) Did the MISSION-CJ Case Manager develop a comprehensive treatment plan? Yes Somewhat No

(Treatment plan should include a list of problem areas to address such as Mental Health, Substance Abuse, Employment, Housing Stability, and other service needs)

D) Did the MISSION-CJ Treatment Plan include a focus on criminogenic needs? Yes Somewhat No

E) Did the Participant receive a MISSION-CJ workbook or download from web? Yes No

F) Did the case manager meet with the Participant to review program goals and expectations? Yes No

G) If the Participant is under community justice supervision, did the case manager obtain appropriate releases of information to allow communication between MISSION-CJ and Justice Personnel. Yes No

H) If the Participant is under community justice supervision, did the case manager meet with the Participant's probation officer, parole officer, or other supervising entity to review the treatment plan? Yes Somewhat No

2. Case Management Services (built off a 12-month model). Time frames should be proportionally reduced for 2-month, 6-month or other timeframes.

A) Did the Participant meet with his/her case manager weekly in months 1-3? Yes No N/A

B) Did the Participant meet with his/her case manager bi-weekly in months 4-8? Yes No N/A

C) Did the Participant meet with his/her case manager monthly in months 9-12? Yes No N/A

D) Please circle each DRT co-occurring disorder treatment session the Participant attended:

(1) Onset of Problems

(2) Life Problem Areas

(3) Motivation, Confidence, and Readiness to Change

(4) Developing a Personal Recovery Plan

(5) Decisional Balance

(6) Developing Strong Communication Skills Recovery

(7) Orientation to 12-Step Programs

(8) Anger Management

(9) Relapse Prevention

(10) Relationship-Related Triggers

(11) Changing Unhealthy Thinking Patterns

(12) Changing Irrational Beliefs

(13) Scheduling Activities in Early Recovery

3. Peer Specialist Support Services

A) How many times did the PSS discuss the workbook? #_____

B) Please circle each peer support specialist-led session the program Participant attended:

(1) Willingness

(2) Self-Acceptance and Respect

(3) Gratitude

(4) Humility

(5) Dealing with Frustration

(6) Handling Painful Situations

(7) Significance of Honesty

(8) Courage

(9) Patience

(10) Medicine Maintenance

(11) Making a Good Thing Last

C) How many peer-scheduled <u>community activities</u> did the program Participate attend? (e.g. museum tours, fishing trips, community service projects)* #_____

D) How many AA/NA meetings did the Participant attend with the peer specialist? #_____

4. Mental Health and Substance Use Services

A) Did the MISSION team provide a referral for additional <u>co-occurring</u> disorders services beyond that of MISSION? Yes No N/A

B) If YES ⇨Did the MISSION team <u>follow up</u> on the referral for additional co-occurring disorders services? Yes No N/A

C) Did the MISSION team provide a referral for <u>additional mental health</u> services beyond that of MISSION? Yes No N/A

D) If YES ⇨Did the MISSION team <u>follow up</u> on the referral for additional mental health services? Yes No N/A

E) Did the MISSION team provide a referral for <u>additional substance use services</u> beyond that of MISSION? Yes No N/A

F) If YES ⇨Did the MISSION team follow up on the referral for additional substance use services? Yes No N/A

Other Services

5. Psychiatric Services

A) Did the case manager provide a referral for psychiatric services? Yes No N/A

B) If YES ⇨Did the MISSION team follow up on the referral for psychiatric services? Yes No N/A

6. Trauma Services

A) Did the case manager provide a referral for trauma-specific services? Yes No N/A

B) If YES ⇨Did the MISSION team follow up on the referral for trauma-specific services? Yes No N/A

7. Housing Services

A) Did the case manager provide a referral for housing services? Yes No N/A

B) If YES ⇨Did the MISSION team follow up on the referral for housing services? Yes No N/A

8. Vocational/Educational Rehabilitation Service Needs

A) Did the case manager provide a referral for employment/educational services? Yes No N/A

B) If YES ⇨Did the MISSION team follow up on the referral for employment/educational services? Yes No N/A

9. Veteran's Services (if Participant is a Veteran)

A) Did the case manager provide a referral for Veteran's services (e.g. obtaining disability payments, changing discharge status)? Yes No N/A

B) If YES ⇨Did the MISSION team follow up on the referral for Veteran's services? Yes No N/A

10. Medicaid or other insurance services (if the Participant is eligible for these services)

A) Did the case manager provide a referral for state Medicaid benefits or other insurance supports? Yes No N/A

B) If YES ⇨Did the MISSION team follow up on the referral for these services? Yes No N/A

11. State Support Services (e.g. services provided by a state mental health authority, services provided through child welfare, etc.)

A) Did the case manager provide a referral for state supports (e.g. State Mental Health Authority services, other)? Yes No N/A

B) If YES ⇨Did the MISSION team follow up on the referral for these services? Yes No N/A

12. Medical Services – Primary Care/Specialty Care/General Health

A) Did the case manager provide a referral for medical services? Yes No N/A

B) If YES ⇨Did the MISSION team follow up on the referral for medical services? Yes No N/A

13. Criminal Justice Services

A) Did the case manager provide regular communication/reports to criminal justice entities as indicated in Participant's treatment plan and as part of Participant's community supervision requirements? Yes No N/A

B) If YES ⇨Did the MISSION team follow up on any needed communications with criminal justice services? Yes No N/A

14. Termination Services

A) Did the case manager conduct a MISSION-CJ discharge session with the Participant in which they reviewed discharge plan and goals? Yes No N/A

B) Are linkages in place to ensure ongoing care of Participant post-MISSION discharge? Yes No N/A

APPENDIX N: Confidentiality Concepts

Albert Grudzinskas, Jr.

This appendix will discuss confidentiality and the principles of law and ethics that govern the protection and control of private disclosures of information among persons. It is of critical importance that clinicians, Peer Support Specialists, criminal justice personnel and anyone involved either in therapeutic or legal issues with Veterans, persons in recovery, persons with lived experience with mental illness, consumers, justice-involved individuals or others in these settings, ***check local regulations*** *for the rules and laws governing these concepts. Jurisdictions vary dramatically with respect to the rules and obligations they impose. The appendix will begin with a brief overview of the relationship between the concepts of privacy, confidentiality, and privilege. It will then discuss how these concepts apply in therapeutic and in criminal justice settings. The appendix will provide examples of when exceptions to the rules might apply. It will provide an overview of the Health Insurance Portability and Accessibility Act (HIPAA) and discuss how it impacts and regulates disclosures of protected health care information particularly in criminal justice settings. The differences between confidentiality concepts in treatment versus research settings will be discussed. Particular attention will be paid to the impact of these principles on the peer-to-peer setting of the Peer Support Specialist. A brief overview of special considerations governing concepts of confidentiality in military settings will also be provided. The appendix will close with some of the lessons learned during the development of MISSION-VET and recommendations for addressing the issues raised in the above-mentioned topics.*

INTRODUCTION

Privacy, Confidentiality, and Privilege

The concepts of privacy, confidentiality, and privilege while related, are distinct with respect to the obligations they impose on clinicians and Peer Support Specialists, and the degrees of protection they afford persons making disclosures of information in therapeutic settings. Privacy is the over-arching ethical principle that governs the nature of communications between people. Confidentiality is the duty imposed (either by law or by ethical obligation) on the receiver of information to not disclose the communications (s)he hears when certain relationships exist between the parties. Privilege (often referred to as "testimonial privilege") is the right of the person making a disclosure of information in certain settings to prevent that disclosure from being repeated in court trials or administrative hearing.

Privacy

Merriam-Webster defines privacy as, "the quality or state of being apart from company or observation… secrecy" (Merriam-Webster Online, 2013). Appelbaum observed that in therapeutic settings, privacy is the interest that persons have in maintaining control of information about them (Appelbaum, 2003). Without more however, the mere fact that we would like something to remain private carries little *lega*l significance. Much has been written about the "right to privacy." The concept has its origins in an 1890 Harvard Law Review article written by Samuel Warren and Louis Brandeis (Warren & Brandeis, 1890). They argued that intruding into and disclosing someone's private affairs caused such harm that it should be considered grounds for being sued. Justice Brandeis later introduced the concept into constitutional law when he wrote in his dissent in the wiretap case of *Olmstead v. United States* (1928,) that:

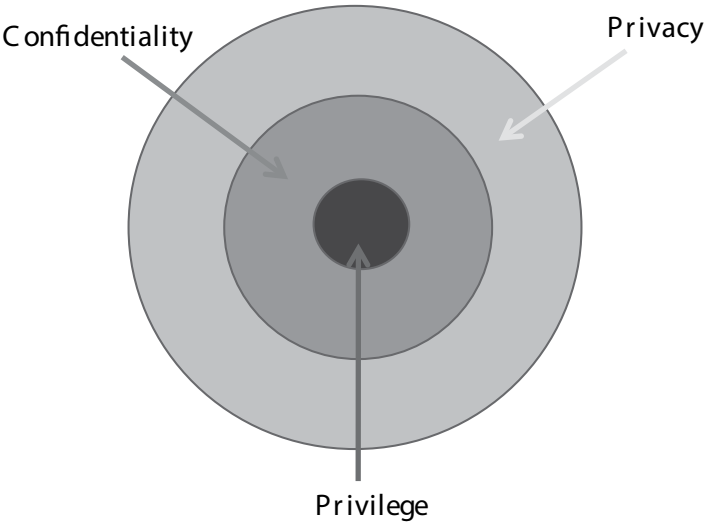
The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings, and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone -- the most comprehensive of rights, and the right most valued by civilized men.

This opinion later formed the basis for the Supreme Court's recognition of the "right to privacy" in *Griswold v. Connecticut* (1965) and *Roe v. Wade* (1973). Justice Brandeis' opinion is also seen as the basis for the constitutional concept of the "reasonable expectation of privacy" test that governs Fourth Amendment law *(Katz*

v. United States 1967) and is the underlying basis for most concepts of confidentiality.

In the California Supreme Court decision of *Long Beach City Employees Association v. City of Long Beach* (1986), Justice Broussard wrote (quoting in part the prior decision of *White v. Davis* (1975)),

The right of privacy is the right to be left alone. It is a fundamental and compelling interest. It protects our homes, our families, our freedom of communion and our freedom to associate with the people we choose. This right should be abridged only when there is a compelling public need. . .If there is a quintessential zone of human privacy it is the mind. Our ability to exclude others from our mental processes is intrinsic to the human personality.



Confidentiality

When someone has an expectation of privacy, and this expectation occurs in a setting where a duty is imposed either by law or by ethical obligation on the receiver of the information, then the concept of confidentiality comes into play. Confidentiality exists in settings where the nature of the relationship between the people imposes a duty on the person hearing the disclosure of information to keep the information private. The duty to keep information confidential exist between clinicians and patients, attorneys and clients, husbands and wives, penitents and confessors, but not (with a few rare exceptions that will be mentioned) in peer to peer relationships without some other aspect of the setting imposing the duty. The duty is imposed in order to encourage persons in these settings to speak freely and without fear of subsequent embarrassment due to disclosure of the information. While confidential information is not accessible to the general public, if it is subpoenaed it must generally be released, unless it is also privileged (to be discussed below).

The idea of confidentiality in treatment settings has its roots in the Hippocratic Oath, which cautioned physicians not to tell those things that "should not be published abroad" (Resier, Dyck, & Curran, 1977). Most states either by statute or by case law have imposed duties on clinicians to continue to keep treatment information from being disclosed. The duty is not without exceptions however. All states, for example, impose a duty on clinicians to report suspected on-going child abuse in order to prevent harm to children. Most states also impose a duty to prevent persons receiving mental health and/or substance abuse treatment from harming themselves or others.

Privilege

Privileged communications are those statements made by people in protected relationships (such as those discussed above in the confidentiality section) that the law protects from forced disclosure on the witness stand. (Mindlin & Heh-Reeves, 2005). All states recognize some form of privilege (see Table 1). In most instances, it is not absolute (safe from all compelled disclosure) but rather is qualified or limited in scope. In situations such as the child abuse or self-harm examples mentioned above some degree of disclosure is permitted to prevent the abuse.

The United States Supreme Court recognized a psychotherapist privilege stemming from fundamental common law principles rather than created by statutes. This helps ensure that the protection afforded the communications cannot be taken away without substantial governmental interests being at stake, and only after strict scrutiny by the courts. The Court held the privilege applies for therapeutic communications to licensed psychiatrists, psychologists, and clinical social workers (*Jaffee v. Redmond*, 1996). The Court observed that as with spousal and attorney-client privileges, the psychotherapist-patient privilege is

"rooted in the imperative need for confidence and trust" (*Jaffee*, at 10, quoting Trammel v. United States, at 51, 1980). Unlike treatment for physical ailments which can often proceed "…on the basis of a physical examination, objective information supplied by the patient, and the results of diagnostic tests," effective psychotherapy "…depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears" (*Jaffee,* at 10). The disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. The mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment. The Court cited the 1972 observation of the Judicial Conference Advisory Committee in recommending that Congress recognize a psychotherapist privilege as part of the Proposed Federal Rules of Evidence, "[A] psychiatrist's ability to help her patients, 'is completely dependent upon [the patients'] willingness and ability to talk freely. This makes it difficult if not impossible for [a psychiatrist] to function without being able to assure . . . patients of confidentiality and, indeed, privileged communication. Where there may be exceptions to this general rule …, there is wide agreement that confidentiality is a sine qua non for successful psychiatric treatment'" (*Jaffee* at 11). The Court then made the privilege universal, rather than having the issue decided on a case-by-case basis. "Making the promise of confidentiality contingent upon a trial judge's later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege" (*Jaffee* at 17).

Table 1. Primary State Privilege Statutes

State	Statute or Regulation	Recognized Peer Exception
Alabama	Ala. Code § 34-26-2 (2013);	
Alaska	Alaska Rule Evid. 504	*
Arizona	Ariz. Rev. Stat. Ann. § 32-2085 (2013);	
Arkansas	Ark. Rule Evid. 503	*
California	Cal. Evid. Code Ann. §§ 1010, 1012, 1014 (2013)	
Colorado	Colo. Rev. Stat. § 13-90-107(g) (2012)	
Connecticut	Conn. Gen. Stat. § 52-146c (2013);	
Delaware	Del. Uniform Rule Evid. 503	*
District of Columbia	D. C. Code Ann. § 14-307 (2013)	
Florida	Fla. Stat. § 90.503 (2013)	
Georgia	Ga. Code Ann. § 24-9-21 (2013)	
Hawaii	Haw. Rules Evid. 504, 504.1	*
Idaho	Idaho Rule Evid. 503	*
Illinois	Ill. Comp. Stat., ch. 225, § 15/5 (2013)	
Indiana	Ind. Code § 25-33-1-17 (2013)	
Iowa	Iowa Code § 622.10 (2013)	
Kansas	Kan. Stat. Ann. § 74-5323 (2012);	

State	Statute or Regulation	Recognized Peer Exception
Kentucky	Ky. Rule Evid. 507	*
Louisiana	La. Code Evid. Ann., Art. 510 (West 1995)	*
Maine	Me. Rule Evid. 503	*
Maryland	Md. Cts. & Jud. Proc. Code Ann. § 9-109 (2013)	
Massachusetts	Mass. Gen. Laws § 233:20B (2013)	
Michigan	Mich. Comp. Laws Ann. § 333.18237 (2013)	
Minnesota	Minn. Stat. § 595.02 (2013)	
Mississippi	Miss. Rule Evid. 503	*
Missouri	Mo. Rev. Stat. § 491.060 (2013)	
Montana	Mont. Code Ann. § 26-1-807 (2012)	
Nebraska	Neb. Rev. Stat. § 27-504 (2012)	
Nevada	Nev. Rev. Stat. § 49.215 (2013)	
New Hampshire	N. H. Rule Evid. 503	*
New Jersey	N. J. Stat. Ann. § 45:14B-28 (2013)	
New Mexico	N. M. Rule Evid. 11-504	*
New York	N. Y. Civ. Prac. Law § 4507 (4507)	
North Carolina	N. C. Gen. Stat. § 8-53.3 (2013)	
North Dakota	N. D. Rule Evid. § 503	*
Ohio	Ohio Rev. Code Ann. § 2317.02 (2013)	
Oklahoma	Okla. Stat., Tit. 12, § 2503 (2013)	
Oregon	Ore. Rules Evid. 504, 504.1	*
Pennsylvania	42 Pa. Cons. Stat. § 5944 (2013)	
Rhode Island	R. I. Gen. Laws §§ 5-37.3-3, 5-37.3-4 (2012)	
South Carolina	S. C. Code Ann. § 19-11-95 (2012)	
South Dakota	S. D. Codified Laws §§ 19-13-6 to 19-13-11 (1995)	*
Tennessee	Tenn. Code Ann. § 24-1-207 (2013)	
Texas	Tex. Rules Civ. Evid. 509, 510	*
Utah	Utah Rule Evid. 506	*
Vermont	Vt. Rule Evid. 503	*
Virginia	Va. Code Ann. § 8.01-400.2 (2013)	
Washington	Wash. Rev. Code § 18.83.110 (2013)	
West Virginia	W. Va. Code § 27-3-1 (2013)	
Wisconsin	Wis. Stat. § 905.04 (2012)	
Wyoming	Wyo. Stat. § 33-27-123 (2013)	

Primary state privilege statutes are listed above. Those marked with a * address peer-to-peer protection.

HEALTH INSURANCE PORTABILITY AND ACCESSIBILTY ACT (HIPAA)

Privacy Rule

In 1996 Congress enacted the Health Insurance Portability and Accessibility Act (HIPAA) to "improve efficiency and effectiveness of health care systems by standardizing the electronic exchange of administrative and financial data" (42 USC 1320d, 1996). The Act creates a federal "floor" to ensure that everyone has some privacy protection. States can and often have created rules that are more stringent than those required by HIPAA. One portion of HIPAA, the "Privacy Rule" (compliance required after April 14, 2003) regulates the use and disclosure of Protected Health Information (PHI) held by "covered entities" (healthcare clearinghouses, employer sponsored health plans, health insurers, and medical service providers that engage in certain transactions) (Terry, 2009). Contrary to myth, HIPAA-covered entities do not include the courts, court personnel, or law enforcement officials such as police and probation. The Privacy Rule, while only a small portion of HIPAA, has generated misunderstandings "…so deeply ingrained that they have assumed the status of myth. These myths have serious negative consequences for persons with mental illness who are justice-involved" (Petrila, 2007).

The Privacy Rule permits disclosure of PHI in a number of different settings. First, if the person whose information is sought to be released provides consent, the disclosure is permitted. The Rule also allows for disclosure in a number of settings without requiring the individual's consent, for example when disclosure:

- Is necessary for treatment, payment, or healthcare operations. This permits one provider to release information to another provider (the "Portability" portion of the law).
- Is necessary for public health activities; or in judicial or administrative proceedings. NOTE: State and federally created privilege may prevent such disclosure.
- Is necessary for law enforcement purposes. "…a covered entity may disclose protected health information in response to a law enforcement official's request…for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person" (45 CFR 164.512(f)(2)(i)). NOTE: Remember, specific state rule are allowed to be more stringent.
- Is necessary to avert a serious threat to health or safety or is mandated under state abuse and neglect laws.
- Is necessary in correctional settings for healthcare, health and safety of the inmate, staff or the facility (such as information regarding escape threats or plans). (Please see generally: Petrila, 2007)

De-Identified Information

The Privacy Rule does not apply to de-identified health information. It permits de-identification in two ways: (1) a qualified statistician or expert must determine that the risk of re-identification is "very small" and must document the methods used to reach that conclusion; or (2) Eighteen specific identifiers must be removed, and the covered entity must not have actual knowledge that the remaining information could be used to identify an individual. The identifiers of the individual -- and of relatives, employers, or household members of the individual -- that must be removed include:

(1) Names;

(2) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code in certain situations;

(3) All elements of date (except year) for dates directly related to an individual, including birth date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(4) Telephone numbers;

(5) Fax numbers;

(6) Electronic mail addresses;

(7) Social security numbers;

(8) Medical record numbers;

(9) Health plan beneficiary numbers;

(10) Account numbers;

(11) Certificate/license numbers;

(12) Vehicle identifiers and serial numbers, including license plate numbers;

(13) Device identifiers and serial numbers;

(14) Web Universal Resource Locators (URLs);

(15) Internet Protocol (IP) address numbers;

(16) Biometric identifiers, including finger and voice prints;

(17) Full face photographic images and any comparable images; and

(18) Any other unique identifying number, characteristic, or code.

As will be explained, de-identifying a data set is particularly important in research settings.

RESEARCH VERSUS TREATMENT

Unlike the protection afforded by privilege rules in treatment settings, there currently exists no recognized exception for testimonial privilege for disclosure made by human subjects to researchers. An obligation to protect confidentiality does exist in the Common Rule, which requires, "That data be monitored to ensure safety to subjects , and that subject privacy and confidentiality be protected ." In many cases the HIPAA rules discussed above also prohibit disclosure without the subjects consent. The obligations prevent public disclosure, but do not protect against compelled disclosure on the witness stand. This is particularly important in settings like MISSION where confidential protected health care information may be merged with a person's criminal offending information. A prosecutor or a grand jury investigating an issue can force researchers to turn over files with PHI having been redacted or removed. One way to prevent such compelled disclosure is to create de-identified data sets for which any "linking" information, such as list linking study identification numbers with the names of participating subjects, has been destroyed.

Certificate of Confidentiality

Researchers promise subjects that their information will be kept confidential, but as we have seen above, that is only one part of the process. In order to fully protect sensitive information regarding criminal activity or substance abuse, some additional protection akin to privilege is required. In a research setting, a Certificate of Confidentiality (so named, but actually providing privilege-like protection) available through the National Institutes of Health [42 U.S.C. 241(d)] helps researchers protect the privacy of human research participants enrolled in biomedical, behavioral, clinical and other forms of sensitive research. (Please see: http://grants.nih.gov/grants/policy/coc/). The Agency for Healthcare Research and Quality [42 U.S.C. 299a-1(c)] and Department of Justice [42 U.S.C. 3789(g)] have similar programs for research they fund. The Certificates protect against compelled legal demands, such as court orders and subpoenas, for identifying information or identifying characteristics of research participants.

Sensitive information includes (but is not limited to) information pertaining to:

- an individual's psychological well-being or mental health;
- substance abuse;
- criminal or illegal conduct;
- sexual attitudes, preferences, or practices;
- studies where subjects may be involved in litigation related to exposures under study (e.g., breast implants, environmental or occupational exposures)
- genetic information or tissue samples; and
- information that, if released, might be damaging to an individual's financial standing, employability, or reputation within the community or might lead to social stigmatization or discrimination.

The protection afforded by the Certificate is permanent as long as the Certificate remains in effect. There have been few challenges to the validity of the Certificates, but the New York Court of Appeals did uphold the validity and prevented disclosure of research material. The United States Supreme Court subsequently declined to hear the case by denying *Certiorari (New York v. Newman, 1973).* The Certificates do not prevent disclosure by the subjects themselves, or where it is necessary to prevent harm or threat of harm, to prevent abuse or neglect, to protect public health (such as knowledge of communicable disease) or for audits of the research. For more information, please see National Institutes of Health, Office of Extramural Funding Certificates of Confidentiality.

PEER-TO-PEER SETTINGS

A shift in treatment modality to include peer-to-peer counselors has developed in clinical and research settings. The term "peer to peer" is usually used to describe persons with shared histories of mental illness, substance abuse, criminal background, or military service who are providing services and/or supports to others diagnosed with a similar illness (Davidson, Chinman, & Sells et al. 2006). The increasing use of peer-to-peer counselors is largely due to research findings and transformation efforts that suggest that peers are able to easily build positive relationships with clients and help promote recovery (Boisvert, Martin, & Grosek, et al., 2008 and Sells, Black, & Davidson, et al. 2008). This is because peers have the ability to act as role models with personal experiences to share, and are often empathetic (Chinman, Lucksted, & Gresen, et al., 2008). One potential issue with this practice is that unlike other clinical staff, peers may not be protected from the consequences of compelled disclosure of information. In most states, peers can be subpoenaed by a court to repeat any information they obtain from clients in treatment or from research subjects. (Please see Chart 1 for a listing of states that recognize peer-to-peer privilege).

While statutory or case law generated privilege for peer-to-peer counselors would be an excellent development, there are things that can be done in the meantime to protect privacy. Agencies employing peer-to-peer counselors should train them in the areas of confidentiality and privilege so that they understand these concepts and their importance. Although training has been done in some instances (Lecomte, Wilde & Wallace, 1999), it should be replicated and become a requirement in all settings where peers are utilized. Agencies and states should also require that all peer supporters be certified. This would standardize the process and prerequisites for being a peer counselor. It would also clarify the role of peers in treatment and research settings, and allow other professionals to recognizing their significance to the communities they work in (Seligowski & Grudzinskas, 2009).

MILITARY CONFIDENTIALITY

As has been discussed, patient and research subject confidentiality is seldom absolute. In military settings, with demands from deployment readiness, mission impact, and regulations regarding mandatory reporting requirements as well as the mixed agency experienced by clinicians (serving both the military and patient needs), the limits of confidentiality are further complicated and compromised (Hoyt, 2013; and Jeffrey, Rankin, & Jeffrey, 1992). Understanding the limits of confidentiality and warning clients of these limits is critical to successful treatment and the maintenance of the privacy of treatment settings. Providers must make service members aware of the fact that legitimate requests for patient information can come from commanders, investigators, or regulatory officials (Johnson, 1995).

Federal law establishes the basis for limited confidentiality of medical records in military settings [45 CFR 164.512(k)(1)]. The Guidelines of the Department of Defense identify several categories of limited confidentiality including: (a) access to records for medical treatment and oversight; (b) command notification; (c) preventing threats to safety; (d) public health purposes; (e) judicial or administrative proceedings; (f) law enforcement investigations; (g) minimal risk research; and (h) specialized military personnel programs (DoD, 2003). The picture is further complicated when service men (National Guard for instance) seek medical or behavioral health attention while on active duty. Few civilian providers are aware for example that command officers have "need to know" authority about a service member's care for purposes such as: personnel accountability, command-directed evaluations, command involvement procedures and duty limiting profiles [45 CFR 164.512(k)(1)]. Service members aware of these limitations are understandably reluctant to seek behavioral health care. However, security clearance may still be suspended for a refusal to submit to a medical or psychological evaluation when "…information indicates the individual may have a mental or nervous disorder or be addicted to alcohol or any controlled substance" (Department of the Army, 2011, p.3)

CONCLUSIONS & RECOMMENDATIONS

MISSION services have developed through several initiatives to inform MISSION-Criminal Justice. In particular, MISSION-DIRECT VET (SAMHSA grant #SM-58804) a court-based alternative to incarceration program that targeted Veterans in the justice system, identified early on the importance of the peer to peer communication and the need to sort through privacy, confidentiality, and privilege issues as these communications might relate to court processes. Several lessons were learned through these experiences. First and foremost, the process of obtaining and maintaining key stakeholder buy-in is critical to the process. Allowing for the airing and resolution of issues before they become problems helped smooth the delivery of services to a vulnerable and often underserved population. In addition to the service members and Veterans, identification of and attention paid to the needs of families proved critical to the success achieved in diverting traumatized individuals away from justice involvement and into a continuum of care. The issues such as confidentiality of communications for peer to peer counselors was handled with a combination of skillful facilitation of stakeholder agreements and education of all parties with respect to multi-systemic needs. Early discussions with clinicians, prosecutors, defense counsel, and particularly judges helped to clarify how the services would be delivered. From these experiences, it appears useful to provide training and education to MISSION-CJ case manager and peer personnel as they embark upon services so that they understand their roles and any limits of confidentiality that might arise as cases return to court. In this way, participants in the program can be best informed about potential communication flow and work with providers to have questions addressed if they are to receive MISSION-CJ services.

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APPENDIX O: Sample Program Services Documents

1. Consent to services
2. Release of information
3. Monthly probation report
4. Incident report

CONSENT TO PARTICIPATE IN SERVICES

Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking – Criminal Justice Edition (MISSION–CJ) is offering you an opportunity to participate in a program which will provide individualized mental health and substance abuse care. You will be provided with supportive services which will help you complete your probation successfully and meet any requirements you may have for mental health and substance abuse treatment. In some instances, MISSION-CJ staff may be able to advocate for you with court personnel in order to have probation with stipulations for treatment instead of going to jail.

MISSION-CJ services include specialized groups designed to address your psychiatric and substance abuse problems at the same time, case management which will focus on getting you needed community services such as benefits, medical care, housing, vocational rehabilitation and peer support. MISSION-CJ staff may often go to clients and work with them in a variety of community settings. This program is aimed at developing an individual's strengths so that problems with mental health and substance abuse become less problematic and the need for continued involvement with the criminal justice system is minimized. Treatment plans will be developed with the client and will be tailored to his or her particular needs.

This program will be compared to other existing programs to determine its effectiveness and to look for ways to provide better care to Veterans involved in the criminal justice system. Therefore, information will be collected throughout your treatment. This information will be kept confidential within the treatment team and program evaluators. It will be used to evaluate the program and will not affect you personally or identify you individually.

If you agree to participate and later decide to withdraw, your withdrawal will not affect any future care you may receive in the community. If MISSION-CJ services have become a condition of your probation and if you are not in compliance with these conditions, a change in your probation status will need to be negotiated.

When you sign this form, you are agreeing to participate in the MISSION-CJ program. At this time, it is important to ask any questions that you may have.

I,_____, have read the above description of the MISSION-CJ program and have decided to participate in it. My signature indicates that I have received a copy of this consent form.

_____

Signature

_____

Date

_____

Signature of person obtaining consent

_____

Date

AUTHORIZATION FORM FOR RELEASE OF INFORMATION

PLEASE PRINT

Name Client _____ Mr#:_____

Client's Home Address _____

Client's Home Phone _____ Date of Birth _____

By signing this Authorization, I authorize the use of disclosure of my confidential and/or Protected Health Information **maintained by:**

Agency/Person _____

Address _____

_____

My health information may be **disclosed** under this Authorization **to:**

Recipient Name and Title _____

Address _____

_____

Phone _____**Fax** _____

SCOPE OF USE OR DISCLOSURE: *PLEASE INITIAL ALL THAT APPLY*
Health information that may be used or disclosed through this Authorization is as follows:

_____ **All health information about me,** including my clinical records, including all psychiatric information created or received by the agency, for all dates of service. This does not include, if applicable, information pertaining to alcohol or drug abuse, or AIDS, ARC or HIV.

_____ Initial here if you are allowing written and verbal **two-way communication** of protected health information between the people/parties listed above.

_____ Information pertaining to the identity, diagnosis, prognosis or **treatment for alcohol or drug abuse** maintained by a federally-assisted alcohol or drug abuse program.

_____ Information regarding **AIDS, ARC or HIV** including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether (i) this test is ordered, performed, or reported and (ii) the test results are positive or negative.

PURPOSE OF THE USE OR DISCLOSURE: The purpose(s) of this Authorization is (are):

❑ Treatment Coordination ❑ Treatment Planning ❑ Other:

❑ Initiated by the Client and the Client does not elect to disclose its purpose. *Note: This box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment.*

This Authorization expires: (Insert applicable event or date – mm/dd/yy) _____

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Client's Signature _____ Date _____

Witness _____

When client is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.*

Print Name _____

Relationship of Representative to client _____

***If client has a legal guardian or proxy:** ❑ **Copy of documentation attached to authorization OR**
❑ **Documentation on file.**

MISSION-CJ Monthly Probation Report

For Month, Year

Client: DOB: MR#:

____ DRT/Peer Groups attended

____ Individual sessions with Clinical Case Manager

____ Individual sessions with Peer Specialist

__ Self help groups as reported by client

Comments:

Case Manager's Name

Clinical Case Manager

Email Address

Phone Number

MISSION-CJ:
CLINICAL INCIDENT REPORT

1. **MCJ Client ID:**_____ 2. ❑ **Male** ❑ **Female** 3. **Date of Report:**_____

4. **Court of Criminal Jurisdiction:**

5. **Name(s) of person making this report:**

6. **MCJ Site:** ❑ Worcester ❑ Lawrence

7. **Incident Date:**_____ 8. **Incident Time:**_____ ❑ am ❑ pm

9. **Last Service Date**:_____

10. **Type of Incident, specify:**

- ❑ Arrest
- ❑ Behavior that could have led to arrest
- ❑ Suicide-related
- ❑ Violence-related
- ❑ Emergency room visit
- ❑ Hospitalization or detox
- ❑ Child abuse/elder abuse/ disabled person abuse

11. **Describe Incident:** (include relevant information, risk factors, health related, etc.; DO NOT include personal identifiers for this report)

12. **External Notification Required (following consultation with Clinical Director):** (Check all that apply)

- ❑ DPPC (Disabled Persons Protection Commission)
- ❑ Elder Affairs
- ❑ Law Enforcement
- ❑ DCF (Dept. of Children and Families)
- ❑ Probation
- ❑ DPH (Dept. of Public Health)
- ❑ Other Describe:

If the incident involves an allegation of suspected abuse (physical, emotional, neglect, etc.) DPPC must be notified regardless of incident location Per M.G.L. 113c.19

13. **Reviewed with supervisors (please list):** ❑ Yes ❑ No

Supervisor Name (s) _____

Date:_____Time:_____ ❑ am ❑ pm Phone:_____

For Project Director Use Only:

14. **Follow up required and Completed:** ❑ Yes ❑ No

Reason(s) and Description:

15. **Serious Adverse Event Reportable to IRB:** ❑ Yes ❑ No ; **Reason:**

APPENDIX P: The Development of Legal Assistance for Homeless and At-Risk Veterans Served by The Department of Veterans Affairs

John Kuhn

Incarceration and Jail Diversion

The strong relationship between homelessness and incarceration (Balshem, 2011) is a primary reason why the VA has made substantial investments in justice-based interventions. The VA's goal is two-fold - divert Veterans from incarceration and aid those Veterans being released from prison re-integrate into the community. The VA has established a number of initiatives to address issues around Veteran interaction with the criminal justice system.

Justice Outreach Homelessness Prevention Initiative/Veterans Justice Outreach (VJO) Program seeks to avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans by ensuring that eligible justice-involved Veterans have timely access to VA mental health and substance use services when clinically indicated, and other VA services and benefits as appropriate. The VJO program, formally launched in 2009, aims to prevent homelessness by providing outreach and linkage to VA services for Veterans at early stages of the justice system, including Veterans' courts, drug courts, and mental health courts, and Veterans in local county and city jails. The VJO Specialists based at each medical center work with local justice system partners to facilitate access and adherence to treatment for justice-involved Veterans. Funding for 173 full-time VJO Specialist positions was distributed in 2010, 2011, and 2012, and these Specialists supported collaboration with the Department of Labor's Incarcerated Veterans Transition Program. In 2012, 27,251 reentry Veterans were provided services through the program. Program enhancement is expected to provide services for 30,000 Veterans in 2013. Due to significantly increased community demand for VA outreach services to Veterans in jails and courts not yet served, additional staffing is planned for 2014.

Communication with officers of the court regarding Veterans' compliance with VA treatment programs, including attendance in treatment and results of toxicology tests conducted for treatment purposes. VJO staff can also work with the courts to connect VA's array of services and benefits for Veterans in need, including:

- Help finding and keeping safe housing;
- Job training;
- Education;
- Medical, dental and mental health care.

Health Care for Reentry Veterans (HCRV), a program designed to address the community reentry needs of incarcerated Veterans. HCRV's goals are to prevent homelessness, reduce the impact of medical, psychiatric, and substance use problems upon community readjustment, and decrease the likelihood of re-incarceration for those leaving prison. In 2012, 10,572 justice-involved Veterans were provided services through HCRV.

Although the VA cannot provide health care for incarcerated Veterans, it can provide support that includes:

- Pre-release assessments;
- Assistance in establishing eligibility for VHA and VBA services;
- Discharge or transition planning to link Veterans to VA or community services upon release to decrease the likelihood of re-incarceration;
- Post-release services in emergency psychiatric or crisis intervention, substance use, transitional housing and employment.

Civil and Family Legal Issues

In addition to noted links between homelessness and incarceration, Veterans themselves have described other, more routine interactions with the criminal justice system that have either exacerbated their homelessness or contributed to housing crises that have placed them at-risk.

To better understand the perspective and needs of homeless Veterans, each year VA staff works with homeless Veterans to conduct a survey process known as the Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) for Veterans. Data collected during the FY 2010 CHALENG

process are from questionnaires completed by homeless and formerly homeless Veterans served by the VA, i.e. the consumers of VA homeless services. By eliciting their feedback, CHALENG aims to empower consumers as active participants in the design and delivery of homeless services. As an additional benefit, by making consumers active partners, clinicians are more likely to successfully engage them in care (Beck, 2010). Through this Veteran-centric process, CHALENG seeks to better understand the needs of homeless Veterans and then work to meet those needs through planning and cooperative action.

In 2010, CHALENG identified that a cluster of needs related to legal assistance was a leading source of concern among consumers. Legal assistance for child support, outstanding warrants and fines, and for help to restore driver's licenses rank as the third, sixth, and tenth highest unmet needs respectively (see table below) out of 42 surveyed needs. These unmet legal needs highlight a trend identified by consumers in the CHALENG report over the previous 3 years.

Top Ten Highest Unmet Needs Identified by Consumers, FY 2008 - 2010

2008	2009	2010
1. Welfare payments	1. Welfare payments	1. Welfare payments
2. Child care	2. Legal assistance for child support issues	2. Child care
3. Legal assistance for child support issues	3. Long-term, permanent housing	3. Legal assistance for child support issues
4. Guardianship (financial)	4. Child care	4. Family reconciliation assistance
5. Family reconciliation assistance	5. SSI/SSD process	5. Guardianship (financial)
6. Long-term, permanent housing	6. Legal assistance for outsta ding warrants/fines	6. Legal assistance for outstanding warrants/fines
7. SSI/SSD process	7. Guardianship (financial)	7. SSI/SSD process
8. Legal assistance for outstanding warrants/fines	8. Family reconciliation assistance	8. Credit Counseling
9. Credit counseling	9. Job training	9. Job Training
10. Re-entry services for incarcerated Veterans	10. VA disability/pension	10. Legal assistance to help restore a driver's license

Veterans find that resolving legal issues can be central to their ability to resolve their homelessness. Currently, many homeless Veterans find that their ability to move into permanent housing is compromised by old fines, debts, and other legal judgments related to the non-payment of child support. VA homeless program staff report that it is not unusual for a homeless Veteran to face the prospect of re-incarceration for misdemeanor warrants stemming from child support in arrears. Unresolved child support debts can result in liens against bank accounts, denial of credit, inability to secure a lease, failure in background checks (commonly a part of job applications), forfeiture of driver's licenses, and ultimately re-arrest. Many of these obligations were incurred while the Veteran was homeless, in a phase of active addiction, or otherwise untreated for a serious mental illness.

For incarcerated Veterans, the growing arrearage from unpaid child support can hurt their ability to reintegrate into the community. Their debts generally grow during incarceration even though the Veteran has no income. As many as a quarter of state prison inmates, and half of all incarcerated parents have open child-support cases (Re-Entry Policy Council, 2005). The prevalence of ex-offenders among those receiving VA homeless services suggests the breadth of the problem; approximately half of all those treated in VA specialized homeless programs have been convicted of felony or misdemeanor offenses requiring them to spend time either in prison, jail, or on probation.

This burden is particularly acute among ex-offenders. The typical incarcerated parent owes $20,000 in child support when released from prison, with payment schedules averaging $225 to $300 per month. Minimum wage workers have little hope of making these payments while supporting themselves. As child support payments are deducted automatically from paychecks, workers often quit once their pay is garnished, returning to the underground economy to avoid child support. For ex-offenders, participation in the underground economy often means a return to illegal activity (Turetsky, 2008). Furthermore, once participating in the underground economy, workers may make reduced or no child support payments placing their children and custodial parents at-risk (Levin et al., 2004) . Hence, legal assistance around the issue of child support is one key to helping Veterans meet their obligations to society, while still having the means to avoid relapsing to homelessness.

Veterans may sometimes be unaware of their obligations. The transient nature of homelessness and fear of the legal system (avoiding court dates) may make it difficult to communicate legal judgments and even paternity determinations to the affected Veteran. Where necessary, other issues related to family relationships, such as access and visitation or domestic violence may need to be addressed.

The Child Support Pilot was launched in 2010 based on the CHALENG findings that child support plays a role in homelessness. VA has worked with the Department of Health and Human Services (HHS) and the American Bar Association (ABA) to develop a pilot program that offers legal assistance to Veterans seeking to negotiate a sustainable child support payment plan. The pilot is currently taking place in Atlanta, Baltimore, Boston, Chicago, Los Angeles, Minneapolis, San Diego, Seattle, and Washington, D.C. These locations were selected as areas where existing resources, local interest, and current state child support laws offer a reasonable prospect for successful collaboration without the requirement for additional financial support. Early results suggest that this collaboration can help Veterans negotiate affordable child support payments and get their driver's licenses restored – often essential for obtaining and maintaining employment.

Supportive Services for Veteran Families (SSVF) is a VA program that provides assistance to impoverished Veterans and their families experiencing a housing crisis. Through grants made to community agencies, SSVF provides homeless prevention and rapid re-housing services. A requirement of these grants is that funded community agencies either directly provide legal services or links Veteran families to needed services. A 2009 Legal Services Corporation report describes the gap between available legal services and the needs experienced by the poor.

- Only 20% of the civil legal needs of low-income Americans are being met.
- On average, low-income households experience 1-to-3 legal problems per year, and roughly 1-in-5 was addressed with the assistance of a lawyer.

- For every client served by a grantee, at least one eligible person seeking help was turned down because of limited resources.

The need for legal services for those facing a housing crisis is varied. Certainly, those facing eviction have an immediate need of such assistance and one example of a provider working with an SSVF grantee to deliver legal services is Pine Tree Legal. Pine Tree has noted that availability of such services can be decisive. Of 959 clients facing eviction proceedings who received extended legal services, 98 percent were resolved in favor of the Pine Tree client.

In 2011, Pine Tree helped Veterans with a broad range of issues:

- 34% housing (esp. eviction, unsafe housing, and reasonable accommodation)
- 34% family (child custody and/or child support, guardianship, domestic violence)
- 15% consumer (esp. debt collection and contracts/ warranties)
- 7% income benefits (esp. Social Security, SSDI)
- 8% other (taxes, employment, health, etc.)

Additional Policy Support: On September 6, 2011 VHA issued Directive 2011-034 which encouraged staff to refer homeless Veterans to legal service providers or referral services for assistance with matters such as child support or outstanding warrants or fines, and to provide office space to legal service providers, when possible. Staff should provide Veterans with listings of local legal service providers, rather than referring them directly to a particular provider. In addition, staff may refer homeless Veterans to the Legal Services Corporation's Web site which lists local legal service providers: www.statesidelegal.org/findinghelp.

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APPENDIX Q: Traumatic Brain Injury (TBI)

Stephanie Rodrigues

Introduction:

A Traumatic Brain Injury (TBI) is, in basic terms, caused by a hit or jolt to the head. A TBI can also be caused by a penetrating head injury. Both can impair brain functioning. The extent of the impairment depends on the severity of the injury to the brain. While not all head injuries result in a TBI, severe brain injury may occur without visible damage to the face, head, or body, examples of which include cuts or breaks in the skin. Because of the nature of the work involved as a soldier, TBIs are especially common among Veterans. Therefore, if you suspect a TBI in a client, an early medical consultation is critical to ensure early intervention. In addition to TBI related statistics, we provide a description of symptoms and tips for prevention. This appendix is intended to provide some basic information and resources related to TBI; it is not a diagnostic tool. An individual with a suspected TBI should contact a primary care provider to undergo screening and obtain a referral for specialized services, if necessary. Recent TBIs may require emergency medical attention. In this appendix we provide links to resources for additional information, including links to services.

Statistics:

- Annually, about 1.4 million Americans have a TBI and about 50,000 cases are fatal.
- At least 5.3 million Americans currently have a long-term/lifelong TBI related disability.
- TBI is most often caused by car accidents, falls, and assaults.

Symptoms: The severity of a TBI can range from mild to severe. To give you an idea of what we mean by this range, mild TBI usually involves a brief change in mental status or consciousness, while severe TBI usually involves an extended period of unconsciousness or amnesia following injury. Depending on the severity of the injury, a TBI can result in short or long-term impairments to independent functioning. Mild symptoms often resolve within hours to days and typically improve over one to three months; however, if symptoms persist without improvement, seeking medical attention is advised as soon as possible. Below, we include a table with a list of mild, moderate, and severe TBI symptoms:

TBI Symptoms by Severity

MILD	MODERATE	SEVERE
Headaches	Trouble Organizing Thoughts	A Period of Unconsciousness for 24 Hours or Longer
Dizziness	Easily Confused	Additional Symptom are similar to Mild/Moderate Symptoms, but more Serious and Longer Lasting
Fatigue	Often Forgetful	
Lack of Concentration	Difficulty Solving Problems	
Memory Problems	Difficulty Making Decisions	
Irritability	Difficulty Planning	
Sleep Problems	Problems with Judgment	
Ringing in the Ears	Difficulty Describing Situations or Explaining Things	
Vision Changes	Speech Problems: Slow, Slurred, Difficult to Understand	
Problems with Balance	Difficulty Finding Words or Forming Sentences	

Tips for Prevention:

- Use your seat belt each time you are in the car, regardless if you are a driver or passenger. Encourage your passengers to wear their seat belts too.
- Use a child safety seat, booster seat, or seat belt to safely secure your child while in the car. Check to make sure that you are using equipment appropriate to the child's height, weight, and age.
- Stay away from alcohol and drugs. If you do consume either, never drive while under the influence or operate heavy machinery.
- Wear a helmet and make sure your children wear helmets when:
  - o Riding a bike, motorcycle, snowmobile, scooter, or all-terrain vehicle.
  - o Playing a contact sport, like football, ice hockey, or boxing.
  - o In or around a construction site.
- Make your living areas (home, office) safer to prevent falls. This includes consideration for special needs of senior citizens and children that may also be living with you.
- Check to make sure that the surface on your child's playground is made of shock-absorbing material. Examples include hardwood, mulch, or sand.
- If you live in an area where it snows or rains a lot, take extra precautions when driving:
  - o Use chains on your tires for snow, when appropriate.
  - o Beware of black ice.
  - o Avoid driving during severe weather.
- Before a snowstorm, make sure to salt your sidewalk and take extra precaution when navigating potentially icy sidewalks.
- Stay away from violence and guns.

Treatment:

Treatment for TBI is usually conducted in a multidisciplinary fashion. This means that if you have a TBI, you will likely have a team of providers who provide specialized services and can inform your care in a combined manner that will enhance your rehabilitation. Examples include a physical therapist, occupational therapist, neuropsychologist, and psychiatrist. Together, your team of specialists will help provide and coordinate clinical care, educate you and your family about your TBI and the available resources best suited to your needs, and inform you about new medical technologies that may enhance your TBI care.

Resources

- **The Department of Veterans Affairs Polytrauma System of Care** (www.polytrauma.va.gov/index.asp) – As a comprehensive TBI website geared toward Veteran consumers, this website provides background and real-life stories to build your knowledge about TBI, as well as updated news, research, and advancements related to TBI. Links to supportive services for both individuals experiencing a TBI, as well as family members/caregivers are also provided.
- **The Defense and Veterans Brain Injury Center** (www.dvbic.org) – Toll-free number for information: 1-800-870-9244. The Defense and Veterans Brain Injury Center (DVBIC) is a part of the U.S. military health system. As part of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), the DCoE has 16 sites that serve active duty military, their beneficiaries, and Veterans with TBIs. A description of the clinical care, clinical research initiatives/educational programs, and support for force health protection services can be found on their website.
- **Centers for Disease Control and Prevention** (http://www.cdc.gov/traumaticbraininjury/) – This website is similar to the websites geared toward Veterans listed above, but is geared toward the general public. Here you will find information about TBI that augments the information provided in this appendix.
- **National Institute of Neurological Disorders and Stroke** (http://www.ninds.nih.gov/disorders/tbi/tbi.htm) – Also geared toward the general population, this website provides general information on TBI, as well as links to current research initiatives and organizations that can help provide additional support.

APPENDIX R: Outline of Typical Criminal Proceedings and Glossary of Legal Terms

Stan Goldman

Outlines of Typical Criminal Proceedings:

Arraignment

There are several ways that a criminal proceeding may be initiated against an individual (e.g., arrest with a warrant, show cause hearing, complaint, indictment). However, it is at an "arraignment" that the defendant typically will first appear in court. Here, he or she will be formally charged with a crime or crimes and be asked to enter a plea (guilty or not guilty) to the charge(s).

Prior to entering a plea, the defendant has the right to consult with an attorney. If he or she cannot afford an attorney (i.e., is "indigent") and if incarceration may be imposed upon a guilty finding or verdict, the court must provide an attorney at public expense. In order to determine whether the defendant is indigent, and to gather other pertinent information for the court (e.g., Veteran's status), a probation officer will meet with the defendant prior to the arraignment.

Assuming the defendant pleads not guilty, the court will next determine whether the defendant will await trial in jail or be released on "personal recognizance," "bail," or, in some jurisdictions, "pre-trial probation." In rare cases, a defendant may be held for a short time (e.g., 90 days) in pretrial detention if found to be too dangerous to be released while awaiting trial.

Evaluations and Negotiation

After the defendant is formally charged at the arraignment and before the trial commences, any number of activities will occur far from public view: investigation of facts, interviewing of witnesses, pre-trial conferences, filing of motions, etc. One, however, is of particular interest: the forensic evaluation of the defendant's competence to stand trial and/or criminal responsibility where his or her mental condition is, or may be, at issue.

Simply put, a defendant who is not competent cannot be tried. And, a defendant who was, at the time of the crime, so mentally incapacitated that he or she could not appreciate that what he or she did was wrong or could not refrain from committing the act, cannot be held criminally responsible.

[Where forensic or other evaluations indicate that available clinical services are likely to be of benefit to the defendant, the defense attorney and prosecutor should strive to reach an agreement, and thereafter recommend to the court, an appropriate disposition].

Plea Bargaining

The vast majority of criminal cases are resolved through "plea bargaining," where a defendant agrees to plead guilty to either a lesser offense or to fewer offenses than originally charged in exchange for the prosecutor recommending a lighter sentence. The judge must approve of the agreement, and if he or she determines that the recommended sentence is too low, the defendant may withdraw the plea and go to trial.

The Trial

If the case does go to trial, the prosecution must prove, beyond a reasonable doubt, that the defendant committed the offenses charged. The defendant need not prove that he or she is innocent, only that the prosecutor's case does not establish guilt beyond a reasonable doubt.

The trial will be before a jury or a judge alone (i.e., a "bench trial" or "jury-waived trial"). First the prosecutor and then the defense attorney will present "opening statements" in which each will highlight the facts of the upcoming case from their respective perspectives. Both attorneys also will present, either at this point or during the testimony of particular witnesses, documents and other objects to be used as evidence.

The prosecution will present its case first. Each witness will be asked questions by the prosecutor ("direct examination"), and then be asked questions by the defense attorney ("cross examination"). The prosecutor may then ask "redirect" questions, and the defense "recross." After the prosecution has presented all of its witnesses, it will end its case (i.e., "rest").

Now it is the defense's turn. However, the defendant is not obligated to present any evidence; again, he or she need not prove innocence. If a defense is put on, the scenario is the same as for the prosecution: direct examination, cross examination, redirect examination,

and recross examination of each witness. Under the Fifth Amendment to the U.S. Constitution, the defendant has the absolute right to refuse to testify.

After the defense attorney rests, both attorneys will present their closing arguments. This time the defense will go first and the prosecution will follow. If there's been a jury trial, the judge will "instruct" and "charge" the jury: that is, delineate and define those laws that are applicable in the case and explain what the jury is to do in its deliberations.

The Decision and Sentencing

In a jury trial, the jury's decision must be unanimous and is called a "verdict"; in a bench-trial (or jury-waived trial), the judge's decision is called a "finding."

There are three possible outcomes: guilty, not guilty and, if at issue, not guilty by reason of insanity. If not guilty, the defendant will be free to leave. If not guilty by reason of insanity, he or she will likely be subject to some form of civil commitment. And, if guilty, a sentencing hearing will be conducted by the judge at which the prosecutor and defense attorney will present evidence as to the most appropriate disposition.

The sentence that the judge may impose for any particular offense is likely to fall within a statutorily established range. Sometimes the defendant will be ordered to serve the entire time at a penal facility. Sometimes, he or she will be placed on probation for the entire time. And often, the judge will impose a "split sentence," whereby the defendant will serve part of the sentence in the facility and the remainder of the time on probation.

Glossary of Legal Terms

Arraignment: the first appearance in court at which the defendant is formally charged and asked to enter a plea (i.e., guilty or not guilty).

Bail: a condition of release, usually monetary, ordered by a judge before a criminal trial. Its purpose is to ensure that the defendant appears at trial.

Bench trial: a criminal trial heard by judge without a jury (also known as a "jury-waived trial").

Beyond a reasonable doubt: in a criminal proceeding, guilt must be established to a moral certainty.

Competence to stand trial: the ability of a defendant to work with his or her defense attorney and to understand, rationally and factually, the criminal proceedings. A defendant who is not competent to stand trial cannot be tried.

Confidentiality: the legal and/or ethical obligation of practitioners of certain professional disciplines (e.g., psychiatrists, psychologists, social workers) to refrain from divulging information about their patients. There are several important exceptions, the most significant of which is the duty to protect patients and others from serious bodily harm.

Defendant: in a criminal case, the person accused of a crime.

Defense attorney or defense counsel: the lawyer who represents the defendant in a criminal case. The lawyer may be hired and paid (i.e., retained) by the defendant or, if the defendant is indigent (i.e., cannot afford to retain counsel), appointed by the court and paid through public funds.

Disposition: the final outcome of a court proceeding; in a criminal case where the defendant has been found guilty, the disposition will be the sentence imposed by the judge.

Finding: a determination made by a judge.

Good conduct date: the date on which a prisoner may be released from incarceration prior to serving the full sentence imposed by earning "good time credits" for participating in various activities (e.g., blood drives, educational programs).

Indictment: a formal charge (i.e., an allegation of a crime) found by a grand jury and presented to a court for prosecution.

Judge: the public official who oversees ("presides" over) court proceedings.

Not guilty by reason of insanity: in most states, a defendant will not be held criminally responsible if he or she was mentally ill or mentally retarded at the time of the crime and, as a result, could not appreciate that what he or she did was wrong or could not control his or her behavior. The consequences of a not guilty by reason of insanity acquittal vary greatly among the states but typically will result in civil commitment of some form.

Parole: early release from incarceration contingent upon a person's ("parolee's") compliance with conditions set by a parole board and supervised by a parole officer.

Personal recognizance: the release of a defendant with no conditions other than his or her promise to appear for trial.

Plea bargain: an agreement between a defendant and a prosecutor in which the defendant agrees to plead guilty to a lesser offense or fewer offenses then originally charged in exchange for a lighter sentence. A judge must approve of a plea agreement.

Privilege: as a general rule, and with very few exceptions, a witness in court must testify to any and all information of which he or she has first-hand knowledge. One exception is "privilege." Several types of privilege have been established: e.g., "priest-penitent," "spousal," "lawyer-client," and "patient-psychotherapist." Thus, for example, a patient may prevent his or her psychologist from divulging in court information that had been shared with the psychologist in private, unless the psychologist had warned the patient of the limits of confidentiality.

Probation: a sentence imposed upon a person ("probationer") after a guilty finding (by a judge) or verdict (by a jury) in which the probationer is released, in lieu of incarceration, subject to compliance with court-ordered conditions. In some jurisdictions, a defendant may be placed on probation before trial (in lieu of bail) and charges may be dismissed upon the successful completion of the probationary conditions.

Probation officer: a court officer who supervises a probationer's compliance with the conditions of probation. Typically, a probation officer will report to the court on a probationer's progress and, should a probationer violate conditions, the officer may seek to have the probationer returned to court ("violated").

Prosecutor: the lawyer who represents the government in a criminal proceeding. The titles vary (e.g., a U. S. Attorney represents the federal government; a state's Attorney General, the state; a District Attorney, a county government).

Verdict: a determination made by a jury.

Witness: a person who testifies in a court proceeding. There are two "types" of witnesses, "lay" and "expert." A lay witness may testify only to information of which he or she has first-hand knowledge (i.e., information that he or she has come to know directly through his or her senses – hearing, seeing, touching, feeling, or smelling). An expert witness may offer an opinion to assist the fact-finder (judge or jury) in resolving a complex issue if the judge determines that the witness is sufficiently qualified to do so.

APPENDIX S: Accessing Important Resources and New Information at the MISSION Model Website

Mason Ziedonis

The MISSION MODEL

The MISSION model website, www.missionmodel.org, was developed to go hand-in-hand and to provide further information regarding this manual, including articles, news videos, testimonials, and access to other MISSION manuals & participant workbooks. These additional materials will help clinicians, case managers, supervisors, and peer support specialists update their knowledge and help them implement MISSION in a variety of settings. Program participants may also find the information helpful. The list below highlights features included in the website.

- **What is MISSION?** All of the key components of MISSION are described succinctly.
- **Past & Active Projects –** The MISSION model began in 1999 with Dr. Smelson and his team. This website section provides information on the numerous projects that helped develop and evaluate the model, including the MISSION Jail Diversion Project that led to this current MISSION-CJ manual.
- **RESOURCES: Manuals & Workbooks –** Downloadable PDFs are available for the MISSION Treatment Manual & Participant Workbook, MISSION-VET Manual & Participant Workbook, and the MISSION Criminal Justice Edition Manual & Participant Workbook.
- **Publications –** Information on the literature supporting the evidence-basis for the MISSION model components is included in this section.
- **News, Updates, and Videos –** learn from videos such as "Jail Diversion and Trauma Recovery." These videos provide another vehicle to describe MISSION services and the need for specific services for special populations.
- **Testimonials –** MISSION participants share their stories of recovery and hope.
- **Contact Us:** Send us your questions and suggestions via email through our website. We want to hear about your experiences implementing MISSION. **Subscribe for Email Updates!**

Please be sure to check back on the site frequently to catch our latest updates.

THE

MISSION

Criminal Justice

TREATMENT MANUAL