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## Case Management

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# Case Management

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## IV. Case Management



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



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

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

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

- Work effectively as a team with the Peer Support Specialist (PSS),
- Orient the Veteran to MISSION-VET services,

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

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

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

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

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

2. ***The MISSION-VET program begins in a setting where the Veteran has recently been housed, such as housing secured through receipt of a HUD-VASH voucher (see Chapter II).*** The MISSION-VET CM immediately assumes responsibility of facilitating the Veteran's treatment plan and serves as either the Veteran's primary or secondary provider of care, depending on whether or not the Veteran is enrolled in another treatment, rehabilitation, or case management program. If the Veteran is not enrolled in such a program, the MISSION-VET CM immediately assumes responsibility as the Veteran's primary treatment provider and focuses on stabilizing

symptoms and achieving (or maintaining) sobriety. The MISSION-VET team works to connect the Veteran to programs that can meet his or her service needs, while the MISSION-VET CM provides DRT psychoeducational co-occurring disorders treatment sessions. In this setting, CTI Phase 1: *Transition to Community*, begins as direct services are provided, community supports are identified, and linkages are facilitated by the MISSION-VET team.

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

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

## Overview of MISSION-VET Case Manager's Responsibilities

CTI Phase 1: Transition to the Community	
<p><b>Program is Initiated in Inpatient/ Residential Treatment</b></p>	<p><b>MISSION-VET CM:</b></p> <ul style="list-style-type: none"> <li>Meets with the Veteran and inpatient/residential treatment staff to discuss program expectations and boundaries, including the responsibilities of the inpatient/residential treatment team and the MISSION-VET treatment team. <i>Note: MISSION-VET staff always serves as secondary provider while Veteran is in inpatient/residential care.</i></li> <li>Meets with inpatient/residential staff to review the Veteran's treatment plan.</li> <li>Conducts 13 psychoeducational <b>DRT</b> co-occurring disorders treatment sessions.</li> <li>Attends discharge planning meetings prior to the Veteran's discharge to assist inpatient/residential staff in identifying community resources essential for successful community integration.</li> <li>Assists with executing the discharge plan and provides linkages to key community supports.</li> </ul>

Table continued on next page.



<p><b>Program is Initiated in the Community</b></p>	<p><b>MISSION-VET CM:</b></p> <ul style="list-style-type: none"> <li>• Meets with Veteran alone or with other assigned care providers (such as HUD-VASH case manager) to discuss program expectations and boundaries.</li> <li>• Completes treatment plan or works with other care providers to review/modify treatment plan.</li> <li>• Serves as either the Veteran’s primary or secondary provider of care, depending on whether or not the Veteran is enrolled in another treatment, rehabilitation, or case management program.</li> <li>• Conducts individual <b>DRT</b> sessions (unless Veteran is residing in congregate living, in which case, consider group format).</li> <li>• Provides linkages to community resources such as mental health, substance abuse, vocational/educational, trauma-related treatment supports.</li> <li>• Tracks Veteran’s progress in use of community resources and supports.</li> </ul>
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**CTI Phase 2: Try-Out**

**MISSION-VET CM:**

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

**CTI Phase 3: Transfer of Care**

**MISSION-VET CM:**

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



 **B. Working Effectively as a MISSION-VET Treatment Team**

The MISSION-VET approach requires CMs and PSSs to work together on teams, with one PSS and one CM assigned to the same Veteran. CMs and PSSs are seen as equal members of the team, who each contributes their unique backgrounds

and experiences to assist Veterans enrolled in the MISSION-VET program. As shown in the table, “Responsibilities of the MISSION-VET Case Manager and Peer Support Specialist,” some roles and responsibilities are specific to the CM or the PSS, while others are shared. For more information on the role of the MISSION-VET PSS, please see Chapter V, Peer Support.

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

<b>Primary Responsibility of CM, with Input from the PSS</b>	<b>Primary Responsibility of PSS, with Input from the CM</b>	<b>Responsibilities Shared by the CM and PSS</b>
<ul style="list-style-type: none"> <li>• Orientation/introduction, mid-program progress check, transition to community, and discharge plans</li> <li>• Management of clinical crises</li> <li>• Delivery of DRT psycho-educational and booster sessions at each visit</li> <li>• Identify, monitor, and provide referrals for trauma-related symptoms</li> <li>• Provide vocational/educational supports as needed: interview skills training, resume building, linkages to education and training programs</li> <li>• Facilitate linkage to other clinical services</li> <li>• Communicate with clinical service providers</li> <li>• Review and work through benefits and entitlements issues (Social Security Income and Social Security Disability)</li> </ul>	<ul style="list-style-type: none"> <li>• Help Veterans advocate for themselves with providers and ensure effective two-way communications</li> <li>• Recreational planning and modeling healthy living using free or low-cost community resources</li> <li>• Linkage to community mental health and substance abuse recovery programs (NA/AA)</li> <li>• Accompany Veterans to clinical appointments, job interviews, recreational activities, and self-help group meetings</li> <li>• Increase motivation toward recovery goals</li> <li>• Assist Veterans with <i>Consumer Workbook</i> exercises and readings, discuss material, and reinforce insights</li> </ul>	<ul style="list-style-type: none"> <li>• Weekly team meetings with staff providing care at inpatient/residential treatment facility</li> <li>• Discharge session from the treatment facility</li> <li>• Linkage to needed community services, including vocational/educational supports and trauma-related treatment resources</li> <li>• Assistance with housing maintenance</li> <li>• Ongoing monitoring of symptoms, psychoeducation and training in symptom management, coping skills, medication compliance, problem solving, and relapse prevention</li> <li>• Transportation assistance</li> <li>• Provide support during job stresses</li> <li>• Provide support during clinical crises</li> <li>• Refer out as appropriate during exacerbation of symptoms</li> </ul>

For the CM/PSS team relationship to work effectively, it is critical that both team members share information with one another about the contact they have with the Veteran. These communications help MISSION-VET team members support each other’s work and track evolving issues that may require special intervention. The PSS may tell the CM that the Veteran has been seeing drug-using friends at their old haunts, or the CM may tell the PSS that a Veteran has been shy and nervous about going to AA meetings and asks the PSS to offer to attend

a meeting with that Veteran. At their regularly scheduled supervision meetings with the Clinical Supervisor, or earlier if necessary, the CM/PSS team should share any serious problems on which they would like guidance or assistance, preferably at an early enough stage to plan an intervention.

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



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

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

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

## **C. Initiating the Delivery of MISSION-VET Services**

The MISSION-VET CM has the primary responsibility of orienting the Veteran to the MISSION-VET program and the expectations that come with being a participant. The Veteran learns about the different services provided, what is expected of those who participate in the program, the different members of the MISSION-VET treatment team and their responsibilities, and how to communicate with each member of the treatment team. The Veteran also receives the *MISSION-VET Consumer*

*Workbook* at this time. The CM begins the process of developing a treatment plan, involving the MISSION-VET PSS as well as VA and community treatment providers as applicable.

## **Identifying and Orienting MISSION-VET Participants**

### **Identifying Program Participants**

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

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

### **Screening Prospective Participants**

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

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

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

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



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

### **Clinical Assessment**

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

### **Orientation to the MISSION-VET Program**

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

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

### ***Introducing the MISSION-VET Consumer Workbook.***

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

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

2. Exercises that are keyed to the DRT sessions which are reviewed in the Peer-led sessions,
3. Advice from Veterans who have made similar transitions which will help program participants settle and adjust into their communities.

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

### **Initiating Treatment Planning**

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

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

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





## MISSION-VET Treatment Plan

### Primary Diagnosis

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### Secondary Diagnosis

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### Other Treatment Providers

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### Service Needs

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

### MISSION-VET Service Delivery

Frequency (Weekly, Bi-weekly, Monthly)

Length (2 months, 6 months, 12 months)



## D. Delivering Dual Recovery Therapy (DRT)

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

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

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

### The Dual Recovery Status Exam

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

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



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

Most sessions involve personalized, hands-on application of the concept to the Veteran's life. As used in MISSION-VET, the first four DRT sessions focus on assessment and treatment engagement, while the last nine sessions are devoted to skills

training in the following areas: Relapse Prevention, Regulating Mood, Regulating Thoughts, and Managing Interpersonal Relationships.

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

## DRT Session Topics in MISSION-VET

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



The extent to which MISSION-VET CMs are knowledgeable about and successfully utilize various evidence-based therapeutic practices during these sessions will influence the service delivery of each session. The following “Therapeutic Techniques” table lists and briefly describes several suggested

evidence-based therapeutic practices that are grounded in motivational interviewing and cognitive behavioral therapy. Detailed descriptions of each therapeutic practice and technique can be found in Appendix F.

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

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

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

## **E. Using Critical Time Intervention (CTI) Case Management**

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

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



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

### **CTI Phase 1: Transition to Community**

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

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

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

If MISSION-VET services commence in the community, the MISSION-VET CM may be either the primary or secondary provider of care. This depends on whether the Veteran is enrolled in a structured outpatient treatment program, such as an Intensive Outpatient Program (IOP), or has another care provider such as a HUD-VASH case manager.

If the Veteran is not enrolled in an outpatient treatment program or does not have another treatment provider, then the MISSION-VET CM serves as the primary provider of care and assumes responsibility for executing the treatment plan, making modifications as needed along the way. Regardless of the treatment setting that the Veteran originates from, the common goal of the first phase of CTI is to identify critical community resources that will help promote the successful recovery of each Veteran. This phase also includes facilitating the ongoing use of community resources and ensuring that each problem area identified in the MISSION-VET treatment plan is targeted.

### **CTI Phase 2: Try-Out**

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

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

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



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

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

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

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

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

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

### CTI Phase 3: Transfer of Care

During Phase 3, the MISSION-VET CM fine-tunes linkages to VA and community supports that were established during

Phases 1 and 2. For example, the CM and Veteran may meet with community providers to identify any existing gaps in service and to ensure that a continuing care plan for the Veteran has been established. As the date for program termination approaches, the CM, PSS, and Veteran reflect on the work that has been accomplished and acknowledge the Veteran's termination from the program.

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

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

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

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



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## **F. Providing Vocational and Educational Support**

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

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

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

### **Vocational/Educational Support Provided by MISSION-VET Case Managers**

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



## **G. Trauma-Informed Care Considerations**

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

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



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

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



### H. Ending the MISSION-VET Program

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

### Topics for Discussion During Final MISSION-VET Session

Review the Veteran's progress throughout the program:

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

Say goodbye.

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

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