A Case Manager's Practical Guide to Implementing MISSION-CJ

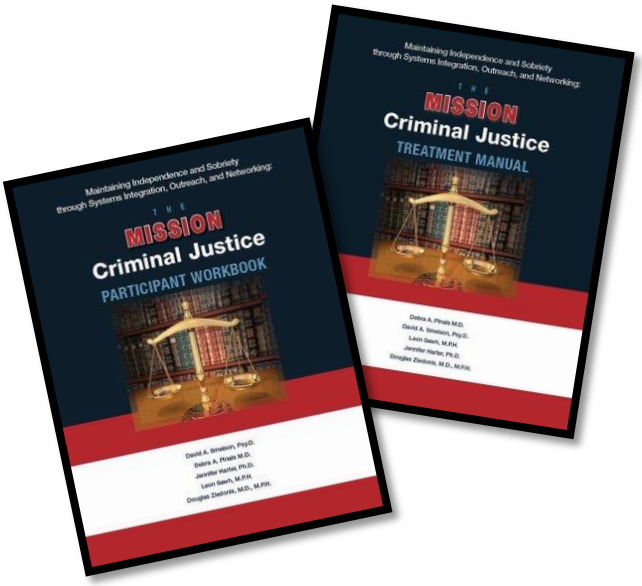
MISSION, *Criminal Justice Edition*

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

Introduction to the Case Manager's Role

Introduction

Welcome to the MISSION-CJ Team! This is a practical guide for on MISSION-CJ Case Managers (CM) on "how to" deliver MISSION-CJ services. This guide does *not* intend to replace the MISSION-CJ Treatment Manual, but highlights key CM roles and responsibilities; service delivery components; and references useful tools and materials for the CM to use as MISSION-CJ is implemented. Corresponding manual page numbers are provided within this guide which link to detailed information in the manual and workbook. For more detailed information on the MISSION-CJ model of care please see pages 59-71 of the treatment manual. To access the manual, visit www.missionmodel.org.



Case Manager's (CM) Role

As part of a team, the Case Manager (CM) works alongside the Peer Support Specialist (PSS). The CM both delivers services as well as links clients to providers and other psychosocial supports in the community. The Risk-Need-Responsivity model (RNR) provides the criminal justice framework for MISSION-CJ implementation, and CMs use this model as they deliver the four components of MISSION-CJ:

Risk-Need-Responsivity (RNR) Framework			
Critical Time Intervention (CTI)	Dual Recovery Therapy (DRT)	Vocational and Educational Support	Trauma-Informed Care

The CM uses the RNR framework to assess clients' risk level for re-offending as well as their specific criminogenic needs, and develops a comprehensive and individually tailored treatment plan that is based upon that assessment. The RNR framework in MISSION-CJ maximizes the effectiveness of MISSION-CJ treatment components, while focusing on the prevention of future criminal recidivism. As such, RNR enhances outcomes from both personal recovery and public safety perspectives.

With regard to the provision of services, the CM uses Critical Time Intervention (CTI), which is a time-limited form of assertive outreach, to structure service delivery. The CM delivers 13 structured Dual Recovery Therapy (DRT) sessions that address both mental health and substance use problems. In addition to these core components of MISSION-CJ, CTI and DRT, the CM also offers support and linkages around employment, either in the form of job coaching or a referral to a vocational rehabilitation specialist, as well as works in a trauma-informed way for those clients whom have previously suffered trauma. Table 1 outlines core and support services provided by CMs. For more information on the core components and the CM's role please see pages 72-88 in the MISSION-CJ Treatment Manual.

Table 1: Brief Overview of Core and Support Services in MISSION-CJ

Risk-Need-Responsivity (pgs. 25-26; 183-194)

RNR is a framework that uses three principles to facilitate successful community re-entry for justice-involved clients, with the overarching goal of reducing recidivism. The three priniciples are briefly described below.

Risk Principle: The CM will provide services that coincide with clients' level of risk to re-offend.
Need Principle: The treatment plan will also include an assessment of clients' specific criminogenic needs.
Responsivity Principle: The CM will maximize the clients' ability to learn from treatment and meet individual goals by providing interventions tailored to each client's learning style, readiness, motivation, and strengths.

Critical Time Intervention (pgs. 79-83)

CTI is a time-limited, intensive case management model that focuses on critical transition periods, enhances continuity of care, and identifies/strengthens formal and informal community supports to prevent institutionalization and homelessness. It is similar to assertive community treatment, but offered for a time-limited period and includes treatment stages and phases briefly described below.

Phase 1 - *Transition or Integration to Community*: The CM will help clients identify critical community resources, facilitate the ongoing use of community resources, and ensure that each problem area identified in the treatment plan is targeted.
Phase 2 - *Try-Out*: Clients become more self-sufficient in the community while the CM offers guided support to help attain goals.
Phase 3 - *Transfer of Care*: The CM fine-tunes linkages to community supports and reflects with each client on the work accomplished.

Dual Recovery Therapy (pgs. 84-86; 205-260)

DRT is an evidence-based psychoeducational therapy that helps clients understand the interrelation of mental health problems and substance abuse. The CM will:

- Provide 13 weekly structured DRT sessions, usually in a group format, during CTI phases 1-2
- Facilitate booster DRT sessions, as needed, during CTI phases 2-3
- Complete a DRT status exam for each DRT session
- Review DRT related worksheets completed in the MISSION-CJ Participant Workbook with the client

Vocational and Educational Support (pgs. 86-87; 107-118; 283-291)

The CM monitors and supports clients' employment and educational goals by:

- Helping clients develop employment goals
- Assessing eligibility for vocational benefits and assistance
- Providing linkages to vocational specialists
- Helping clients understand benefits packages and retirement plans
- Assisting clients in managing conflicts with co-workers or supervisors
- Role-playing job interviews to provide direct feedback in a trusted environment
- Referring clients for academic assessments to determine additional educational supports (e.g., tutoring, disability services, etc.)

Trauma-Informed Care (pgs. 87; 119-134; 292-293)

Being "trauma-informed" means being aware of the possibility of trauma among clients; knowing and being able to

recognize symptoms of trauma; being aware of the impact trauma has on the lives of clients; being able to screen for trauma; and knowing how and when to refer out for specialized help. MISSION is *not* a PTSD intervention. The CM will:

- Screen for and identify trauma-related symptoms and disorders
- Refer clients to resources qualified to treat PTSD related disorders as necessary
- Create a welcoming and safe environment
- Focus on resilience, self-healing, mutual support, and empowerment
- Ensure voice, safety, autonomy, choice, trustworthiness, and the elimination of coercion

Getting Started with MISSION-CJ

The Case Manager has the primary responsibility of orienting the client to the program and its expectations. The following are steps that the CM can take to identify, orient, and initiate treatment planning with clients. MISSION-CJ can be initiated with clients involved in the criminal justice system in one of two ways - in lieu of incarceration or as a re-entry program. Further detail on initiating the delivery of MISSION-CJ services can be found on pages 75-78 and in Appendix E, pages 200-204, of the manual.

Step 1: Screening and Enrollment of Participants

All referred clients should be screened to ensure that they meet program eligibility criteria. Eligibility criteria for MISSION-CJ include:

- Active or prior criminal justice involvement
- Diagnosed with both a co-occurring substance use disorder and mental illness (COD)
- Willing to take part in the program and receive services
- Able and willing to live in the community - may need input or approval from authorities
- Capable of consenting to services, usually without any active concerns about competence to stand trial

During the screening, the CM describes the MISSION-CJ program to the client, and if he/she is eligible and interested, the CM proceeds with the enrollment process (i.e., reviewing and signing enrollment documentation such as the treatment contract and releases). During the screening, if there is a concern about the client's competence to stand trial, the CM, in collaboration with the MISSION-CJ Clinical Supervisor (CS), should assess the client's capacity to participate in the program, and follow-up with criminal justice personnel as needed. Following the screening and enrollment process, the CM conducts a thorough RNR, mental health, substance use, and psychosocial needs assessment.

Step 2: Providing Clients with an Orientation to MISSION-CJ

The introductory meeting is an opportunity for the CM to learn about the client's goals, barriers, strengths, hopes, and interests, as well as, triggers, coping skills, available supports, risk level for re-offending, and criminogenic needs. The CM describes his/her role as the client's designated CM and how the program works. The PSS can also be included in this introductory meeting but may do one on his/her own as well. The meeting is usually scheduled for 45 minutes. In addition to introducing MISSION-CJ, the CM explains to the client the CM's role in probation; types and frequency of monitoring; and possible consequences of lack of participation. Table 2 includes areas to review with the client during his/her orientation to MISSION-CJ.

Table 2: Key Program Elements to Review with MISSION-CJ Clients

	Key Program Elements
MISSION-CJ Structure	• Program Length (2, 6, or 12 months) • Team Based Approach: CM and PSS work closely together as a team to help the client; CM and PSS have distinct yet complementary roles

	• Frequency, duration, location of the intervention (e.g., weekly DRT sessions, monitoring, home-based and in community sessions)
MISSION-CJ Goals	MISSION-CJ… ✓ Addresses co-occurring mental illness and substance use disorder (COD) ✓ Helps the client in reaching personal goals in his/her recovery ✓ Helps the client avoid further arrests and remain out of jail ✓ Helps the client transition into the community ✓ Helps the client reach employment and/or educational goals ✓ Encourages the client to engage in healthy community activities that he/she enjoys ✓ Provides linkages and transportation to community resources to help the client meet his/her goals ✓ Coordinates care of clients across providers, including collaboration with community supervising entities
Program Requirements and Policies	• Privacy • Confidentiality (i.e., mandatory reporting, communication between CM and PSS) • Privilege • Information sharing - Release of information to outside providers *See Appendix N, pages 298-306 of the treatment manual for more information*

Step 3: Initiating Treatment Planning

The treatment plan is informed by the Risk-Need-Responsivity assessment (see page 6 of this guide); mental health, substance use, and psychosocial needs assessment; discussion of the client's goals, supports, personal strengths, and potential obstacles to recovery; and information gathered from other sources (i.e., medical records, probation, and other providers). The CM, with feedback from the PSS, collaboratively develops a treatment plan with the client and then discusses it in detail to ensure an understanding of goals. An example of a MISSION-CJ treatment plan is on page 24 of this guide, as well as in Appendix H of the treatment manual on pages 269-270. The CM and the client review the treatment plan regularly to identify new goals and ways to solve challenges the client may come across on his/her road to recovery. The treatment plans are also reviewed regularly in team meetings and fine-tuned when necessary to reflect achievements, changed or new goals, and updated objectives. Although the CM is responsible for the treatment plan, the CM solicits and integrates the PSS's feedback into the plan throughout treatment.

Utilizing the Risk-Need-Responsivity (RNR) Framework in MISSION-CJ Implementation

Using the RNR Framework in Treatment Planning

The Risk-Need-Responsivity (RNR) model is considered a best practice for professionals working with individuals in criminal justice settings and has been shown to effectively reduce recidivism. A RNR structured treatment support plan is a map specifying where clients are in recovery from substance use and criminality, where they need to be, and how they can best use available resources (i.e., personal, program-based, or criminal justice) to get there. The RNR Treatment Support Plan can be found on the MISSION website under Risk-Need-Responsivity Clinical Series at http://www.missionmodel.org/clinical/. The treatment support plan also serves as a basis of shared understanding between the client, MISSION-CJ team, other treatment providers, and criminal justice personnel. The CM should complete the RNR Treatment Support Plan at the beginning of initiating treatment (generally within the first three sessions) for all MISSION-CJ clients. The plan can be used as a way to synthesize information attained from multiple sources including a client interview (i.e., MISSION-CJ baseline assessment), collateral sources (i.e., probation officer), treatment providers, and client records. A critical component of this plan is the inclusion of available risk-needs screenings and assessment results. The RNR Treatment Support Plan does not replace, but complements, your agency's established screening and assessment process and documentation. The RNR Treatment Support Plan should be reviewed and updated with progress monthly. In addition to the MISSION-CJ manual, MISSION providers may also reference the RNR treatment guide and webinar located at www.missionmodel.org.

The Three Core Principles of the RNR Model

The RNR Model is a framework designed for interventions for offenders to better organize their needs and develop an inclusive treatment plan. The main objective of the RNR framework embedded in MISSION-CJ is that the program will focus on individual and systems level outcomes that decrease clients' likelihood of being involved in the criminal justice system again. RNR has three core principles which are briefly described in Table 3. For more information, and a case example of the RNR model please see pages 34-37, and Appendix C, pages 183-194, of the treatment manual.

Table 3: Brief Overview of Core Principles of the RNR Model

RNR Core Principle	Description
Risk	The MISSION-CJ team will match the level of service to clients' level of risk to re-offend.
Need	The MISSION-CJ team will assess each client's specific criminogenic needs and build treatment around those needs.
Responsivity	The MISSION-CJ team will work to maximize each client'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 client.

RNR Model: Risk Principle

The CM will evaluate each client's level of risk to re-offend. In order to determine risk, the CM may use structured assessments and/or documentation to distinguish risk-level. After determining risk-level, the CM matches

the client with the level of services he/she needs (e.g., higher risk would need intensive services such as residential treatment). The CM also takes into consideration the intensity of services the client needs as well as other recommendations such as frequency of meetings. Listed below are recommended steps for CMs to follow that are relevant to the Risk Principle. Further detail can be found in Appendix C, on pages 183-185 of the manual.

Step 1: Request permission from the client, court, and/or correctional agency to review the client's legal records.
Results of previously administered structured risk assessments can be found in the client's legal records. It is important to request permissions for these records early in order to obtain them in a time frame that does not delay the client's treatment. The CM should use test results from the most recent testing completed, however due to the variations in assessments all results should be reviewed. The CM should also use his/her judgment as to whether or not additional risk assessments are necessary.

Step 2: If information on risk level is not available, or was based largely on clinical judgment, then conduct a structured risk assessment that is based on the client's length and breadth of criminal history.
The CM can use a structured risk assessment if information is missing or not enough information about the client is available. Information that is important to obtain includes, but is not limited to: age, age of first offense, number of prior offenses, variety of prior offenses, rule violations while on conditional release, etc.

Step 3: Match clients to the appropriate MISSION-CJ protocol based on the results of the risk assessment and collaborate with programs that match client's risk level.
Once the level of risk of the client is determined, the CM can begin to plan the intensity of treatment services. Treatment considerations that depend on the level of risk include the recommendation for intensive services (e.g., residential or inpatient treatment), frequency of appointments, number of months of MISSION-CJ treatment, types of referrals, frequency/level of monitoring, etc.

RNR Model: Need Principle

After the CM determines the client's level of risk, he/she can then specify what needs need to be met to treat the client. When developing the treatment plan the criminogenic needs must to be taken into account. The "Central Eight" criminogenic needs are presented in Table 4 below (adapted from Bonta & Andrews, 2007). This list is then divided into the "Big Four" (i.e., factors associated with the strongest recidivism risk) and the "Moderate Four" (i.e., risk factors that have less of an impact on recidivism). Each of these risk factors should be targeted for change on the client's treatment plan.

Table 4: Eight Criminogenic Needs

	Risk Factor	Behavioral Manifestation
Big Four	History of Antisocial/Criminal Behavior	• Criminal Record
	Antisocial Personality Pattern	• Impulsivity • Aggression • Irritability
	Antisocial Cognitions	• Rationalize criminal activity • Negative attitude towards the law
	Antisocial Associates	• Friends with criminal histories

		• Friends with anti-social attitudes • Lack of pro-social supports
Moderate Four	**Family Support**	• Interpersonal difficulty with primary family members including parents, spouses, siblings, etc. • History of poor parental monitoring and lack of 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)

The following are the recommended steps for CMs to take when addressing the criminogenic needs of each client. Further detail can be found in Appendix C, on pages 185-186 of the manual.

Step 1: Conduct a clinical evaluation that primarily covers the dynamic "Central Eight" criminogenic needs.
The CM can complete a needs assessment, using a structured assessment or clinical interview. The CM's evaluation should include whether or not the client:

- ✓ Exhibits an antisocial personality pattern or antisocial cognitions
- ✓ Has a peer network of individuals involved in criminal activities
- ✓ Has significantly unstable relationships with family members
- ✓ Has limited education/job skills
- ✓ Has limited avocational interests or pastimes
- ✓ Has ongoing substance use problems or is at high-risk for relapse to substance use

Step 2: When possible, use a structured instrument that considers strengths, special responsivity factors, and case management planning.

Step 3: Cover the same domains of a needs assessment for all clients, regardless of sociodemographics.

RNR Model: Responsivity Principle

Once the risk level and criminogenic needs of the client have been determined, the CM uses the Responsivity Principle to specify interventions that will be delivered to the client which maximize his/her potential to reach treatment goals. The following are the recommended steps for CMs to take in applying the risk assessment and criminogenic needs of a client to his/her treatment plan. Further detail can be found in Appendix C, on pages 186-190 of the manual.

Step 1: Formally or informally assess clients and revise the MISSION-CJ treatment plan accordingly.

The CM assesses for information regarding: cognitive impairment, motivation and readiness for change, personal strengths, practical barriers to treatment attendance, and sociodemographics.

Step 2: Administer and/or work with clinicians/linkages who can administer an assessment of global personality functioning to obtain information on (a) antisocial personal patterns and cognitions, and (b) personal strengths.
The following traits are predictors of antisocial behavior and CMs should give these traits special attention when reviewing assessment results: anger, hostility, aggression, antagonism, alienation, distrust, impulsivity, sensation-seeking, and self-centeredness/narcissism.

Step 3: Ask clients for their personal goals regarding (a) treatment, and (b) the personality assessment they received.
During early sessions with the client, the CM asks what the client's goals for treatment are and inquires about what behaviors the client wishes to change. This discussion helps the CM to understand what information may be most important when reviewing the assessment and giving feedback to the client.

Step 4: Provide feedback to clients using a collaborative approach to assessment.
The CM uses a collaborative approach to assessment and feedback, working along with the client to see if the client agrees or disagrees with the assessment results. It may be helpful for CMs to encourage clients to identify which aspects of their own thinking are problematic and contribute to their criminal recidivism.

Step 5: Discuss with clients which traits would be most beneficial to monitor over time, and conduct periodic assessments based on level of risk.
The CM engages the client in a collaborative discussion to identify those traits that would be most beneficial to monitor over time. The CM encourages the client to keep a log of the frequency of behaviors that are indicators of the trait (e.g. the trait of aggression can be monitored by the number of arguments with others). The CM and the client review changes in targeted behaviors to monitor the client's progress. In addition, the CM periodically re-administers personality assessments in accordance with the client's level of risk throughout MISSION-CJ.

Step 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.
While CMs and other relevant parties will have recommendations about which needs to prioritize in the treatment plan, CMs are encouraged to give considerable weight to the needs that are most important to the client and strive to deliver on these needs early and often during the intervention.

Step 7: For clients in whom antisocial personality patterns and cognitions are identified as criminogenic needs, a structured cognitive behavioral therapy group for recidivism risk could be offered.
The CM provides referral to evidenced-based cognitive-behavioral group interventions designed to modify antisocial personality patterns and cognitions, such as Moral Reconation Therapy, Thinking 4 Change, and Reasoning & Rehabilitation. Additionally, in their own individual sessions with clients, CMs can engage clients in thought restructuring exercises to modify antisocial thinking patterns.

Case Manager's Responsibilities: Critical Time Intervention (CTI)

The CM works in collaboration with the PSS to provide services and support to clients on their caseloads. As clients are introduced to MISSION-CJ, CMs are responsible for the orientation, assessment and linkage, treatment, and tracking of each client through the program. Table 5 outlines the key CM responsibilities per CTI phase. An outline of CTI phases and CM responsibilities can be found on pages 79-83 of the manual, and case examples can be found in Appendix H on pages 265-267.

Table 5: Case Manager Responsibilities per CTI Phase

CTI Phase 1: Transition to Community
Note: When the program is initiated in a **re-entry** context, the CM may begin groups and meetings with clients in the facility. The CM also meets with criminal justice representatives to learn more about each client and helps facilitate a discharge plan. During CTI Phase 1, CMs: ➢ Meet with each client and their criminal justice representatives to orient them to the MISSION-CJ model and program requirements ➢ Work together with clients to develop comprehensive treatment plans that includes clients' treatment needs, individual goals, and identification of appropriate team responses to meet these needs ➢ Provide DRT sessions, usually in a group format, delivered at least once a week ➢ Meet with each client once a week for a case management session focused on assessing and providing linkages to community supports ➢ Assess and track each client's progress and use of the community resources/supports that have been established ➢ Provide assertive outreach to ensure treatment engagement and retention (i.e., home visits, in-community sessions, etc.) ➢ Meet periodically with criminal justice representatives to review treatment plans and supervision requirements
CTI Phase 2: Try-Out
During CTI Phase 2, CMs: ➢ Work together with each client to monitor and revise treatment goals in the treatment plan ➢ Provide remaining DRT sessions and begins to provide booster DRT sessions as needed ➢ Meet with each client, as needed, for case management sessions ➢ Continue to facilitate linkages that have been established ➢ Identify problem areas that need new linkages, and provides clients with additional community linkages; empower clients to identify resources independently ➢ Monitor for slips and relapse. If relapse occurs it should not be punished - it should be framed as something that can occur on the road to recovery ➢ Continue to identify any gaps in clients' support systems, barriers in accessing services, or areas where more support is needed ➢ Begin to taper frequency and intensity of the intervention as clients become more independent in the community ➢ Increases assertive outreach if clients become disengaged (i.e., no shows)
CTI Phase 3: Transfer of Care
During CTI Phase 3, CMs:

- Review and fine-tune community-based resources and supports with each client
- Meet with providers to review the transfer of clients' care and identify any gaps in services
- Reflect on accomplishments during the program
- Discuss a discharge and transition plan with each client
- Discuss the end of participation in MISSION-CJ in a framework that acknowledges the work accomplished as another step in recovery

Assertive Outreach

The CTI phases described above rely heavily on the delivery of assertive outreach by CMs and PSSs. Assertive outreach is a way of organizing and delivering care via a CM/PSS team to provide intensive, highly coordinated, and flexible support and treatment for clients across CTI phases. It includes such activities as home visits, meeting with clients in their local communities, etc. It has been found to increase engagement and improve outcomes. CMs engage in assertive outreach activities throughout MISSION-CJ delivery. Outreach should be increased when concerns regarding engagement arise, for example if the client begins to miss appointments or disengage.

Case Manager's Responsibilities: Dual Recovery Therapy (DRT)

DRT is an evidence-based therapy that addresses both mental health and substance use recovery. DRT sessions help clients understand the relationship between their mental health problems and substance use, and how to address the challenges these connections bring. DRT is delivered in 13 weekly sessions in CTI phases 1-2 and booster sessions are delivered as needed in CTI phases 2-3. Sessions can be delivered in a group or individual session format, however group sessions are highly recommended. Additional information on DRT can be found in the MISSION-CJ Treatment Manual on pages 84-86, and in Appendix F beginning on page 205.

Dual Recovery Status Exam

The DRT Status Exam, with criminal justice elements, is used in every DRT session to structure the session to focus on both mental health and substance use. The exam is formatted as a checklist, and functions as a "to-do" list and helpful guide for the CM to use during sessions. The CM can have a copy of the exam with him/her in the session and check to ensure that he/she has covered each item on the exam. The exam is located on page 23 of this guide. For additional tools and techniques to structure DRT sessions, also reference Appendix G, beginning on page 261 of the MISSION-CJ Treatment Manual.

Ways to Structure Individual DRT Sessions

DRT sessions are fairly structured sessions; however the session content should be individually tailored to the client's needs and goals. The following techniques and activities are common to individual DRT sessions and can be used as a guide to structure the session.

- **Welcoming.** The CM begins by welcoming the client to the session. The CM can use the DRT Status Exam checklist to structure a welcoming check-in.
- **Introduction of the Topic**. The CM introduces the DRT topic and explains why it may be important and relevant to the client's goals. The CM should directly relate the topic to the client. To build on the topic, the CM provides a brief informative and interactive presentation of the DRT topic by integrating materials from the exercises and readings in the Participant Workbook; encouraging the client to record any notes or insights to the exercises; and using engaging questions to prompt discussion.
- **Engagement and Feedback**. The CM provides the client with a safe environment to engage in a discussion of his/her understanding of the topic and an opportunity to share personal connections with the topic. This allows the CM to engage and offer clarification and additional feedback to the client on his/her individual circumstances in an empathic and respectful manner.
- **Modeling**. The CM teaches the client the skills offered by the DRT session by modeling them. CMs may role-play skills with the client to illustrate how to use a skill. For example, during the "Anger Management" session the CM may choose a situation and role-play the situation in session to model adaptive ways to manage situations which trigger anger.
- **Reorientation**. The CM encourages the client to engage in effective actions that reinforce new skills or insights.
- **Closing**. It is important that some signal be given to indicate that the session is formally closed. Some sessions end with a summary of take home points, review of a collective goal, or homework - something to try during the coming week. For example, if the client learned positive ways to manage situations which trigger anger, he/she is

encouraged to try them before the next session. The client should be reminded of the time and place of the next session.

Ways to Structure Group DRT Sessions

Similar to individual DRT sessions, group DRT sessions are fairly structured sessions but have a slightly different format. Group size ranges from 5-10 members and sessions last between 45-60 minutes. These sessions may begin in a prison/jail setting. It is recommended that groups remain separate for clients at high-risk and low-risk of re-offending. The following activities are common to DRT groups and can be used as a guide for structuring the group. It is not necessary to incorporate every activity mentioned here in each group meeting agenda.

- **Greeting of New Members**. Older members greet and welcome new members at the door when they arrive, introducing them to other members.
- **Opening of Meeting**. At the agreed upon time, the meeting is called to order by the CM or a designated group member. Some groups open meetings with a quote, mantra, or even a mindfulness activity, such as relaxation breathing.
- **Introduction of Members**. Going around the room, each member can introduce himself/herself and state their reasons for coming to the group. This is especially appropriate for new groups forming to help members get to know one another and learn about common concerns. Offer members the option to "pass," if they would rather not introduce themselves.
- **DRT Status Exam Round Robin Check-in**. Going around the room in a "round robin" style, utilizing the Status Exam structure if preferred, each member can provide a Reader's Digest version of their week in the following areas: substance use since last meeting; tracking of mood symptoms since last week (i.e., on a scale from 1-10); medication compliance or changes; and engagement in pro-social supports and activities (e.g., 12 steps, pro-social peers and family members). An outline for participation can help keep members on track when they speak. This outline can be posted in the room to remind members of the structure.
- **Discussion, Education, and Information Sharing Related to DRT Topic**. Here are some ways to structure the group discussion:
    - ***Introduction of the Topic.*** The CM provides an introduction to the topic, why it was chosen, and why it is something important for members to think about. To build on the topic the CM provides a brief didactic and interactive presentation of the DRT topic. The CM encourages participating members to use the exercises and readings in the Participant Workbook to follow along with the material covered during DRT sessions, and to record any notes or insights to the exercises.
    - ***Round Robin.*** The CM can ask a question to spark discussion. Otherwise, the CM may ask members how they responded to exercises in the Participant Workbook and go around the group as each member responds, giving everyone an opportunity to share their insights and responses.
    - ***Brainstorming***. Ideas are shared in a spontaneous way. Creative thinking is encouraged by not judging any particular idea. For example, during the "Scheduling Activities in Early Recovery" session, members can call out all of the positive activities they have engaged in and the CM can write them on a flip-chart to generate discussion of activities.
    - ***Role-playing*****.** Acting out a situation (e.g., how to communicate effectively with your spouse) can be helpful and fun. Some members enact the role-play while others observe and react or comment.
- **Closing**. It is important that some signal be given to indicate that the meeting is formally closed. Some groups end with a mantra, collective goal, or homework - something to try for the group during the coming week. For

example, members may be encouraged to try one of their peers' positive activities that were called out during the discussion. Members are reminded of the time and place of the next meeting.

Participant Workbook Utilization in DRT Sessions

Using the Participant Workbook for DRT sessions requires close coordination between the CM and the PSS regarding what is occurring in DRT sessions. Outside of the DRT session, the PSS works with clients on completing the DRT exercises in the workbook for the upcoming DRT session and/or clients may choose to do this work individually with just a quick check-in with the PSS about it. Completing the DRT worksheets is not a substitute for the DRT groups – clients are encouraged the week of the DRT session to review that session topic with the PSS. Clients are encouraged to bring the completed worksheets and workbook to each DRT session.

DRT Sessions with Corresponding Participant Workbook Pages

Below are descriptions and examples of the content in each of the 13 DRT sessions with the corresponding worksheet pages in the Participant Workbook. DRT exercises begin in Section C of the Participant Workbook on page 78.

Session 1: Onset of Problems *Exercise Worksheets located on pgs. 80-82 of the Participant Workbook*	
Description of Topic	Clients learn about the dynamic relationship between mental health and substance use problems.
Notes for the Facilitator	*Explain* that there is usually a pattern to when symptoms begin and that symptoms for mental health and substance use are often interrelated. *Show* clients how to fill out the timelines and go over the sample. *Discuss* common patterns amongst members in the group.

Session 2: Life Problem Areas *Exercise Worksheets located on pgs. 83-85 of the Participant Workbook*	
Description of Topic	CMs and clients review the problems they have experienced in major life domains and examine the degree to which these problems have affected their lives.
Notes for the Facilitator	*Explain* that this exercise will help clients and their MISSION-CJ teams understand how problems related to mental health and substance use are each affecting their quality of life. *Explain* that these problems will reoccur in discussions throughout DRT. Go around the group and have members *share* problems and *give examples* from each area, focusing on one area at a time. **Note**: Following sessions build upon and use the problem areas identified during this session.

Session 3: Motivation, Confidence, and Readiness to Change *Exercise Worksheets located on pgs. 86-87 of the Participant Workbook*	
Description of Topic	Clients complete a readiness ruler worksheet for each domain or life problem identified in Session 2. Rulers will help clients understand their stage of readiness to address each problem area.

Notes for the Facilitator	*Explain* to clients that a sense of importance, confidence, and readiness are all aspects of motivation. *Encourage* clients to answer honestly for each area they address. Go around the group and have members *share* problems they explored, the motivation they find to address them, and implications for recovery. **Note**: Having extra rulers during all of the sessions will make it easy for clients to explore different areas in which change is needed in their lives as they go.

Session 4: Developing a Personal Recovery Plan *Exercise Worksheets located on pgs. 88-90 of the Participant Workbook*	
Description of Topic	Treatment goals are reviewed and emphasis is placed on the importance of using and engaging in community substance use and mental health resources necessary to meet treatment goals.
Notes for the Facilitator	*Build* on the life problem areas identified in Session 2, *encourage* clients to refer back and *identify* positive steps they can take to address the problem. *Encourage* clients to *share* their thoughts with others who play a key role in their hopes for recovery. Give clients the opportunity to *share* around various strategies they have suggested for themselves in each area. **Note**: Encourage clients to complete the PICBA exercise beginning on page 42 of the Participant Workbook to decide how they want to address each set of problems.

Session 5: Decisional Balance *Exercise Worksheets located on pgs. 91-93 of the Participant Workbook*	
Description of Topic	The worksheet is used to help clients identify the benefits and negative consequences of maintaining problematic behaviors and weighing the costs and benefits of continuing problematic behaviors.
Notes for the Facilitator	*Ask* clients to pick the biggest problem area in their lives. *What behavior is the root of these problems?* *How could it be changed?* *What are the benefits and negative consequences of change?*

Session 6: Developing Strong Communication Skills *Exercise Worksheets located on pgs. 94-96 of the Participant Workbook*	
Description of Topic	Clients learn to recognize effective and problematic communication styles. The worksheets will assist clients in developing effective communication skills necessary for communication with those who play a key role in their recovery.
Notes for the Facilitator	Have clients *identify* elements of poor communication that applies to them. *Discuss* why they have used these forms of communication. Have clients *identify* elements of good communication they would like to use. *Role-play* good and poor communication skills and *provide feedback.*

Session 7: Orientation to 12-Step Programs *Exercise Worksheets located on pgs. 97-100 of the Participant Workbook*	
Description of Topic	Emphasis is placed on orienting clients who have never attended 12-step meetings to the structure, culture, rules, and language of the programs. Emphasis is also on improving attendance at these programs.
Notes for the Facilitator	*Encourage* clients to *share* experiences they have had at programs. *Role-play* ways to overcome any barriers to attendance. *Share* information about types of groups and meeting times in the immediate area. *Talk* about each step and what it means to each client.

Session 8: Anger Management *Exercise Worksheets located on pgs. 101-103 of the Participant Workbook*	
Description of Topic	Focus is on pro-social skills training, moral reasoning, and anger control training. The goal is to teach clients cognitive strategies to combat unhealthy thinking styles. The CM and the clients also discuss problematic behaviors in relation to values and goals.
Notes for the Facilitator	*Brainstorm: Why it is that one person gets really angry at something while another person just gets annoyed at the same thing?* *Identify: How do you know when you're really angry? What is the difference between anger and frustration?* *Discuss* negative consequences for becoming angry and out of control. *Share* techniques on cooling down.

Session 9: Relapse Prevention *Exercise Worksheets located on pgs. 104-111 of the Participant Workbook*	
Description of Topic	Clients learn to identify and review strategies that can be used to increase the likelihood of sobriety and decrease the chance for relapse. Emphasis is placed on how clients' mental health problems can lead to relapse and strategies that can be employed to prevent this from occurring.
Notes for the Facilitator	*Discuss* the chart on relapse prevention. *Review* safe coping strategies, and have clients *share* strategies they have found effective. *Fill out* the worksheet on the "Change Plan". *Encourage* clients to *practice* positive coping strategies.

Session 10: Relationship Related Triggers *Exercise Worksheets located on pgs. 112-116 of the Participant Workbook*	
Description of Topic	Clients will learn how unhealthy relationships can contribute to a high risk of mental health symptom exacerbation and/or substance use relapse.
Notes for the Facilitator	*Discuss* readings that come before the worksheet. *Fill out* the first two questions on the worksheet. Go around the group and *encourage* members to share their answers.

Session 11: Changing Unhealthy Thinking Patterns *Exercise Worksheets located on pgs. 117-127 of the Participant Workbook*	
Description of Topic	Clients learn how unhealthy thinking patterns can perpetuate emotional problems and result in substance use as a maladaptive coping mechanism.
Notes for the Facilitator	*Discuss* the descriptions of each of the various forms of unhealthy thinking. *Discuss* examples of stinking thinking. *Review* examples identified by clients on the worksheets and then *identify* healthier responses. *Explain* that we have a choice in how we think about something happening. Assign group members to think of healthy responses for some of their unhelpful ways of thinking.

Session 12: Changing Irrational Beliefs *Exercise Worksheets located on pgs. 128-131 of the Participant Workbook*	
Description of Topic	Clients identify dysfunctional beliefs and learn how to modify those beliefs to maintain flexibility in thinking.
Notes for the Facilitator	Have clients read through the examples of irrational thoughts and check those that apply to them. *Review* the examples. Have the group reframe each of the examples.

Session 13: Scheduling Activities *Exercise Worksheets located on pgs. 132-136 of the Participant Workbook*	
Description of Topic	Clients learn the importance of scheduling regular healthy activities in maintaining recovery.
Notes for the Facilitator	*Help* clients *identify* a guiding vision of what they want their lives to be like and how they want to use their time.

Case Manager's Responsibilities: Providing Vocational and Educational Support

Clients present with a variety of vocational and educational needs, such as needing help obtaining employment, maintaining employment, and applying for educational programs. The CM's general role includes monitoring and supporting clients' vocational and educational goals on the treatment plan; assessing clients' eligibility for vocational benefits and assistance; and providing clients with linkages to vocational specialists and vocational rehabilitation programs when needed. The CM has additional responsibilities depending on each client's risk level and the extent of their involvement in the criminal justice system. MISSION-CJ CMs:

- Assist in obtaining and evaluating criminal background checks
- Assist with filing for expungement of criminal charges or convictions
- Link clients to legal professionals for assistance
- Address employment-related issues with probation and/or parole
- Link clients to potential employers
- Link clients to specialized vocational training programs

Additionally, the CM's role varies slightly based on clients' educational and/or vocational needs and goals as displayed in Table 6. More information on the vocational and educational support provided by the MISSION-CJ team can be found in the MISSION-CJ Treatment Manual on pages 86-87, 107-118, and Appendix K beginning on page 283.

Table 6: Case Manager's Role in Providing Vocational/Educational Support Based on Clients' Needs

Employed Clients	Unemployed Clients	Supported Education
Clients continue to need support as they move through different job stages, face challenges and stigma, and learn their role in the workplace, therefore CMs: • Help clients understand benefits packages and plan for retirement • Teach skills that will help clients maintain employment (e.g., time management, conflict resolution skills, and organizational skills) • Address symptom exacerbation on the job and related coping skills • Discuss the importance of medicine maintenance and impact of medication side effects on job functioning (i.e., timing of	Clients may experience difficulty maintaining a job, therefore CMs: • Identify the positives and negatives of the methods clients have been using in their job search and discuss them • Discuss employment in a focused and goal-oriented manner • Develop an employment goal with each client based on past experiences, preferences, and their current life situation • Review employment related workbook exercises on pages 67-71 of the Participant Workbook with clients and utilize employment related resources on pages 283-291 of the manual with	Clients may want to pursue educational goals, therefore CMs: • Explore career and educational goals and preferences, so that schools/training programs can be chosen to apply to • Refer clients for academic assessments to determine how much additional educational support is needed (e.g., tutoring, mentoring, disability services) • Track each client's progress towards his/her goals by tracking the number of identified potential schools, schools applied for, follow-up on school applications, interviews and outcomes • Form working relationships with

medication, fatigue and scheduling job shifts)	clients • Identify potential employers and gather necessary employment documents (i.e., applications, resume) and personal documents (i.e., social security cards, proof of citizenship, transcripts) • Help clients prepare for job interviews by getting the necessary attire, conducting mock interviews, and providing feedback • Track each client's progress towards his/her goals by tracking the number of identified potential jobs, jobs applied for, follow-up job applications, interviews and outcomes • Educate clients, as needed, on the difficulties of the job market and focus on practical barriers to obtaining and maintaining employment • Address possible criminal justice issues/barriers related to employment (i.e., myths vs realities of having a criminal record and seeking employment)	the schools clients are applying to and obtain information on available support services (most colleges and training programs have school-based student service departments and service coordinators as well as campus-based support groups) • Assist with enrollment and college readiness tasks (e.g., course selection, books, financial aid) • Provide regular or periodic check-ins to monitor and support each client's academic progress • Provide assistance with each client's application for benefits

Criminal Justice Barriers/Challenges

MISSION-CJ clients often lack the resources and basic skills to find and maintain a job, and face both individualized and systemic barriers to employment. Individualized job related barriers can include: social skills, social networks, symptoms/relapses, job histories, motivation, and low socioeconomic status. While systemic barriers can include: employer/government ex-offender hiring/criminal record policies, workplace stigma, job competition, and new and unfamiliar workplace technologies. As a result of these obstacles, MISSION-CJ clients may be disinclined to look for employment because of shame, resentment, or the belief that it's a "lost cause". MISSION-CJ CMs convey the belief to clients that with proper support, preparation, and dedication successful employment is possible, and work with clients

as well as systems to remove the obstacles noted above. Further information on this topic can be found on pages 108-109 of the treatment manual.

Case Manager's Responsibilities: Trauma-Informed Care Considerations

Many clients have experienced at least one traumatic event in their life. Therefore MISSION-CJ CMs are trained to identify and monitor trauma symptoms and their impact on treatment and recovery. With that said, MISSION-CJ is a trauma-informed intervention and *not* a trauma treatment program. Being "trauma-informed" means:

- ✓ Being aware of the possibility of trauma among clients
- ✓ Recognizing the symptoms of trauma
- ✓ Being aware of the impact of trauma on the lives of clients
- ✓ Screening clients for trauma
- ✓ Knowing how and when to refer clients out for specialized help

During MISSION-CJ, the CM will screen all clients for trauma symptoms. If the client has clinically significant trauma symptoms, the CM will make a referral to have the client formally assessed by a qualified assessor (i.e., licensed clinical professional trained in diagnostic assessment and PTSD assessment/treatment). If the client is found to meet criteria for current PTSD and is in need of PTSD-focused treatment, the CM can work with the client and qualified assessor to identify and enroll the client in an evidence-based PTSD treatment program such as Seeking Safety, Cognitive Processing Therapy (CPT), etc. With close CM coordination and collaboration, PTSD specific treatment can occur simultaneously with MISSION-CJ services. Figure 1 provides an outline of the trauma-informed role of the MISSION-CJ CM. For more information on trauma-informed care considerations see pages 87, 119-134, and Appendix L, beginning on page 292, of the treatment manual.

Figure 1: Trauma-Informed Case Managers

Trauma-Informed Role of the Case Manager	
	CMs screen for and identify trauma related symptoms and disorders. CMs will use validated screening tools, such as the PTSD Screen.
	CMs ensure that clients who need specialized treatment are referred to resources qualified to treat PTSD and other trauma-related disorders.
	CMs serve clients with trauma histories who do not require specialized trauma-related treatment by utilizing present focused treatment approaches, where the CM teaches the clients coping skills (e.g., altering present maladaptive thought patterns/behaviors, relaxation and breathing exercises), providing psycho-education regarding the impact of trauma on the client's life, and teaching problem solving strategies that focus on current issues.
	CMs recognize the links between past trauma and present difficulties when working with clients.
	CMs provide ongoing support for those clients receiving treatment from a specialized provider.
	CMs coordinate care with specialized providers.
	CMs coordinate trainings to court personnel and community supervising agencies (e.g., probation, parole) and others on trauma-informed service delivery and the issues related to trauma for MISSION-CJ clients.

The Overlap of Criminogenic Risk and Trauma-Related Symptoms

When screening clients for trauma-related disorders, CMs should be mindful that several symptoms associated with a trauma history are also associated with criminogenic risk factors. Therefore, when assessing for trauma, CMs should carefully tease apart trauma symptoms from those related to personality disorders or anti-social behaviors/cognitions, and remain cognizant that there can be a co-existence of antisocial patterns that are separate and distinct from trauma. Table 7 shows how some components of criminogenic risk overlap with potential trauma-related symptoms (adapted from Bonta & Andrews, 2007). For more information, see pages 125-126 of the treatment manual.

Table 7: 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 • Reckless behavior
Antisocial Personality Pattern	• Impulsivity • Aggression • Irritability	• Irritability • Aggressive behavior • Persistent negative trauma-related emotions
Antisocial Cognitions	• Rationalize criminal activity • Negative attitude towards the law	• Persistent distorted blame of others for causing the traumatic event or resulting consequences
Antisocial Associates	• Friends with criminal histories • Friends with anti-social attitudes • Lack of pro-social supports	• Detachment or estrangement from others
Family Support	• Interpersonal difficulty with primary family members including parents, spouses, siblings, etc. • History of poor parental monitoring and discipline	• Feeling alienated from others
Leisure Activities	• Lack of participation in pro-social recreation	• Markedly diminished interest in important recreational activities
Education and Employment	• Lack of success in school or work settings • Lack of enjoyment in school or work settings • Lack of opportunity for school or work engagement	• Markedly diminished interest in important school or work activities • Problems in concentration • Sleep disturbance • Avoidance of trauma-related cues
Substance Use	• Substance use disorder (abuse or dependency)	• Substance use • Relapse

DRT Status Exam Checklist with Criminal Justice Elements

- ✓ **Set agenda for session (Client and Case Manager)**
- ✓ **Check-in with regard to any substances used since last session**
- ✓ **Check-in about adherence to terms of probation/parole/specialty court (if applicable)**
- ✓ **Assess substance use motivational level**
- ✓ **Explore compliance with probation/parole attendance**
- ✓ **Check-in about leisure time activities**
- ✓ **Check-in about recent family conflict**
- ✓ **Check-in about current peers and whether they create any antisocial influences**
- ✓ **Track symptoms of depression or anxiety, and other mental health challenges**
- ✓ **Explore compliance with medications prescribed**
- ✓ **Discuss the primary agenda topic(s) for the session**
- ✓ **Ask about attendance at 12-Step groups and other elements of treatment**

Additional Notes

Example of a Completed MISSION-CJ Treatment Plan

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 abuse treatment (currently participating)**
- **Acute psychiatric care**
- ***Other Needed Services***
  - **Housing Needs: currently receiving residential care**
  - **Outpatient mental health/substance abuse treatment: referral needed once discharged from residential substance abuse treatment**
  - **Medical Care: diabetes management**
  - **Medication Management: psychiatric/diabetes medication management**
  - **Dental Services**
  - **Benefit entitlements**
  - **Vocational Supports: increase job-related experience; link to services**
  - **Cognitive Behavioral treatments to address impulsivity and criminal thinking patterns**

MISSION Service Delivery

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

Treatment Goals & Objectives: **Client is currently receiving care in residential substance abuse treatment program. In addition, client is being followed by MISSION-CJ staff. 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 apt: **Mon Tue Wed Thu Fri Sat Sun** Time: **11:00 am/pm**
Provider:
Location: