Family and Social Support Module

Developed by:
Ayorkor Gaba, Psy.D.

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The MISSION materials mentioned within the document in addition to all versions of the MISSION treatment manual and their corresponding workbooks are available for download on the MISSION website at www.missionmodel.org. You may also contact the MISSION team through the website or Dr. David Smelson directly (see contact information below) regarding any questions about the MISSION Model and/or the materials.

For questions regarding the use of this material, please contact:

David A. Smelson, Psy.D.
Professor and Vice Chair of Clinical Research
Department of Psychiatry, University of Massachusetts Medical School
55 Lake Avenue North
Worcester, MA 01655

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INTRODUCTION

Family support can play a significant role in helping homeless clients achieve their goals. Family support has been shown to reduce risk factors for chronic homelessness, recidivism, relapse, and re-entry/reintegration problems. Although many MISSION (Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking) clients' family relationships are strained and disrupted, it is important for MISSION case managers (CM) and peer support specialists (PSS) to understand, assess, and address (when appropriate) the unique barriers and challenges to re-connecting and re-engaging MISSION clients with their families.

This module will provide CMs and PSSs with effective clinical strategies and tools to:

- ✓ Assess family and social support
- ✓ Increase motivation and engagement for positive family and social support
- ✓ Provide communication and problem solving skills to begin to negotiate and repair relationships with family members
- ✓ Provide brief outreach, intervention, and referral to clients and their families

DEFINING FAMILY

Families come in all shapes and sizes and can range from biological close relatives (i.e., mother, father), to extended family members (i.e., second cousin), and/or to family members of choice (i.e., childhood friends, partners, neighbors, fellow service members). MISSION clients may present with different family structures, dynamics, and complexities. A homeless woman with a mental health disorder who has estranged adult children; a man who is seeking treatment via the support of his uncle; a homeless woman who mentions an "enabling" relationship with her homeless boyfriend; or a Veteran who has been staying with different platoon members during periods of homelessness, are all a part of nuclear, extended, or nontraditional family networks that could be potential supports in their treatment.

Due to the high rates of separations between homeless clients and their family members, it is important to be mindful that family composition and the definition of family in this population may be fluid and change over time (Paquette & Bassuk, 2009). MISSION staff will encounter clients who have been separated, estranged, and/or disengaged from family members for significant reasons including a history of abuse, domestic violence, and/or neglect at the hands of their family members. In these cases, it is very important to acknowledge and validate this history, and take a broader look at the "family" network to identify potential supports. For these reasons, the family support module will focus on a broad and inclusive definition of family, where family includes whomever the client perceives to be a "family" member and/or significant social support.

WHY IS FAMILY SUPPORT IMPORTANT?

Family support has been identified as an important factor in reducing the risk for a multitude of problems that are common for MISSION clients. For example, a study examining family supports among homeless individuals receiving case management services and access to Section 8 housing,

found that at a 3 year follow-up, high levels of family contact were associated with significant increases in housing stability[1] (Wood, Hurlburt, Hough, & Hofstetter, 1998). Another study found that these findings held true regardless of an individual's demographic background, history of homelessness, and illness chronicity (Pickett-Schenk, Cook, Grey, & Butler, 2007). Last, a recent study found that family supports not only improved housing stability, but also contributed to greater community integration outcomes. Surprisingly, these findings were consistent whether the support was physically or virtually present (i.e., family contact primarily via social media, Skype, email and phone contact; Chan, Helfrich, Hursh, Rogers, & Gopal, 2014).

There are many hypothesized reasons for the association between family support and improved outcomes. For example, some researchers assert that the positive relationship between family presence and community integration may be related to the individual's role in the family as a form of meaningful activity (Nelson, Clarke, Febbraro, & Hatzipanteli, 2005; Wireman, 2007). Essentially, the opportunity to foster family membership becomes a critical goal towards the individual re-establishing a meaningful role in the community. Re-establishing a meaningful role then has a positive impact on integration activities and broader community relationships (Chan et al., 2014). Others assert that increased family contact, support, and satisfaction involve enhanced levels of family caregiving that allow individuals to establish and maintain stability (Pickett-Schenk et al., 2007).

FAMILY SUPPORT AND SPECIAL POPULATIONS

Similar results have been found for the relationship between family support and other problem areas that are common for MISSION clients, such as substance use, re-entry, and re-integration.

Homeless

Substance use ranks high among factors that distinguish homeless people from those who have never been homeless. The strong relationship between co-occurring substance use in homeless men and women has been documented across many studies (Glasser & Zywiak, 2003). This relationship is stronger for those who have less family support (Caton, Shrout, Eagle, Opler, & Felix, 1994). Additionally people with co-occurring disorders[2] (COD) are more likely to become homeless following the loss of family support (Brunette, Mueser, & Drake, 2004).

Criminal Justice Involved Persons

It is also well known that family support is a critical factor for people involved in the criminal justice system, particularly for prisoners transitioning from incarceration to the community. For example, family support and contact pre- and post-release, in the form of prison visits and housing, financial, and emotional support have been shown to be important for former prisoners' transitions from prison to the community (Sullivan, Mino, Nelson, & Pope, 2002) and associated with better reentry outcomes (La Vigne, Shollenberger, & Debus, 2009).

Veterans

[1] Wood, Hurlburt, Hough, and Hofstetter (1998) defined housing stability as residing independently in an apartment or in community housing for 80% or more of the follow-up period.

[2] Co-occurring disorder is having a co-occurring substance use and mental health disorder (COD).

Additionally, many MISSION clients are also Veterans. Family problems, substance use, and mental health issues are among the main causes of homelessness among Veterans. Family problems, including a lack of support from family members, are significant within Veteran populations (Benda, 2001). Benda (2006) found that family supports can aid in recovery from mental health disorders and substance use in homeless Veterans. This relationship between family supports and recovery is especially true for women. Findings suggest that social support from family and friends is more beneficial to female Veterans than to male Veterans (Benda, 2006).

Couples

Couples are an important subset of the family system and family support. Couple relationships are often overlooked in research and interventions with homeless clients. Homeless clients report both intact and estranged couple relationships. These relationships are important factors in increasing or decreasing risk factors for many problems. A recent study found that despite barriers and difficulties, homeless individuals who use drugs can, and do, engage in functional and positive romantic relationships (Stevenson & Neale, 2012). There have been a small number of studies examining romantic relationships in this population. These studies have found that homeless individuals are indeed monogamous and committed to their partners, support each other emotionally, and having a partner could improve health and wellbeing, as well as increase feelings of support (Nyamathi, Bennett, Leake, & Chen, 1995; Nyamathi, Wenzel, Keenan, Leake, & Gelberg, 1999; Rayburn & Corzine, 2010; Wesley & Wright, 2005). In addition, homeless couples report the following specific benefits to being in a relationship: decreased anxiety and isolation; increased feelings of safety and security; and increased support in the management, control, and reduction of drug consumption (Stevenson & Neale, 2012; Simmons & Singer, 2006).

Although, many MISSION clients may be estranged from their spouse/partner and/or are in unhealthy relationships, it is still important to understand these relationships, assess risk and protective factors within these relationships, and provide clients with tools to manage these relationships, especially within the context of their recovery.

EFFICACY OF INTERVENTION MODELS INTEGRATING FAMILY SUPPORT

Intervention models, such as Assertive Community Treatment (ACT) model, have demonstrated the effectiveness of integrating family outreach and intervention. ACT is a service-delivery model that provides comprehensive, locally-based treatment to people with serious and persistent mental health disorders and shares similar underlying principles as the MISSION model. A core component of the ACT model is to work extensively with the clients' support systems, including their families. Some ACT programs explicitly include a family outreach worker who provides psycho-education to the clients' family members, facilitates family meetings (not therapy) to address family concerns, and informs the treatment team of family dynamics that impact the treatment plan. In ACT, more intensive family contact by the ACT team was associated with an increase in the days that clients had stable housing. This suggests that family support plays an important role in reducing clients' risk for chronic homelessness (Dixon, Stewart, Krauss, Robbins, Hackman, & Lehman, 1998).

As outlined above family support and intervention can have a significant impact in the lives of MISSION clients. The following sections of the module will outline how CMs and PSSs can work together to facilitate positive family supports in the client's life. Briefly, with clients' permission, the

MISSION CM/PSS team is encouraged to involve clients' families when clinically appropriate. If family connections are disrupted, CMs/PSSs work with their clients to determine if re-building these family connections would facilitate positive outcomes, and if not, what other positive social relationships might be built (e.g., extended family, friends, partners) to help bring positive connections back into the client's life. Last, the CM and PSS work together to provide brief outreach, intervention, and then referral to clients and their families.

PART II: THE FAMILY MODULE IN MISSION

ASSESSMENT

Assessment is a critical and ongoing activity in effective treatment planning and delivery. In MISSION, the clinical supervisors (CS) or the case managers (CM) complete the initial formal assessment to identify the client's diagnosis, needs, and eligibility. Following the assessment, the client is introduced to his/her permanent MISSION CM/PSS's team. This initial meeting is an excellent opportunity to begin to assess the client's family supports and the client's motivation to engage these supports.

Suggested Assessment Questions[3]:

1. *I see you stay with your brother from time to time....Tell me about your brother? How does he help you (or not) with your substance use problem? Co-morbid problem? Transition back into the community? With your housing situation?*

2. *You mentioned you are seeing someone. Who? Do you stay together in the same place? For how long? How long have you been dating? Tell me about your girlfriend/boyfriend. How does she/he help you (or not) with your substance use problem? Co-morbid problem? Transition back into the community? With your housing situation?*

3. *Do you have any family members (children, siblings, extended family) in the area? Do you see or talk to them? How about in other areas? Do you see or talk to them? What is your relationship like with them?*

4. *I heard you mention [friend]. How often do you see him/her? Would you call him/her a close friend? Do you talk to her/him about what you are working on here?*

5. *Do you think it would be helpful to have your [family member, wife, husband, girlfriend, etc.] attend one meeting here with you? We like to work with family members and clients together since family members can often be very helpful, especially in the long run after you stop coming here. Do you think she/he would be interested in coming?*

ASSESSING THE APPROPRIATENESS OF FAMILY SUPPORTS

In addition to assessing if there are any family supports available, it is also important to assess if support from specific family members would be appropriate. Below are guidelines to consider in making this assessment.

CIRCUMSTANCES WHERE RE-ENGAGEMENT AND FAMILY INVOLVEMENT MIGHT NOT BE APPROPRIATE

Purposeful Decisions by the Client

[3] Adapted from Elizabeth Epstein ABCT manual

- The client states that he/she has made a purposeful decision to not engage with a family member because of the family member's negative influence and/or behaviors. The family member also deals with his/her own substance use problems; is involved in illegal activities; and/or other negative behaviors (e.g., gang involvement).
- If the client states that he/she has made a purposeful decision to not engage with a family member because he/she has been abusive – emotionally, physically, and/or sexually.

Legal Issues

- The client or family member's contact is legally sanctioned (e.g., restraining order, supervised contact).

Domestic Violence

- If there is moderate to severe domestic violence between the client and the family member, do not consider using the family module. A better option for an abusive partner who may want to change is a Battering Intervention and Prevention Program (BIPP) designed specifically to address their abusive behavior first.
- If the family member is openly hostile towards the client. One-on-one outreach and brief intervention directly to the family member before having a family session may help to reduce hostility.

Instability of the Family Member

- The client or family member displays current psychiatric symptoms such as severe depression, personality disorder, or psychotic symptoms. Family member involvement may be delayed until psychotic symptoms have stabilized.
- The family member is currently struggling with moderate to severe alcohol or drug use. For example, if the family member cannot attend a family meeting clean and sober.

SPECIAL CONSIDERATION: *ASSESSING FAMILY VIOLENCE*

It is important to note how critical it is to assess for family violence. Family violence is any act committed between family or household members, including children, that is: intended to result in physical harm or bodily injury (e.g., physical pain, illness, or damage to the victim's physical condition); assault or sexual assault; or a threat that reasonably places the member in fear of immediate physical harm or bodily injury, assault, or sexual assault. It can also include emotional use, controlling behaviors, and stalking.

Domestic violence will be prevalent in the MISSION population. The majority of homeless women are victims of domestic violence. It is also a significant problem within Veteran populations as well; combat Veterans are responsible for almost 21% of domestic violence nationwide (Van Winkle & Safer, 2011). If you suspect your client may be involved in an abusive relationship it is important to ask directly, refer the client to a domestic violence services agency, and create a safety plan if needed (see Appendix D for a Domestic Violence Screener).

ROLES AND RESPONSIBILITIES OF THE CM AND PSS TEAM

In many cases, the client may be reluctant to reconnect and/or engage a family member for many reasons (e.g., shame, burned bridges, family conflict, family cut-offs, etc.). In the initial assessment, CMs and PSSs should not "push" the client to reconnect with or include a family member in a subsequent session. Instead teams should provide psycho-education about how family members can be helpful, explicitly ask and understand client's reluctance, reflect their concerns, and integrate continual assessment of the client's potentially changing family supports and motivation to reconnect and/or include family supports into the treatment plan.

As the relationship develops with the client, the CM and PSS should assess and motivate clients to reconnect with positive family and social supports. For example, in providing practical support to a client, a PSS may accompany a client to a medical appointment. In the midst of transporting the client, the PSS may be briefly introduced to the client's girlfriend. While driving, the PSS can informally assess couple supports by asking similar questions included above and may want to share his/her own personal successes in engaging his/her spouse/partner in his/her own treatment and recovery.

USING GENOGRAMS AND ECOMAPS EFFECTIVELY

CMs can construct either a genogram or an ecomap with clients to further assess and begin to motivate clients to reconnect with these linkages. The genogram and ecomap are useful components of any family assessment. The genogram provides a quick snapshot of family members from an intergenerational perspective, such as how they are related and potential sources of support for the family. The ecomap provides information about systems outside of the family that are sources of support or stressors to the family. These assessment tools can reveal valuable sources of support that are not currently being used or accessed.

In addition, the ecomap and genogram can be effective tools to use to explore cultural factors with MISSION clients. They both place emphasis on the value of communal relationships, highly valued in non-Western cultures, and highlight the interrelatedness of family members and even communities on individual development and growth. They can serve as a foundation for discussions surrounding cultural and family messages around mental health, culture, and stigma. Both tools can be used concurrently. Their visual format not only provides a wealth of information, but also offers a succinct picture of the client's complex relational and cultural world.

A genogram is the drawing of a family tree that records information about family members and their relationships over at least three generations (McGoldrick, Gerson, & Schellenberger, 1999). Genograms are widely used in family therapy and in health care settings. They offer a rich source of information for planning intervention strategies because they visually display the family in a way that provides a graphic overview of family complexities. It can be used to facilitate engagement with the client and to record the history and current status of a given family. The genogram does not have to be completed in one sitting. As the CM and PSS continue to work with the client, family information can be added (by either the CM, PSS, or both) to the genogram over time in a continual process.

An ecomap provides information about systems outside the "traditional" family that are sources of support or stressors to the family (Friedman, Bowden, & Jones, 2003). The ecomap is a visual representation of the family unit in relation to the "community"; it shows the nature of the relationships between the client and their family members and the client and the world around them. Thus, the ecomap is an overview of the client in his/her situation, picturing both the important protective and

stress-producing connections between the client (within the context of the family) and the world (Hanson, 2001). Genograms and ecomaps have been successfully used in treatment with homeless clients (Hertlein & Killmer, 2004). Guidelines for completing a genogram or ecomap have been included in Appendix A.

INTRODUCING MISSION TO THE FAMILY

MISSION staff may have a unique vantage point and access to the client's family supports because they are transporting clients and meeting with clients in the community. PSSs may observe clients with their family members, be introduced to clients' family members, etc. The PSS can start having informal discussions with their clients regarding family support early in treatment, as suggested above. If the client expresses interest in engaging a family support, the PSS should discuss this with the CM before any outreach to the family member. Both the PSS and CM should be in agreement that the family support would be helpful in the client's treatment plan. After getting consent, the PSSs may be the first point of contact with the family member. For example, in dropping off a client, the PSS should briefly introduce himself/herself to the family member, informally discuss the importance of family members in bolstering treatment, and gauge their interest. Ideally, when feasible, the PSS should speak with the family member while the client is present.

Here is an example of an informal contact with a family member that the client, Chris, wants to involve in his treatment.

"*Hi! My name is John and I have been working with Chris at the MISSION program. It's nice to finally be able to talk with you. I have seen you a couple times when I have dropped him off. Chris has given me permission to talk with you a bit about the program and what he is working on. The program's goal is to help Chris maintain sobriety and find stable housing. We have recently been talking about how important it is to have family support on his path to recovery. He mentioned that you have been important in his life and it might be helpful to have you join a couple of sessions so you can know what he is working on and the two of you can learn some tools together to better communicate and solve problems. It wouldn't be a therapy session, just a couple meetings with Chris, myself, and his counselor to talk about those things. We have found that clients who involve their family and have family support have a better shot at reaching their goals and maintaining them in the long run, so I think it would be important for you to join us. How does that sound?*"

Figure 1. Example of an informal contact introducing MISSION to the client's family member/social support.

PSSs can also role-play with their client effective ways to talk with their family member(s) about coming in for a family meeting. Utilizing skills reviewed in the Peer Led sessions, such as communication and problem solving, PSSs can help the client develop and implement a plan to have a conversation with their family member(s) about attending a family meeting.

Increasing Motivation and Engagement for Positive Family Support

Even after a thorough assessment, clients may not want to reconnect with family members, let alone, involve family members in treatment. Clients often feel that they have put their families through enough, caused irreparable damage and pain, been abandoned by their families during their toughest times, treated poorly by their families, etc. It is important that CMs and PSSs explore these thoughts and feelings with the client. Accepting the client's initial resistance to reconnecting and/or including their family members in treatment may lead to a missed opportunity to enhance treatment impact. Keep in mind that the client's motivation to reconnect with family members may change throughout the course of treatment, therefore the CM/PSS should continue to check-in regarding family supports. For example, a client may be more apt to re-engage with a family member once they have had a couple successes under their belt and have started to experience an increase in self-efficacy and self-esteem (e.g., 3 months of sobriety, GED completion, maintained stable housing, etc.).

CMs and PSSs should take a motivational stance when discussing family supports with clients. Your job will be to help the client weigh the pros and cons of reconnecting and/or improving their relationship with their family member(s). A useful tool to use to guide this discussion is the decisional matrix (see Appendix B for a Decisional Matrix worksheet). The CM or PSS can help the client list out the pros and cons of reconnecting with family members and/or including them in treatment versus keeping things as is.

Suggested Way of Moving Through the Decisional Matrix

1. Discuss benefits of keeping things the same in their relationship with their family member(s) first;
2. Then discuss the emotional costs of keeping things in their relationship with their family member(s) the same;
3. Followed by a discussion of the costs of reconnecting/including the family member(s); and
4. Concluding with the benefits of reconnecting/including family members

Dancing with Discord

Part of the work will be to roll with the resistance (now known as "dancing with discord") by avoiding arguing for reconnecting with/including family supports and directly opposing resistance. The goal will be to avoid confrontation; allow the client to be the primary resource in finding answers and solutions, and offer (not impose) new perspectives. One of the main sources of resistance will be that clients may be afraid of being made a scapegoat or afraid that difficult family or personal secrets will be revealed in a family meeting. The CM should reflect the client's concern and offer a new perspective by reframing the idea or goal in a way that acknowledges potential negative consequences and emphasizes positive aims. The CM should assure the client that a family meeting does not have to go where the client does not want it to go. The CM should make it clear that he or she will make every effort to focus on the issues the client is comfortable discussing instead of issues that he/she is not ready to discuss. The CM can say:

> *"The family meetings are not therapy sessions. They are introductory meetings to help give you and your family an opportunity to discuss your goals, find ways to be supportive, and learn some basic skills to communicate and solve problems. As I said, it is not therapy and will focus on setting a foundation for re-connection. We will only deal with the issues that you want to*

discuss. You'll be the boss. I am here only to help you to the extent that you say." (Adapted from Szapocznik, Hervis, & Schwartz, 2003).

As noted throughout this module, it is important that clinicians not “push” clients around this issue. It is suggested that CMs continually assess and use motivational strategies to increase positive social supports throughout treatment.

Confidentiality

Some clients will worry about family members finding out details of their alcohol or drug use or other private issues that they are not yet prepared to share with their family members. CMs need to reassure clients that private matters can be kept confidential if they wish during the brief family meetings. In discussing confidentiality with the client, the CM should be explicitly clear with the client about what the CM will and will not disclose to the family member. CMs should explain to the client that it is important to be open about certain information (e.g. relapses), with their family members and should encourage their clients to be honest. The CMs should not take the lead in disclosing this information (i.e., relapse) to family members during the initial outreach call or family meeting. These issues can be addressed if and when the client and their family member follow-up with treatment and services referrals.

Uninterested Clients and Unavailable Family Members

It is important to utilize psycho-education and the motivational techniques outlined above to encourage all clients to engage with positive family and social supports. There will still be clients who are not interested in engaging and reconnecting with their family members. It is still important to review the information outlined in the family meetings to provide clients with the tools to begin the process of re-engaging with their positive family members when they are ready. Adaptations can include psycho-education on the impact of substance use and mental health within the family, role-playing potential discussions between the client and family member(s) utilizing good communication skills, focusing on extended family and friends, and/or revisiting the Personal Life Problem Areas Worksheet to identify and work on some goals regarding family and social areas.

As mentioned earlier, family support can have a positive impact even if it is remote or virtual support (i.e., via phone or email). Therefore, if the client identifies a family member(s) who does not reside in the area as a potential positive support, it is recommended to reach out to the family member and possibly have them join family meetings by phone (e.g., client in the office with MISSION team and family member on the phone) or via video conference, such as Skype or Facetime (if available at your organization). One can also encourage clients to reach out to these supports on their own utilizing some of the communication skills outlined in this module.

Outreach to Family Members

If the CM and PSS determine that there is a potentially helpful family member(s) during the assessment process, the client is willing to have the family member(s) participate, believes the family member(s) will agree, and family engagement will bolster the client’s progress, then the next step is to have the client sign a release of information so that you can call and/or speak with the family member(s) to potentially include them in a family meeting. Contact with the family member(s) should

be friendly and psycho-educational. MISSION staff should track all family supports, outreach, and interventions on the client's services delivery tracking form.

Here is an example of a CM's initial contact with Todd, who is the brother of a client who is struggling with substance use, Cindy.

"As you may know, Cindy is now in treatment with us here at [program], and she has given me permission to contact you regarding her treatment. We have discussed the idea of your joining her here for a session or two, and she is excited about that, so I decided to give you a call to chat with you a bit and see if you think that would be a good idea. I often find it helpful to have family members come in for a family meeting. You are in a good position to help me figure out how best to help Cindy. Also, coming to a couple meetings with Cindy will allow you to see first-hand what she is learning here, and to understand how she can get stable housing, cope with her PTSD, and feel better. Then you will be able to help her in her recovery long after we're finished with treatment here. Also, we've found the issues that she is struggling with (i.e., substance use, mental health, and/or chronic homelessness) often damages relationships, and I can help you begin to repair that damage if you'd like to come in with your sister. How does that sound?"

Figure 2. Another example of an informal contact introducing mission to the client's family member/social support.

If the family member(s) says **yes**:

- ✓ Schedule a family session within the week. Make sure you have the client's availability to ensure efficient scheduling.
- ✓ Describe the structure of the family meeting (i.e., length-90 minutes, who will be there-CM, PSS, the client and the family member, location-your office at the MISSION site or at the family member's or client's home).
- ✓ CMs and PSSs should assess any safety concerns prior to scheduling and conducting a home session.
- ✓ Provide a reminder call the day before the appointment.

If the family member(s) **begins to ask questions** about the client's care, program attendance, presenting problems, etc.:

- ✓ Acknowledge and empathize with their concerns

> "*Sounds like Chris means a lot to you and you are concerned. That's why I think it is so important for you to come in, so you two can learn ways to talk to each other about these issues without the conversation getting hostile.*"

- ✓ Respect client confidentiality. MISSION staff should not provide the details of the client's treatment and presenting problems (i.e., numbers of days abstinence) in this initial contact. One can say:

> "*Although Chris gave me permission to call you and schedule this first meeting, our policies do not allow me to provide those kinds of details. Once you come in, we can help you talk directly with Chris about these issues. His peer specialist and I will be there to teach the both of you some tools to help you communicate and facilitate the conversation.*"

If the family member(s) says **no**:

- ✓ Briefly explore their rationale for saying "no."
- ✓ Validate their concerns and provide concrete details about the nature and purpose of the family meetings to address any of their concerns (i.e., this is not a therapy session, the member will not be asked to provide "concrete" forms of support such as housing, financial assistance in the session, the family member is not committing to being involved in long-term treatment, etc.)
- ✓ If the family member(s) still says "no", CMs could say:

> *"It sounds like there has been a lot of damage, pain, and disappointment in your relationship with [the client's name] and you are not ready right now to address it. As I mentioned, we've found the issues that she/he is struggling with (i.e., substance use, mental health, and/or chronic homelessness) often damages relationships, but with help and repair, healing can happen. If ever in the future, you would like to come in with [the client's name], please give me a call. Here's my number. I thank you so much for your time and I'll let him/her know that you will not be able to participate."*

- ✓ Inform the client that the family member(s) has declined. Help client process any reactions. Provide psycho-education and support.

> *"Thank you for giving me permission to speak to your brother John. As we discussed at that time, we weren't sure if he was ready to participate. I was able to speak to him and at this time he is not ready to come in. I know this must be difficult to hear. How do you feel about John's response? (Provide space for the client to discuss his/her reaction. Provide empathetic and reflective responses. Instill hope)... In my experience working with families, I know that many family members' initial reaction/response is not always their final reaction/response. With time and healing, he may or may not change this mind. It is of vital importance for you to continue on your journey… even if one family member is not willing. One healthy change in the family system allows for other healthy changes to be made. Very often, the unwilling family member can be drawn into the process as they have more time to reflect and one continues on their own recovery journey. As we work together more and with time, we can consider talking with John again or seeing if there is anyone else in your family/social network that would be helpful to include. How does that sound?"*

PART III: IMPLEMENTING THE FAMILY MODULE

ORIENTATION TO THE FAMILY MEETING

The CM can provide MISSION clients up to 3-4 family meetings. Each meeting should be approximately 60-90 minutes. Meetings should be structured to help assess family supports, identify how a family member(s) can be helpful, provide psycho-education and some tips on improving family relationships, and make a referral to additional services (i.e., couple or family therapy), if needed. The CM and PSS can facilitate family meetings. If the client and family member(s) have an especially contentious relationship, it is highly recommended that both the CM and PSS are present and facilitate the family meeting. CMs should take the lead in facilitating the family meetings, with the PSS providing support. The CM should document all family meetings on the client's service delivery tracking form.

It should be made clear to the client and family member(s) that family meetings are *not* therapy sessions. Clients and family members should be encouraged to share their questions, concerns, and feelings. The CMs and PSSs role is to make sure that the family meeting does not become a context for sharing deep-seated emotional feelings. Strong feelings are generally present in these meetings, and some sharing of emotion is necessary. However, opening up too much emotional content can be counterproductive, so assessment, psycho-education, and support are the main areas of focus. Interactive discussion is encouraged in the context of increasing the client and their family members' understanding of the client's presenting problem, importance of family support, brief strategies to address common relational issues, and available resources for continued family support. CMs should also review program confidentiality policies with the family member, explain that there generally will be no contact outside of the family meeting without the client's permission, and the CM may make treatment referrals for the family member(s), if needed.

When the client and their family member(s) arrive, it's helpful to spend a few minutes chatting with the family member, to begin to develop rapport. Here is an example of a chat between the CM and the client, Brad's, fiancé.

"As you probably know, Brad is now in his third week of treatment with us. We appreciate you coming in today and your support of Brad in his efforts to achieve his goals (i.e., remain abstinent from alcohol and drugs, get into stable housing, address his PTSD, etc.). Today we will discuss your role in helping Brad to [goal] (e.g., stay abstinent, feel less depressed/anxious, etc.). We also may review some skills for both of you to improve your communication and/or relationship, and some service options to help both of you. Do you have any questions before we continue?"

Figure 3. Example of an introduction during a family meeting to build rapport.

PROMPTS TO ENGAGE THE FAMILY MEMBER(S)

- *To what extent have the two of you discussed [client's] participation in the program/treatment?*

- *Have you ever been in any kind of session like this before (i.e., experiences with family support services, family outreach services, family therapy, couples therapy)?*
- *What do you hope to get out of meeting today?*

Provide a Rationale for the Family Meeting

Here are some examples of what a CM who is working with a client struggling with recovery and their family member(s) can say to orient them to the meeting and its importance.

Example 1. Addressing the Family as a Whole

"We have asked you to come in as a family. This is because, as you know, drinking and drug use (mental health or chronic homelessness) affects the family as a whole. Family members usually have some feelings and reactions to their loved one's drinking/drug use (mental health disorders, unstable housing). Sometimes family members try over and over to help their loved one stop (get help or get into a stable housing situation). Sometimes they give up or get angry. That is, family members of people who drink or use drugs (has a mental health disorder, experience chronic homelessness) usually try different ways to cope with problems related to their loved one's use (health, housing); some ways are more effective than others. Today, we will discuss specific ways that [your family member] can be supportive to you, [client], in your recovery. This support can be very helpful in also helping you maintain recovery (abstinence, stable housing)."

Example 2. Problem Solving

"Another common thing that happens when a loved one is using and has unstable housing, is that small problems become difficult to cope with. Family members begin to lose their ability to deal with each other and solve problems. We may cover some skills to solve problems better as well."

Example 3. Lack of Communication

"We have also found that in many families where one person has a drinking or drug problem, there are family problems. Usually, communication between family members is poor, or filled with negative emotions such as anger, withdrawal, heavy silence, etc. We will introduce some skills to help improve your communication."

Example 4. Basic Goals

"Of course, we understand that the couple of meetings we will have together may not be enough to address all the family difficulties that may have arisen over the years. We hope to give you some basic understanding and skills, and to get you interested and started on a new path together. In the future, you may decide to pursue additional services like family counseling or family support groups (such as Al-Anon, NAMI) to follow-up on some of the skills we'll introduce. For these meetings, our goals are to:

1) *Help you and your family member(s) understand what you [the client] are working on and identify some small goals for your relationship.*
2) *Begin to work together to help support [client] with his/her treatment (e.g., remain abstinent, address their PTSD, get into to stable housing, etc.).*
3) *Learn some tips on how to solve problems when they come up.*

4) *Begin to develop more effective communication skills.*
5) *Identify resources that can help you work on these goals.*

How does that sound?"

EXAMPLE 5. GROUND RULES

"Talking about these goals may be difficult, so I have found it helpful to set up some ground rules. One of my ground rules is that I will stop the session, if arguing becomes too intense and will ask for everyone to take 5 minutes to calm down. What are some of your ground rules (e.g., one person talks at a time, no name calling, etc.)?"

MANAGING THE FAMILY MEETING[4]

From the beginning of a CM's work with the client and his/her family, it is important to set the stage with some basic rules for the family meetings. In this way you will begin to help the client and their family member(s) with their communication skills, establish yourself as the manager of the meeting, and help prevent episodes of overt anger and argument that might derail the meeting. Families can be quite angry at one another by the time the client has started to attend treatment. Therefore, it is not unusual for the client and/or their family to exhibit anger, blaming, resistance, and sadness during sessions.

Some expression of anger is unavoidable and even desirable. First, it gives the CM a chance to observe typical communication interactions between the client and their family member/partner, so he/she can assess where they need to improve their communication. The CM can also use this to help tailor his/her brief intervention and select an appropriate referral for additional services/resources to help them to address these patterns.

High levels of aggression and hostility in the meeting are not helpful. Thus, the CM, with the PSSs' support, must carefully monitor the type and amount of conflict in the session, and consciously decide when to let it continue, and when and how to step in and redirect. In other words, conflict is natural, expected, and has a useful place. The CM ***must*** be in control of the meeting at all times, and expression of the conflict is at the discretion of the CM. If conflict is intense and escalates to the point where the CM feels out of control of the session, it is time to model a "time out." In these moments, the CM could say:

> *"This arguing is getting too intense now and isn't helpful. It looks like we need to take 5 minutes to calm down, so let's take a break, take a little walk one at a time, and then re-connect."*

During the break, the PSS may accompany the client and reinforce strategies to help the client calm down to return to the meeting. For example, the PSS can review with the client deep breathing, anger management strategies, etc. (i.e., skills outlined in the MISSION Participant Workbook and MISSION manual). The CM can provide support to the family member(s) at this time by providing some tips to help them calm down as well.

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[4] Adapted from Elizabeth Epstein ABCT Treatment manual

If that doesn't work, then the CM needs to end the meeting and spend the rest of the time individually with the client or family member(s), taking turns to see each individually or if the PSS is in the meeting, he/she can meet with the client while the CM meets with the family member(s). Before ending such a meeting, take 5-10 minutes at the end of the meeting to debrief the client and their family member/partner, reflect on what has happened, predict that one or both individuals may want to continue the argument in the car on the way home or during the week. Let each person talk about this a bit, and highlight the detriments of doing so.

> "*Continuing this argument in the car or on the phone would be an exercise in frustration for both of you. You're not ready to talk about this together without a third party there. I suggest you really make the effort to let this rest for now, even if it means not talking to each other on the way home or this week. We can talk about it together again or you can revisit this once you start the family-counseling program. How does that sound?"*

When to let conflict continue in a meeting:

1. At the beginning of the session it is helpful to let the client and their family member(s) argue a bit in session so that you can observe communication patterns, strengths, and deficits.
2. When the arguing is constructive, let it continue (i.e., not escalating, no personal attacks, appropriate responding, even if angry).
3. When you understand that this client and family member(s) has been unable to discuss these issues at home, let them air these issues; however, step in, manage the conflict, and teach them to discuss these issues using good communication skills.

When to step in and stop the conflict in a meeting:

1. When one or both people are yelling, screaming.
2. When communication tactics are extremely poor - attacking each other's character, calling each other names.
3. Either person is getting extremely upset.
4. Any sign of threatening behavior.
5. When the communication is frustrating and not effective, and after you have evaluated deficits (i.e., continually interrupting each other, not addressing what the other person just said, never making eye contact, talking simultaneously, one person dominating the conversation, etc.).

How to step in and manage the meeting:

1. First lay the ground rules at the beginning of the meeting so the client and their family member/partner can expect you to step in and redirect at any time.
2. Use nonverbal behavior as you speak (i.e., hold up your hands to signal "stop"; lean forward into the client and their family member and begin talking).
3. Feel free to interrupt the arguing.

> "*Okay - let's not spend the whole time arguing like this. I assume this is what you do at home (or when you are together) and I'm glad you gave me a chance to*

observe one way you communicate. But I don't want to let you spend your whole time here doing that, because I see that it's frustrating for you both (or all of you) and not all that effective for either of you (any of you). We can address these same issues, but I want to give you some tools to communicate about them in a way that will be more helpful and feel better to both of (all of) you."

4. If argument begins again, just hold up a hand.

   "Okay! Let's not go there for now." Or,
   "*Okay! John, let's see if we can help you say that in a way that Lilly will be able to hear better."* Or,
   "Let's see if we can help you say that in a nicer way." Or,
   "John - let Lilly finish and then you'll have a turn to speak your peace." Or,
   "*I can't hear either of you when you're both talking at the same time. John, why don't you go ahead and then we can hear Lilly's view."*

5. Try not to refer to either the client or their family member(s) in the room as "he", "she", or "they." Always use their names.
6. If the client or their family member(s) is complaining about the other to the CM, using third person, it is usually inappropriate (especially after initial assessment and rapport-building sessions) to redirect his/her comments directly to the family member.

   "Lilly why don't you say this to John." Or,
   "Say it to John. I want you to use these meetings to start to get used to talking to each other in effective ways. I will step in to point out a good communication style or communication errors."

FAMILY MEETING CONTENT

Family meeting content is not fixed, should build on learning from the Peer Led and Dual Recovery Therapy (DRT) sessions, and should be tailored to the unique relational needs of the client and their family member/partner. Included below are suggestions for family meeting content and sequence of meetings.

DRT is delivered by MISSION CMs through 13 weeks of structured psycho-educational sessions. Many of these sessions (i.e., life problem areas, communication skills training, changing unhealthy thinking patterns, etc.) fit nicely with the goals of the family meetings (e.g., providing psycho-education about CODs, improving communication, etc.). Therefore the CM can include a family member(s) in a session where he/she is delivering a full DRT session or integrate elements from DRT into the family meeting.

For most family meetings the sequence will be as follows:

Session 1: *Psycho-education*
Session 2: *Communication Skills*
Session 3: *Coping Skills and/or Problem Solving Skills*
Session 4: *Referral*

SESSION 1: FAMILY PSYCHO-EDUCATION[5]

Family psycho-education is a structured approach for partnering with MISSION clients and their families to support their path to stable housing and recovery. The goal is for the MISSION clients and their family member(s) to receive information about homelessness and related problems such as substance use and mental health disorders, and be introduced to problem solving, communication, and/or coping skills.

The following are the topics that can be addressed in the psycho-education provided in family meetings. The CM should select topics that are most relevant to the client's current presenting problem**:**

- Overview of Mental Health and/or Substance Use Disorders, and Homelessness: *Prevalence, symptoms, causes, and basic concepts*
- Effects of Mental Health and/or Substance Use Disorders, and Homelessness: *Impact on the individual, family system, and individual members, including children, and housing*
- Overview of Recovery: *Recovery issues for the client, highlighting family issues in recovery*
- How the Family Can Help: *Behaviors that are helpful in supporting the client's recovery*
- Family Recovery Issues: *How a family member can heal from the adverse effects of the client's illnesses and/or problems and involvement in a close relationship with the client*
- Self-help Programs: *Programs available for family members, how they can help, and how to gain access to them*
- Relapse: *Common warning signs of relapse, the importance of relapse prevention planning, how the family can be involved, and how to deal with an actual lapse or relapse*

Please see the Family and Social Support Workbook for supplemental materials.

PERSONAL LIFE PROBLEM AREAS

One way to integrate family psycho-education is by utilizing the Personal Life Problem Areas worksheet in the MISSION Participant Workbook, which is also provided in the Family and Social Support Workbook. The client and their family member(s) can spend a session working with the CM on the "Personal Life Problem Areas" to identify areas of focus in the client's treatment or review an already developed "Personal Life Problem Areas" worksheet. For instance, a client may share with their sibling, parents, or adult children that they have decided that the two most pressing problems are active drinking and anxiety. Thus, the initial treatment plan has focused on an abstinence plan (including detoxification), and a plan for monitoring the anxiety symptoms. In the discussion, the CM should provide extensive psycho-education about each of the areas, including the role of family support in helping address these life areas and explore ways in which the family member can be

[5] Adapted from Mercer, & Woody,1999

helpful in the client's recovery. The client and his family member(s) may decide it would be helpful for the sibling to join the client at an AA meeting and/or attend an Al-Anon meeting. The CM might decide, with the family, that skills training to prevent relapse would be useful with the family member present. The CM would meet with the family member and client to provide one introductory skills training meeting and then refer them for further family services, if needed.

Here is an example the CM can use for giving rationale and an explanation of the life areas list.

"So when [client] and I first started meeting we spent a lot of time identifying aspects of his/her daily life that he/she might want to discuss as we went along in treatment or that he/she was not entirely happy with. Take out – Personal Life Problem Areas worksheet the client completed. *We've broken down "*Personal Life Problem Areas*" into 8 major categories, since we've found that these are the areas that are generally the most important to people. It's hard to juggle family/job/money/responsibilities and people can usually identify at least a few areas where they might want to change how things are going for them. We have used this list to help with treatment planning. [Client name], can you share with [family member's] what you have on your list?"*

Figure 4. Example of a providing psycho-education.

The CM should work with the client and the family member(s) to discuss the areas the client included and also identify areas that are problematic for the client and their relationship. Try to elicit content from both the client and the family member(s). Provide psycho-education as you review the areas. Also try to elicit ways in which the client can be part of the treatment plan to address certain areas (i.e., Life Area: Fighting with Family, Intervention: *My brother will come to 1-2 family meetings and we will continue in family therapy to learn communications skills to help us communicate better*).

SESSION 2: COMMUNICATION SKILLS

Many families struggle with effective communication skills. This may be especially true for homeless individuals who have experienced elongated physical and emotional cut-offs from family members, high levels of family conflict, etc. Therefore, all family meetings should generally include communication skills training.

CMs can start a communications focused session by saying:

"Drug use (mental health, chronic homelessness) usually has a negative effect on families and relationships. So, we will be working together to begin helping you develop new ways to interact. Don't expect too much, just practice the exercises as best you can; you have to start somewhere and we cannot cover everything at once here in our meetings. We will just introduce the skills that hopefully you can continue to work on in family therapy. I'd like you all to try to especially avoid saying things like, "I won't do it unless he/she does it first." You each have to do your own bit in good faith. It doesn't help to blame each other or look for the 'cause'. Pay attention to your own behavior and what you can do to make the relationship better, not to what your family member(s) is or is not doing. If you both (all) do that, we can make progress."

Figure 5. Example of a communications centered discussion.

The basics of good communication are included in the "Developing Strong Communication Skills" chapter in MISSION Participant Workbook as well as the Family and Social Support Workbook. CMs should review both "good and poor communication" handouts in the workbook so the client and their family member(s) can both identify which they are using and when. CMs and PSSs should role-play the communication skills for the client and their family member(s) and then have the client and their family member practice talking about a topic they choose. The topic should not be related to a major disagreement they have. For example, they can discuss their thoughts on working on their relationship in family therapy. Since these family meetings are not on-going therapy, the CM should first start off with a topic that is less heated. Inform the client and their family member that you will interrupt them frequently to point out when they are using good and poor elements of communication, and to redirect the conversation to make it more effective.

SESSION 3: COPING SKILLS

CHANGING UNHEALTHY THINKING PATTERNS

From observing, the family's interactions, the CM and PSS may decide the family's struggle with unhealthy thinking patterns is really getting in the way with communication and must be addressed. In a "coping skills" focused family meeting, the CM can focus on teaching the client and the family member(s) to question the logic of irrational thought patterns and challenge these thoughts.

Here is a suggested way the CM can introduce how to identify unhealthy thoughts and thinking patterns:

"Learning to identify and change unhealthy thinking patterns is a cornerstone of addressing all sorts of problems, including relationship conflict. When someone has had problems in their family relationships, for example, the person may begin to see the person and relationship "through distorted glasses" and often have many depressing, angry, "put-down", punishing, or guilt-related thoughts. These unhealthy thoughts usually make families feel worse. To break the cycle, it is helpful to identify these negative thoughts and learn to challenge them and replace them with more helpful thoughts. In many cases unhealthy thoughts are part of a chain reaction leading to many issues (poor communication, unhealthy relationships, etc.).This meeting will begin to teach you [the client and the family member(s)] to question the logic of irrational thought patterns and replace them. This technique will also be helpful to apply to situations that trigger relationship problems for the both of you."

Figure 6. Example of how the CM may approach unhealthy thoughts/thinking.

EXAMPLE

Rick is a 33-year-old with a drug addiction. Rick has been abstinent from all alcohol and drugs for three months and is beginning to feel better about himself. One day at work, Rick's boss berates him for a mistake that he has made. The boss is very angry and Rick is very upset by this incident. As he drives home that evening, he begins to think more about it.
Here are his thoughts:

- *"I really made a terrible mistake."*
- *"I must be stupid for doing such a thing."*
- *"I'm just no damn good."*
- *"He probably doesn't like me anymore because he was so angry and I'm so dumb."*

Rick has made a number of jumps in rational logic in this sequence. He assumes that because he made a mistake, he is not very intelligent and is completely worthless. He also assumes that since his boss became angry with him, neither his boss nor anybody else cares about him.

The CM's objective is to encourage the client to: (a) more objectively evaluate the situation in question; and (b) question the validity of each statement he makes to himself. For example, Rick might begin by questioning whether he was, in fact, responsible for the mistake.

Rick comes home and appears very upset and refuses to tell his family member(s) what is going on. The family member begins to think:

- *"He's using again."*
- *"He's angry with me."*
- *"I can't take this. He has to get out."*
- *"He always messes up a good thing."*

The CM's objective is to encourage the family member(s) to: (a) more objectively evaluate the situation in question; and (b) question the validity of each statement the family member(s) is making. For example, the family member(s) may question if they may be making assumptions.

EXERCISE

Choose a situation (a current problem), and have the client relate the thoughts he/she might have about the situation; evaluate the thoughts in terms of whether they are helpful (i.e., healthy) or not helpful (i.e., irrational, unhealthy) in terms of dealing with the situation or helping him/her to feel better. Engage the family member by having him/her share their thoughts about the situation. Chances are he/she may have some unhealthy thinking patterns of their own.

Review the "stinking thinking" worksheet in the MISSION Participant Workbook and the Family and Social Support Workbook and/or refer to the "Common Cognitive Distortions for Families" worksheet in Appendix C. See if either person can recognize types of thoughts they have on the list, including thoughts related to their relationship.

During the meeting, the CM and PSS should begin to help the client and family member(s) label types of stinking thinking that ring a bell. Help the client and family member(s) begin to challenge some of these thoughts.

SESSION 4: REFERRAL

As mentioned, clients and family members are informed of the brief nature of family meetings at outreach. It is important to identify clients who would benefit from a continued family-based intervention. These clients include clients and family members who are motivated to re-engage, are demonstrating poor communication patterns, have a high level of tension/conflict, request continued services, and/or present with significant family dynamics impacting treatment and recovery. These clients should be referred to specialty providers in family and/or couple treatment. The primary goals in making the referral are to identify an appropriate intervention (i.e., family therapy, couple therapy, support groups, etc.) and to facilitate service engagement.

Ideally, the CMs and PSSs have working knowledge of the services in the area and can provide detailed information to the client and family member of the different types of services available. To facilitate engagement, the CM and PSS may use motivational enhancement techniques to help clients and their family member(s) address any ambivalence. PSSs can provide transportation to initial appointments. PSSs and CMs can follow-up with the client after an appointment. The CM should get a release to speak with the additional provider (i.e., family therapist).

The referral should be documented in the client's treatment plan and service delivery tracking sheet. The CM and PSS should continue to assess family supports throughout treatment and follow-up with the client to assess changes in family supports and relationships.

If prior family meetings were successful, it is strongly encouraged to have an additional family support meeting during the period leading up to discharge. In theory, the discharge planning process begins at the time of admission. One of the goals from the start of the client's participation in MISSION is to develop a support network (including family). As treatment progresses, the client's team helps the client prepare for reintegration into his/her career/school, community, family, and life. Family supports should be included in discharge planning.

This last family meeting could focus on having the client share his/her discharge and relapse prevention plan with their family member/partner and identifying ways in which the family member/partner can be a support. The PSS and CM could provide psycho-education about relapse prevention, identifying warning signs and developing a relapse prevention plan integrating family supports. Many families and clients struggle with understanding their role in relapse prevention and support (e.g., being hyper-vigilant or accusatory to not knowing what to do if their family member starts using again).

UTILIZING THE WORKBOOK

To enhance delivery of psycho-education and brief skills training in family meetings, the CM/PSS can utilize sections of the MISSION Participant Workbook (as highlighted above) and/or utilize the Family and Social Support Workbook. For example, when utilizing the Participant Workbook, the CM or PSS could integrate Part 2 of the MISSION Participant Workbook which includes a brief description of the most common mental health conditions experienced by individuals in the MISSION program and a table with the most common medications used to treat these conditions as well as their possible side effects into a family session focused on enhancing a shared understanding of CODs and their treatment. In utilizing the MISSION Participant Workbook, the CM/PSS can pick and choose materials to integrate into the family meeting as needed and tailor these sessions to areas that seem most appropriate and relevant for the specific client and family member(s).

The CM or PSS can also choose to utilize materials from the Family and Social Support Workbook. This Workbook was designed to complement MISSION family support meetings. The goal of the workbook is to provide additional resources and psycho-education focused on increasing family members' understanding of co-occurring disorders and related problems, provide select tools to help enhance communication between the family member to support recovery, and is responsive to issues that are common for families struggling with CODs and related problems.

The MISSION Participant Workbook, and the Family and Social Support Workbook are seen as important components of the family meetings and symbolically offer the client and their family member(s) a set of support materials that will assist them in the family's journey toward recovery. Both the CM and PSS play a critical role in the client and their family member's use of exercises and readings contained in these materials. Workbook materials can be delivered in a very structured format. Alternatively, the exercises can be individually tailored based on the client's and family member's needs and stage of recovery.

CONCLUSION

Bolstering family support is important in helping MISSION clients reach their goals. This 3-step family support module – assessment, brief intervention, and referral – can be successfully implemented, address related challenges, provide preliminary skills to improve their relationships, and provide referrals for additional family related services and interventions.

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APPENDIX A: *Guidelines for Completing a Genogram and Ecomap*

GENOGRAMS

CREATING YOUR GENOGRAM

- Use a larger piece of paper to give yourself plenty of room for recording extra information over time
- Always put a date on the genogram and a date next to additional information recorded
- You can keep the guide with the symbols beside you as you complete it with your client. You don't need to memorize the symbols
- Start with questions that are relevant to a social relationship your client has mentioned… *"You said you are staying with your wife at your mother's house?"*

USING YOUR GENOGRAM IN TREATMENT

- It is often helpful to keep the genogram in your client's file to refer to and add to in subsequent sessions.
- You may ask them to tell you a bit about each person. "*Tell me a bit about your wife.*"
- As the client tells you about family members and relationships, make a note alongside the name.
- Ask about relationships between family members.
  - *Who are you closest to?*
  - *What is/was your relationship like with...?*
  - *How often do you see...?*
  - *Where does...live now?*
  - *Is there any one here that you really don't get along with?*
  - *Is there anyone else who is very close in the family? Or who really don't get along?*
- Ask about characteristics or habits of family members, particularly those relevant to presenting problems: alcohol/ drug use, physical and mental health, violence, crime/trouble with the law, employment.
  - "*You mentioned that you and your wife used to use together, is she still using now?*"
  - "*Sounds like your mother's health has been declining since she went off her meds. What is she taking medication for? How long has she struggled with schizophrenia?*"
- Ask about culture
  - *Where were you born? Where were your parents born?*
  - *When did you immigrate? When did you parents immigrate?*
  - *In your culture (religious group, country of origin, etc.), how are things handled in the family?*
  - *Any cultural beliefs regarding mental health, substance use, or seeking treatment.*
- Ask about family values, beliefs and traditions.

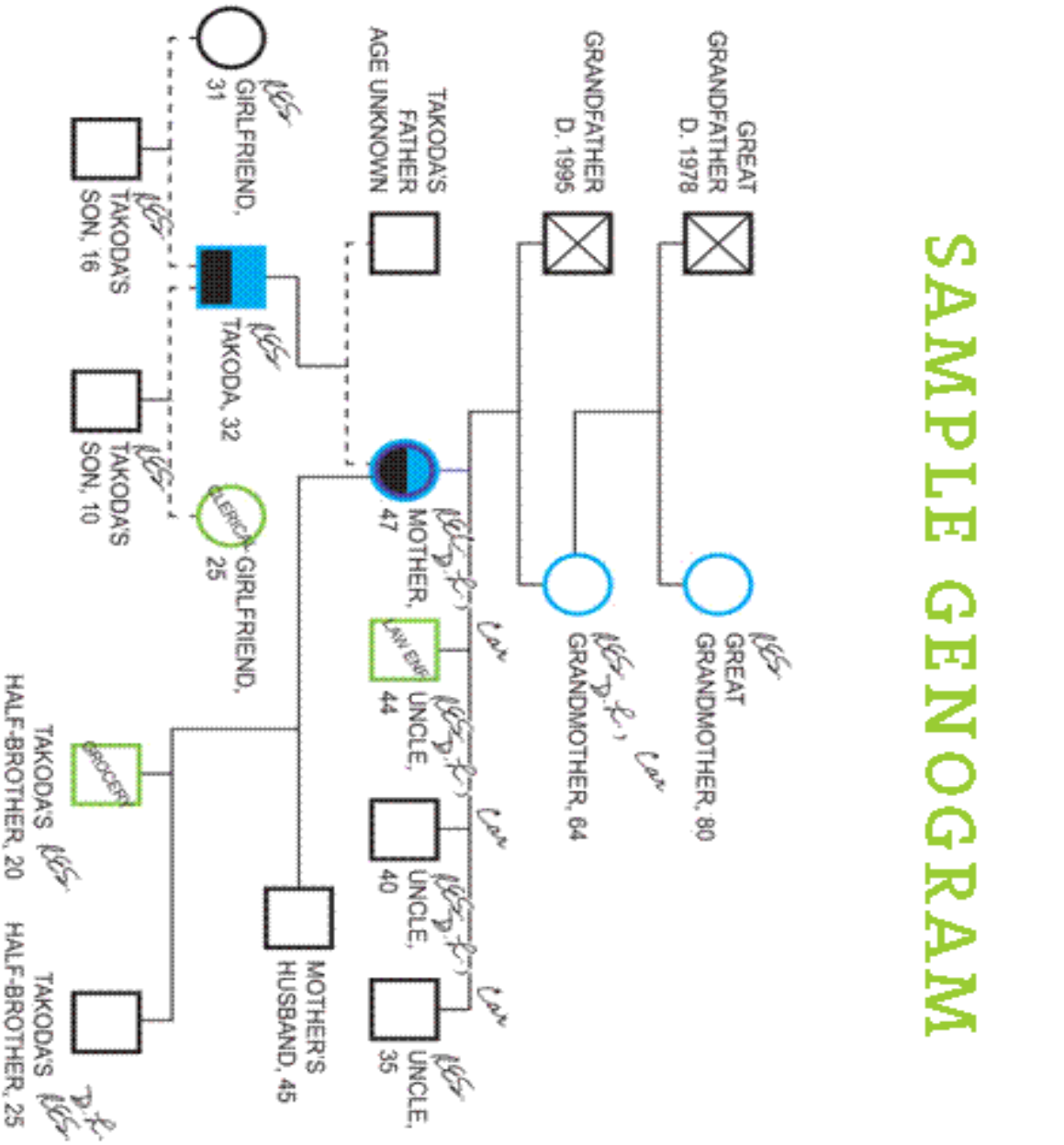
SYMBOLS FOR DRAWING THE GENOGRAM OR FAMILY TREE

Symbol	Description	Information to Add
	Female Symbol	Name, age
	Male symbol	Name, age
	Unknown gender	Name, age
	Married	Year or ages
	Estranged/Distant relationship	Commencement date or ages
	Separation	Date or ages
	Divorce	Date or ages
	Death	Small cross in the corner or that symbol, date if known
	Enclose the members living together; for example, who the client is living with	
	Conflictual relationship	
	Very close relationship	
	Distant relationship	
Note: List children in birth order and put names and ages either within the symbol or underneath.		

For further genogram support please visit http://wellsk.faculty.mjc.edu/genogramdetailed.pdf

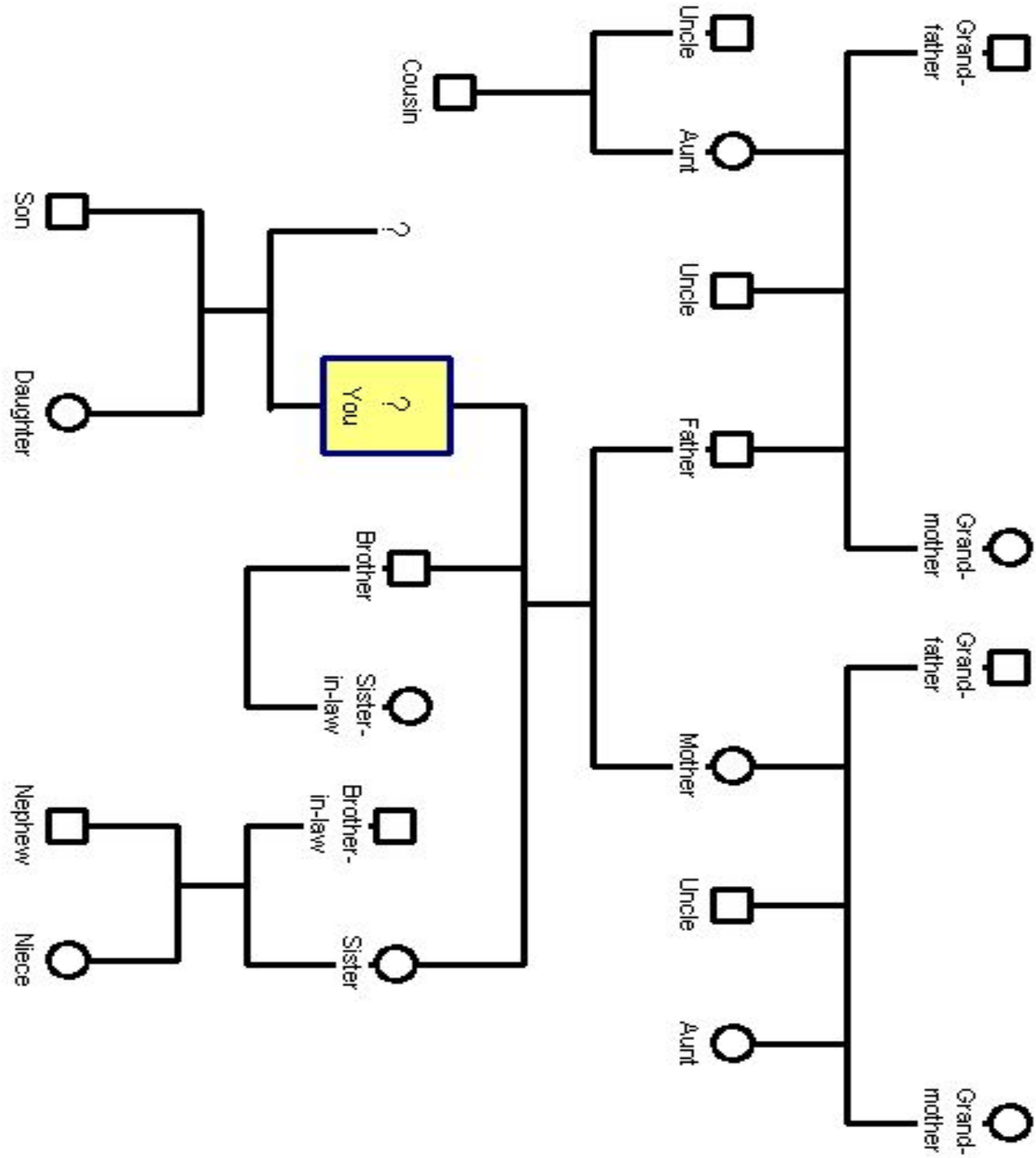
SAMPLE COMPLETE GENOGRAM

Source: The Vera Institute of Justice



SAMPLE BLANK GENOGRAM

Source: Genopro

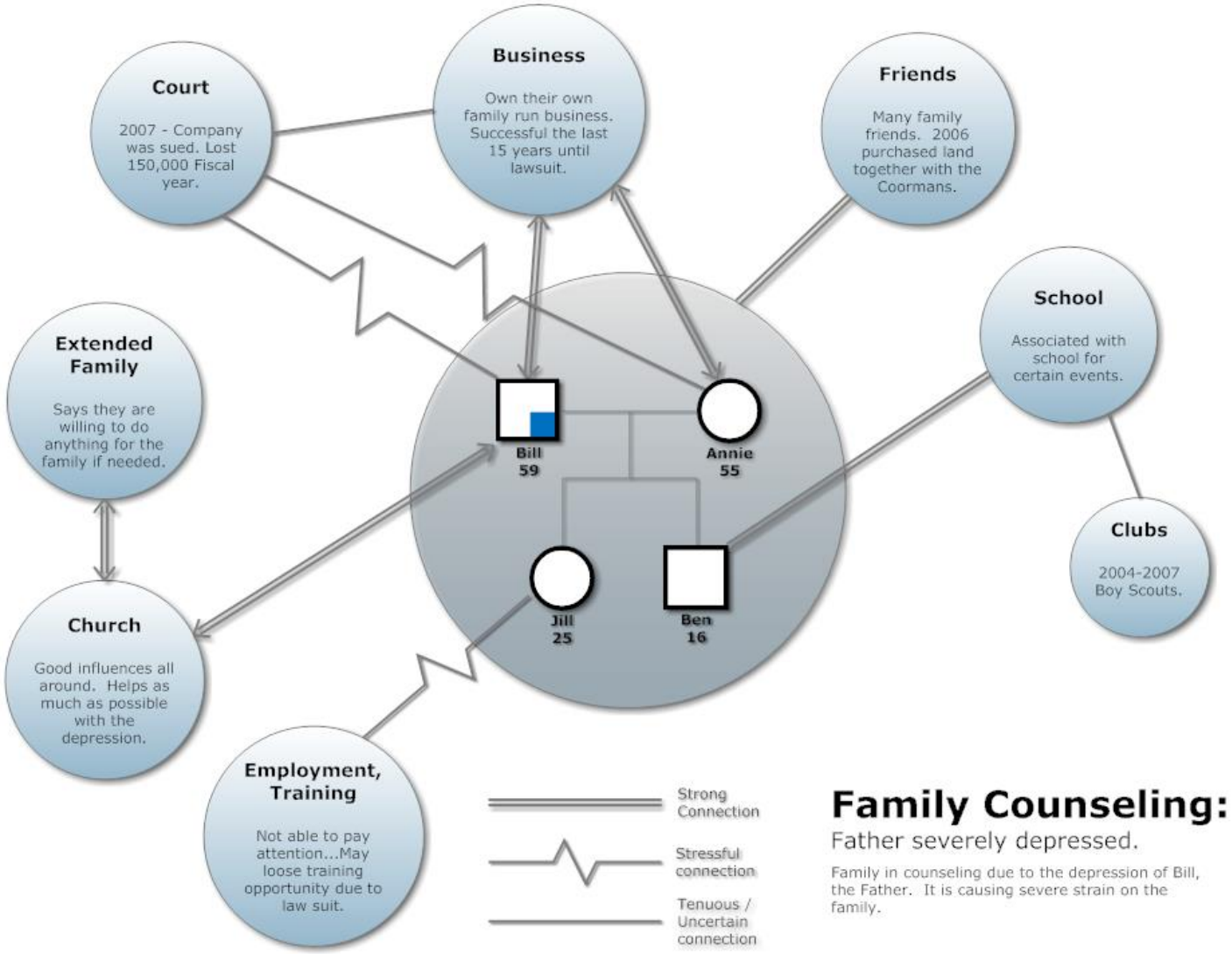


ECOMAP

- To complete the ecomap, the genogram of the family is placed in the large circle at the center of the map. This circle marks the boundary between the household and its external environment.
- The smaller outer circles surrounding the center circle represent significant people, agencies, or institutions in the family's context.
- Lines are drawn between the circles and the family members to depict the nature and quality of the relationships and to show what kinds of resources are going in and coming out of the family.
    - Straight lines show strong or close relationships; the more pronounced the line, the stronger the relationship.
    - Straight lines with slashes denote stressful relationships.
    - Broken lines show tenuous or distant relationships.
    - Arrows show the direction of the flow of energy and resources between individuals and between the family and the environment.

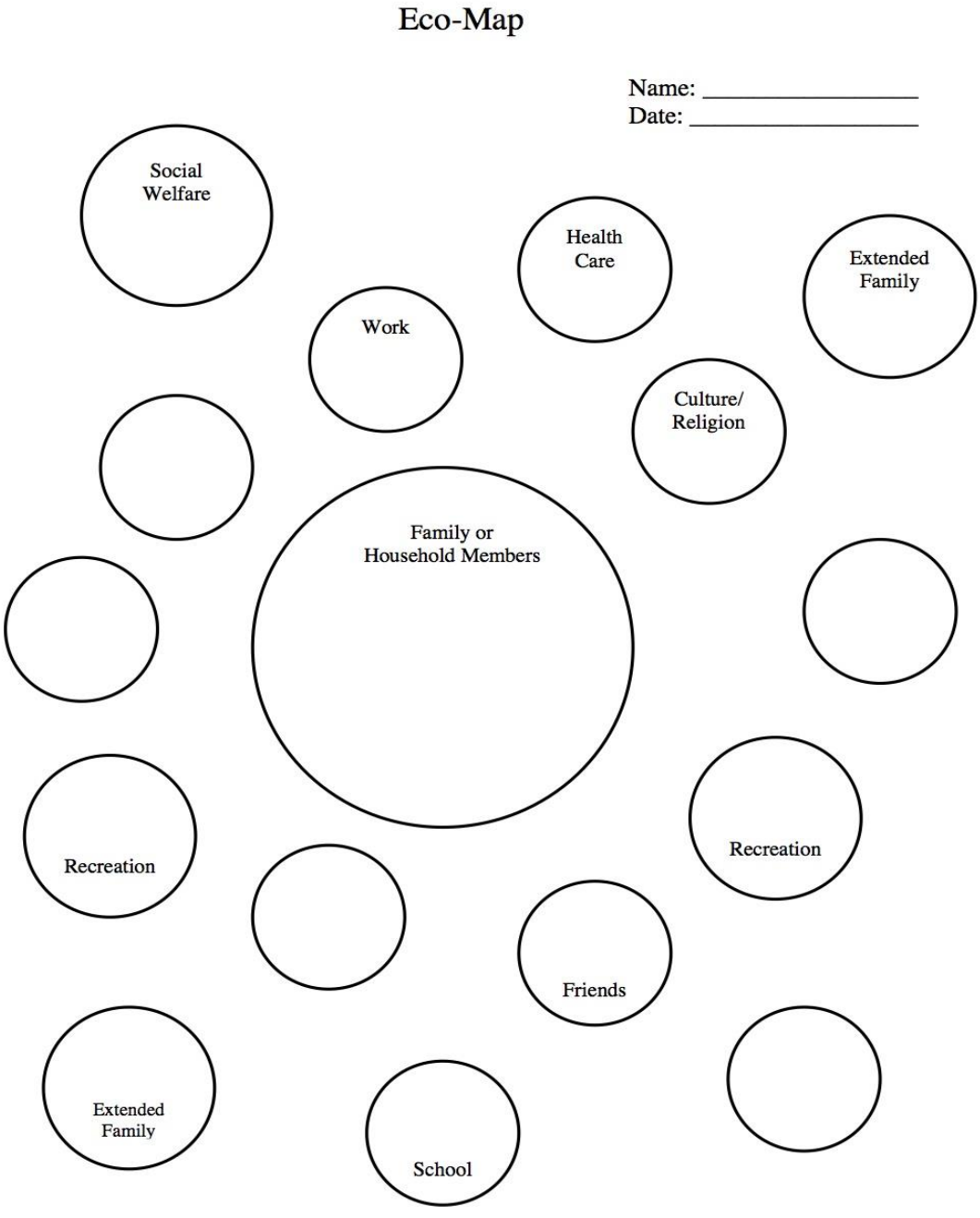
SAMPLE COMPLETED ECOMAP

Source: smartdraw



SAMPLE BLANK ECOMAP

Source: Hartman & Laird, 1983



From: "Family-Centered Social Work Practice" Hartman & Laird

CMP 105
Family / Child Assessment
12/2005

APPENDIX B: *Decisional Matrix of Change Worksheet*

When we think about making changes, like re-engaging and re-connecting with family members, most of us do not really consider all sides in a complete way. Instead, we often do what we think we "should" do, avoid doing things we don't feel like doing, or just feel confused or overwhelmed, and give up thinking about it at all. Thinking through the pros and cons of decisions is one way to help us make sure we have fully considered a possible change.

Instructions: Below, write in the reasons that you can think of in each of the boxes for changing or not changing.

	Benefits/Pros	Costs/Cons
Making a Change		
Not Changing		

APPENDIX C: *Common Stinking Thinking in Families*

Common types of thinking errors that family members/partners may use when they think about problems.

Labeling - you attribute a negative personality trait to your family member/partner leading you to believe that he or she can never change.

"She's passive-aggressive."
"He's the victim."

Fortune-telling - you forecast the future and predict that things will never get better, leaving you feeling helpless and hopeless.

"He'll never change."
"I'll always be unhappy in my friendship with her."

Mind-reading - you interpret the motivations of your family member/partner as hostile or selfish on the basis of very little evidence.

"You don't care how I feel."
"You're saying that because you're trying to get back at me."

Catastrophic thinking - you treat conflict or problems as if they indicate that the world has ended or that your relationship is awful.

"I can't stand her excuses, they ruin everything."

Emotional reasoning - you feel depressed and anxious and you conclude that your emotions indicate that your relationship is a failure.

"We must have a terrible marriage because I'm unhappy."
"I don't have the same feelings toward him that I used to--therefore we're no longer in love."

Negative filter - you focus on the few negative experiences in your relationship and fail to recognize or recall the positives. You probably bring up past history in a series of complaints that sounds like you're putting your family member/partner on trial.

"You were rude toward me that one time I came around to see you last year and you never had my back."

All or nothing thinking - you describe your interactions as being all good or all bad without examining the possibility that some experiences with your family member/spouse are positive.

"You're always negative."

Discounting the positive - you may recognize the positives that do exist, but you disregard them by saying-- *"that's what a Mom should do."*

Perfectionism - you hold up a standard for a relationship that is unrealistically high and then compare your relationship to this standard.

“No one else has these problems with their brother.”

“Shoulds” - you have a list of "commandments" about your relationship and condemn yourself (when you're depressed) or your family member (when you're angry) for not living up to your shoulds.

"My friend should always know what I want without my asking."
"If my spouse doesn't do what I want her (him) to do I should punish him (her)."
"I shouldn't have to work at a relationship--it should come naturally."
"Talking about these things just makes them worse."
"My brother should change first."
"It's all his/her fault, so why should I change?"
"If I don't get my way, I should complain (pout, withdraw, give up)."
"I should try to win in all of our conflicts."
"My mother should accept me just the way I am."
"If we're having problems it means we have an awful relationship."

Personalizing - you attribute your family member’s moods and behavior to something about yourself or you take all the blame for the problems.

"If it weren't for me, my family wouldn't have any of these problems."

Externalization of responsibility - you believe that all the problems in the relationship are out of your control.

"If it weren't for her, we wouldn't have these problems."
"He argues with me, that's why we can't get along."

Appendix D: *Domestic Violence Screener H.A.R.K*

The H.A.R.K. model can be a helpful framework for identifying people who may be in an abusive relationship (Sohal, Eldridge, & Feder, 2007).

Adapted "Setting the Scene" for asking the H.A.R.K screening questions:

- "*How have things been at home with your family member/partner living with you again?"*
- *"I know you've mentioned that your partner becomes aggressive when he drinks…I am concerned that you may be at risk letting him stay at your apartment."*
- *"Our past few meetings I have noticed several bruises on you…and it is important that I ask about your safety."*
- *"I am concerned that this injury seems to be more severe than I would expect from tripping…"*
- *"It is good that you have asked for emergency contraception…can I just ask whether the sex that happened was with your consent?"*
- *"Are you safe to go home?"*
- *"Do you have a family member or close friend you're able to stay with in case you needed to?"*

Adapted H.A.R.K screening questions:

Humiliation:

"Have you been humiliated or emotionally abused in other ways by your family member?"

Afraid:

"Have you been afraid of your family member?"

Rape:

"Have you been raped by your family member/partner or forced to have any kind of sexual activity?"

Kick:

"Have you been physically hurt by your family member?"

H.A.R.K Scoring:

Tally 1-point for each "yes" response. A score of 1 or higher indicates that the individual is likely to have experienced interpersonal violence. The score can range from 1-4, the higher the score the more likely interpersonal violence has occurred.

Additional follow-up questions to clarify H.A.R.K responses:

"Does your family member make you feel bad about yourself?"
"Do you feel you can do nothing right?"
"What does your family member do that scares you?"
"Have you ever felt like you had to have sex when you didn't want to?"
"Have you ever been forced to do anything you are not comfortable with?"
"Does your family member threaten to hurt you?"

APPENDIX E: *Acronyms*

Acronym	Phrase
AA	Alcoholics Anonymous
ACT	Assertive Community Treatment
BIPP	Battering Intervention and Prevention Program
CM	Case Manager
COD	Co-occurring Disorder
CS	Clinical Supervisor
DRT	Dual Recovery Therapy
GED	General Education Development
MISSION	Maintaining Independence and Sobriety through Systems Integration, Outreach, and Network
NAMI	National Alliance on Mental Illness
NIDA	National Institute on Drug Abuse
PSS	Peer Support Specialist
PTSD	Post-traumatic Stress Disorder

APPENDIX F: *Glossary*

Assertive Community Treatment (ACT)- Treatment model that provides individually tailored services directly to the client. More detail on ACT can be found at http://www.namihelps.org/assets/PDFs/fact-sheets/General/Assertive-Community-Treatment.pdf.

Community integration- Working with individuals to comfortably introduce, or reintroduce, them into the community, or communities, of their choice.

Co-occurring disorders (COD) - The existence of both mental health and substance use disorders.

Debrief- A discussion or reporting about an individual's understanding of an event that just occurred. For example, asking a client about a topic that was discussed during the session before the client leaves.

Ecomap- A diagram that depicts an individual's personal and social relationships with environmental factors that he/she regularly encounters.

Empathy- The ability to understand another's feelings from their point of view or by placing yourself in their shoes.

Estranged relationship- A relationship that has been distant for a long time to the point of alienation.

Genogram- A diagram that depicts an individual's family tree. It can also include a family's medical history.

Harm Reduction Theory - An approach which uses practical strategies and ideas to reduce the negative consequences associated with risky behaviors. Some examples are needle exchanges, methadone or SUBOXONE programs, and condoms/dental dam availability. Organizations that institute this theory do not demand full abstinence, but rather meet people where they are at with the goal of reducing harm. You can find more information at http://harmreduction.org/about-us/principles-of-harm-reduction/.

Intervention- An action, such as a treatment, therapy, or skill, to improve a situation.

Legally sanctioned- A decision/circumstance that is enforced by the law, which results in a penalty if not followed.

MISSION (Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking) - A wraparound service intervention designed to meet the needs of those experiencing homelessness and co-occurring disorders.

Motivational Interviewing (MI) - A goal-oriented, client-centered approach that utilizes the Stages of Change Theory to help clients explore their ambivalence by strategically using skills such as asking open-ended questions, active listening, and reflecting. There is more information at http://motivationalinterviewing.org/

Psycho-education- Education that can be provided to those seeking treatment for a mental health disorder or for those who are supporting an individual with a mental health disorder.

Resistance- An individual's refusal to agree or comply.

SAMHSA (Substance Abuse and Mental Health Services Administration) - The agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance use and mental health on America's communities.

Stigmatization- Generic negative labeling of a group of people based on an assumed characteristic or trait.

Trauma-Informed Approach - A model that maintains that providers should presume going in to every relationship that there may have been some form of trauma (e.g., use, neglect, loss, etc.) in the person's life and then act accordingly when meeting with them. Some examples are letting the person choose where to sit, leaving the door open during meetings, not coming up behind someone, not hugging, and not touching without permission. You can find more information at http://www.samhsa.gov/nctic.