Permanent Supportive Housing Resource Guide

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PREFACE

This second edition of the Permanent Supportive Housing Resource Guide mirrors the tremendous progress that has been made towards ending Veteran Homelessness by placing greater emphasis on issues and strategies related to maintenance of housing, community integration and recovery for the previously homeless Veteran. This guide attempts to organize and encapsulate a broad spectrum of information relevant to staff working with Veterans in Permanent Supportive Housing. The material is organized in what was intended to be a logical order. For example, Housing First, which is now official policy, is discussed much earlier in the guide than in the prior iteration and sits as a culmination of sorts of the broad principles of Patient Centered Care, Recovery, Harm Reduction and Trauma Informed Care which are foundational to its implementation and success. Information relevant to staff and team operations follows this opening section with special emphasis placed on Team Based Care and care delivered in the community. The third section contains a variety of clinical and practical topics that case managers and others involved in the care of Veterans seeking or in permanent supportive housing are likely to face. While the material is organized in a progressive manner it is expected that the reader may wish to go directly to a particular chapter and the format and chapter style supports this. It is the desire of all who worked on this guide that the material will be relevant, useful and digestible. It is recognized that in spite of being a substantial document it is far from comprehensive and the reader should consider it but one of the potential tools necessary to utilize in developing competency in this unique clinical arena. It is similarly acknowledged that information is never static or complete and this document is intended to be "living and evolving" with anticipated updates as new material becomes available.

In addition to the many esteemed authors who contributed material for this resource guide, I wish to acknowledge Mitra Eframian, Stephanie George, Darin MacCatherine, Joe Ronzio, and Paul Smits, whose special contributions on the editing, formatting, and user interface were essential in getting this final product out.

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Section 1

Key VA Principals & Policies

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Chapter

1

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Patient Centered Care

"The disease-driven approach to care has resulted in spiraling costs as well as a fragmented health system that is reactive and episodic as well as inefficient and impersonal."

- The Institute of Medicine Summit on Integrative Medicine and the Health of the Public, Feb 2009

The Veterans Health Administration (VHA) has declared the delivery of Personalized, Proactive, and Patient-Centered Healthcare for Veterans to be the top priority.

- **Personalized: tailoring a person's healthcare to their individual characteristics, medical conditions, genes, circumstances, values, etc.**

- **Proactive: using strategies that strengthen the person's innate capacity for health and healing (salutogenesis), such as mind-body approaches and nutritional strategies prior to surgery or chemotherapy.**
- **Patient-driven care: healthcare that is based in and driven by what really matters to the person in their life, and aligns their healthcare and goals accordingly. This requires that we change the conversation and start from a different place.**

The statement not only captures essential features of a quality healthcare experience but is transformative in nature. Healthcare delivery has been increasingly driven by "the system" as opposed to the patient. Care typically has been splintered and episodic with providers identifying patient needs and leading the course of action, complicated by the variability in treatments stemming from providers' unique beliefs and desires a "find it and fix it" mentality, supported by evidence based tools has been a core feature of the current approach. Patients present with symptoms, providers assess those symptoms, make hypotheses about likely causes (i.e. differential diagnosis) and test those hypotheses by gathering more history, examining the patient

and performing laboratory and other tests. Once a diagnosis is made, treatment is offered. The mark of success in this approach is reduction of symptoms or disease remission.

In the latter part of the last century, medical science began to identify more tools for prevention of disease as well as processes to improve management of chronic illnesses once they have developed. Expanded immunization capabilities, identification of habits and behaviors linked to health, public sanitation and other efforts became increasingly important in healthcare. Toward the end of the last century, the focus of the healthcare system began to move beyond the individual provider-patient interaction toward improving or maintaining the health of entire populations, based on such preventive healthcare efforts. Some healthcare systems, such as Accountable Care Organizations and the Department of Veterans Affairs (VA) assume responsibility for the health of specific populations. This type of care emphasizes prevention, screening, early intervention and disease management.

Despite all the gains in the last century, patients continue to look for something more than relief of symptoms: improved function in family and society. Treatment of disease alone may be necessary but not sufficient to restore or improve function. Patient-centered care is an effort to understand the values, goals and needs of individual patients beyond symptom reduction and make the patient the leader of the treatment team. As the diagram below indicates, treatment of disease plays only a small role in overall health.
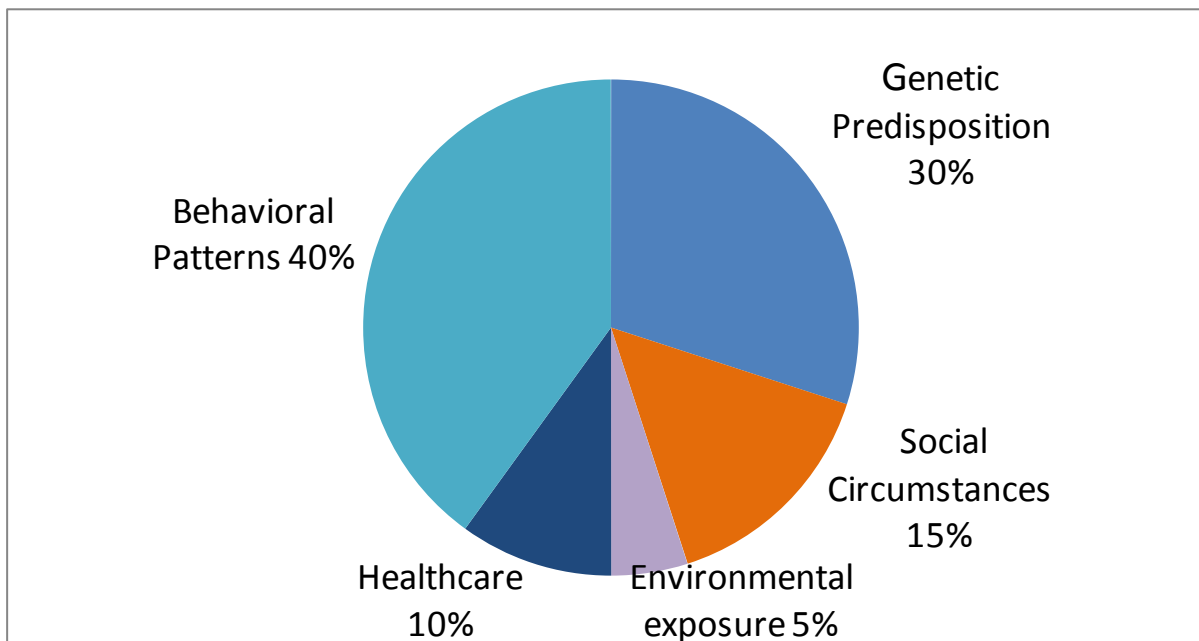

Figure 1. Relative Contributions to Premature Mortality
Source: Schroder, "Improving the Health of the American People," New England Journal of Medicine, 2007

In a personalized, proactive, patient-centered system the care delivered occurs as part of a continuous, long-term relationship where the patient is in control and his or her goals and values lead to variability and customization (Adapt. IOM 2001). A strong relationship allows the provider team to partner with the patient to help create their plan. Strong communications and a healing environment with an emphasis on personal mastery and change are essential. What matters to the patient is the basis of their personalized health plan. It should be noted that this fundamental shift in power and perspective does not lessen the emphasis on establishing evidenced based optimal practices in disease prevention and management. Quite to the contrary, in a personalized, proactive, patient-centered system multiple realms of a Veteran's life become viable areas of focus for data driven interventions in a manner consistent and supportive of the Veteran's unique beliefs and desires.

The proactive component of the model speaks to the approach of optimizing health and well-being in all aspects of a person's life which can influence outcomes. Many of the techniques which may be employed are outside the realm of what has traditionally been considered part of our healthcare delivery system. An incomplete list of potential strategies include: mindfulness, exercise, yoga… This reiterates the notion that it is the patient, not the system that is of utmost importance and being part of the traditional medical model is secondary to what the patient identifies as essential. With patient-centered care, the healthcare system functions to provide state of the art disease management but also to optimize health and well-being. Providers respect the patient as the principle decision maker and are considerate of the values and goals of the patient while working with a holistic approach.

Ideally, an effective patient-centered care system blends evidence based treatment of illness into a "whole health" approach that includes many different tools: Personal Health Planning; Patient Education & Shared Decision-Making; Stepped and Chronic Care Models; Collaborative Treatment Planning; Biomedical care; Psychological interventions; Self-Care Strategies; Complementary and Integrative Approaches; Skill Building; and Integrated Health Coaching.

The principles of Patient-Centered Care are to be foundational to all operations within VHA but the very nature of the model makes the creation of overly concrete algorithms or handbooks difficult if not impossible. Flexibility and adaptability to each Veteran patient is essential. Personalizing care requires a level of communication that goes beyond superficial greetings and in-depth probing of physical complaints. It requires an openness to explore multiple realms of a patient's life and a desire to be a partner in positively influencing factors deemed vital. We know from a variety of sources that what matters most to an individual patient may not be the same as the clinician's priority. This can be especially true if the clinician is operating in a narrowly focused arena as opposed to being part of an interdisciplinary team. Indeed, a key feature of the delivery strategy is the use of collaborative teams.

Teams have a distinct advantage over individual isolated providers in working with patients that have multiple, often complex needs. Community based clinical case management has traditionally been organized around some sort of team model but in a restricted, problem based system the teams can be fairly loosely organized and do little more than provide support and back-up to one another. As treatment goals and strategies become broader and more comprehensive teams need to operate with synergy. A varied collection of professionals on the team aids in this as well. Having physicians, nurses, psychologists, social workers, therapists, peers and other specialists interfacing with the patient increase the odds for connecting with high need Veterans and meeting their needs in a timely manner.

This recognition was central to the development of Assertive Community Treatment (ACT) teams for the care of seriously mentally ill adults within the community. This model has a robust evidence base and has been very influential in the evolutions of a number of VA community-based case management programs including Mental Health Intensive Case Management (MHICM) and the U.S. Department of Housing and Urban Development – U.S. Department of Veteran Affairs Supportive Housing (HUD-VASH). An interdisciplinary team delivering care can address more areas of importance in a Veteran's life than any one individual provider if they function in a cohesive fashion organized around the Veteran patient.

This recognition also played a role in the VA's transition to Patient Aligned Care Teams (PACTs) for the delivery of primary care. Healthcare services research continues to demonstrate that interdisciplinary care provided by a team produces improved outcomes when compared to the traditional one doctor/one patient model of care. The VA's PACT, which began implementation in 2010, is one example of team-based care and is well along the way to full implementation throughout VHA. The PACT now provides primary care for most patients enrolled in VA primary care. PACT consists of a team of providers, or the "teamlet", which includes: a Medical Doctor (MD) or advanced practice nurse like an ARNP collaborating with an MD, a Registered Nurse (RN), Licensed Vocational Nurse, and a clerk. This teamlet manages a panel of about 1,200 primary care patients. Expanded teams, comprised of several teamlets also include other disciplines, such as social work, mental health, clinical dietetics and clinical pharmacy. Those other disciplines provide consultation and care for patients enrolled in the PACT.

In addition to regular PACTs, many VA facilities have specialized PACTs for certain populations, such as Geriatrics, Women Veterans, Seriously Mentally Ill (SMI), Spinal Cord Injury (SCI), and others. A few VA facilities now also have specialized PACTs for homeless Veterans, or Homeless Patient Aligned Care Teams (H-PACTs). These H-PACTs differ from usual PACTs in that are expected to be transitional rather than long-term. Once a Veteran is in stable housing, longer term PACT care usually transitions to a regular primary care PACT.

As team-based care becomes more prominent within VA, we are better positioned to provide patient-centered care, but operational strategies also need to accompany this new structure. One instrument, which has been employed to identify areas of importance in a Veteran's life and elicit his or her goals, is the Personal Health Inventory, or PHI. The PHI is a questionnaire that stems from the Circle of Health pictured below:
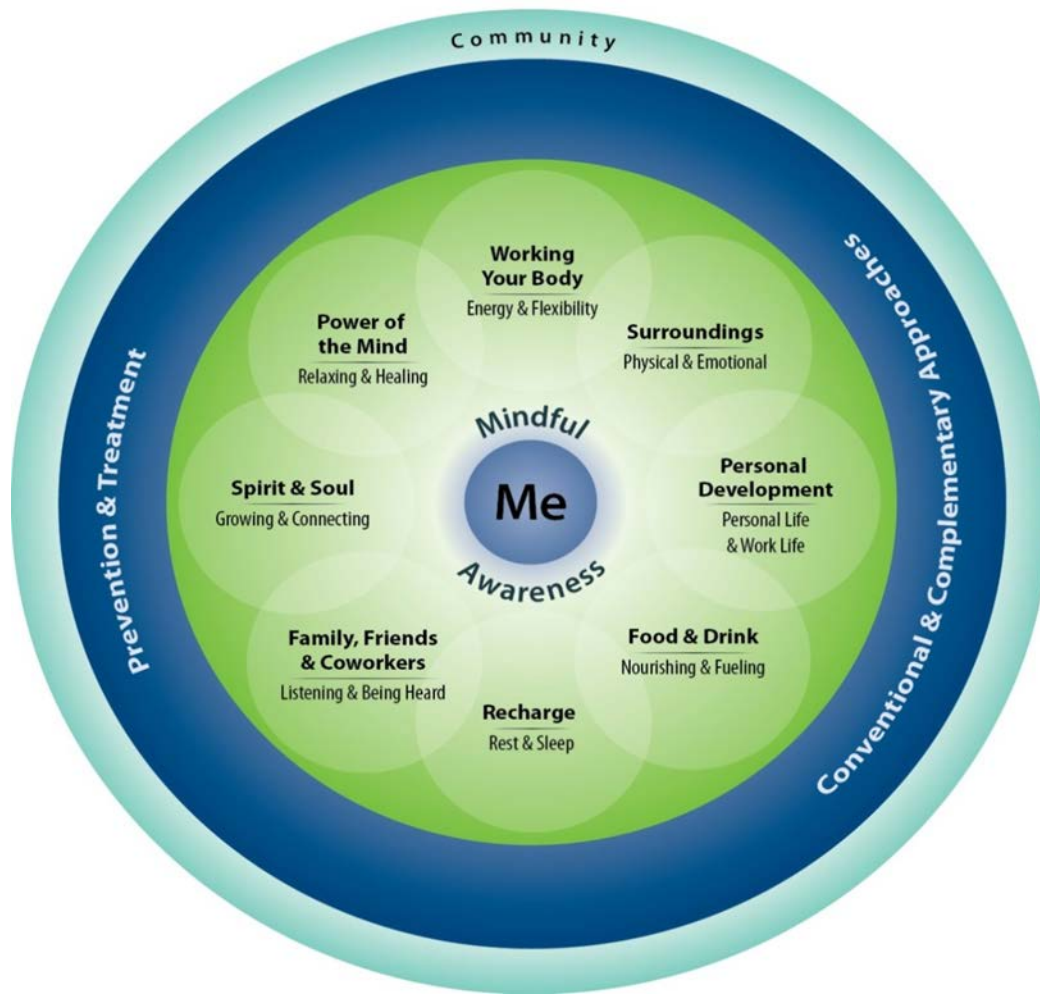
Figure 2. Circle of Health Diagram

The Circle of Health is a way to organized and consider the complex constellation of items that comprise life and, by extension, an optimal healthcare experience. The Veteran patient is at the center of the circle emphasizing his or her primacy in the decisions surrounding their life guided by their unique values and goals. Mindfulness is also in the inner portion of the circle demonstrating that awareness of circumstances, symptoms, options, opportunities, and interactions is a key factor in proactive, comprehensive healthcare. The next ring of the circle contains eight areas of self-care

where a Veteran patient can make choices that can have a dramatic impact on their overall health. The eight (8) areas are working the body; surroundings; personal development; food and drink; recharging; family, friends, and co-workers; spirit and soul; and power of the mind. The next ring identifies professional care, both traditional and complementary, that can be employed for health and well-being. At the outer portion of the circle is the community the Veteran conceptualizes and lives in.

The PHI poses questions under each realm with a 1-5 rating scale to assist the Veteran and team in considering each facet and its current state as well as potential opportunities for impact. The items and corresponding questions are not difficult to identify with but considering all of them within healthcare interactions is not common. The "Chief Complaint" or some prioritizing of needs has historically been the standard. Multiple programs or specialists may exist but typically each has been narrow in focus viewing other items as either something to deal with later or someone else's problem. In a Personalized, Proactive, Patient-Centered system this manner of doing business needs to change. Research has long demonstrated the inaccuracy of a mind/body duality with clear demonstration that they are interactive and that mental states can significantly impact not only physical health but also the success of medical interventions. By extension, social and community factors as well as lifestyle choices are known to be key determinants of healthcare outcomes. Simply looking at an organ system or an isolated problem doesn't have potential impact of a broader wellness model.

It must be stated that at times of more severe compromise a particular realm may take precedent. This notion follows logically from Maslow's Hierarchy of needs which recognizes that some basic elements must be secured before other avenues or goals can be pursued. We know that the first priority for anyone is safety and security. Issues such as hunger, an imminent threat, or homelessness need to be addressed before a Veteran patient and his or her team can adequately other issues. For many clients of VA's community case management programs this includes finding and maintaining a safe place to live. This recognition was a key component to VA's transition from a treatment first model to a Housing First one.

In some respects, case managers in homeless programs and other community based clinical case management settings become virtual members of the PACT for the specific Veterans they serve. While not formally part of the PACT, they may interact with anyone on the team to assure that overall care is well coordinated and all team members fully understand and support the overall treatment plan as well as specific aspects of it. In the early stages of care with a homeless or newly housed Veteran, the plans to address homelessness or housing stability may be the top priority of the team, since finding stable housing is often far more important to an individual than managing blood pressure, losing weight or giving up smoking. The social work case manager on the expanded PACT or the RN care manager on the teamlet will likely be primary points of contact and interaction for the homeless case managers.

That said, homelessness doesn't eliminate the other components on the Circle of Health and both in the pre-housed state and, especially after being housed it is important to be mindful of the whole person and be respectful of their values and goals. For the individual who has yet to fully engage with the team an object demonstration of broad interest can be a powerful tool to strengthen the therapeutic alliance. For the Veteran who is engaged but yet to be housed the identification of areas of importance and potential impact could help in the identification of features in a property or neighborhood that could impact success. And, for the newly housed Veteran a comprehensive assessment of their current and desired state coupled with a reinforcement of the internal and external tools available can allow for treatment planning and choices that continue them on a path of broad recovery. Indeed, stable housing is often only the first step toward improving well-being and function. Once housing is secured, most individuals remain at risk unless we do more. This becomes the time that Veterans are able to begin to focus on their lives and can identify what is important to them. By applying the principles of patient-centered care, we can be part of their recovery as productive members of society.

Early piloting of the PHI has shown that Veterans focus most on the social environment, day to day life, and general health and least on disease focused goals and outcomes. A conclusion from the pilot was that Veterans were thinking of their health as more than just biomedical concerns. This same broadening of perspective is anticipated for team members working within this paradigm as well.

The concepts of Patient-Centered Care, Housing First, and Recovery are well aligned and complementary. The Substance Abuse and Mental Health Services Administration (SAMSHA) has defined recovery as, "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential". The four dimensions that support a life in recovery are: Health, Home, Purpose, and Community. Through a Patient-Centered care model, those working in clinical case management programs can be of assistance, by not only helping secure and maintain permanent housing but also by fostering awareness, empowerment and healing relationships.   From the onset, it has been emphasized that our housing efforts are to be Housing First not Housing only and the patient-centered care model and recovery provide the framework for addressing the environmental needs of Veterans in view of their total care.

> *"You ought not to attempt to cure the eyes without the head or the head without the body, so neither ought you attempt to cure the body without the soul….for the part can never be well unless the whole is well."*
>
> *- Plato*

Chapter
2

Recovery

T he historical roots of Recovery began in the 1800s and early 1900s with outraged writings about conditions and treatment in mental hospitals. From this, policy changes developed, including the formation of an advocacy group, the National Committee on Mental Hygiene, that later became the National Mental Health Association (Satcher,2000). The modern roots of Recovery grew out of the 1970s consumer movements. These movements started after the deinstitutionalization in the 1960s when people who were living in mental institutions, often for many years, were moved to community-based environments. These events coincided with the 1960s civil rights movement. The consumer movement grew from the dissatisfaction of former patients in mental hospitals who felt marginalized by society and powerless over their own lives. Their advocacy work brought mental health concerns and consumer voice to a more prominent place in society. Recovery, as we now think of it, began to find voice in the larger community in the mid-1980s. Early research on Recovery began as a challenge to the widely-held idea that the best outcome that someone with serious and persistent mental illness could hope for was to maintain a state of stability. In 2003, the President's New Freedom Commission of Mental Health Report and the accompanying letter to the President from the Chair of the Commission recommended transforming the nation's approach to mental health care, so as to ensure "that the mental health service and supports actively facilitate recovery...Too often today's system simply manages symptoms and accepts long-term disability" (New Freedom Commission on Mental Health, 2003, p. 1).

It is particularly noteworthy that the authors cast a vision for the future of mental health care:

We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating   fully   in   the   community

Visit this link to see a copy of the full report from the New Freedom Commission on Mental Health
http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport.htm

Recovery in VA

In 1997, the VA began to embrace Psychosocial Rehabilitation (PSR) principles and practices that facilitate recovery, by adopting the VA Clinical Practice Guideline for Psychosis. In 2003, coinciding with the release of the report from the President's New Freedom Commission on Mental Health, the VA's Mental Health Strategic Plan charted commitments to evidenced-based practices, consumer-driven care, and a more recovery-oriented mental health system. The Mental Health Strategic Plan was subsequently reduced to policy via VHA Handbook 1160.01 "Uniform Mental Health Services in VA Medical Centers and Clinics" which was finalized in September 2008. Among other contributions, VHA Handbook 1160.01 defines minimum clinical requirements and delineates the essential components of a recovery-oriented mental health program that is to be implemented nationally. The handbook can be found on the following site: http://www1.va.gov/vhapublications/publications.cfm?pub=2.

This landmark change necessitated an expansion of rehabilitative practices that promote empowerment of the Veteran, work and life skill development, family and social supports, as well as effective coping methods and problem-solving strategies. The Recovery movement continued to grow in VA. In 2006, VA established Local Recovery Coordinator (LRC) positions at each facility. LRCs are a key component of the infrastructure to transform mental health care to a more veteran-focused and recovery-oriented system. LRCs are tasked with overseeing, facilitating and promoting recovery-oriented practices at their local facility. They serve as champions, ombudsmen, and consultants to mental health care providers—ultimately working to transform the future of services for veterans and their families. VHA's efforts to transform mental health services include establishing a Psychosocial Rehabilitation & Recovery Services Section to establish policy for mandated recovery-oriented programs and approaches such as Mental Health Intensive Case Management (MHICM), Psychosocial Rehabilitation and Recovery Centers (PRRCs), Peer Support providers, and LRCs.

What is Recovery?

Some examples of how recovery has been defined over the years include:

- "Gaining an internal sense of control" (Estroff, 1989).
- "A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony, 1993).
- Reframing illness as only a part of the self, not the whole (Jacobson & Greenley, 2001).
- "Improvement in coping with symptoms and the stresses of daily life is another common theme of recovery…" (Mueser et. al, 2002).

- "Process of minimizing the destructive impact of the illness while simultaneously identifying and building on a person's strengths and interests in order for the person to have an identity and live beyond that of 'mental patient' " (Davidson & Roe, 2007).

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2012). SAMHSA also describes that a *philosophy of recovery-oriented care* incorporates ten core principles:

1. Recovery emerges from hope.
2. Recovery is person driven.
3. Recovery occurs via many pathways.
4. Recovery is holistic.
5. Recovery is supported by peers and allies.
6. Recovery is supported through relationship and social networks.
7. Recovery is culturally-based and influenced.
8. Recovery is supported by addressing trauma.
9. Recovery involves individual, family, and community strengths and responsibility.
10. Recovery is based on respect.

To illustrate how Recovery applies to holistic health, SAMHSA describes four major dimensions supporting a life in recovery:

- **Health**: overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
- **Home:** a stable and safe place to live;
- **Purpose:** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- **Community**: relationships and social networks that provide support, friendship, love, and hope.

To read more about these SAMHSA elements and definitions, please see: http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/#.Va6DJDYw_5p

For SAMHSA'S Working Definition of Recovery, see: https://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf:

To view a poster illustrating SAMHSA elements with VA-specific examples, please see the Elements of Recovery (Appendix I). This document was created by the University of Iowa Psychiatry Department and adapted by the Mental Health service line at the Iowa City VHA.

To read more about a holistic health and wellness approach, please see the Components of Proactive Health and Well-Being brochure at: http://healthforlife.vacloud.us/

Office of Patient Centered Care and Cultural Transformation site: http://vaww.infoshare.va.gov /sites/OPCC/Shared%20Documents/Brochures/OPCC_Components_Brochure_Sept2014.pdf

What is Psychosocial or Psychiatric Rehabilitation (PSR)?

The concept of Psychosocial Rehabilitation (PSR) is closely related to recovery and is sometimes confused with recovery. The difference is that PSR is a *process* that facilitates recovery while recovery is both a *process and an outcome* for individuals. PSR principles and practices (i.e., specific services, techniques, and provider attributes) facilitate recovery for individuals with mental health challenges. The Psychiatric Rehabilitation Association (n.d.) offers the following PSR definition:

> *"Psychiatric rehabilitation promotes recovery, full community integration, and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person-directed and individualized. These services are an essential element of the health care and human services spectrum, and should be evidence-based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice"*
>
> *(Psychiatric Rehabilitation Association (n.d.), About PRA section).*

The Psychiatric Rehabilitation Association sets forth the following 12 core principles and values of PSR practice:

> **Principle 1:** Psychiatric rehabilitation practitioners convey hope and respect, and believe that all individuals have the capacity for learning and growth.
>
> **Principle 2:** Psychiatric rehabilitation practitioners recognize that culture is central to recovery, and strive to ensure that all services are culturally relevant to individuals receiving services.

Principle 3: Psychiatric rehabilitation practitioners engage in the processes of informed and shared decision-making and facilitates partnerships with other person identified by the individual receiving services.

Principle 4: Psychiatric rehabilitation practices build on the strengths and capabilities of individuals.

Principle 5: Psychiatric rehabilitation practices are person-centered, they are designed to address the unique needs of individuals, consistent with their values, hopes and aspirations.

Principle 6: Psychiatric rehabilitation practices support full integration of people in recovery into their communities where they can exercise their rights of citizenship, as well as to accept the responsibilities and explore the opportunities that come with being a member of a community and a larger society.

Principle 7: Psychiatric rehabilitation practices promote self-determination and empowerment. All individuals have the right to make their own decisions, including decisions about the types of services and supports they receive.

Principle 8: Psychiatric rehabilitation practices facilitate the development of personal support networks by utilizing natural supports within communities, peer support initiatives, and self- and mutual-help groups.

Principle 9: Psychiatric rehabilitation practices strive to help individuals improve the quality of all aspects of their lives; including social, occupational, educational, residential, intellectual, spiritual and financial.

Principle 10: Psychiatric rehabilitation practices promote health and wellness, encouraging individuals to develop and use individualized wellness plans.

Principle 11: Psychiatric rehabilitation services emphasizes evidence-based, promising, and emerging best practices that produce outcomes congruent with personal recovery. Programs include structured program evaluation and quality improvement mechanisms that actively involve persons receiving services.

Principle 12: Psychiatric rehabilitation services must be readily accessible to all individuals whenever they need them. These services also should be well coordinated and integrated with other psychiatric, medical, and holistic treatments and practices (Psychiatric Rehabilitation Association (n.d.) Core Principles and Values section).

One way to think of this is that recovery is what the person with the mental health challenge does to reclaim their life while PSR principles and practices are what others, including providers, family members, and others in the community, use to facilitate the person's recovery.

Facilitating Recovery in Your Practice

When thinking about making your practice recovery-oriented, two areas to consider are environmental aspects along with staff training and awareness. The environment of care is important in promoting recovery oriented practices. In general terms, the goal is to provide an environment that is "health promoting," safe, respectful of privacy, and comfortable. The environment should be one that fosters hope and shows respect for each Veteran.

Staff are key to promoting recovery for Veterans. Their attitude, language, and behavior ideally reflect the belief and expectation that recovery is possible. Training in recovery can be very helpful and is a resource that the facility LRC can provide or coordinate. In addition to the topics discussed earlier in this chapter, other topics to consider for training and/or discussion include stigma, recovery-oriented language, knowing the Veteran as a person, shared decision making, holistic care, and evidence based programs and practices.

Stigma related to mental illness—whether it is public- or self-stigma—has been shown to interfere with seeking treatment, to decrease self-esteem, and to limit or eliminate many opportunities in life (Corrigan, 2004; Markowitz, 1998; Rusch, Angermeyer, & Corrigan, 2005). Stigma can be defined as an attribute or aspect that diminishes or devalues a person who possesses that attribute or aspect. Paying close attention to language and the power that it holds is very important when working to become more recovery oriented and reduce stigma. Consider how a group of people or an individual is labeled or referred to in discussions. For example: "Joe is an addict." vs. "Joe is in recovery from alcohol addiction." These statements actually convey different ways of thinking about someone. In the former, Joe is defined by his addiction. In the latter, Joe, first and foremost, remains a person who happens to be recovering from an alcohol issue.   Being mindful of the impact of language supports the notion of getting to know the Veteran as a person who has unique needs and is recovering from specific challenges. For more information on recovery language, see Appendix II: MH Recovery Language, or visit the following websites:

> http://www.ct.gov/dmhas/lib/dmhas/recovery/APPENDICES.pdf.
> http://mob.mhcc.org.au/media/5902/mhcc-recovery-oriented-language-guide-final-web.pdf

Another important aspect of facilitating recovery in your practice involves partnering with Veterans through shared decision making (SDM). SDM, an important aspect of patient centered care, is based on the values of personal (Veteran) responsibility and autonomy. SDM is a process that

requires that a physician or other treatment or service provider 1) understand what the Veteran knows about the process/procedure/concern; 2) provides good quality information to expand what the Veteran knows such that he or she is sufficiently informed to make a good decision; 3) support the Veteran in their deliberations as he or she thinks through various options, potential risks and benefits associated with each option, and how these options, risks, and benefits relate to personal values. SDM has been written about primarily in the physical health literature, but the theory and models translate well to any provider-Veteran relationship and strongly support a recovery orientation. A model illustrating this process has been proposed by Elwyn and colleagues (Elwyn et al., 2012). To read more about this process, see:

    http://link.springer.com/article/10.1007/s11606-012-2077-6

Utilizing evidenced-based programs and practices whenever possible to help Veterans reach their goals is also a recovery-based approach. Evidence-based programs and practices are those that clinical research has demonstrated to be effective (SAMHSA, (n.d.), Prevention Training and Technical Assistance section). Utilizing evidence-based treatments, programs, and practices that help Veterans achieve their recovery goals are ways to ensure you are providing the best and most effective PSR services. To read more about evidence-based treatment and to find examples of evidence-based programs and practices, visit the following links:

    http://www.nrepp.samhsa.gov/
    http://vaww.mentalhealth.va.gov/ebp/index.asp

VHA Recovery-Oriented Resources and Referrals

There are numerous recovery-oriented resources and referral options available within the Veterans Health Administration for Veterans recovering from serious mental illnesses. These include, but are not limited to, Intensive Case Management (ICM) programs including MHICM, RANGE, and E-RANGE programs, PRRCs, inpatient mental health programs, Compensated Work Therapy (CWT) programs, and Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs). There are also multiple mail groups and SharePoint sites available that will link you to information about these programs and link you to other practitioners with similar interests and needs. The LRC assigned to your facility can help you access specific Veterans Health Administration resources that will help you develop and refine your recovery-oriented practice.

In summary, PSR principles and practices promote recovery for people with serious mental illness that is holistic, strengths-based, individualized, and person-centered. Recovery, as defined by the person in recovery, reflects the unique dreams, aspirations, values, personal goals, and preferred roles in the community fueled by hope for a better tomorrow. One of our primary roles in the VHA is to help Veterans define the vision of what their personal recovery "looks like" and help them set

personal goals related to actively pursuing it. The following vignettes illustrate a variety of typical recovery experiences achieved by Veterans in Permanent Supportive Housing.

Vignette #1

When I met Steve, he was a 100% Service Connected Veteran with a Serious Mental Illness (SMI). Over the six decades of his life, he was in and out of VA psychiatric care facilities and state hospitals so many times he had lost count. To some, Steve was seen as a bit of a nuisance, attempting to socialize with others somewhat inappropriately and "causing problems" on a regular basis. Adding to the issue was the fact he was a very large, overbearing man that often struggled with medication issues leading to incontinence.

On a nice fall day, Steve came to my office unannounced. I had never seen him like this. He was dressed in a button-up shirt and a tie. He asked to speak with me about our Supported Employment program. Apparently he had found a pamphlet in a waiting area and thought this would be helpful to him. We discussed the program, his interest and the process for seeking a referral through his psychiatrist. Later that day, his psychiatrist called and *apologized*, but indicated that Steve had interest in the Supported Employment Program. Steve had explained to his psychiatrist that he "needed a sense of purpose in his life."

We enrolled Steve in Supported Employment. To absolutely everyone's surprise, Steve showed up on time, fully participated with his Supported Employment provider and literally nailed his first "job" interview in the community. Many of his providers quickly had to address their own beliefs about stigma, self-direction and empowerment. But most importantly, it is what happened next that altered my view of recovery forever.

Steven landed his first job in his life at age 60. It was a volunteer job actually—at a non-profit treatment center in town. His job was to answer the phone, direct calls and provide customer service. To some, this seemed like a lot of responsibility for a guy that had not worked in adulthood. Steve took it all in stride, and within two weeks, was requesting additional duties. His Supported Employment provider was asked by Steve to come to his worksite to teach him how to vacuum a floor. And the next thing we knew, he was cleaning baseboard and carpets, taking complete pride in his work and office area. He did this job for six months, without missing a day of work and never showed up late.

One early summer morning, I arrived early for work, sadly to learn that Steve had passed away over the weekend from a heart attack. Many who knew him were very saddened by the news, as in some ways he had quickly become an icon for recovery. Now, we have come to believe that Steve spent

his last days happier than he had been in years. He had found purpose and value in his life and in doing so, left a lasting impression about recovery for all those who knew him.

Vignette #2

Mike is a large and to some, intimidating Army Veteran. At the age of 54, he is also divorced and a father of one daughter, whom he lost contact with years ago. Mike had struggled for many years with his diagnosis of Bipolar Disorder and amphetamine addiction. After years of drug use, he had lost his job, was chronically homeless and living at a local shelter in his hometown.

The Mike his mother knew was much different. Mike had been a "good boy" and grew up playing sports along with many of his friends. He had also been an avid fisherman.   As a young adult, he enlisted in the Army. Later, he worked for over twenty years for the city. He was a proud Veteran and father of a beautiful daughter.

Mike had come to the VA Medical Center as a last resort. He was now living in temporary VA housing. He had remained clean and sober for over eight months. He was working with a large team of healthcare professionals, leading to some stability in his life. But, he remained lonely, sad and disconnected from friends and family.   Family and friends had given up on him over the years, likely due to his behavior related to his drug addiction.   Long ago he had given up his hobbies. Life had become shallow, without purpose or meaning. The day Mike met Bill, a *Peer Support Specialist*; Mike had secretly been contemplating suicide for several months.

Mike considered his Peer Support Specialist different from the other folks at the hospital. In fact, his Peer Specialist didn't spend any time talking about what he "should" be doing or working at getting Mike "back to baseline". There was no talk of "medication compliance" or lectures about missed appointments. Instead, they focused on what Mike was interested in, developing some meaningful personal goals. They discussed what a life in recovery would look like for Mike. When Mike met with Bill, he began to feel empowered in his own life. The focus became one of self-direction and rediscovering his long-forgotten personal strengths.   He began to feel hope and this was evident through his sense of humor that had returned.

After several months of meeting with his Peer Specialist, and mutually sharing their stories of recovery, Mike developed a new pathway for himself. He qualified for a pension through the city, relieving his financial concerns.   He found himself more motivated and started setting some personal goals that seemed unattainable months earlier. He actually bought a small home through a VA loan. He bought a used truck. He started fishing again. This led to some new friendships. Life became fuller and more meaningful. Many of his healthcare providers were 'amazed' at his progress, as they had previously assumed stability was about as good as it was going to get for Mike.

It is not all perfect. His daughter is not yet ready for a close relationship. But they have started talking over the phone. Mike still experiences daily struggles with his addiction and has found a community program that is supportive and helpful. His new friendships are strong.   Bill and Mike periodically still meet. Now they usually talk about things like fishing, maintaining his truck, house remodeling projects and his future plans.

This is an example of recovery. It is not a linear journey, but one with many bumps and potholes. Through a Veteran-driven, collaborative relationship based on respect and identified strengths; Mike is now more connected to his community, involved with others and hopeful about his future. He has actually continued to follow a treatment plan with his healthcare providers and has found greater value and importance in sticking with his treatment plan on his personal path of recovery.

Vignette #3

J.A desperately wanted to become a Federal employee. Over the years, he had applied for positions several times, but somehow could not even score an interview.

Most of the time, J.A managed his mental illness without difficulty.   He had gotten involved in mental health care largely to have a prescriber help with medication management. But, after another employment rejection letter, he had become more depressed. His doctor suggested Therapeutic and Supported Employment Services (TSES) as well as Peer Support through the VA.

With guidance from TSES staff, J.A tried to muster up the belief that perhaps this would be a new start. He worked at accepting suggestions from staff about his resume and approach to attaining employment. As a step toward employment, he began volunteering at a local Federal agency.

Through this process, J.A began to feel more hopeful. His confidence increased. He attributed much of this to the support and enjoyable conversations he also was having with his assigned Peer Support Specialist. In fact, it felt like mutual support as they often shared their approaches to self-care, managing illness and overcoming adversity. He appreciated the openness and ease of the relationship. Through mutual support, J.A began to identify his strengths and focused much less on his illness.

It was a Tuesday and J.A was excited about his job interview. With the help of others, he had gotten an opportunity. As it turned out, the interview process was with an entire committee, and he nailed it! He was confident with his interview responses and felt very good about himself. His TSES provider and Peer Support Specialist were very proud of him.

J.A is a now a Federal employee. For the last three years, he has worked full-time for a VA Medical Center. He has achieved very solid performance appraisals, and most recently was an *"employee of the*

month." He has met someone, and is considering asking for her hand in marriage. He continues with peer support, and now volunteers some time each week at a local food bank in the evenings.

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Chapter
3

Harm Reduction

What's in this Chapter?

Harm reduction originally referred to policies and interventions aimed primarily at reducing the negative health, social, and economic consequences of drug use and has been applied to a variety or risky behaviors. It is built on a belief in and respect for the rights and dignity of people who engage in a risky behavior and incorporates a variety of strategies to meet people "where they are." Harm Reduction includes, for example, practical strategies to reduce negative consequences of drug use incorporating a spectrum of strategies from safer use to abstinence. It has also been applied to medication non-compliance, behaviors associated with psychiatric symptoms, and non-payment of rent. Harm Reduction strategies are a key element of Housing First model for permanent supportive housing.

Each of us uses some form of harm reduction in our everyday lives, including wearing seat belts, reusing hotel towels to cut down on water use, talking to our doctors about medication side effects, and helping our children to select clothing that reduces risk of sunburn or frostbite. In fact, negotiating risk is an unavoidable part of life, and harm reduction techniques can be applied to most situations where behavior presents a risk and alternatives to choose from are available.

Most social service programs already employ harm reduction techniques in some form. For example, the following are all examples of harm reduction strategies: switching shifts to enable staff to attend to important personal business, making rental payment agreements with tenants, encouraging Alcoholics Anonymous (AA) participation when people are still using, welcoming people back right after a slip, and exploring alternatives such as taking a walk at night so as not to disturb neighbors when voices become bothersome.

In this chapter you will learn about:
- Key principles of harm reduction
- Evidence supporting harm reduction
- Why harm reduction is an important strategy to end Veterans homelessness

- Types of harm reduction practice
- Common misperceptions about harm reduction
- Strategies in harm reduction practice
- Common challenges in harm reduction practice

Key Principles of Harm Reduction

Harm reduction is informed by specific individual and community needs, and, as such, there is no universal definition or formula. However, the following principles are usually central to the practice of harm reduction:

- Accepts that risk is part of the human experience and chooses to minimize its harmful consequences to both the person engaged in the risky behavior and to others, rather than ignore or condemn the person or behavior;
- Is based on a public health evaluation of harm: that which reduces risks to health and well-being is offered as an alternative over options that can cause greater harm;
- Accepts that people will try different strategies based on their own experience and perceptions. As long as these strategies do not present imminent, grave risk to themselves or others, workers' role is to raise awareness of the risks and problem solve ways to decrease the risk;
- Does not minimize the harm and danger associated with drug use or other behaviors; recognizes that many risky behaviors also provide benefits and that these benefits must be considered in order to understand the each person's perspective and help reduce harm;
- Understands most risky behaviors, such as drug use, as a continuum from severe to total abstinence and acknowledges that some forms of the risky behavior are safer than others;
- Considers improvements to quality of life and well-being, both of individuals and communities, and not necessarily abstinence or compliance with a treatment regimen, as the criteria for evaluating intervention success; prioritizes decreasing the negative consequences of drug use or other behaviors, rather than decreasing the behavior without either excluding or presuming a long-term treatment goal of abstinence or treatment compliance;
- Accepts the individual and provides services that are non-judgmental and non-coercive to help people to reduce harm;
- Involves people served in meaningful ways when designing programs and policies;
- Empowers people to share with each other information, support and strategies tailored to the actual conditions of their lives and recognizes that people themselves are best positioned to design approaches that will reduce the harm.

Evidence-Base for Harm Reduction

Despite the fact that harm reduction is a relatively new approach to substance use, having primarily been developed over the past 25 years, there is an extensive and rapidly expanding body of literature

on interventions that fall within the approach. The most extensive research on harm reduction to date has focused on intravenous drug use. This evidence: offers clear support for interventions that work, such as methadone and other replacement therapies and needle exchange; indicates that other interventions show promise, such as peer naloxone distribution, and drug consumption rooms; reveals that some interventions are under-researched, such as education and communication programs; and suggests that the impact of interventions may be enhanced by, or even dependent upon, providing a package of different services, thereby, offering the recipient with choices. At the same time, no reliable evidence exists to support concerns that any of these interventions, when well-managed, leads to increased harm for those using them or encourages drug use in the wider community. In addition, considerable research points to the fact that when you put people in treatment who do not desire abstinence, success rates are very low(European Monitoring Centre for Drugs & Drug Addiction, 2010).

More recently, studies have begun to demonstrate the effectiveness of housing-based harm reduction interventions. For example, one randomized controlled study found that homeless participants, who received immediate housing without treatment prerequisites, obtained housing more quickly, remained stably housing, and reported higher perceived choice; and, while substance abuse treatment utilization was higher for the control group, which received housing contingent on treatment and sobriety, there were no differences in substance use or psychiatric symptoms. This suggests that housing first models do not increase substance use despite the lack of abstinence and/or treatment requirements, and the model is as successful at addressing mental health though **services are not required as a condition of tenancy (Tsemberis et al., 2004).** Similar to other fields, like oncology or psychiatry, while evidence for effective approaches is available, more research is necessary.

Why is Harm Reduction an Important Strategy to End Homelessness?

In 2010, the U.S. Department of Veterans Affairs (VA) committed to ending Veteran homelessness in the United States by 2015. Based on an estimate, there were 57,849 homeless Veterans on a single night in 2013 (U.S. Department of Housing & Urban Development, 2013). Homelessness and drug use often overlap, and the harms associated with each exacerbate the other. As a result, responding to these inter-related issues through an integrated approach is an important aspect of ending Veterans' homelessness. Effective intervention for homeless individuals who use substances requires comprehensive, highly integrated and individually-centered services; Housing First (HF) is one such intervention. Grounded in harm reduction principles, it offers individuals experiencing homelessness immediate access to permanent housing with a low-threshold for entry and without prerequisites like sobriety. HF is a specific model of permanent supportive housing that has been endorsed as an evidence-based practice by SAMHSA.

Traditionally, many housing programs for homeless people have required Veterans to demonstrate "housing readiness" before offering permanent housing, for example, by showing sobriety and compliance with medications and other types of treatment. This approach had the unintended consequence of granting greater access to service-intensive housing to Veterans with less intensive needs, while leaving those with more intensive needs on the streets or in shelters. By contrast, the Housing First approach seeks to help Veterans to obtain housing, specifically those with long histories of homelessness and complex needs.

Traditional housing readiness models often place a heavy emphasis on compliance with rules, such as sobriety, mandatory participation in case management and treatment compliance. Such requirements can create a cat and mouse dynamic between staff and tenants, whereby staff is tasked with policing the rules, and tenants creatively find ways to skirt the requirements. Furthermore, rules are rarely consistently enforced, since staff recognizes that discharging residents for rules violations results in repeated episodes of homelessness, a phenomenon often referred to as "churning". In addition, rules that mandate service participation put the onus of engagement on tenants who may have repeatedly experienced failure in previous services and have little evidence or hope that services can work. Instead of service participation requirements, a harm reduction approach uses Motivational Interviewing (see below) and other creative strategies to engage tenants, demonstrate service effectiveness, build trust, and progress towards goals that the tenant values.

Like other harm reduction strategies, the Housing First approach meets people who use substances "where they are" recognizing that housing provides a foundation from which a person or family can access the supports they need to achieve stability and pursue personal goals, which may include beginning the recovery process.

Types of Harm Reduction Practice

There are many different types of practice that fall under the umbrella of harm reduction. For example, providing simple information to help prevent overdose, reduce the spread of diseases, or help people to understand the amount of alcohol in typical serving sizes. Harm reduction can also include housing first models of supportive housing and Motivational Interviewing, a counseling technique that helps people to identify their problems, resolve ambivalence and build motivation regarding change in small increments over time. Supply distribution programs intended to reduce risk of injury and disease, such as condom distribution, needle exchange, and biohazard container distribution are also examples of harm reduction.

Harm reduction focuses on immediate, achievable goals, an approach applied to many causes of harm. For example, automobile accidents are a leading cause of death in the United States. Despite the death toll, serious injuries, and environmental consequences, elimination of automobiles is not widely considered to be realistic. Instead, policies and interventions focus on strategies like speed

limits, seat belt and child restraint use, drunk and distracted driving prevention, and emission controls. These harm reduction strategies have been successful at reducing the risks associated with automobile use. Similarly, throughout history, various forms of drug use have been an enduring part of the human experience, and eliminating drug use entirely is unlikely to be feasible, but reducing its harmful consequences is both possible and desirable.

Examples of Harm Reduction in Permanent Supportive Housing

Peter Smith receives a notice that his rent is overdue. His worker helps him to develop a simple chart that outlines his options (e.g., ignore the notice, contact the landlord to negotiate a payment agreement, get help from a friend/church/rent arrears program, or abandon the apartment). The chart also explores the factors in favor and against each option and any non-negotiable factors (e.g., must consistently pay rent in full to remain in the apartment).

Julia Tratta has what appears to be a significantly infected wound at an injection site and does not wish to seek treatment. Her worker helps her to explore any concerns she might have about the consequences of that choice (e.g., infection spreads, she is in too much pain to attend an event she was looking forward to, she loses her arm and can no longer paint), the consequences of seeking treatment (e.g. she feels ashamed about her drug use, she is hospitalized and goes into withdrawal), and various options she has (e.g., ignore the infection, a home visit by a nurse, or a consultation to help manage the pain).

See table below for a sample harm reduction plan.

Common Misperceptions about Harm Reduction

Misperception: Harm reduction condones or encourages drug use and other risky behavior.
Harm reduction approaches accept individuals' decision to use drugs or engage in other risky behavior as a fact without moralistic judgment that either condemns or approves of the behavior. Rather, it addresses the consequences of behaviors and helps people to reduce risks.   Harm reduction celebrates any positive change a person can make, for example, complete abstinence or using drugs in a safer way.

Misperception: Harm reduction fails to offer abstinence as an option.
Harm reduction prioritizes decreasing the negative consequences of drug use, rather than decreasing the drug use itself without either excluding or presuming a long-term treatment goal of abstinence. When abstinence is desired by the user, it may be the most feasible and effective way to reduce harm. Depending on the individual needs of the user, abstinence may be a prioritized goal. Since harm reduction promotes client choice, some people may choose to continue to use, while others may choose treatment and abstinence. A harm reduction approach does not rule out abstinence in

the longer term, just because someone is choosing currently to use. Harm reduction approaches are often the first step towards eventual abstinence and many participants may ultimately seek traditional treatment options. Interventions that promote abstinence using non-judgmental and non-coercive means are considered a subset of harm reduction.

Misperception: Harm reduction interferes with traditional substance abuse treatment.
At first glance, harm reduction may not seem to have anything in common with a traditional treatment approach. However, counselors in traditional treatment programs are often already using some elements of harm reduction, including educating Veterans about risks associated with drug use and developing individualized recovery plans that use strategies informed by a person's history, support networks, and strengths.

Misperception: Harm reduction protects people from the natural consequences of their choices and means that anything goes in a program.
Though harm reduction is a person-centered approach that is grounded in client choice, as is always the case in life, choices have consequences, and there are clinical and legal parameters around choice in a harm reduction model. For example, Veterans who chose to participate in a Housing First program must sign a lease defining their legal and financial obligations. Tenants who choose not to pay their portion of the rent or to otherwise violate their lease will face eviction, and those who are violent or otherwise present a danger to self or others will face the same legal consequences as anyone else.   However, in a harm reduction approach, it is understood that people make mistakes, and that mistakes are an opportunity to learn. As a result, typically, in a Housing First program eviction does not result in discharge from clinical services and the program will help the person secure alternative housing and continue to practice making choices that reduce harm and lead to the things s/he wants out of life.

Strategies in Harm Reduction Practice
Use Motivational Interviewing techniques.
Motivational Interviewing (MI) is a clinical technique that helps people to identify their problems, resolve ambivalence and build motivation regarding change. The MI counseling style generally includes the following elements: establishing rapport with the client and listening reflectively; asking open-ended questions to explore the client's own motivations for change; affirming the client's change-related statements and efforts; eliciting recognition of the gap between current behavior and desired life goals, asking permission before providing information or advice; responding to resistance without direct confrontation; encouraging the client's self-efficacy for change; and developing an action plan to which the client is willing to commit.

Use the lease as an opportunity to be where the tenant is.
When a tenant first signs a lease and moves into housing, it can be an important new beginning that offers a renewed sense of hope and provides a window of opportunity. It may also be a time when

the Veteran is eager to move on from their former life and disengage from service providers.   A Veteran who doesn't wish to discuss his or her substance use, mental health symptoms or other sensitive topics may be open to discussions about tenancy rights and obligations. For some, this may be the first time they have ever had a lease or had lease provisions explained. Discussions of tenancy tend not to be stigmatizing and can be a good place for the worker to quickly provide useful, concrete assistance, thereby establishing a non-threatening role and an opportunity to build trust and credibility.

The worker can also use obligations like rent and utility payment as the focus of establishing a plan to reduce risk.   For example, the plan might acknowledge the monthly costs of purchasing substances and include using a representative payee to ensure rent and essential bills are paid first; or, the plan might call for the worker to accompany the vet to cash his/her monthly check and purchase money orders to cover those obligations. When they occur, lease violations can be a natural way to discuss negative consequences of substance use and plan ways to reduce harm together. Non-judgmental exploration of ways in which eviction might interfere with the Veteran's short and long-term goals, can be an important opportunity to build motivation to stay housed and plan risk reduction strategies. A clearly defined process outlining the steps that will occur and who is responsible for each can be an important tool to inform matter-of-fact discussions around reducing harm from rent non-payment. See the Rent Arrears Flow Chart in the HUD-VASH Resource Guide for Permanent Housing and Clinical Care at:

http://100khomes.org/resources/rental-arrears-flowchart

Use Person-Centered Planning (PCP).
Person centered planning helps someone to recognize his or her desires and interests, determine what s/he wants out of life and establish hope that those things are possible. It then designs services to help the Veteran achieve those things. PCP is an ongoing problem-solving process that helps people to plan for their own futures, by defining a vision for what that future will look like. It helps people to increase control over their own lives by developing the relationships, accessing the supports, and building the skills and abilities needed to achieve personal goals. It is a structured way to organize planning that empowers people to actively shape their futures by defining personal values and preferences, acknowledging and building on strengths, and identifying needs, desired outcomes, and goals of the individual.

By helping the person to define their personal goals in both the immediate and long-term, the worker is able to create openings to help the person identify consequences of behavior on goal achievement and plan strategies to reduce harm.   For example, if a Veteran has no interest in reducing alcohol use and a short-term goal of visiting an ex-girlfriend, he may recognize that his

friend will not want to visit, if he cannot show up sober. Identifying that short-term goal, may provide a structure around which the worker can help the Veteran to plan how he might be sober for two hours per week, thereby enabling a regular visit and reducing the harm caused by drinking.

Know when it is a good time to approach someone and when it is better to wait.

A Veteran who is very intoxicated, agitated, gathered with a group of drinkers, or otherwise currently engaging in risky behavior may not be able to engage productively in person centered planning, and the worker may not feel safe. In these circumstances it might be better to postpone working with a Veteran. For example, if you are feeling unsafe, do not enter the premises; instead, call a second person who can join you for the meeting or ask to meet with the Veteran in a public space. If a Veteran is intoxicated or has company that is intoxicated, the worker might schedule an appointment for a different day and/or in a different location.   The worker should use clinical judgment and the support of a supervisor to develop a plan to safely provide services to each person. This might include, for example, scheduling a time to see the Veteran early in the morning, before s/he has begun drinking. If the worker has been threatened or is unable to identify a safe way to serve the Veteran the situation be referred to the risk management committee within the VA.

Recognize mistakes as an opportunity to learn.

Accept that mistakes are an inevitable part of life, approach mistakes as a fact without judgment, and recognize them as an opportunity to learn. It is important not to impose artificial consequences (e.g. telling a Veteran that if he misses another appointment he will be kicked out of the program), but rather to help people build awareness of consequences that naturally occur. (e.g., missing too many appointments at a clinic may mean having to find another doctor). Similarly, even if someone is evicted from his or her apartment, this does not need to result in discharge from clinical services. Whenever possible, the worker should continue to provide supports, help identify a new housing unit, and continue to build opportunities to practice making choices that reduce harm.

Clearly define factors that are non-negotiable.

Some behaviors may pose a grave, imminent risk, and in some cases, that risk could extend to others beyond the Veteran himself. In those cases the worker should not merely discuss the pros and cons of the behavior as an available option, but rather take all available steps to prevent that behavior. For example, if a Veteran makes a specific, credible threat of violence against his landlord, the worker would immediately inform a supervisor and take all steps necessary to meet associated legal obligations and prevent the violence.

Sample Harm Reduction Plan				
Risk	Options	Factors in Favor	Factors Against	Non-negotiable Factors

Eviction: tenant has 'guests' in apartment, partying & disturbing neighbors	Explore shared housing or roommates to reduce loneliness	Might resolve problem with landlord Reduces loneliness	Strong preference to live alone	Only person named on lease can live in housing
	Find another location to socialize	Reduces impact on neighbors	Costs more money to socialize elsewhere Not feeling welcomed	Drinking, smoking, etc. may not be permitted
	Find time to socialize that is less disruptive to neighbors	Could reduce impact on neighbors	Friends sleep late and don't want to socialize earlier	Must always allow neighbors "peaceful enjoyment"

Table 1. Sample Harm Reduction Plan

Common Challenges in Harm Reduction Practice

Safety, Liability, and Ethical Dilemmas:

Veterans, particularly those with long histories of active substance use and homelessness, may have serious medical conditions that are exacerbated by continued use. In some cases, risky behaviors may put people in immediate danger (e.g., smoking while using oxygen) and might raise questions about whether you or others on the treatment team could be morally or legally responsible for any resulting harm. As necessary, workers should take immediate action to prevent grave harm as described above. To help manage less imminent concerns, be sure to coordinate closely with others on the treatment team using non-coercive discussions of risks and benefits to arrive at shared decisions. For example, enlist the treating physician to fully disclose to the Veteran the clinical complications of ongoing use and help you to understand what symptoms might indicate a need for emergency treatment. Also, be sure to get support and guidance from your supervisor and keep him or her informed about the details of the risks and options for each Veteran. By documenting in the Veteran's clinical record the treatment approach and plan, associated risks, efforts to communicate those risks, and contacts with collateral providers, you can help to ensure that the entire treatment team is well informed and best able to arrive at shared decisions and provide the Veteran with appropriate information and supports. In some cases, a Veteran may not be competent to make his or her own medical decisions. If you suspect that may be the case, work with your supervisor to secure an appropriate professional assessment.

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Trauma-informed Care for Homeless Veterans

Introduction

This chapter offers both information and practical guidance related to implementing trauma-informed care in service to homeless Veterans and those Veterans who are at risk for homelessness. Definitions, prevalence rates, and specific practice recommendations are described. Trauma-informed care is different than "trauma-focused" interventions as trauma-informed care does not depend on discussion of trauma histories rather it involves the recognition of the impact of trauma in one's life. Homeless and at risk Veterans can and do recover from trauma and it is critical that case managers are knowledgeable regarding how to assess for trauma and to recognize how trauma-related sequela can impact treatment engagement and recovery.

Trauma-Informed Care

Trauma-informed care (TIC) is both a philosophical perspective and an approach that acknowledges the pervasive influence and impact of trauma on an individual, partners, dependents, caregivers, service providers and organizations. Trauma-informed programs and services are based on an understanding of a survivor's vulnerabilities and triggers and how they may impact the way the individual accepts and responds to services and the world around them. TIC is about promoting safety and stability and minimizing additional harm to the Veterans served including avoiding re-traumatization (i.e. causing a triggering event that returns the Veteran to an acutely traumatized state. Services are person-centered and strength-based.

TIC takes into consideration how traumatic events impact the way a survivor relates to self, others and the future. According to SAMHSA, TIC includes having a basic understanding of how trauma affects the life of individuals seeking services. There is no singular definition of what constitutes TIC, but the three common components include: (1) A basic understanding of trauma (including behavioral responses to trauma, associated symptoms, training, consultation and supervision in screening, assessment and treatment), (2) Creating an environment of physical and emotional safety for the trauma survivor and providers (e.g.., ensuring privacy, confidentiality, respecting cultural

differences, and awareness of trauma triggers), and (3) Adopting a strength-based approach to services (e.g., fostering skill-building, mastery, resiliency, a future orientation, increased self-efficacy and rebuilding control through choice and empowerment). TIC is necessary to eradicate homelessness among Veterans. Care that does not integrate these components can lead to re-traumatization and ultimately inhibit recovery.

What is Trauma?

According to the current psychiatric classification system (the Diagnostic and Statistical Manual for Mental Disorders-5), a traumatic event is one in which the person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows (one required):

- Direct exposure.
- Witnessing, in person.
- Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
- Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

Types of Trauma

Trauma experienced by homeless Veterans may or may not be related to military service. Homeless Veterans may have experienced prolonged and/or repetitive incidents of trauma before becoming homeless including during childhood as well as during homelessness. In addition to combat, military sexual trauma, and other trauma related to military service several types of trauma may be common in homeless Veterans such as being a victim of interpersonal violence (e.g., child sexual or physical abuse or adult sexual or physical assault). Trauma is in fact implicit to homelessness in some instances as the McKinney-Vento Homeless Assistance Act encompasses in the definition "any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life threatening conditions in the individual's or family's current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing in that having no consistent shelter".

Emotional and Psychological Symptoms Related to Trauma

There is a wide range of potential reactions to trauma and not all people who experience trauma develop a diagnosable mental illness such as Posttraumatic Stress Disorder (PTSD), which has specific criteria that need to be met. Additionally, many people are known to use alcohol and/or

drugs to help cope with painful emotional reactions to traumatic experience(s). Specific diagnostic criteria for PTSD can be found in the DSM-5 or by visiting www.ptsd.va.gov/professional/PTSD-overview/dsm5_criteria_ptsd.asp, yet symptoms related to trauma broadly include:

- Shock, denial, or disbelief
- Anger, irritability
- Mood swings
- Guilt, shame, self-blame
- Feeling sad or hopeless

- Confusion, difficulty concentrating
- Anxiety and fear
- Withdrawing from others
- Feeling disconnected or numb
- Sadness

How Pervasive is Trauma?

Veterans who have been identified as homeless have likely experienced a traumatic event at some point across their lifespan. Indeed, prevalence rates among samples of Veterans and those who are homeless suggest that the majority of have likely experienced at least one potentially traumatic event in their life and most have likely experienced multiple traumas. Many experience their first trauma prior to becoming homeless. A lack of studies focused on homeless Veterans means that results be generalized from studies of civilian samples. It appears that exposure to trauma increases with homelessness as does the experience of potentially dangerous situations seeming normal and not provoking an emotional response. Additionally, the development of PTSD is related to increased risk for chronic and recurrent homelessness.

- The prevalence of lifetime traumatic exposure among homeless civilians is estimated to be as high as 98% in samples surveyed.
- Approximately 60% of men and 50% of women experience at least one traumatic event.
- About 7-8% of the population will meet criteria for PTSD at some point in their lives.
- Approximately 5.2 million adults have PTSD in a given year.
- Experiencing symptoms of PTSD, but not meeting the full diagnosis (partial or sub-threshold PTSD) also affects 6.6% of the general population.

Other Potential Effects of Trauma

Exposure to trauma is also associated with mental health problems such as depression, suicidality, and substance abuse. Additionally, trauma has been linked to impaired occupational and interpersonal functioning and increased physical health problems, potentially leading to early mortality. Traumatic events are thought to indirectly lead to homelessness due to the severity of related mental health symptoms, and the inability to maintain employment, strained interpersonal relationships and diminished social support. One significant component of TIC is the creation of reliable interpersonal support and identifying any social resources that may have been previously

abandoned or lost. Overcoming a Veteran's interpersonal disconnection requires trustworthy rapport building and dependability of service providers.

Helping Traumatized Homeless Veterans

The first step in successfully integrating TIC is acquiring an understanding of trauma-related reactions, psychiatric symptoms, and triggers related to trauma. In this learning process, it is essential that providers know themselves and recognize their own reactions to people and situations. Boundary setting continues to be necessary and appropriate, but punitive, authoritarian, or overly reactive responses should be avoided. A compassionate approach that client-centered and strength-based is foundational. A TIC approach decreases the power differential between Veteran and provider and provides additional options that empower Veterans to make recovery-promoting choices. Optimally organizational and/or program administration along with all support staff should be knowledgeable about, invested in, and working from a TIC approach. This creates consistency and predictability for clients.

When working with homeless Veterans, healthcare providers will want to be prepared to:

- Engage in self-care;
- Screen for trauma and PTSD in homeless Veterans;
- Create an environment that is safe for clients both emotionally and physically;
- Utilize strength-based approaches;
- Create policies and procedures that are trauma-informed when possible;
- Be aware of the association between homelessness, trauma and PTSD;
- Be aware of the relationship between trauma and addiction;
- Provide resources to educate Veterans about trauma effects and PTSD; and
- Refer Veteran to appropriate services for trauma-focused treatment.

Self-Care

Working with people who have experienced serious trauma can be extremely stressful potentially leading to negative emotional, physical, and cognitive reactions. This experience is often referred to as "secondary" or "vicarious" traumatization. Secondary traumatization and extensive histories of personal adverse events are well documented among providers in the human service and healthcare setting and can negatively impact providers' own health and well-being. Every person working with homeless Veterans needs to engage in self-care and develop self-awareness regarding to the challenges in working with this population. Specific awareness includes but is not limited to identifying: What are your own triggers? How do you manage stress? What is the scope and limits of your own professional competency and capacity in working with trauma survivors? Where are your own boundaries? Knowing your own limitations and identifying positive coping for stress is essential for clients and providers alike. Engaging in regular supervision can assist to manage professional

stress, and when needed providers should identify outside professional resources if feeling overwhelmed and/or when practiced healthy coping strategies (e.g., exercise, talking with peers, taking personal time) become inadequate.

Screening

Formal diagnostic assessment related to psychiatric symptoms precipitated by trauma should be conducted by licensed mental health clinicians. However, screening tools are available to identify the presence of traumatic events in Veterans' histories. The Primary Care PTSD Screen (PC-PTSD) is a brief screening tool currently being used within the VA and includes four questions. If one question is answered positively the Veteran should be referred for more formal assessment. The PC-PTSD can be downloaded as a PDF:

http://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp.

Creating Emotional Safety

Perhaps the most foundational component to TIC is creating emotional safety for clients. This requires providers' ongoing practice of compassion, validation, and non-judgment. Those providing services to Veterans are recommended to maintain a position of non-judgment that avoids criticism even when maintaining boundaries and creating expectations. This is reflected in the language used in professional interactions, but when Veterans' behaviors are viewed as "lazy", "aggressive", or "manipulative" providers should consider how trauma histories may have influenced the behaviors that are being judged. Providers are also recommended to:

- Validate the emotions that a client experiences rather than purely rationally evaluating the "facts" of their report. If Veterans begin to describe an event a validating response may include "that must have been very frightening" or "it sounds like that made you angry".
- Normalize trauma reactions and responses, say things like, "You are not alone," or "This has happened to other Veterans."
- Reflect what you are hearing so that the Veteran knows that you are listening and understanding them. "So what I am hearing is that …."
- Recovery from trauma will in part depend on provider's ability to tolerate discomfort and strong emotions from clients. Emotional safety means establishing boundaries that can accommodate the frustration, anger, fear, grief, and shame that often are a result of trauma.
- Avoid the need to take control of a situation when a client is in distress. Assist the client to identify what they need rather than what you believe they need.
- Build authentic relationships, which is often difficult in the limited time that provider have to spend with clients. It is essential to create reasonable expectations and not making promises that cannot be kept. One of the great strengths of many people with extensive histories of trauma is his or her ability to quickly "read" or scan a situation and the people that they are interacting with to determine if people can be trusted.

- Understand that recovery is not an entirely linear process. Veterans may be making great strides and suddenly regress to past challenging behaviors. In many instances making change is very emotionally provocative and those are the times where support may be most needed.
- Avoid asking intimate questions about a client's history in front of anyone else.
- Work towards understanding how each person's upbringing cultural background affects their beliefs and reactions. Understand cohort differences both related to age and the cultural differences between eras in history (e.g. the late 1960's vs. 2010).
- Approach interactions from a place of compassion.
- Consider the potential power differential between client and provider.

Creating a Safe Physical Environment

Considerate design and use of the physical environment (e.g., offices and waiting areas) can likely impact the level of safety and comfort that Veterans experience. Even when limited resources are available creative and considerate choices can be made to increase a sense of safety. These recommendations are not exhaustive, and in fact providers are encouraged to think creatively about how office and service environments could appear to provide greater comfort and feelings of safety.

- White noise machines generate privacy and decrease distracting background noise.
- Acoustic barriers can also assist to maintain privacy and confidentiality
- Eliminate barriers to exits when possible so as to create a sense of easy exit and decrease the potential for feeling "trapped".
- If space is restricted when meeting with clients allow them to choose where to sit.
- Avoid punitive signage when possible such as "NO CLIENTS BEYOND THIS POINT!"
- Clearly post-consumer and/or clients rights.
- Create well lit spaces inside and out and in individual offices consider lamp lighting rather than solely using overhead fluorescent lights.
- Incorporate colorful and living decoration when possible (e.g., plants and fish tanks).
- Utilize cheerful decoration such as paintings and photographs when possible.
- Provide comfortable seating in offices and common areas.
- Provide water.
- Ensure that all areas are accessible to people with visual or mobility impairments.

Utilize Strength-Based Approaches

Survivors of trauma demonstrate resiliency and adaptability daily. Even when behaviors appear risky or maladaptive, the behavior has developed to maintain survival. Viewing homeless Veterans as resilient is strength-based.

- Identify what strengths have allowed the client to survive through trauma and homelessness.

- Help Veterans identify choices and options and assist them to consider the possible outcome.
- Promote and reward incremental social engagement.
- Support the Veteran in decision-making rather than having them follow directions and orders.
- Use strength-based language such as "people who have suffered from mental illness" rather than "the mentally ill".

Identifying Triggers

Identifying a Veteran's triggers can reduce potential negative reactions to trauma. Understanding both interpersonal and environmental triggers may also help avoid re-traumatization. It is appropriate to ask, "Could you share with me things that increase stress for you so that we can try and plan to get your needs met with those in mind?" Triggers may include events that many take for granted as socially acceptable such as being touched on the arm or standing too close. Other environmental triggers may include loud noises that are startling or sitting with one's back to the doorway. Triggers can be discussed and assessed once rapport is established.

Develop Policy and Procedure

A goal for providers is to develop policies and procedures that are consistent with a TIC approach. The goal is to create clarity and transparency in an effort to support safety and clear expectations. Clients should be made clear about practices regarding confidentiality and under what conditions their personal information will be shared. Additionally, assisting clients to understand what they are eligible for and assisting them to connect with those resources engenders trust and promotes partnership. Veterans should be active participants in developing their goals and plans. Policy and procedure should reflect a process concerning what the Veteran identifies as most important.

Barriers to TIC for Traumatized Homeless Veterans

There are numerous provider, Veteran and systems barriers to providers delivering and Veterans receiving TIC.

Provider barriers can include the following:
- Lack of awareness
- Discomfort in asking about trauma/PTSD
- Lack of information about referral services
- Secondary traumatization
- Provider "burnout"

Veteran barriers can include the following:
- Emotional pain (such as self-blame or shame)

- The belief that talking about trauma will make things worse
- The belief that VA providers cannot be trusted
- Active substance abuse and dependence
- Little or no existing social support
- Limited positive coping strategies
- Pending criminal charges
- Unemployment or underemployment

Attention to Special Populations

There are special strengths, needs and barriers for sub-populations of homeless Veterans. Below are factors requiring consideration, although these points and sub-categories are by no means exhaustive.

Recent Combat Cohorts:
- This population is twice as likely as other Veteran populations to be diagnosed with a mental health disorder or traumatic brain injury (TBI) at the time of discharge from active duty.
- Rates of PTSD much higher in Veterans who served in Iraq or Afghanistan homeless Veterans than in previous eras.
- Comorbid mood disorders extremely high in Iraq and Afghanistan homeless Veterans.
- Recent returnees are becoming homeless more quickly.
- Unemployment rates are nearly double the national average in Veterans aged 20-24.

Women:
- Trauma (especially sexual abuse) is highly prevalent in homeless mothers.
- A diagnosis of PTSD is also extremely high in homeless mothers.
- Mothers may have health and human service involvement (i.e., children in state care).
- There is an increase in combat-related trauma in this population.
- Women experience higher rates of suicidal ideation and suicidal attempts.
- Fewer female focused services available.
- Few family shelters and family housing available.

Aging Veterans:
- Increased physical health problems and medical comorbidities related to extended years homeless and in active addiction.
- Older Veterans may not have as much information as younger Veterans regarding trauma and PTSD.
- Vietnam Veterans may have had increased negative experience with VA services.

Rural Veterans:

- Incidence of homelessness among Veterans in rural and suburban areas is on the rise.
- Veterans in rural areas are more likely to be homeless for longer periods of time.
- Rural homeless Veterans are less likely to receive a mental health diagnosis.
- Are more likely to experience serious co-morbid medical, dental and vision problems.
- Are less likely to receive public assistance.
- May need to travel large distances to receive care.

Dually Diagnosed:

- Studies have found that more than 50% of individuals seeking substance use treatment endorse experiencing a traumatic event in their lifetime.
- Up to 34% of patients in substance abuse treatment have both a substance abuse diagnosis and PTSD diagnosis.

Additional Considerations

- Trauma survivors frequently decline referrals -- this may be especially true of homeless Veterans.
- Most people who have been traumatized just want to forget about it, hoping their trauma-related problems will go away by themselves.
- Veterans may not realize the connection between homelessness, trauma and PTSD. They may not realize the toll trauma may have taken upon their emotional and physical health (e.g., depression, PTSD, chronic pain, etc.).
- Evidence-based psychotherapies for PTSD are available. These interventions are provided by licensed clinicians within the VA healthcare system. Availability and accessibility to these interventions can be looked in to by case managers to assist Veterans in identifying the appropriate level of care.

Evidence-Based Psychotherapies for PTSD

There are two evidence-based psychotherapy treatments for PTSD that the VA engaged in disseminating nationally: Cognitive Processing Therapy (CPT), and Prolonged Exposure (PE). CPT is a 12-session trauma-focused manualized treatment that can be delivered in a variety of formatting including group, individual or combined group and individual format. CPT involves helping individuals increase their understanding of unhelpful thought patterns about a traumatic event and teaching alternative, healthier ways of thinking. PE is a trauma-focused manualized individual therapy which is typically delivered in eight (8) to 15 sessions. PE exposes individuals to trauma-related situations that are objectively safe but presently avoided due to trauma-related distress (in vivo exposure). Individuals are also exposed to trauma memories by having the person repeatedly recount out loud the details of their most disturbing event (imaginal exposure).

Summary

Although homeless Veterans are at high risk for experiencing traumatic events while homeless, we also know that a significant number of homeless Veterans have experienced trauma across their life time. These experiences do not always lead to a diagnosis of PTSD, followed by provision of evidence based treatments for PTSD. We also know that many homeless or recently housed homeless Veterans with a diagnosis of PTSD, do not access and complete evidence based treatments for PTSD.   This leaves a large gap in addressing both homeless Veterans with PTSD, and those without a diagnosis of PTSD, but where trauma has affected their coping skills, life functioning, and relationships, all factors that impact cyclical or sustained homelessness.

Trauma informed care is a perspective that provides education and awareness, both for homeless Veterans and their care providers, about the impact of trauma. This perspective is built on the belief that understanding how to engage Veterans through practices that reduce shame and fear, while building safety, trust and hope, will ultimately lead to greater recovery and less cyclical homelessness. Without trauma informed care we risk practices that may unintentionally re-traumatize through avoidance in addressing these concerns, or lack of awareness in how to address them. It has been reported that building trauma informed care into homeless Veteran programs not only builds hope and expands the path for recovery of homeless Veterans, but it also reduces burn out and distress among providers.

Recommendations on where to begin:
1. Conduct an organizational assessment of your team/program on trauma informed care
2. Think as a team about how you want to approach screening for trauma in your setting
3. Utilize educational tools on basics related to understanding trauma
4. Start thinking about how you can enhance your environment to promote physical and emotional safety
5. Review your teams usage of strengths based approaches to services
6. Become aware of practices that may be unintentionally re-traumatizing
7. Develop a goal within your team to start on one or two areas for positive change to become more trauma informed
8. Track your changes to be sure that they are moving in the direction you had hope (Plan Do Study Act cycle http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx)
9. Involve Veteran stakeholders into the process of change
10. Support each other through the fears that will come up through this process of change

Resources
1. http://www.ptsd.va.gov/ (see continuing education sections an screening sections)
2. http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

3. Trauma-Informed Care Fact Sheet: www.va.gov/homeless/nchav/index.asp

Chapter

5

HOUSING FIRST

Introduction

H ousing First (HF) is an internationally recognized evidence-based program that provides immediate access to permanent housing and support services to individuals who are homeless. HF is tailored for individuals who, in addition to homelessness, have complex psychosocial and medical needs. HF provides services on a voluntary basis, without requiring treatment for psychiatric problems or sobriety as a precondition for housing. Provision of stable, permanent housing is the first task for providers of HF; support and treatment tailored to the individual's needs and preferences are continually offered, but they are not emphasized until after the individual is housed. HF is based on the belief that housing is a basic human right and a basic entitlement for Veterans with complex psychosocial and medical needs. Housing First, patterned after the Pathways model, is now the principal model for the VA's permanent supportive housing program, HUD-VASH.

> **In this chapter you will learn:**
> - The program principles and values of HF;
> - How HF is a central component of VA's effort to end homelessness among Veterans, specifically its application in VA's permanent supportive housing program HUD-VASH;
> - How HF differs from traditional housing and treatment models; and
> - The services and support HF provides to support housing stability, recovery, and community integration.

After reading this chapter, you will be able to understand how HF is practiced in the context of VA's permanent supportive housing program.

Aim of the Chapter:

The main purpose of this chapter is to explain how Housing First operates and how the model is incorporated into the HUD-VASH program to more efficiently and effectively end homelessness for Veterans, especially those who have complex needs and have remained chronically homeless.

The chapter describes how using the HF model for permanent supportive housing programs

significantly improves the effectiveness of the program.   HF is an excellent fit in permanent supportive housing.

> **The program:**
> a) Provides immediate access to housing without prerequisites;
> b) Targets those who have remained homeless for years and who have complex clinical needs;
> c) Has two main program components: permanent housing in the form of independent apartments (HUD's Section 8 voucher) and off site treatment teams; and
> d) Uses a treatment philosophy that is consumer-directed or Veteran-centered.

The chapter describes how housing and supports are provided with an emphasis on Veteran-centered services can be provided to support recovery and community integration.

Housing First and Permanent Supportive Housing

Housing First (HF) is a form of Permanent Supportive Housing designed specifically for individuals who are homeless and have complex mental health, substance use and primary healthcare needs. What is unique about HF is that the program does not require Veterans to participate in treatment or attain sobriety as a precondition for housing. Traditional housing programs typically require stability and sobriety as a condition for housing, and once housed, Veterans must continue to remain in treatment and to maintain sobriety in order to keep their housing. HF eliminates these conditions in order to provide more rapid re-housing and greater rates of long-term success in treatment by providing services on an entirely voluntary basis. The success of the HF approach is well-documented, and has resulted in its endorsement by the US Interagency Council on the Homeless (USICH), which includes 15 federal agencies and several advocacy groups.

The Housing First component of the VA's HUD-VASH program is a natural evolution in a VA recovery-oriented program, since Veterans essentially drive their own care by utilizing the permanent Housing Choice Vouchers and accessing an array of services offered by HUD-VASH Case Managers, the local area VA Medical Center (VAMC), or other community-based services. In order to end chronic homelessness among Veterans, the programs adopting HF will target those Veterans most in need of permanent housing, with co-occurring mental health and substance use disorders. HUD-VASH will be expanded into a model that implements the key features of an Assertive Community Treatment (ACT) or Intensive Case Management Model (ICM), along with HF.

The traditional approach, sometimes referred to as the 'continuum of care' or the 'treatment first' approach, has been, until recently, the prevailing program model for homeless services, including the VA's homeless services.   'Treatment first' programs are based on the assumption that

individuals with psychiatric problems and/or addiction issues must first stabilize these conditions before they can be successfully manage housing.   While this model achieves housing stability for about half of the people it serves it leaves homeless all those who cannot manage to achieve sobriety or psychiatric stability in order to gain entry.   This group, who cannot or will not participate in treatment or attain sobriety has until now remained homeless or they have repeatedly gone to treatment in hopes of achieving stability but to no avail.

For Veterans who have shunned services and remained homeless or those who have repeatedly tried and failed in 'treatment first' programs we need another approach. For this group we cannot demand sobriety and clinical stability as a condition for getting and maintaining housing. If we do, they may never get into housing.

HF is designed specifically for this group. In HF programs use or relapse after one is housed does not mean eviction, it means support and treatment. HF programs separate the requirements for housing form the requirements of treatment.   Housing is secured and Veterans are entitled to remain housed as long as they meet the terms and conditions of the standard lease. Even though they are in HUD-VASH programs, they have the same rights and responsibilities as every other tenant in the community.

HF programs succeed in engaging, housing, and keeping housed Veterans who have remained homeless for years and who traditional housing providers have labelled 'treatment resistant' and 'not housing ready'.   HF offers Veterans the opportunity to live in a neighborhood and an apartment of their own choosing. The Veteran who participates is transformed overnight from someone who had been homeless, living on the streets to a tenant, living in his or her own apartment in a decent building in their community. Overnight, the Veteran goes from down and out to dignified. The Veteran intuitively understands that the HF program's offer of decent affordable housing is really an invitation to gain access to self-determination, self-respect and self-esteem.

Housing First effectiveness and Permanent Supportive Housing

Housing First (HF) is an especially effective model when working with Veterans in particular because many have histories of trauma and the likelihood of their accepting any services is increased when those services are offered on their own terms. In HF programs the Veteran is in control of the decision making process that determines the pace of engagement, the type of service, and the frequency and duration of service. The Veteran-centered approach is a core service philosophy in HF programs and fits well with the general profile and earlier training Veterans have received which emphasizes independence, survival, personal pride, self-determination, and a tendency to consider hardship within the context of the extremes of military service. Rather than asking a Veteran to compromise a sense of autonomy to accommodate to petty program demands,

or bureaucratic red tape, HF embraces this self-determination and resiliency by honoring the Veteran's wishes to live in a housing unit of one's own choice and by providing services and support that are directed by the Veteran. Although at one point Veterans may have followed orders without question for the good of this nation, they now need individually tailored, responsive services that can follow the pace and direction of Veterans own goals. This approach is fundamental to HF.

Housing First Evaluation

Adopting Housing First (HF) principles into permanent supportive housing has proven to be remarkably effective. The National Center on Homelessness among Veterans (the Center) conducted a 14-city HF demonstration project. The Center trained the VA's permanent supportive housing programs (HUD-VASH) in these cities on implementing HF-improved targeting with the goal of admitting primarily chronically homeless Veterans; those Veterans with the most complex needs. The outcomes of this initiative included: reduced use of inpatient mental health and primary care services, by the Veterans in the demonstration; and an achieved average of 80% housing stability, which is consistent with other high fidelity HF programs (http://www1.va.gov/HOMELESS/NationalCenter.asp; Tsemberis et al, 2004).

In addition to the Veteran-centered and community-based treatment philosophy, the HF model has remarkably consistent positive results for achieving housing stability and community integration for individuals that were previously considered to be 'treatment resistant' and 'not housing ready' (see SAMHSA National Registry of Evidence Based Practices). The HF model is now endorsed as a recommended practice by the USICH, HUD, and the VA. The USICH has endorsed Housing First as "a proven method of ending all types of homelessness" and "the most effective approach to ending chronic homelessness."[1] In 2012, the VA made Housing First official policy for the HUD-VASH program and began utilizing the key principles of the HF approach in VA Homeless Programs. For more information about Housing First, see:

https://pathwaystohousing.org/housing-first-model.

Before Housing First: The Traditional Homeless Services Approach

The HF program model was born out of frustration with, and stands in stark contrast to, traditional approaches to homeless services in which treatment requirements and expectations of

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[1] U.S. Interagency Council on Homelessness. The housing first checklist: a practical tool for assessing housing first in practice.

consumer stability have interfered with ending an individual's experience of homelessness. The underlying assumption of traditional approaches is that the individual must change, improve, or stabilize, before he or she can transition to the next phase in what is usually a series of programs that may eventually result in permanent housing.   In traditional approaches, Veterans must 'graduate' through a series of placements–typically starting with drop-in centers or shelters, as they comply with treatment and sobriety they move through transitional housing, and, finally, into permanent housing–they get to keep their housing by demonstrating treatment compliance, psychiatric stability, and abstinence from substance abuse as depicted in Figure 3 (Henwood et al, 2010).

Within this stepwise approach, if a client relapses, becomes unstable, or chooses not to follow rules necessary for the housing program, he or she must leave the program and/or become institutionalized, which, by default, entails sacrificing their current living situation and the prospect of permanent housing.Within the traditional approach, the motivation for change is believed to come from the promise of permanent housing. Yet, this external incentive system, some call it coercion, is a high stakes proposition, in which a permanent end to homelessness depends upon an individual's ability to manage conditions that, by nature, are difficult to overcome and are often recurring. This may help explain why traditional service approaches have had only limited success addressing chronic homelessness.

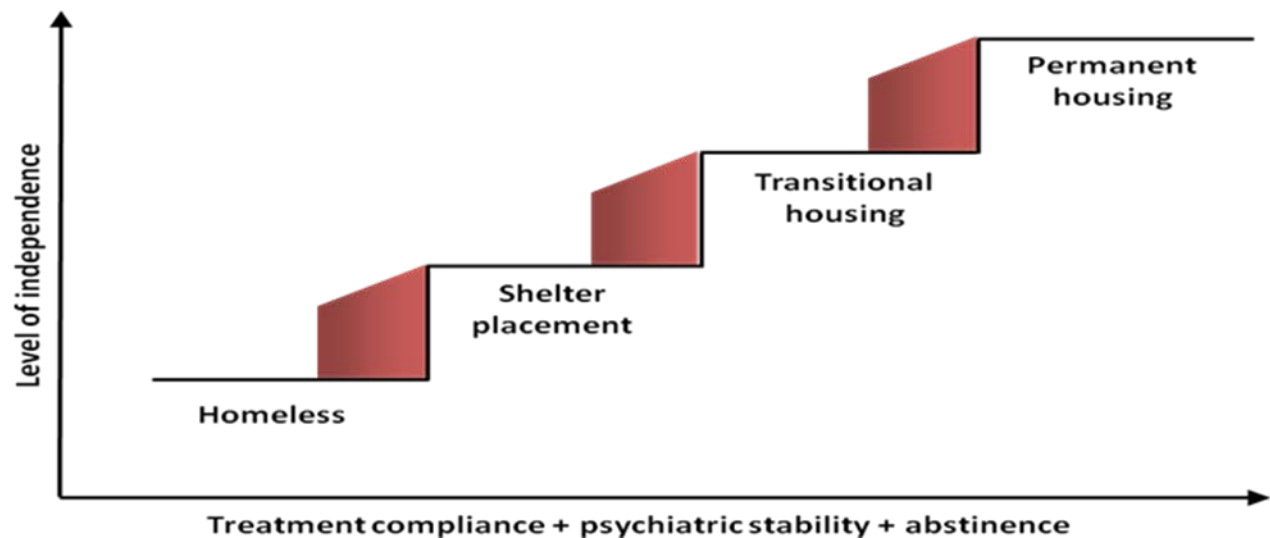**Figure 3. Traditional approach: a continuum of programs, in which housing stability and independence increases only as consumers demonstrate compliance, stability, and abstinence.**

Housing First's Revised Approach

In contrast to traditional service approaches, HF starts with immediate access to permanent, scattered-site housing. From the point of admission into the program there is a discussion about

what the Veteran wants most – housing. Staff begins with a discussion of housing related issues, choice of neighborhood, type of apartment, applications for the housing voucher, and other housing related topics. The apartment search begins right away.

The HF model does not leverage the offer of permanent housing in exchange for participation in treatment, and therefore creates a fundamental separation between permanent housing and clinical services. In separating housing from services, HF effectively replaces the discussion of "earning" housing with the idea of a 'right to housing', as depicted in Figure 4 below.
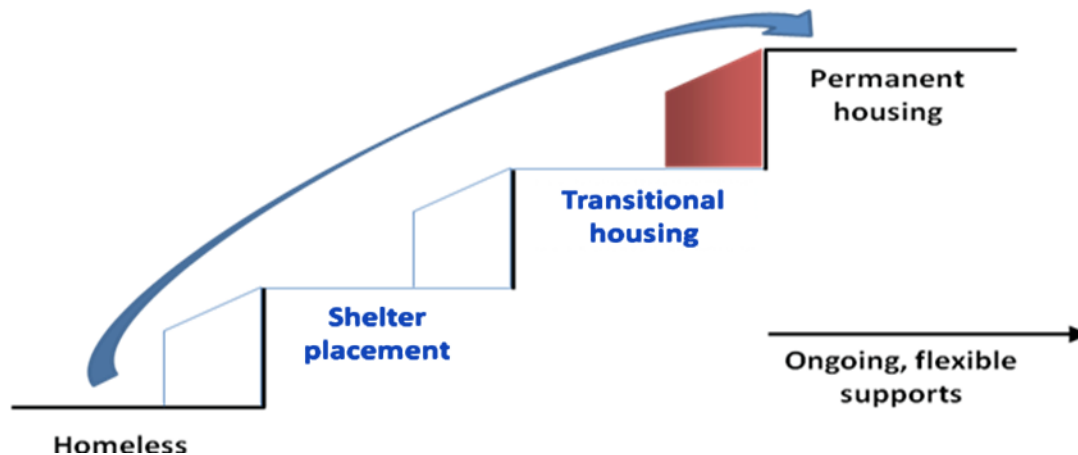
Figure 4. Housing First bypasses a step-by-step approach to earning housing through participation in treatment and provides immediate access to independent, permanent housing with flexible support services.

Housing First Program Principles and Values

In 2010, VA began working closely with Pathways, Inc. to develop a Housing First approach in its rapidly expanding HUD-VASH Program. Much of the HF approach became the foundation for VA's HF approach.

<u>Five Essential Housing First Program Principles</u>

While offering a simple, straightforward solution to homelessness, the HF program is a complex community mental health intervention that includes both a housing program and a services component. The program has numerous operational dimensions and protocols that are well defined (Tsemberis, 2010).[3] The focus here is to present five key program principles upon which this effective and humane intervention is based:

1) Veteran-directed services
2) Separation and coordination of housing
3) Support and clinical services (case management/interdisciplinary team)

4) Program's recovery orientation
5) Community integration and social inclusion

1) Veteran-Directed Services

HF's empirical evidence for ending homelessness, achieving housing stability, and doing it with a cost-savings over traditional services[4], has driven its rapid growth and dissemination. These facts at times overshadow the consumer-driven service approach that is actually the key to the success of this intervention. Recall that most programs Veterans have encountered in their pursuit of housing are characterized by numerous rules regarding treatment, sobriety, curfews, length of stay, overnight guests, mandatory program activities from having meals to social participation, and other requirements. The HF program is demand free: it puts the Veteran in control of the decisions-making process and supports the Veteran as s/he begins to design his or her own program with the resources the program provides and the assistance of the staff.

2) Separation and Coordination of Housing and Services

In the HF approach, the agency operations are functionally and physically separated into two parts. Functionally, housing search, housing management, and financial/budgeting assistance are delivered by one arm of the program, while the ongoing personally-tailored support services are delivered by service teams. In VA, services teams are located either at the VAMC or a community-based setting and make home visits to Veterans living in their own places located throughout the community. There are no services for Veterans in the buildings they live other than perhaps a superintendent who manages the property for the landlord.

From the start, housing is offered as a matter of right and all conversation about securing and maintaining housing is focused on leases, inspections, keys, repairs, furniture, pots, pans, sheets and towels, and other apartment- and household-related content. The security of housing is free from leverage, and there can be no discussion of revoking the right to housing based on "non-compliance" with treatment plans, or "treatment non-adherence." The separation of housing and support functions both promotes the value that housing is a basic right, and avoids the problems of difficult or potentially unethical dual relationships (for example where the worker acts to evict his client).

In addition, the separation of housing and services serves a valuable function, making graduation from services particularly stress-free. One's apartment is not at risk when services are no longer needed. When the Veteran is doing well, perhaps receiving services from a VA Primary Care, Mental Health, or Homeless Team and no longer needs a home visit for support it is time for graduation. In the HF program as in HUD VASH, the team will stop making house calls and there is no need for the Veteran to move anywhere else. He is already living independently, in the same apartment, building, neighborhood, community as he been for years. He graduates, the

services walk away, he doesn't have to move anywhere, is already home. Note, however, that while housing and services are separate, both the housing and services components of the program must communicate and be well-coordinated.

3) Support and Clinical Services

Given Veterans' complex services needs of the chronically homeless population, services can best be provided through a multi-disciplinary team, such as an Assertive Community Treatment (ACT) team or enhanced intensive case management (ICM) teams, teams that may include a part-time prescriber or nurse and have lower caseload ratios than regular case management.

In practice, the ideal clinical support team provides services along a continuum of intensity, where the Veteran moves from high intensity through moderate to low intensity at their own pace, and with the possibility for increasing or decreasing intensity at any time, according to need. From the moment of entry into HF services, Veterans should receive a message of welcome and hope (e.g., this team is here to help you get better and we will be here as long as you need us).

4) Recovery Orientation

The HF approach embodies a recovery orientation that is now the cornerstone of mental health service reform (New Freedom Commission on Mental Health, 2003). The concept of recovery refutes long-held misconceptions that all serious mental illness is a lifelong, crippling, degenerative condition (Hopper, 2007). Inspired by the protests of individuals who had been diagnosed with serious mental illness, yet experienced and then told their stories of recovery, decades of research indicate that recovery is not only a possibility, but a reasonably attainable goal for persons with serious mental illness (Harding et al, 1987; Harrison et al, 2005). And it is a consensus among mental health experts at the Substance Abuse and Mental Health Services Administration that now guides innovation in mental health service development (SAMHSA, 2006).

Recovery is not only about reducing symptoms, or reducing hospital visits, or reducing drug and alcohol use, or increasing treatment compliance. Recovery is much broader and includes all domains of life. It is all about the quality of one's life that is beyond the restriction or limits of their psychiatric diagnosis or their addition. It is about connecting with family, making friends, getting a degree, a job, a relationship, a pet, going out to dinner and movie with a friend, it's about starting that journal or taking a new class. Recovery is increasing the amount of time your life is spent in positive pursuits. It is much broader than the 'service array' offered by most programs. In some instances Veterans do not believe that they can fully pursue the options they desire or they have long ago abandoned the hope of trying to pursue their dreams. Staff must find a way to encourage and rekindle these sometimes long dormant dreams, encourage Veterans to take new chances, experiment, and help them regain a sense of control, security, and possibility in their lives.

Recovery orientation in the HF approach should incorporate the following elements of recovery

laid-out by Onken, Ridgway, Ralph, and Cook (2007):

- It should be a hope-instilling practice (convey the message that recovery is possible).
- Relationships are foundational – a positive and warm relationship between team members and Veterans must be cultivated for the practice to work.
- Opportunities/choices/options really matter.
- Peer support and recovery role models are of primary importance.
- People need knowledge and skills to self-manage their condition.
- An emphasis on holistic wellness and positive lifestyle is healing.

Here it is noteworthy to emphasize the role of peer support specialists in promoting a recovery orientation, particularly because, at the time of this writing, HUD-VASH has recently embraced the employment of peer specialists on teams. Peer specialists, or Community Integration Specialists (CISs) – a newly developed position in the VA with the purpose of serving the homeless population specifically, in provider roles are an everyday role model to both staff and consumers. Their presence speaks to the fact that those diagnosed with severe mental illness can and do recover. Peers help to eliminate the 'us' serving 'them' and reinforces the idea, 'I did it and you can too.' It is important to create a team and agency culture to ensure that peer providers are respected and valued for their contributions and to ensure that that they are never regarded or treated as a 'junior case manager.'' There is no substitute for lived experience of recovery on the team.

5) Community Integration and Social Inclusion

Community integration is a critical aspect of the Housing First (HF) practice. While a recovery-orientation instills the hope that an end to suffering from mental illness is possible, it is integration into the community and social inclusion that promote and support the experiences of dignity and human connection that are critical to wellness. HF practice should promote individuals' active participation in their communities – whether they be neighborhood communities, communities of interest (such as chess or knitting), communities of religious believe and practice, if that is of interest to the person, family, or other groups that come together and give us a sense of belonging.

Providing scatter-site housing is an important part of promoting community integration. Living in housing 'like you and I live in,' and not in a program, fosters an authentic feeling of belonging and simultaneous independence – of equal citizenship. Practically, the provision of scatter-site housing allows families can reconnect and live together if they want to, new relationships can be built without any need for reference to 'the housing program where I live,' and there are more possibilities for participation in community social, religious, and cultural events. As community integration and social inclusion grow, they become the platform from which graduation from HF programs is possible.

Values: Choice

Veteran Choice or Veteran-directed services is the core philosophical and practice principle of HF programs. The centerpiece of HF is based on psychiatric rehabilitation philosophy that honoring consumer choice is the most effective means of offering support. Providing treatment in the context of coercion and force introduces distrust and disrespect between providers and the individuals they serve. Such a context naturally breeds distrust, and a weak working alliance between them. Thus, from a practical perspective, providing real client choice in services is a key factor in promoting effective services. But choice is also a value that stands on its own. Choice is self-determination -- the freedom for which Veterans defend their country. When individual choice is not respected, the experience for a Veteran can be deeply humiliating, undignified, inhuman, and unjust.

But ensuring that choice is always paramount in service delivery is not always simple. This requires active, empathic listening to what your clients are requesting and helping them to realize their own self-stated goals. This 'consumer-directed' or 'Veteran-centered' approach is in stark contrast to the practice of clinician-as-expert that is prevalent in most programs serving this population. It may take individuals who have not succeeded in treatment before a long time to trust that choice is real in this context. But when a provider earnestly persists in embodying the value of choice in all he or she does, choice becomes not only real, but transformative, and extremely effective for motivating lasting changes that improve Veterans' lives.

Housing First Services

The starting point of the program is to ask Veterans what they want. The program begins by honoring and fulfilling the request that most people who are homeless say they want first — "A place of my own to live." Almost all individuals who have experienced homelessness want a place of their own[2].

Housing First Housing Services

From the start, HF staff should be asking questions that relate to the choices and preferences of the Veteran. This sets the stage for establishing a comfortable home environment, which is necessary for providing effective services in HF. When first meeting a Veteran, conversation can begin immediately with housing preferences. Questions that a HF staff member could ask are:

- Do you have a preference for a neighborhood?

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[2] However, it is important to note that some do not. In some cases, a Veteran might say he/she would like to live in a program with other Veterans. Consistent with HF values, HF staff should honor that choice and the program staff should help the Veteran identify and apply to such a program or any other program of their choosing.

- Would you like a studio or a one bedroom?
- Are there other people in your life you want to live with or near?
- What about a pet?
- What type of furniture would you like?
- And after moving in - What can I help you with next?

Apartments are rented from private landlords in the community, in normal community buildings, not a program. No more than 20% of the units in any one building are rented by program participants. (This varies as we go from urban to suburban and rural settings.) The key principle here is the exact percentage, the principle is the housing is normal housing and not a building operated by housing program. Thus, the apartments and the Veterans living in them are integrated into the community. There is nothing that distinguishes these apartments or these buildings from any others in the neighborhood. Housing 'like you and I live' reduces stigma and does not identify a Veteran as living in a program for the homeless or the mentally ill.

While Veteran Choice drives the provision of housing (location, type, etc.), housing type and neighborhood choices are restricted by affordability and suitability of available units. Apartments are rented at fair market value, qualify for Section 8, and must pass HUD's Housing Quality standards inspection.

Housing Agreement
Within the HF program, Veterans have the same rights and responsibilities as all other tenants holding a standard lease, but they are asked to sign a specific rental agreement with the program to ensure that minimal requirements for remaining in the program are met. They are required to pay a percent of their income in rent, and take good care of their homes, and agree to meet with program staff on average once a week at their apartment. The purpose of the visit is manifold, but one of the aims is to maintain communication and identify any problems associated with the apartment, landlord, neighbors, or independent living. Program staff encourages and foster normative relationships with landlords, neighbors, family, and other natural support networks that promote community living tailored to the individual needs of each Veteran.

Interim Housing
The use of interim housing is recommended when working with Veterans who are literally homeless. Interim housing can consist of a motel room, a YMCA, YWCA, safe haven, other transitional housing program; anywhere where the Veteran can stay off the streets while their apartment is found. Interim housing is also useful if the Veteran is relocating out of one apartment and into another but the second has yet to be found.

Ideally, immediately after the Veteran agrees to enroll in the HUD-VASH program and he or she is found eligible, the team is prepared to take steps and help the Veteran exit from homelessness

that same day. This can be easily and effectively accomplished if the program has an established relationship or agreement with an agency that operates one of the interim housing program types described above.

This type of interim housing has several advantages:

- The Veteran gets some rest and begins to feel better.
- Team members gain the Veteran's confidence that this program can make things happen.
- Team members are viewed as trustworthy because they are true to their word.
- The Veteran begins to believe that things might really change.
- Team members can easily locate the Veteran the next day for follow up.

The Role of the Housing Specialist

VA's permanent supportive housing programs utilizing HF should be organized operationally to help Veterans identify, rent and move-into an apartment quickly. It is important that these programs develop systems and procedures that will facilitate rapid movement through the housing selection and acquisition process. Given that the HF program works closely with community landlords, building managers, temporary housing providers and the local housing authorities, assigning a Housing Specialist to focus on housing is highly recommended. A Housing Specialist can commit attention and resources to the maintenance of the apartments, managing the relationship with the landlord, and ensuring the lease renewals and other lease obligations are met more efficiently than clinical support staff.

Renting many apartments on the open real estate market is a skill that is needed, but may not be readily available to all teams. If a Housing Specialist is not part of the team's staff in VA's permanent supportive housing programs, it is useful to identify a member of the team who can best fill that role. The Housing Specialist may be someone with previous experience working in business or real estate.

However it is addressed, there needs to be a staff member whose responsibility is the property management component of the program. Their responsibilities include securing available units on the open market from private landlords, assisting with securing the voucher, and developing systems to expedite these processes in order to guarantee immediate access to housing – a hallmark of the HF approach. This is also the person the landlord would call if there was a problem with the apartment.

Housing First Support Services

Finding a safe, affordable apartment typically takes between two and four weeks, and Veterans are encouraged to think about their choice because this will be their home for a while. They do not have to take the first apartment they are shown. They are told they can see two or three

apartments from which to choose, however, more often than not, they select the first unit they are shown. During this interim period, team members meet frequently with the Veteran to ensure that day-to-day needs are met. They address health issues; apply for benefits, identifications, or other needed documents; clear outstanding warrants or other legal issues; and attend to any number of other matters that need to be addressed given the enormity of the impending transition.

The clinical team works closely with the Housing Specialist (if available) or with landlords and the local public housing authority to ensure that an appropriate apartment is located and the Section 8 voucher is secured. A member of the HF treatment team attends every housing meeting, accompanies the Veteran when he or she views apartments, and—after the apartment is selected, passes inspection and the lease is signed—the team helps the Veteran move in.   If the landlord requests an interview with the Veteran, the staff prepares him or her for the interview by role playing the landlord-tenant interview and posing questions that one would expect from a landlord. If the Veteran is nervous about the interview, role playing and reviewing the type of information the Veteran should or should not disclose to the landlord is often helpful.

Operational Considerations at the Intersection of Housing and Services

Although the clinical and housing services provided under the HF permanent supportive housing model are separate, they are also complementary. Each team has the freedom to navigate the intersection between housing and services in their own way, but planning ahead for these issues is a critical management responsibility, which generally falls to the Team Leader, ahead of the establishment of HF services.

Some of the interactions between the separated housing and service aspects of the program can seem trivial, such as setting up responsibility for minor repairs, or furniture purchases, and others are clearly of great importance, such as coordinating rental payments. But all of these issues deeply affect the functioning of the program, the morale of the staff, and the experience of the Veterans receiving services. Planning for them is essential.

Repairs and Maintenance

Inevitably, an ongoing issue in this model of scattered site rentals is the issue of repairs. There are always some repairs to be done in a small fraction of apartments at any one time. It is essential for the housing staff and clinical staff to meet on at least a weekly basis, because it usually takes both teams to address problems as they arise. A frequent occurrence in an apartment where something is broken, such as a window, stove, or light switch. The clinical team or the Veteran alerts the housing staff who will work with the building manager and the Veteran to set up a time for this repair. This can go very smoothly if the teams are working well together, or it can become a great source of frustration and difficulty for the Veteran if the housing and clinical teams are not well coordinated.

Purchasing Furniture and Furnishing Apartments

It is usually the clinical case management team that works with the Veteran to ensure that the apartment is furnished and is equipped with all that is needed, along with the set-up of all utilities, prior to the client's move-in day. It is helpful to have agreements with furniture providers or local furniture banks for specific furniture packages. This ensures that furnishing the apartment does not slow the move-in process.

Rent and Vouchers

The clinical team usually ensures that the client's rent is paid on time every month, and the team works with the client to establish a monthly budget so that all utilities are paid in full on their due date.

Being the Representative Payee

The program may offer to arrange representative payee services or offer other budgeting services to help ensure that bills are paid. Although program guidelines may vary regarding who can be designated as the representative payee, clinical, housing, and administrative services should be well coordinated to ensure a Veteran's rent is being paid.

Tracking Payments, Contracts and Reporting Responsibilities

Another area that requires close communication is the tracking and reporting of responsibilities to governing authorities and funding agencies. Because there are so many areas where coordination between housing and services must be precise, planning ahead of time for how these services will be handled separately, yet integrated, is essential.

The best way to do this is by maintaining frequent, clear communication between housing and clinical services. The need for seamless coordination cannot be emphasized enough. Clinical and housing staff must be open with each other about their concerns and priorities, and both teams must be committed to HF and client-driven care.

Operational Considerations for VA's Permanent Supportive Housing Programs

While the needs are great and the services insufficient to meet all of them there are two things that can ensure the success of the services team: a) services must be offered or provided in the sequence that is consistent with the Veteran's priorities; and b) service providers must convey the hopefulness and the clear message that their intention is to help.

Additionally, teams should be are located off-site, but available on-call 24 hours a day, 7 days a week. And most services should be provided in the community, at a Veteran's apartment, workplace, or neighborhood.

ACT vs. ICM teams

The choice of ACT or ICM teams (or a hybrid that may be less than ACT or more than ICM) is based on current best practices within mental health services and is in part limited by availability of staff, resources, and funding. The key aspect of providing service support to newly housed Veterans, regardless what the staffing pattern may look like, is to ensure that the Veteran will be getting the level of services needed to ensure their well-being. Matching services intensity to service need is more important than the manner in which this accomplished.

It is useful for all teams to use a team approach and to meet on a regular basis to ensure that every Veteran is served properly. The purpose of regular meetings is to review the findings from the last contact, plan the next visit and make sure every single Veteran is discussed, not just the ones who are in crisis.

Developing Provider Networks

Careful planning by local Homeless Program staff must occur to assess available resources vis-a-vis the needs of the Veterans when implementing an assertive or intensive model, matching the frequency and the intensity of services with the needs of the Veteran. The addition of VA substance abuse specialists and cross training in co-occurring disorders is also a key component to any HUD-VASH Housing First team.

At its core, however, HUD-VASH support services need to be flexible and promote the Veteran Choice Program. Services that may be needed often exceed what the team can provide.

Interdisciplinary teams can provide many services directly, whereas ICM teams will have to develop provider networks and collaborative relationships with other providers to better coordinate the needed services. Services that are needed include the usual mental health, addiction, social services, and support. However, among the chronically homeless, we can expect there will be a need to address acute and chronic health problems so collaboration with primary care is a must. There will also be needs for nutrition counseling, supported employment, budgeting, spirituality, self-help groups, family systems support, supported education, and others.

Primary Care Integration

Integrating primary care through the VAMC, usually a nurse practitioner is a priority given the prevalence of multiple and chronic physical health conditions. In instances where the team has a part-time specialist such as a nurse practitioner (NP) or a prescriber, it is important to make maximum use of their time. If possible, it is optimal to ask Veterans to come to the team office to see the specialist. However, it should also be clearly understood that the specialist will make house calls when necessary.

Ongoing Support and Treatment

It is vital for the service and support team to realize that there are many needs that a Veteran has after he or she is housed. The program selects people with complex needs and those needs do not disappear once the person is housed. Because the Veteran is housed we have an opportunity to begin to address these needs. The Veteran is no longer focused only surviving homelessness they can begin to focus on other dimensions of their life. This can be difficult and painful. It may lead to relapse. The difference in the HF program is that the relapse will be responded to with support not eviction.

Harm Reduction

Staff uses a harm reduction approach when addressing substance use and mental health issues that incorporate a "stages of change" approach to treatment which again, is self-paced and self-determined (Prochaska et al, 1992). Harm reduction practice is interwoven into the HF program. Eliminating treatment and sobriety as prerequisites to housing is the first example of harm reduction practice in HF. This "housing first" approach acknowledges that the harms that homelessness does can be simply and effectively eliminated – much more so than the experiences of mental illness and addiction – and so it is a practical first step to reduce the harms experienced by a homeless Veteran. And, as a first step, providing housing honors the Hippocratic principle that health professionals should not only help eliminate harms, but do no harm.

But once the Veteran is housed, how does harm reduction practice within HF progress? By considering the needs that the Veteran identifies that can improve his or her quality of life. The first goal for most Veterans, in this respect, is to maintain their housing. One of the challenges in making this adjustment is for formerly homeless Veterans to realize that the community standard or their new neighbors' standards for accepting psychiatric symptoms and drug or alcohol use is often very different than the standards of the streets. Harm reduction is about reducing the risks a Veteran faces so that he or she can realize their goal of keeping their apartment and adjusting to their new social and cultural environment. Harm reduction is practiced from engagement, through securing housing and on to maintaining housing. As with consumer-driven services, it goes hand-in-glove with HF.

Some Veterans will have a very positive response to having a place to stay and will want to begin work on mental health and addiction recovery goals. Other will want to reconnect with family. Some may want traditional treatment through referrals to community providers. Whatever it is, the support staff is there to help Veterans meet their goals. In instances when services are needed but cannot be provided directly by the case management team, for example physical exams, educational programs or finding a place to worship, the team helps the Veteran access that resource at the medical center or in the community.

Limits to Choice

HF seeks to maximize choice, because the experience of choice promotes autonomy, dignity and hope, which are critical to recovery. But providing and promoting choice does not mean that limitless choices are available to participants. Veterans participating in the HUD-VASH Program may be asked to expand their geographic preferences and modify some of their housing preferences so that expeditious location of housing can be achieved to end their homelessness.

Responsibility for the Lease and Weekly Home Visits

Not only do natural limits on freedom apply (naturally, not all choices are available to all people at all times), but in order to participate in HF, one must agree to basic requirements around housing and services: that they can choose any neighborhood in the city, or choose not to sign and agree to the terms of their lease. Nor does 'choice' mean the program seeks to exempt Veterans from any of the obligations of any other citizen. 'Choice' really means that even though they need economic support and social services, Veterans in the program can still have the option to choose one neighborhood, or building, or apartment over another. And they can choose the types of services and supports that seem right to them. Or they can choose not to engage in services. But the principle of choice in HF does not mean the program is laissez-faire or hands-off. In order to ensure both independence and safety, and that each person enrolled has the on-going opportunity to engage in treatment, there are two requirements for maintaining enrollment in HF:

1) Responsibility for the lease, and
2) Agreeing to a weekly home visit by members of the HF team in the apartment.

It is useful to remember that the role of the team is a support service to the Veteran. As such, when the support services are operating well the Veteran should be very glad to have a home visit. When the Veteran is refuses a home visit, or is not at home at the scheduled time of the visit, it may be a signal that there needs to be a review or reassessment of the relationship between the support service provider and the Veteran. It may require a change of approach or a change of case manager. What is not an option is to stop making home visits. The team and the Veteran must work together and negotiate an acceptable solution.

Conducting Home Visits

The home visit represents the heart and soul of the program. While it takes place in an informal setting it is actually a targeted clinical intervention where important communication takes place and where the therapeutic relationship is developed. It takes training and practice to conduct effective home visits. There is a lack of formal boundaries when making a home visit, and therefore in this casual setting it is essential that the staff always maintains clinical and ethical boundaries.

Making a home visit provides an opportunity to make innumerable observations about a Veteran's life. In some ways, it is a very intimate experience, in that it allows a member of the treatment team to

visit the very center of the Veteran's life. Staff not only ask about, but actually observe, how a Veteran is managing and maintaining their living space; the condition of the apartment, the degree to which it is personalized, the kinds of personal effects, their photographs, groceries, magazines, books, musical tastes, the condition of their kitchen, bedrooms, and bathroom. All these observations can provide the team member with volumes of data about the Veteran's lifestyle before anyone has even uttered a word. There is more information than can be discussed in any one visit. This is a long term process and the relationship builds over time and at the Veterans pace. For more on Home Visits, see Chapter 10.

Scheduling Home Visits

In many ways, the home visit really starts *before* the actual visit. It begins as a discussion with the Veteran, and it continues while working out a time that is convenient for the Veteran. Spontaneous home visits should only be done if there are concerns that a client is in danger, hurt, or ill and only after all other ways to contact the client have been exhausted. Building relationships, after all, takes time—some Veterans may be suspicious of the team's motives for making the visit and it takes time to build credibility and trust. Others are concerned that the team may find evidence that would lead them to take the apartment away (the team does not have that power). Veteran's choice in scheduling the time and duration of visit should be honored.

Providing Services on Home Visits

Home visits often include the provision of services such as delivering medication, counseling, and discussions about household management. The conversation during a home visit can be about specific clinical services, instrumental or housing needs, family issues, safety, financial management, transportation, shopping, and other areas discussed during the development of the treatment plan. During the early phases of the program Veterans may deny problems or troubling issues they are facing. To foster trust, team members must convey acceptance and concern; not judgment.

Home visits can create an opportunity to connect and work on developing a deeper and more authentic relationship. To do this, HUD-VASH team members must be focused, but not hurried or rushed. It is important to realize that Veterans will not open up and ask for help unless they first trust the staff member. If there is problem with the relationship between the staff member and the Veteran the Veteran may not be home when the visit occurs.

Another dimension of the home visit is that it creates a shift in the power dynamics between clinician and consumer. If the home visit is to occur it is under the control of the Veteran. This coupled with the HF program philosophy that does not mandate participation in treatment as a condition for keeping housing poses a continual challenge for the team to ensure they are developing a positive and constructive relationship with each Veteran and providing the kind of support and services the Veteran values. This is the best way to ensure that the home visits will

occur on a regular basis and will provide a productive forum for recovery.

Conclusion

Through it all, the program's commitment is to the Veteran, first and foremost, and to recovery. The HF team will assist the veteran to manage any crisis and leverage housing not as a stick, to be taken away or threatened based on problem behavior, but as the carrot, that motivates lasting change. We have learned that providing ready access to housing will immediately cure homelessness even for people with complex needs. The programs support and treatment services are the reason people can effectively maintain their housing. It is these supports provided with this philosophy that help Veterans keep their housing, and begin the journey of recovery and community integration. Through cooperation between HUD and VA, a Housing First approach can be realized for Veterans, many of whom have been homeless for years and who have been diagnosed with psychiatric disabilities, addiction disorders, acute and chronic health problems. In order to guarantee success, the program must provide training for HUD-VASH staff and adhere to fidelity to the HF program model.

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Section 2

Operational Essentials

Chapter

6

INTRODUCTION TO HUD AND PUBLIC HOUSING AUTHORITIES

What's in this Chapter?

The HUD-VASH program is a unique partnership between two federal agencies, the Departments of Veterans Affairs (VA) and Housing and Urban Development (HUD), implemented on the local level by participating Veterans Affairs Medical Centers (VAMCs) and/or Community Based Outpatient Clinics (CBOCs) and local public housing agencies (PHAs). Annual Congressional allocations to HUD allow it to provide long term rental assistance through the Housing Choice Voucher (HCV) program to eligible homeless Veterans. The authorization for the HUD-VASH program also allows HUD to modify those aspects of the HCV program that are not statutorily mandated to facilitate access to the program by homeless Veterans.

After Congress appropriates resources to extend HUD-VASH, HUD and the VA collaborate to allocate those resources to VAMCs and CBOCs where there is considerable unmet need for homeless assistance and significant numbers of homeless Veterans. On a regular basis HUD and the VA will review the allocation of vouchers and depending on utilization and demand may reallocate some vouchers to areas of the country where need and demand are greater.

At the local level the HUD-VASH program is a partnership between PHAs and corresponding VA Homeless Programs at VAMCs and CBOCs. Each PHA selected by HUD to administer the program receives funding sufficient from HUD for the number of vouchers allocated to it and related costs of administering the subsidy. VAMCs, with vouchers designated, obtain additional staffing authorization to provide case management and related services. As the program has developed and expanded since its reactivation in 2008, each VA/PHA partnership has developed and matured. In most instances PHAs and their VA counterparts meet regularly in person or by conference call to review progress in leasing units and to identify and resolve any problems in operations that may have arisen.

While funding for housing subsidies goes to the PHAs, participating VAMCs and CBOCs obtain additional staff authority to cover case management and related housing stabilization services. VAs

have some flexibility in designing their HUD-VASH support teams including social workers, peer support specialists, substance use disorder specialists, nurses, and other medical personnel.

The successful implementation of HUD-VASH at the local level requires extensive collaboration and coordination between the VA and the local PHA. Working in close cooperation can significantly decrease the amount of time it takes to get a homeless Veteran placed in housing and can help to assure that the Veteran once placed in housing will be able to sustain the placement.

In this chapter you will learn:

- The specific roles of the VA and PHAs in implementing the HUD-VASH program;
- How the Housing Choice Voucher (HCV) Program operates including assistance provided, program requirements, Veterans obligations, and special provisions to assist people with disabilities to participate in the program;
- How the process of getting a Veteran into long term housing unfolds and steps that can be taken to facilitate this process; and
- How to support Veterans in their housing and prevent program terminations and/or evictions from housing and what to do in the event that a formerly homeless Veteran loses the HUD-VASH subsidy.

Introduction to Housing Choice Vouchers

Veterans who participate in the HUD-VASH program will receive long term rental assistance through HUD's Housing Choice Voucher program (HCV). This program is the successor to the 'Section 8' program and is often still referred to by that name.

The HCV program is administered at the local level by public housing agencies which are also referred to as housing authorities. These are locally chartered organizations, approximately 2,250 across the country and are authorized under state legislation. They range in size from those in major metropolitan areas with thousands of units to small rural PHAs, many serving fewer than 100 families. HUD issues detailed regulations on the HCV program but also allows PHAs considerable leeway in designing and implementing HCV programs to address local needs and circumstances. PHAs are allowed to establish local priorities for the types of households to be served through HCV, can adjust the amount of subsidy provided to address market circumstances, and can decide whether to include 'special housing types' such as cooperative housing, shared housing or congregate housing in their assistance program. PHAs are required to develop Administrative Plans every five years. These plans specify how the HCV program will be operated by the PHA and are required by HUD to be consistent with the local jurisdiction's Consolidated Plan, which in turn is expected to be consistent with the local Continuum of Care plan to prevent and end homelessness.

The goal is to coordinate all these federal housing resources in order to have maximum impact on locally identified needs.

In the 'regular' (other than HUD-VASH) HCV programs, PHAs are responsible for maintaining waiting lists, screening households for eligibility, admitting families into the program, verifying participant incomes and calculating subsidy amounts, determining whether rent charges are 'reasonable', inspecting housing units to confirm that they meet Housing Quality Standards (HQS), and processing regular subsidy payments to landlords. In HUD-VASH, some tasks such as referrals to the PHAs and prioritizing Veterans for assistance are handled by local VA Homeless Programs. In all other tasks, the PHAs and VAs cooperate to assemble necessary documentation and assist homeless Veterans to secure and execute leases for housing assistance.

The great majority of assistance provided through HUD-VASH comes in the form of 'tenant based rental assistance' (TBRA). In TBRA, assisted households locate their own housing from among existing rental units in the community. Eligible Veterans are free to choose housing anywhere in the catchment area of the VAMC or CBOC provided that the VA can effectively deliver case management services to the selected location. The limitations on Veteran's housing choice in the HCV program include: the Veteran must be able to afford the housing (with the addition of the housing subsidy), the unit must meet HUD's Housing Quality Standards (HQS), and the landlord must be willing to rent to the Veteran and enter into an agreement with the PHA. (See section about HUD's HQS later in this chapter.)

In some limited instances, HUD-VASH assistance is also used for 'project-based' vouchers. In this instance, the housing subsidies are 'based' in specific apartment buildings that meet HUD requirements and pass HQS. Veterans assisted through project-based HUD-VASH vouchers agree to live in specific buildings often with other Veterans and/or other eligible families.

Fitting the partnership that is the HUD-VASH program, local PHAs and VAs have separate criteria and roles in determining initial and continuing eligibility. These roles are summarized in the following chart.

Eligibility Determination Summary		
Issue	**Role: VA**	**PHA**
Prioritizing Assistance	The VA determines which homeless Veterans are appropriate for referral. Policy is for programs to serve at least 65% chronically homeless Veterans	PHAs are not involved in determining whether the Veteran is homeless or is eligible for VA benefits.
Determination of homelessness	The VA determines the Veteran's homeless status using the definitions of 'homeless' and 'chronically	Once the VA makes these determinations and confirms that the Veteran is willing to

Eligibility Determination Summary		
Issue	**Role: VA**	**PHA**
	homeless' under the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009.	participate in case management, the Veteran is then referred to the PHA.
Health care eligibility determination	The VA is solely responsible for determining whether the Veteran is eligible for VA provided health care services	
Service record and discharge status eligibility determination	The VA will determine whether the Veteran is eligible based on the nature of separation from active duty. The DD-214 is required as documentation.	
Case management needs	The VA determines whether the Veteran is willing to participate in case management provided by it. Failure to engage or participate in case management could be reason to terminate or deny participation in HUD-VASH. If, in the determination of the VA, case management is no longer required to maintain housing stability, the Veteran can continue to receive the HUD-VASH housing subsidy.	
Income eligibility for initial program participation	HUD-VASH workers should discuss income eligibility requirements prior to referral to the PHA. The income limits should be explained as well as the requirement to pay rent and to otherwise abide by the terms of the lease.	The PHAs are responsible for collecting and verifying income information, determining whether the Veteran is income eligible to participate, and calculating subsidy amounts. If the Veteran and his/her family total income exceeds the maximum threshold (50% of the area median income), the PHA will determine that the Veteran is ineligible.
Sexual Offender Status	Prior to referral to the PHA, the VA should assess whether the Veteran or any member of his/her household is on a lifetime sexual offender	PHAs are required to refuse an application for HUD-VASH if any member of the Veteran household is subject to lifetime

Eligibility Determination Summary		
Issue	**Role: VA**	**PHA**
	registry in any state. If the offender is the Veteran, the household will be ineligible; if the offender is another member of the household, the family can be served provided that the offender does not live with them.	registration under a sex offender registration program in any state. If the offender is a family member other than the eligible Veteran, the family can only be served if that member is permanently removed from the household.
Assessment of housing quality	The housing search process should be assisted by the VA case manager, peer support specialist or other members of the VA care team. VA staff should be familiar with HUD HQS and avoid units that clearly will not meet the standards. The case manager and Veteran should evaluate potential housing units while considering recovery and treatment goals	Prior to a Veteran receiving approval to occupy a housing unit with a HUD-VASH subsidy, the PHA must conduct an inspection of the unit using HUD HQS. PHAs must also determine that the rent requested by the landlord is 'reasonable'. Housing quality and family income must be re-inspected and re-verified annually.
Tenancy Obligations	HUD-VASH is a lease based program; provided the Veteran and his/her family abide by the terms of the lease, they must be allowed to maintain occupancy. VA case managers should be familiar with the terms of the lease and obligations of tenancy, be a secondary point of contact for landlord in the event of issues arising with the Veteran, and assist the Veteran in meeting financial obligations including maintaining utilities and paying his/her required rent payment.	Landlords are required to notify PHAs before commencing any eviction actions and eviction is only allowable through court order. If a Veteran in HUD-VASH is evicted from a unit, the PHA may terminate the HUD-VASH voucher and end the Veteran's participation. This decision can be appealed and the VA is authorized to re-refer a Veteran for another voucher, if the VA determines this is in the Veteran's best interests. PHAs may only deny new voucher requests if the Veteran is over-income or if he/she or a family member is on a sex offender registry.
Changes in family composition	After initial lease up, the addition of any family member to the household requires PHA approval according to	The PHA is only obligated to add family members as a result of birth, adoption or court-

Eligibility Determination Summary		
Issue	**Role: VA**	**PHA**
that may add persons to the housing unit.	the PHAs normal standards and not the HUD-VASH criteria. Therefore, some family members may be denied participation. To avoid this, the VA Case Managers should assist the Veteran in identifying all family members that might plan to live in the housing and include them as part of the initial referral to the PHA.	awarded child custody. In all other cases, the PHA may use the criteria specified in its Administrative Plan to determine whether it will permit additional family members to join the household in the assisted unit.

Table 2. VASH Eligibility Determination Summary

The VA determines eligibility and prioritization for HUD-VASH. Eligibility is based on whether the Veteran meets HUD's definitions of "Homeless" and "Chronically Homeless" [HUD Homeless Definition Final Rule: https://www.hudexchange.info/resources/documents/HEARTH_Homeless_Definition_FinalRule.pdf] . In addition to meeting the homeless definition in order to be eligible for HUD-VASH, Veterans must: have an armed forces discharge status that meets eligibility requirements, be eligible to receive health care services from the VA, and be willing to participate in VA provided case management. The discharge status and VA health care eligibility are determined by the Veterans Benefit Administration. VA HUD-VASH case workers make the determination as to whether the Veteran is homeless will participate in case management.

Prioritization: The VA's goal has been to target at least 65% of the HUD-VASH vouchers to Veterans experiencing Chronic Homelessness. Priority should be given to Veterans who meet the chronic homeless definition. When vouchers are available, priority should be given to chronically homeless Veterans. When interest lists are maintained, priority on any list should be given to chronically homeless.

The PHA verifies documents and income information, ascertains sex offender status, reviews documentation on all family members, and confirms that household income does not exceed 50% of the area median income (information found here: http://www.huduser.org/portal/datasets/il/il2014/select_Geography.odn). PHAs will be seeking government issued documents that provide Social Security Numbers for all household members, photo identification and evidence of legal immigration status. The PHA will also seek third party documentation of all reported income.

The Operating Requirements for the HUD-VASH program developed by HUD [http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-7081.pdf] requires PHAs to accept the *Certificate of Release or Discharge from Active Duty* (DD-214) or the VA verified *Application for Health Benefits* (10-10EZ) as verification of SSN and cannot require the Veteran to provide an SSN card. These documents must also be accepted for proof-of-age purposes in lieu of birth certificates or other

PHA required documentation. Photo IDs issued by the VA must also by accepted by the PHA if it requires such identification. These cards may also be used to verify SSN and date of birth. However, if the household contains non-Veteran family members, these members will be required to produce evidence from non-VA sources that they are eligible.

The PHA will then conduct a 'briefing' in which the HCV program will be explained and information provided on the housing search process. PHAs and their counterpart VAs have, for the most part, developed procedures for conducting these briefings for HUD-VASH Veterans, coordinating group sessions, having a regularly scheduled session for Veterans, and tracking the accomplishment of this step and the issuance of a HUD-VASH voucher.

Once the voucher has been issued the Veteran and his/her family have up to 120 days to locate housing and submit a Request for Tenancy Approval to the PHA (RFTA). However, Veterans participating in the VA's supportive housing program are encouraged to work with their HUD-VASH case managers and staff to secure housing as quickly as possible. This occurs when the Veteran has identified a unit, the rent is affordable with the subsidy provided, and the landlord is willing to lease the unit to the Veteran. The Request for Tenancy Approval Form can be found here: http://portal.hud.gov/hudportal/documents/huddoc?id=DOC_11736.pdf. Once the RFTA has been submitted, the PHA will inspect the housing to make certain that it meets HUD Housing Quality Standards. A checklist containing the HQS requirements is found here: http://portal.hud.gov/hudportal/documents/huddoc?id=DOC_11775.pdf. It is recommended that VA case workers and peer specialists familiarize themselves with these inspection standards and use them to conduct a pre-check of the unit. Units that clearly will not meet the standards should not be submitted to the PHA. The checklist may also be shared with landlords who are unfamiliar with the housing choice voucher program to assist them in understanding the PHA's inspection process and what the PHA will be looking at when it

> **Serving households with no income**. The priority on serving chronically homeless people in HUD-VASH means that there is a strong possibility that long term homeless people eligible for HUD-VASH may not have any income (earned or benefit income) at the time of enrollment. From a case management perspective, participants with no legitimate source of cash money are highly challenging and the first order of business will be to arrange regular income for the Veteran. PHAs are allowed to charge minimum rents and are frequently reluctant to admit households with no income into the housing choice voucher program. Please see section on "Hardship Requests" to address the situation

inspects the unit. All units assisted through HUD-VASH must be pass a HQS inspection prior to their being occupied by assisted Veterans. The units must be re-inspected on an annual basis. The landlord and the tenant (assisted Veteran) are required to cooperate with the PHA in the inspection process. In the event that the unit fails the initial or annual re-inspection the landlord will be given

the opportunity to make repairs and correct the condition(s) that caused the unit to fail inspection. If improvements are made, the landlord can request a re-inspection from the PHA.

In addition to verifying that the selected housing units meet HQS, the PHA must also determine that the rent being charged is 'reasonable.' Reasonable means that the unit's rent is comparable to that of similar non-luxury housing in a similar location with similar amenities. After passing HQS and the rent on the unit being determined to be reasonable, there are two remaining issues prior to the Veteran moving into the unit. First, the PHA must verify that the Veteran family will not be paying more than 40% of their adjusted income for rent on initial occupancy. This requirement is only for the initial occupancy and has no effect on any future rent increases or family income changes. The landlord must also be willing to incorporate

> **Unit Pre-inspection**
>
> The HUD-VASH Operating Requirements permit PHAs to pre-inspect units in order to maintain a pool of eligible units and to expedite the lease-up process. If a HUD-VASH family selects a unit that passed a HQS inspection (without an intervening occupancy) within 45 days of the date of the RFTA, the unit may be approved.

the 'Tenancy Addendum' into the lease [http://portal.hud.gov/hudportal/documents/huddoc?id=DOC_11738.pdf]. This addendum to the residential lease specifies the responsibility of the tenant and PHA, clarifies that there are no additional charges beyond the tenant rent payments, and specifies the grounds for the termination of tenancy and that evictions may only occur pursuant to a court order. Finally, the landlord must enter into a 'HAP Contract' (Housing Assistance Payment) with the landlord [http://portal.hud.gov/hudportal/documents/huddoc?id=52641.pdf]. The HAP contract specifies the PHAs obligation to the landlord and the landlord's obligations to the PHA under the housing choice voucher program.

HUD-VASH case managers can and should assist PHAs in assembling documentations to verify identity and income. HUD rules allow PHAs to accept original third party documentation verification of income supplied by applicants for vouchers. PHAs should work with Veterans and their families to ensure that documentation is in place for all members of the household.

Understanding the HUD-VASH Rental Assistance Subsidy

The subsidy provided to recipients of Housing Choice Vouchers pays the difference between the reasonable cost of decent, safe and sanitary housing and the required monthly rent payment of the Veteran and his/her family. The amount of the HUD subsidy cannot exceed the lesser of the reasonable rent or the HUD published Fair Market Rents (FMRs) [the current Fair Market Rents for all jurisdictions in the country can be found here: http://www.huduser.org/portal/datasets/fmr.html]. FMRs are inclusive of utility costs. Each PHA is required to develop a 'utility

allowance' schedule. These 'allowances' are projections of utility costs for energy conserving household. The allowance is based on the types of energy consuming appliances contained in the unit and the type of fuel (electricity, gas, etc.) used.

In a typical HUD-VASH situation, the Veteran's required rental payment (referred to by PHAs as the Total Tenant Payment or TTP) will first be applied to utility costs. For example, if a Veteran has a utility allowance of $60 and he/she is paying utilities, the first $60 of his rent (Total Tenant Payment) will be applied to utilities. If the $60 equals the tenant rent payment, then the Veteran has no further rent payment obligation and the PHA will pay the rent directly to the landlord. If the Veteran's required rent is greater than $60, he/she will pay the amount over the utility allowance directly to the landlord. If it is below $60, the PHA will either reimburse the Veteran or pay the overage directly to the utility.

Minimum Rent and Hardship Requests

HUD allows PHAs to charge a minimum rent not to exceed $50. The minimum rent is a flat rate and does not change based on a Veteran's actual income or lack of any income at all. The requirement for a minimum rent payment has constituted a barrier to participation by some homeless Veterans in particular those with no incomes.

HUD requires that PHAs grant exemptions to the minimum rent when the Veteran is unable to pay the minimum rent because of a long-term financial hardship. This includes cases where the Veteran is at risk of eviction because of inability to pay the minimum rent, loss of income or employment which makes it impossible for the Veteran to meet the minimum, a change in family composition such as a death in the family that results in a long-term inability to pay the minimum rent, or lags in benefits as a Veteran awaits receipt of VA, SSA, or other assistance benefits. If the Veteran is unable to pay the minimum rent and it poses a barrier to participation in HUD-VASH, the Veteran is eligible to seek a hardship exemption to the minimum rent.

When the Veteran requests a hardship exemption to the minimum rent, the PHA must:

- Temporarily suspend the minimum rent and adjust the voucher subsidy so as to not be based on the Veteran's payment of the minimum rent. This should be effective on the first of the month following the Veteran's notification to the PHA of his/her changed circumstances or inability to pay the minimum rent.
- Evaluate the hardship exemption request and determine if the hardship is temporary in nature or a long-term circumstance. If the hardship is not temporary, the PHA must provide a hardship exemption to the minimum rent. If, however, the PHA determines that the hardship is only temporary, the minimum rent will be reinstated retroactively to the date it was suspended. The PHA is required to offer the Veteran a reasonable repayment agreement for the minimum rent charges accumulated during the suspension.

If the PHA declines to offer the Veteran a hardship request, this is a decision that can be appealed. The appeal will need to demonstrate that the Veteran's inability to pay the minimum rent is based on a long term and continuing hardship and that failing to provide the hardship exemption will either force the Veteran to lose his/her housing assisted by HUD-VASH or not be able to end their homelessness with a HUD-VASH subsidy.

Although sometimes local PHAs have been reluctant to issue hardship exemptions, HUD is strongly committed to ending Veteran homelessness and if the requirement to pay a minimum rent is preventing a Veteran from leaving homelessness or posing a threat of a return to homelessness among Veterans who have been assisted, then VA case managers should work as closely as possible with their PHAs to arrange hardship exemptions.

Maximum Subsidy under HUD-VASH

The HUD-VASH subsidy can never be greater than the difference between the payment standard for a unit of appropriate size for the Veteran and his/her family and the Total Tenant Payment (explained below) required to be paid by the Veteran household. PHAs are allowed to set their 'payment standards' at between 90 and 110% of the HUD posted Fair Market Rents (FMRs). The lower payment standard may permit the PHA to serve a larger number of families but if the number is set too low, then families may not be able to locate decent, safe and sanitary housing which is affordable based on the payment standard. A higher payment standard will solve this problem but may reduce the number of households that may be served.

Calculating Income and Deduction

HUD-VASH participants are required to pay as rent the greater of: 10% of their total (gross) income, 30% of their adjusted income, or if there is housing component to their public assistance, the amount of public assistance funds allocated for housing costs. In the majority of cases, the Veteran's rent payment will be based on 30% of adjusted income.

HUD recognizes five adjustments to gross income to generate the adjusted gross income. Two of these adjustments apply to all households; the remaining three apply to elderly or disabled households only.

- All households are eligible for a **dependent deduction of $480/dependent/year**. To be a dependent, one must either be below 18 years of age or a full time student. Full time students are defined by the educational institution. Foster children do not qualify for the deduction nor does the household head or the co-head. There is no limit as to the number of $480 deductions a household may claim as long as there is a corresponding number of qualifying dependents.
- All households are eligible to deduct **'reasonable child care expenses.'** Childcare is provided for children under 12 years old when it is necessary to allow a household member

to work or to attend an educational program focusing on job skills/employability. The amount deducted for childcare cannot exceed the amount earned and the costs must be consistent with what typical families in the community pay for the service.

- Households headed by an **elderly or disabled person are entitled to an annual deduction of $400**. Only one such deduction is permitted per household. Elderly is 62 and over.

- Elderly or disabled households are allowed to deduct **excess medical expenses.** These are non-reimbursed cash expenditures for medical expenses (medications, insurance premiums, medical professional services, vision services, dental services, payments on medical bills, health care facility costs) which exceed 3% of the household's gross income. Although the household must be elderly or disabled to qualify for this, the medical expenses of all household members can be deducted.

- Disabled households are entitled to a deduction for **disability assistance expense.** This allowance covers care attendants and/or auxiliary apparatus for any family member who is a person with disabilities provided that these expenses are necessary for a family member (including but not limited to the person with disabilities) 18 years of age or older to be employed. The allowance is equal to the amount by which the cost of the care attendant or auxiliary apparatus exceeds three percent (3%) of gross annual family income. The amount of this deduction cannot exceed the income of the family member freed for work. Auxiliary apparatus includes wheelchairs, ramps, adaptations to vehicles but only if these items are directly related to permitting a member of the family to work.

- If the family is eligible for both the excess medical expense and disability assistance expense deductions, the amount of the deduction is equal to the sum of the medial and disability assistance expenses minus three percent of the gross family income.

Housing Persons with Disabilities

In addition to the additional income deductions available to persons with disabilities, people living with disabilities are entitled to some additional assistance and benefits to assure that they have equal access to participation in the housing choice voucher program. These include:

- The right to have the services of a 'live-in-aide', if needed;
- The right to request 'reasonable accommodations'; and
- Access to the 'earned income disregard' benefit.

Prior to exploring these additional benefits, its first necessary to clarify how HUD defines a 'person with disabilities.' This definition is found at 24 CFR 5.403. A person is considered disabled for the housing choice voucher program if:

1. He/she has a disability as defined in the Social Security regulations. At 42 USC 423 this is defined as: "an inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted, or can be expected to last for a continuous period of not less than 12 months"; or
2. He/she is determined to have a physical, mental or emotional impairment that:
   - Is expected to be of long-continued and indefinite duration,
   - Substantially impedes ability to live independently, and
   - Is of such a nature that the ability to live independently could be improved with more suitable housing conditions; or
3. He/she has a developmental disability as defined in 42 USC 6001 that is severe, chronic, persistent after early childhood, likely to continue indefinitely, and which results in functional limitations in multiple areas of major life activities.

Anyone receiving disability benefits from the Social Security Administration (Supplemental Security Income – SSI – or Social Security Disability Income – SSDI) is automatically considered disabled for the housing choice voucher program.

Disability as defined under category two above must be certified in writing by a state licensed clinician and that determination must reference the three factors listed – duration, impact on independent living, and potential for increased function with improved housing circumstances.

Live-in Aides

People who are live-in aides perform necessary functions for people living with disabilities in order to enhance their ability to live independently in the community. A person who is a live-in aide although living with the Veteran and his/her family is not considered by HUD to be a member of the household.

In order to be classified by HUD as a live-in aide, the person must meet HUD's definition which is found at 24 CFR 5.403. A 'live-in aide' is a "person who resides with persons with disabilities and who is: (1) determined to be essential to the care and well-being of the person(s); (2) is not obligated to support the person(s); and (3) would not be living in the unit except to provide the necessary supportive services." To be qualified as a live-in aide, a person has to meet all three conditions.

The definition does not directly exclude family members from being live-in aides but certain relationships such as spousal would not qualify since they are obligated to support the person with disabilities and would be living together regardless of live-in aide status. A parent or other relative of the person with disabilities might qualify since they are no longer obligated to support a person past the age of majority and in many instances would not otherwise be living in the same unit as the person with disabilities.

When a person meets the definition of a live-in aide, the following will apply:

▪ The person is not considered a member of the household and therefore his/her income is not considered for either eligibility or subsidy determination purposes; and
▪ The PHA must subsidize a unit with sufficient bedrooms so that, at a minimum, the Veteran and the live-in aide are able to occupy separate bedrooms.

Changes in VA caregiver support programs may result in alterations to these criteria for the VA programs. Spouses and other family members may now be eligible for caregiver assistance benefits. However, the VA's determination that a spouse is an eligible caregiver does not mean that the PHA is required to recognize them as live-in aides.

Earned Income Disallowance for Persons with Disabilities

This is an incentive for persons with disabilities to return to the labor force. It addresses the fact that as a housing choice voucher holder's income increases, his/her subsidy benefit from the program decreases. This 'disallowance' allows individuals with disabilities to engage in gainful employment and not experience a reduction in their subsidy for a limited period.

To qualify, a Veteran must meet the definition of a person with disabilities. Further, the increase in income must be as a result of employment; increases in benefit (unearned) income do not qualify for the disregard. Finally, the increase in income must fit into one of the following categories:

▪ An increase in employment income for a person with disability who had been unemployed for a year or more prior to the current employment; or
▪ An increase in employment income for a person with disability as a result of participation in any economic self-sufficiency or job training program; or
▪ An increase in employment income for a person with a disability during or within six months of receiving benefits from Temporary Assistance to Needy Families (TANF).

When these conditions are met, the housing choice voucher recipient receives the following benefits:

▪ For a period of twelve months, starting at the date of the increased employment earnings, 100% of the increased income resulting from employment is not considered by the PHA when calculating the rental assistance benefit. In the extreme case, if the participant had $0 income prior to the employment and had no other source of income, he/she would pay $0 for rent for the first 12 months post-employment.
▪ At the one year anniversary of the increased income resulting from employment and for the following 12 months, only 50% of the increased income from employment is counted for the purposes of subsidy determination.

- The benefit is tied to the actual dates of employment and not when the PHA performs an income recertification.
- Should there be an interruption in the period of employment; the benefit is suspended until earned income once again increases. However, once this benefit is initiated, there is a 48 month limit as to how long it will be available. At the end of the 48 month period, the benefit ceases regardless of the employment/income status of the Housing Choice Voucher (HCV) participant.

Reasonable Accommodations for Persons with Disabilities

Section 504 of the Rehabilitation Act of 1974 prohibits discrimination solely on the basis of a disability under any program or activity receiving federal financial assistance. The rule requires recipients of federal funds (PHAs in this instance) to ensure that individuals with a disability receive the equal opportunity to participate in programs and services in the most integrated setting.

Reasonable Accommodation

This is a change, adaptation or modification to a policy, program, service or workplace that will allow a qualified person with a disability to participate fully in a program, take advantage of a service or perform a job. Reasonable accommodations may include, for example, accommodations which are necessary in order for the person with disabilities to use and enjoy a dwelling including public and common use spaces. Since persons with disabilities may have special needs as a result of their disabilities, treating them the same as all others may not ensure that they have an equal opportunity to use and enjoy a dwelling.

The definition of a person with disabilities for the purpose of a reasonable accommodation differs slightly from that indicated above for the housing choice voucher program. Under Section 504, an 'individual with disabilities' is any person with physical or mental impairments that substantially limit one or more major life activities. The list of disabilities is long and includes learning disabilities, diabetes, alcoholism, emotional illness, cancer, heart disease, HIV/AIDS and more. It does not include current, illegal use of or addiction to a controlled substance.

PHAs are not required to take any actions that would result in a fundamental alteration in the nature of the program or that present an undue financial burden. PHAs are required to provide any accommodation that does not fundamentally alter the assistance program or provide undue financial burdens.

Examples of Reasonable Accommodations for Disabled Veterans in HUD-VASH

Application process:

- Providing additional time to supply required material to the PHA.

- Required PHA briefing on the housing choice voucher program provided in an accessible format or location.

Housing Search:

- Extending the housing search period beyond the minimum 120 day term
- Providing a higher payment standard (for an accessible unit or a unit located near transportation if such transportation is needed to access services related to the disability). The PHA can approve an increase of up to 110% of the Fair Market Rents and the local HUD office can approve a request to provide up to 120%.
- Granting permission to rent from immediate family members if this will allow a Veteran with disabilities to participate in HUD-VASH.
- Granting permission to use some of the 'special housing types' such as congregate housing or manufactured housing that is not otherwise allowable under the PHA administrative plan.

Leasing process:

- Allowing service animals to reside in the unit even if there is a no-pets policy.
- Assigning parking spaces for people with disabilities, providing assistance or special support to a person with disabilities around the disposal of refuse.
- Making reasonable modifications to the dwelling unit so that the person with disabilities can have the full enjoyment of the unit.

In requesting a reasonable accommodation, it is necessary to establish an identifiable relationship between the accommodation requested and the person's disability. PHAs are allowed to verify a Veteran's disability only to the extent needed to determine that the Veteran is qualified to reside in the housing and that there is an actual need for the requested accommodation. PHAs are not permitted to require that the Veteran allow them to access confidential medical records or to enquire into the specific nature of the disability.

Requests for reasonable accommodations can be made verbally or in writing but it is generally preferable to maintain a written record. A request should minimally include the following:

- Statement that the request is being made because the Veteran has a disability;
- Explanation of the specific accommodation being requested;
- An explanation of the relationship between the accommodation requested and the Veteran's disability that requires the accommodation.

The rights of disabled persons to equal access to HUD benefits and services are enforced by HUD's Office of Fair Housing and Equal Opportunity. HUD-VASH participants who feel that they are

experiencing discrimination because of their disability or any other proscribed reasons may obtain assistance from Fair Housing Agencies. These agencies can be located through an online searchable database found at: http://fairhousing.com/index.cfm?method=agency.search.

Locating Housing for HUD-VASH Participants

The great majority of the housing assistance provided through HUD-VASH comes in the form of tenant based rental assistance. This type of assistance allows participants to choose housing in the community that meets their needs provided that the housing meets HUD housing quality standards, the rent is 'reasonable', and that is affordable to the Veteran with the benefit of the housing subsidy. Participants have considerable freedom in choosing units provided that the specified requirements are met.

Participation in the program starts with locating suitable housing, submitting a request for tenancy approval (RFTA) to the PHA, ensuring that the landlord is willing to rent to the Veteran, and verifying that the Veteran family will not pay excessive rent on initial occupancy.

PHAs are able to provide limited support to assist this process:

- Providing lists of landlords who are willing to participate in the housing choice voucher program;
- Pre-inspecting units, if requested, in order to develop a pool of potential units for the Veteran to choose from;
- Assigning a single intake worker and inspector to work with the HUD-VASH program;
- Scheduling PHA housing choice voucher briefings on a special day to assist HUD-VASH participants.

The burden of locating a suitable dwelling unit and securing the landlord's permission to rent to the Veteran falls to the Veteran. This can be challenging logistically – being able to travel to view multiple possible dwelling units – and interpersonally – the Veteran has to explain the program and secure the cooperation of the landlord. This can also be a time consuming process which is restricted by the limitation that the housing search period may not exceed 120 days and the VA and HUD's goal of getting HUD-VASH vouchers under lease as quickly as possible.

There are a number of ways in which the VA can assist a Veteran in successfully completing the housing search process:

- In conjunction with the PHA convene one or more landlord fairs. These are events in which the HUD-VASH program can be explained to interested landlords. Ideally, they will include presentations by the VA on the importance of helping these Veterans and from landlords who are participating in the program.

- Through the use of peer specialists or VA case managers assist the Veteran in the search for housing. This can include providing transportation and assisting the Veteran in explaining the program to the landlord and in any negotiations that are needed to secure agreement.
- Training peer specialists or a VA case manager in the HUD housing quality standards. This will allow a preliminary review of the unit to occur and avoid time loss for unit inspections that will not meet the HQS standards.

HUD Housing Quality Standards

The housing choice voucher program provides participants with considerable opportunity to locate and lease housing of their choice in their community. As a matter of public policy and to prevent participants from having to live in substandard housing, HUD requires that all assisted units be inspected prior to occupancy and at least annually. If the unit does not meet the standards, the landlord has the opportunity to make repairs or improvements sufficient to bring it up to the requirements. When the repair work is completed, the PHA will re-inspect.

The inspection checklist for the housing quality standards [http://portal.hud.gov/hudportal/documents/huddoc?id=DOC_11775.pdf] covers each room in the dwelling unit, the appliances, sanitary fixtures, smoke detectors, lead based paint, as well as the exterior and general health and safety issues. It is recommended that VA workers print out this checklist and provide it to peer specialists or VA workers who accompany Veterans as they search for housing. This should prevent units that will not likely pass inspection from being referred to the PHA for inspection, which will otherwise likely delay the process of getting the Veteran into permanent housing.

PHAs Flexibility in Administering Housing Choice Vouchers

The housing choice voucher program is in many respects a partnership between HUD which provides the funding and establishes the regulations and local PHA agencies that administer the program. HUD allows the PHAs to craft voucher programs that are responsive to local needs and conditions. To ensure that PHA plans are consistent with federal requirements and consistent with local needs, HUD reviews and approves the PHA plans.

The Public Housing Agency Administrative Plan

HUD requires that PHAs adopt written Administrative Plans that set forth local policies for program administration. These are often posted on websites maintained by the PHAs or local government. VAs working with PHAs in the HUD-VASH program should obtain a copy of the PHA's Administrative Plan and familiarize themselves with its content and local policies.

The Plans must comply with HUD regulations and identify the PHA's policies in the areas in which HUD allows PHAs discretion to set local policy. HUD now also requires that the PHA Plans be

consistent with the local jurisdiction's Consolidated Plan which establishes general policies and specific action plans for affordable housing, community development and special needs housing.

The table below presents a number of variations that are allowable in PHA Administrative Plans that can affect homeless Veterans who are accessing the HUD-VASH program:

PHA Plan Requirements that may affect homeless Veterans	
Subsidy Standards	Each PHA is allowed to establish its own subsidy standards for determining the unit size requirement for families of different sizes and compositions. These will determine what size a unit the family will be subsidized for.
Absence from Unit	Families may be absent from their units for limited periods of time and continue to receive rental assistance. A Veteran, for example, may be hospitalized for a brief period. The HUD regulations limit this absence to no more than 180 days in any given year. PHAs, however, in their Plan may limit this period to less than the HUD maximum. If the PHA has set the period below 180 days, a disabled Veteran could request a reasonable accommodation to extend the period for up to the HUD maximum of 180 days.
Payment Standards	HUD sets the Fair Market Rents on an annual basis for each market in the country. PHAs are allowed to set their payment standard at anywhere between 90 and 110% of the FMR. If the PHA chooses a standard below the FMR, that becomes the limit on the subsidy in the jurisdiction. However, participants who are disabled can request a higher payment standard as a reasonable accommodation if the need for a higher standard can be linked to the disability.
Minimum Rents	HUD allows PHAs to charge a minimum rent of up to $50/month. This rent may be charged regardless of the participants actual (or lack of) income. If the PHA sets a minimum rent, it must also establish a process for requesting and granting hardship exemptions to the minimum rent.
Policies on Special Housing Types	HUD regulations allow housing choice vouchers to assist a range of housing options including: homeownership, cooperative housing, manufactured housing, group homes, congregate housing, and shared housing. PHAs are allowed to identify which if any of these special housing types they will assist. However, HDU requires that PHAs allow special housing types if needed for persons with disabilities.

Table 3. PHA Plan Requirements that May Affect Homeless Veterans

Definition of Family

24 CFR 5.403 "Family includes but is not limited to, the following, regardless of actual or perceived sexual orientation, gender identity, or marital status:

   (1) A single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person; or
     (2) A group of persons residing together and such a group includes but is not limited to:
        a.   A family with or without children
        b.   An elderly family
        c.   A near-elderly family
        d.   A disabled family
        e.   A displaced family and
        f.   The remaining member of a tenant family.

This definition means, in effect, that PHAs must recognize as 'families' any group of persons that identifies as such.

Moving to Work PHAs

Moving to Work (MTW) is a demonstration program for PHAs that gives them the opportunity to design and test innovative strategies for using federal housing assistance more efficiently, help residents to find employment and become more self-sufficient, and increase housing choices for low income families. Each PHA must apply to HUD for MTW designation. Currently about 40 PHAs participate in the program. A map showing all participating PHAs can be found here: http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/ph/mtw/mtwsites.

MTW agencies have the flexibility to make significant changes in the operations of their housing choice voucher program including increasing the percentage of rent that needs to be paid. Housing choice voucher programs operated by MTW agencies are significantly different than traditional voucher programs. In the initial stages of HUD-VASH, VAs that were working with MTW agencies experienced some initial confusion as MTW voucher programs work very differently than regular voucher programs.

However, HUD in establishing the HUD-VASH program specifically exempted HUD-VASH vouchers from the flexibilities and changes allowed for MTW agencies. Therefore even if PHAs are allowed to use different procedures because they are a MTW agency, they are required to follow the regular housing choice voucher procedures for HUD-VASH units. This is specifically indicated in

the   HUD-VASH   Operating   Instructions   issued   by   HUD   and   found   here: http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-7081.pdf.

Portability of HUD-VASH Vouchers

Another key element in the Housing Choice Voucher program is 'portability'; this is the right of any eligible family who has been under lease in the voucher program to relocate to anywhere in the US where there is a PHA operating a HCV program. This allows families to move to where there is greater economic opportunity or to relocate closer to family and other supports. In the regular HCV program, this right is obtained after the family has completed at least one lease term living within the jurisdiction of the PHA that originally issued it the voucher.

There are elements of portability in the HUD-VASH program but they operate considerably differently than in the regular program. In the regular voucher program, participants must initially locate a unit within the jurisdiction of the PHA that has issued the voucher. Only upon completion of that initial lease term, will the family be eligible to move outside of the PHA's jurisdiction with HCV assistance.

Scenario 1: HUD-VASH Voucher Recipient Moving within the Jurisdiction of the Servicing VAMC/CBOC

In a significant difference from the regular HCV program, HUD-VASH recipients on initial lease-up are allowed to live anywhere within the service area of the VAMC or CBOC where they obtain care. Provided that VA case managers are effectively able to provide services, the Veteran is not required to choose a unit within the jurisdiction of the issuing PHA. The PHA into whose jurisdiction the Veteran is moving will administer the voucher (including inspections and subsidy payments) and bill the PHA to which HUD issued the HUD-VASH voucher. Because this is a significant change from the regular voucher program, some PHAs may initially be reluctant to allow this.

It should be noted that the payment standard on which the voucher subsidy will be based is specific to the jurisdiction where the unit is located. It may be higher or lower than that which is in effect for the PHA with the HUD-VASH vouchers but it will determine the amount of subsidy received. Also, if the Veteran is being issued a voucher for the first time, the income limits for participation will be based on the income standard in the jurisdiction in which the unit is located.

Veterans are able to move within the jurisdiction of the VAMC or CBOC at any point, provided that they are in compliance with their lease. If the lease has ended or the landlord is willing to allow the Veteran to end the lease, then the family can relocate to any housing that meets program requirements and that is sufficiently accessible for the VA to provide case management.

Scenario 2: Long Distance Moves – Outside of the Jurisdiction of the VAMC/CBOC
Unlike the regular voucher program, moves outside of the jurisdiction of the servicing VAMC/CBOC are more challenging: it is allowed but ONLY if the VAMC/CBOC serving the area where the housing is located have available case management and a HUD-VASH voucher slot. It is entirely at the discretion of the VAMC/CBOC where the Veteran is seeking to relocate of whether to admit the relocating Veteran.

In many instances there will be existing 'interest lists' or priorities for accessing assistance established by the VAMC/CBOC in collaboration with local homeless continuums of care. There is no requirement to prioritize moves from other VAs so there is no assurance that this form of portability will be available.

However, if the VA has determined that the HUD-VASH recipient is no longer in need of case management, there are no restrictions on portability and the Veteran and his/her family would be able to move to any jurisdiction where there is an operational HCV program.

If the VA determines that case management is no longer required, the PHA *may* offer the family continued HCV assistance with one of its regular vouchers and free up the HUD-VASH voucher for another eligible homeless Veteran. This is entirely at the option of the PHA. In this instance there would be no need for the Veteran to be on the PHA waiting list, as a HUD-VASH participant, he/she is already a participant in the HCV program and can transfer from a HUD-VASH voucher to a regular voucher. If the PHA has no regular vouchers to allocate to the Veteran, he/she will continue to use the HUD-VASH voucher even if VA provided case management is no longer required. Should the Veteran family move from a HUD-VASH voucher to a 'regular' voucher, all the standard policies of the regular voucher program would then apply to that family.

Keeping Veterans Housed in HUD-VASH

HUD-VASH is a lease based program. Participants have the protection of a lease including mandatory lease provisions that must be included in order to receive assistance under the HCV program.

Participants have basic rights including:

- The right to live in decent, safe and sanitary housing that is free from environmental hazards such as lead based paint.
- The right to have necessary repairs made in a timely manner.
- The right of privacy. Landlords may only enter the unit for a reasonable business purpose and only after reasonable notice is provided in writing. In the event of an emergency where imminent risk to property or persons is present, the landlord may enter without advance written notice.

- If the landlord is not maintaining the unit, the PHA can re-inspect the unit and is authorized to without payments until the apartment meets HQS standards. The HUD-VASH participant is not allowed to withhold his/her portion of the rent but may notify the PHA and the landlord and the PHA can take steps to get the unit repaired.

Along with tenancy rights, HUD-VASH participants also have the obligations of tenancy. Failure to meet these obligations could be grounds for the landlord to seek to evict the tenant and could result in the loss of the HUD-VASH voucher (see Terminations, below).

Making sure that HUD-VASH participants are aware of the obligations of tenancy is an important task for VA case managers and peer specialist staff. As a requirement of obtaining HCVs, HUD-VASH participants must do the following or risk loss of their voucher:

- Follow the terms of the lease; maintain utilities, make required payments to landlords, maintain sufficient sanitary standards, limit occupancy to persons named on lease, not engage in illegal activity;
- Provide accurate information to the PHA for annual recertification;
- Report changes in income and family composition; except for birth, adoption, or court-ordered custody, written approval must be received in advance from PHA prior to adding household members
- The unit must be the sole residence;
- The unit cannot be without the Veteran or family members living in it for longer than 180 days; family members can be temporarily absent but the unit must be occupied.
- HUD-VASH participants cannot vacate an assisted unit without first notifying the PHA.
- Allow the PHA to inspect the unit annually and at other times, as required.

The lease and the required addendum require that the landlord only evict through legal action and upon securing a court order. In many instances, eviction can be prevented. Strategies on how to prevent eviction are discussed in the Working with Landlords Chapter. This chapter covers the PHA aspects of program termination.

Terminations

Although PHAs will frequently terminate vouchers upon the eviction of the participant, they are not required to do so. The PHA enters into a Housing Assistance Payments (HAP) contract with landlords. According to the terms of that agreement, it automatically terminates upon termination of the lease which will occur as a consequence of eviction. In the regular HCV program, termination of the HAP contract will almost always result in termination of the voucher. However, HUD-VASH provides additional opportunities for Veterans to retain their housing assistance.

HUD-VASH differs significantly from regular vouchers when it comes to accessing voucher assistance after being terminated from the program. In the regular program, termination would, at a minimum, put the household at the bottom of a very long waiting list. Depending on the specific PHA Plan and the reasons for the termination, they might be restricted from the program.

HUD-VASH only allows PHA two reasons for denying a voucher to an eligible Veteran: the household is over-income for the jurisdiction in which application is made and/or any member of the household is on a lifetime sexual offender registry in any state. Therefore any Veteran family terminated from the HUD-VASH program would have to be issued a new voucher from the PHA if the VA made the decision to re-refer the Veteran for a voucher.

Because the HUD-VASH program is intended to be a partnership between HUD, the VA and the local PHAs and because re-issuing vouchers is a time consuming process, HUD strongly encourages the VA and the local PHA to communicate prior to terminating any vouchers. The VA should inform the PHA of the intention to re-refer a Veteran, if this decision has been made, and should review with the PHA steps that will be taken to prevent the Veteran from once again placing his/her housing and voucher at risk.

The allowable causes for terminating a lease and tenancy include:

- Serious or repeated violation of the lease including failure to pay rent and/or failure to maintain utilities.
- Criminal activity including threats to health and safety of other residents, PHA or landlord employees, violence or drug related activity.
- Disturbance of other tenants.
- Destruction of property.
- Living or housekeeping habits that cause damage to the unit or premises.

However, actual or threatened domestic violence cannot be used as grounds for the termination of the lease of the victim of the violence or threats.

PHA Appeals Process

Prior to terminating any HCV participant, a PHA must provide the opportunity for an appeal of that decision through a process referred to as an 'Informal Hearing.' Any notice to terminate a HUD-VASH voucher from the PHA must contain notice of the right to an Informal Hearing. The notice to terminate must include:

- A statement of reasons for the decision;
- A statement that an informal hearing can be requested if the participant does not agree with the PHA decision; and

- A deadline for submitting the request for a hearing.

As part of its Administrative Plan, the PHA is required to specify how the appeals process will be conducted. HUD requires that:

- The informal hearing cannot be conducted by the person who made the decision under review or a subordinate of that person;
- The HCV participant must be given the opportunity to present oral or written objections to the decision; and
- The PHA must provide prompt written notification of its final decision after the informal hearing, including providing a written statement of the reasons for the final decision.

The participant facing termination is entitled to be represented at the hearing (legal or otherwise) but the PHA has no obligation to pay for this representation. In making the final decision, the PHA must consider 'mitigating circumstances related to the disability of a family member.' The PHA needs to consider whether reasonable accommodations should be provided to a disabled participant to enable them to continue in the program. If the decision to terminate was related to alcohol or substance use, the PHA may predicate its decision on the Veteran's participation in treatment and rehabilitation as a condition for continued HCV participation.

In addition to appealing a decision to terminate a Veteran from HUD-VASH, informal hearings can also be used to appeal: income, tenant payment and utility allowance determinations, unit size decisions, and denials of hardship exemptions to the minimum rent and denial of admission of additional household members.

ASSESSMENT AND TARGETING

Introduction

T he success and cost-effectiveness of permanent supportive housing as a solution to addressing homelessness is directly related to the degree to which the intervention is effectively targeted. This is for two reasons. First, permanent supportive housing is uniquely suited to serve the subset of people experiencing homelessness whose complex health and behavioral health conditions necessitate a combination of long-term rental assistance and ongoing supportive services in order to achieve and maintain housing stability. For this subset of people experiencing homelessness, permanent supportive housing has been shown to be unparalleled in improving housing stability, while supporting physical and behavioral health. When targeted to high utilizers of health care services, supportive housing has also been shown to achieve public cost offsets by decreasing the use of emergency health care and correctional services. Paradoxically, however, the people who benefit the most from permanent supportive housing (those with intensive and complex service needs) are often the least equipped or tenacious about seeking assistance. Proactive targeting strategies can ensure that permanent supportive housing reaches this high-need and often high-cost subset of homeless individuals.

Second, more deliberate and intentional targeting can also ensure that housing assistance is matched appropriately to levels of need, resulting in a more efficient use of resources. Resources needed to create and operate permanent supportive housing are not insignificant. To ensure its cost-effectiveness, permanent supportive housing should be provided to people who truly require the level of support it provides. Many people experiencing homelessness do not have complex behavioral health conditions and do not need long-term rental assistance and supportive services to exit homelessness. For such people, either affordable housing without long-term supportive services or short-term rental assistance with time-limited services (e.g. rapid re-housing assistance) may be sufficient and appropriate. Providing permanent supportive housing may be unnecessary and costly. Moreover, research suggests that providing intensive interventions to populations with lower needs can actually have a negative effect, as it can disrupt natural support systems.

Thus, the effective targeting of permanent supportive housing is both about ensuring that it is reaching the highest need (and highest cost) people, while also ensuring that is not being used for people who do not need its level of support. This chapter provides an overview of targeting

strategies for permanent supportive housing to achieve both goals, including responsive and proactive approaches, prioritization, outreach and engagement, and Housing First.

What is Targeting?

'Targeting' refers to the approach by which a particular intervention reaches and serves its intended or desired population. In contrast to program 'eligibility,' which defines who a particular program *can* serve (typically based on laws and regulations), targeting has to do with who a program *should* serve—that is, who is most appropriate for, or in need of, a particular intervention. In some cases, eligibility and appropriateness for a program or intervention may be closely aligned or identical. There are many cases, however, when eligibility and appropriateness differs, wherein who is eligible for a program is broader than who is appropriate for it. Policymakers may be reluctant to make eligibility overly restrictive through legislation or regulation. Or in some instances, knowledge gained over time—through trial and error or through program evaluation—may have refined thinking on who is best suited or most appropriate for a particular program or intervention, but previously established eligibility for program remains unchanged.

In the case of permanent supportive housing, many or all people experiencing homelessness may be eligible for permanent supportive housing, depending upon its funding sources. However, the population for whom permanent supportive housing is the most appropriate intervention is the subset of people experiencing homelessness with disabling health and behavioral health conditions, particularly people experiencing chronic homelessness. Targeting strategies help to ensure that permanent supportive housing is provided to the subset of eligible people who are most appropriate for this intervention. For example, eligibility for the HUD-VA Supportive Housing (HUD-VASH) program is open to all Veterans experiencing homelessness. However, HUD-VASH is best suited to serve the subset of Veterans experiencing chronic homelessness as well as those with disabling conditions.

It is possible to both under-target as well as over-target an intervention. Under-targeting is when a program is serving people who do not truly need the level of support it provides. Over-targeting is when a program serves people whose needs are so severe that the level of support provided is inadequate. Given permanent supportive housing's intensity of support, there is greater danger of under-targeting than over-targeting. However, there may be rare instances when a person's service needs are so complex or severe that they will require a setting that has a higher level of care than permanent supportive housing.

At a minimum, permanent supportive housing should be targeted towards people (including Veterans) experiencing chronic homelessness, defined as four episodes of homelessness in the last three years or a minimum of one year of continuous homelessness. Other individuals experiencing homelessness who have high or severe service needs should also be considered. Various approaches

can be adopted to ensure that permanent supportive housing is reserved only for people who truly need the level of support it provides and reaches people with the most severe needs. These approaches are discussed in the next section.

Approaches to Targeting: Responsive and Proactive

There are essentially two approaches to targeting in permanent supportive housing—targeting strategies that are responsive and targeting strategies that are proactive.

Responsive Targeting - Coordinated Assessment

Responsive targeting strategies focus on the question of who, among a given set of people known to be experiencing homelessness, is permanent supportive housing the most appropriate intervention. Responsive targeting is essentially a triage function, in which people are sorted into levels or categories of need based on specific criteria, typically through some form of assessment tool. Permanent supportive housing is then offered to people identified with the highest needs. This approach is 'responsive' in that it responds or reacts to the high demand for homeless services or assistance.

Many communities are implementing responsive targeting through 'coordinated assessment' or 'coordinated entry.' Coordinated assessment is a process in which a community's homeless services and programs use a common set of criteria and/or a standardized and reliable tool to assess the needs and strengths of people experiencing homelessness in order to determine what level and type of assistance is most appropriate. Through coordinated assessment, community homeless services and programs can sort individuals and households known to the homeless service system based upon their needs and strengths, and identify which persons need permanent supportive housing and which can be served through other interventions such as affordable housing, rapid re-housing, or other interventions.
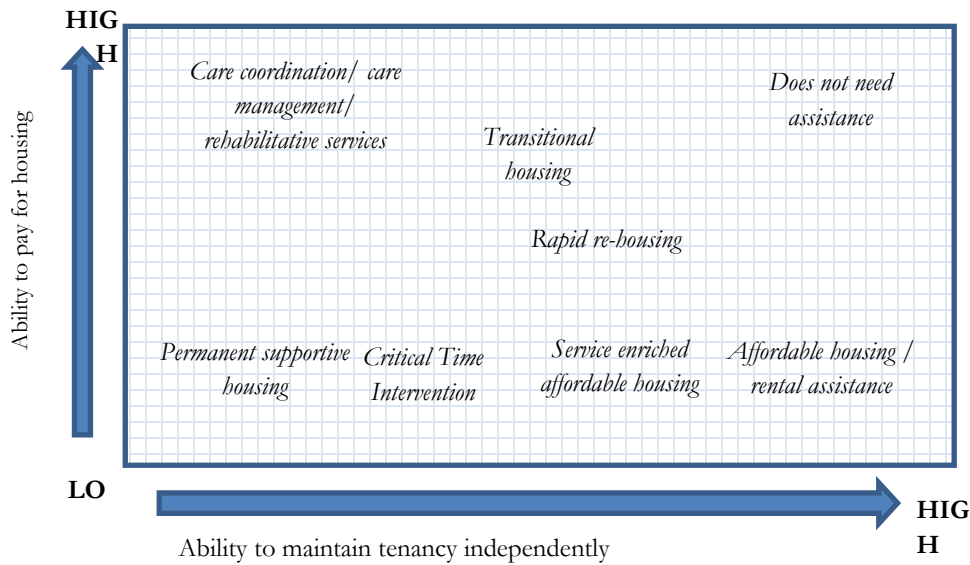
HIGH

Ability to pay for housing

Care coordination/ care management/ rehabilitative services

Does not need assistance

Transitional housing

Rapid re-housing

Permanent supportive housing

Critical Time Intervention

Service enriched affordable housing

Affordable housing / rental assistance

LO

Ability to maintain tenancy independently

HIGH

Figure 5. Coordinated Assessment Conceptualized

The starting point for coordinated assessment is valid and consistent criteria for sorting or triaging people into need categories. Ideally, the criteria used to sort people into need categories should be limited to two primary factors:

1) A person's practical ability to pay for market-rate rental housing and
2) A person's capacity to maintain independent tenancy.

As illustrated in Figure 1, permanent supportive housing is most suited to people who have the least ability to pay for market-rate housing (e.g. because of their disabilities and limited income earning potential through employment) and the least ability to maintain ongoing tenancy without supportive services. On the other hand, people who have limited ability to earn income, but who do not need ongoing supportive services to maintain successful tenancy may simply need affordable housing or rental assistance (to varying degrees). People who have greater earnings potential and the ability to maintain tenancy without assistance are not appropriate for permanent supportive housing.

The use of arbitrary or invalid criteria could lead to mismatches between interventions and levels of need, such as when people with less intensive needs are referred to permanent supportive housing or when people with high and complex service needs are referred to less intensive interventions. Another risk is when criteria is used that is not consistent with a Housing First orientation, such as when people are deemed unsuitable for permanent supportive housing simply on the basis of current   or   past   alcohol   or   drug   use.

In most instances, the criteria for sorting people into categories or levels of need will be operationalized through the use of an assessment tools and questions. Assessment tools and questions should be validated—tested to determine if they accurately measure the intended factor or characteristic—and reliable—tested to ensure that they produce consistent results. For the purpose of coordinated assessment, tools should also be brief easy to administer, and trauma-informed. People being assessed should feel safe and comfortable responding to questions. Both the tool and the person administering the tool should recognize that many people experiencing homelessness have experienced trauma in their lives and that sensitivity should be exercised when exploring certain subjects or experiences.

Coordinated assessments should also be person-centered, non-directive, and uphold client choice. People experiencing homelessness understand their circumstances and what they need. When various interventions are clearly explained, they can be the best judge of whether a particular option or intervention is appropriate. Coordinated assessment should also not restrict housing choices under any circumstances. The choice over one's housing is not only a legal right, but also a major determinant of housing satisfaction and success.

A key limitation of responsive targeting approaches such as coordinated assessment is that these strategies tend to focus primarily on people who are already known to the homeless services systems. Simply put, coordinated assessment works to the extent that people are available and present to be assessed. Individuals with sporadic and episodic encounters with homeless service settings—such as people who experience unsheltered homelessness or people who cycle in and out of institutional settings such as hospitals and jails—are less likely to be assessed through a coordinated assessment process. A second limitation with coordinated assessment is that even the most astute assessment tools are prone to error and severity may be underestimated. Many people experiencing chronic homelessness who have severe needs may not present as such. For instance, people with serious mental illnesses sometimes exhibit "negative" psychiatric symptoms—being reserved, quiet, and withdrawn—and consequently, may not be assessed as having high needs, despite having significant barriers to independent living in housing.

Proactive Targeting - Case Finding

To ensure that these individuals are reached, communities can also adopt targeting strategies that proactively seek out persons who need permanent supportive housing. Proactive targeting strategies typically involve efforts to actively identify and recruit people who are both appropriate candidates for permanent supportive housing, but also those who are less likely to seek out assistance on their own. It can also involve strategies to identify people who have particularly high or severe service needs, as evidenced by their vulnerability or their high utilization of public services.

Proactive targeting begins with case finding, which can be performed in one of two ways. One approach entails coupling homeless outreach with screening tools or instruments like vulnerability

indices that identify people with severe needs. This approach may be particularly useful for identifying supportive housing candidates who experience unsheltered homelessness.

> *Example: Community Solutions' 100,000 Homes Campaign and Vulnerability Index*
>
> The 100,000 Homes Campaign is a national movement of communities working together with the goal of providing housing to 100,000 vulnerable individuals experiencing homelessness. The Campaign's model involves mobilizing social services staff and volunteers to canvas streets and emergency shelters and screen individuals experiencing homelessness through a Vulnerability Index—a tool designed to assess mortality risk factors associated with homelessness. All individuals are placed on a registry, which rank orders them based on their vulnerability score. Individuals with higher scores are prioritized for permanent supportive housing assistance.

(100K Homes Vulnerability Index can be found at: http://100khomes.org/resources/the-vulnerability-index.)

A second approach involves the analysis or matching of administrative data to identify persons whose patterns of service use indicates high needs. For example, Homeless Management Information Systems (HMIS) can be analyzed to identify persons with long histories and/or repeated use of homeless services which, when coupled with disabling conditions, may indicate high or severe service needs. HMIS data can be matched with healthcare and/or corrections administrative data to identify people with high utilization of multiple emergency services such as shelters, hospitals, and jails, who are likely to have complex service needs. Once cases are found, communities can create and target a specific list of identified persons who are potential candidates for permanent supportive housing to be engaged, typically through outreach.

> *Example: CSH's Frequent Users Systems Engagement (FUSE)*
>
> The Corporation for Supportive Housing (CSH) has worked with a number of communities to match HMIS data and administrative data from corrections and health care systems to identify individuals experiencing homelessness who are high utilizers or frequent users of public systems. Data matches result in a list of individuals who are engaged through outreach and in-reach and offered permanent supportive housing. Such outreach takes place within homeless service settings as well as jails, hospitals, and other institutional settings. Evaluations of FUSE efforts have found significant reductions in jail, emergency health, and other services following permanent supportive housing placement.

(Additional information about the FUSE model can be found at http://www.csh.org/fuse.)

A limitation of proactive targeting approaches is that they are not, by themselves, exhaustive and tend to favor the selection of particularly high need cases. Not all people who need permanent supportive housing may be identified as vulnerable, have a lengthy history of shelter use, or high utilization of emergency services. Moreover, administrative data, particularly when matched with other systems, is seldom complete, leading to the omission of some individuals. In contrast with coordinated assessment, proactive targeting also does not provide an answer to the question of what type of assistance or intervention should be provided to people who do not need permanent supportive housing.

Comparison of Responsive and Proactive Targeting		
	Responsive	**Proactive**
Addresses problem of…	Which persons, given a set of people known to homeless services system, need permanent supportive housing (versus other interventions)	How to reach persons who are less connected to homeless services (e.g. unsheltered) who have particularly high needs (e.g. high utilizers of emergency services)
Identifies appropriate candidates through…	Selection criteria, common assessment tool	Vulnerability index, Data-driven case finding (data matching)
Criteria for targeting	Functioning, severity of health status, independent living skills, etc. as assessed through a standardized and reliable tool	Duration/length of homeless services use; high utilization of emergency services
Limitations	May not capture people who are less known to homeless services (e.g. unsheltered, people with high mobility, people with frequent contact with hospitals and jails, etc.)	Tends to focus on highest need cases only; incompleteness of administrative data

Table 4. Comparison of Responsive and Proactive Targeting

Prioritization
Related to the concept of targeting is the concept of prioritization, which involves establishing a sequence or order in which people are provided with assistance.
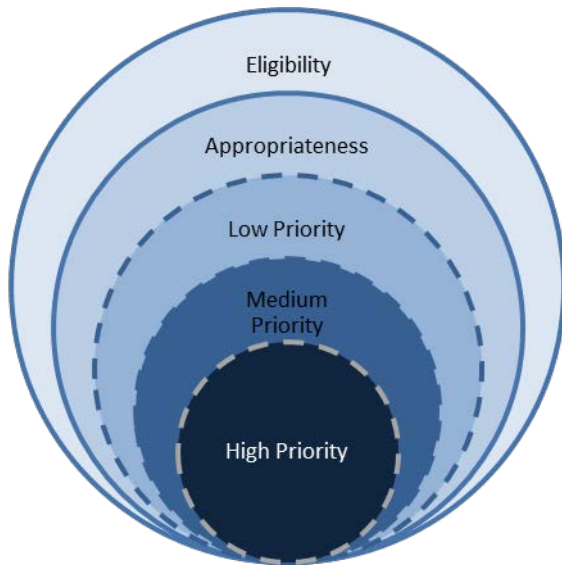
Figure 6. Prioritization

Among the subset of people experiencing homelessness for which supportive housing is most appropriate, criteria may be used to order people based on their severity of needs and adopt policies that ensure that people with more severe needs are given assistance before others who are appropriate or eligible. Prioritization may be important when supportive housing resources are scarce, as well as to ensure that people who have the greatest challenges are provided with assistance as they may be less able to self-advocate for assistance. In some instance, people may be prioritized for supportive housing because of their particularly vulnerability, such as have higher risk of premature mortality or acute illness.

When people are prioritized for permanent supportive housing based upon the severity of their needs, it is important not to mistake prioritization from appropriateness or even eligibility. While some individuals may be moved to "the front of the line" to receive assistance through permanent supportive housing, many more people may also legitimately need permanent supportive housing. If access to permanent supportive housing is limited only to those who are deemed to have highest priority, this will result in many people remaining homeless without viable alternatives.

Outreach, "In-Reach," and Engagement

Whether a community is using responsive or proactive approaches or both, targeting also requires effective and persistent outreach services to engage people identified as needing permanent supportive housing. This is because the very people permanent supportive housing is designed to serve may also be the least equipped to seek help or self-advocate. Lengthy and complex housing application and placement processes can also be overwhelming and lead to attrition prior to lease-up in housing. Persistent and often multiple attempts at engagement are needed to help people

overcome their fear or mistrust of services, as well as to help them navigate the housing application and lease-up process.

Outreach services should not be limited only to people who are unsheltered (e.g. sleeping on the streets, under bridges, in transit stations, or other places not meant for human habitation.) Outreach may also be thought of as "in-reach," where outreach services collaborate with emergency shelters, hospitals, alcohol and drug treatment programs, and jails, and are able to directly engage persons identified as needing permanent supportive housing in these settings.

Housing First and Housing Admissions Policies

Targeting strategies in permanent supportive housing will be successful only to the extent that people identified as needing permanent supportive housing actually obtain it. When supportive housing programs have tenant selection practices that screen out people with high service needs or criminal histories, this could undermine targeting practices. Therefore, targeting strategies in permanent supportive housing should be implemented alongside Housing First approaches, in which permanent housing is offered to people experiencing homelessness with minimal preconditions and barriers to entry.

In addition, the housing admissions and tenant selection policies of permanent supportive housing programs must accommodate or be in alignment with targeting and prioritization strategies. For example, permanent supportive housing programs should not admit tenants strictly on a "first come, first served" basis, but should incorporate tenant selection policies that give preference to people targeted or prioritized for assistance.

Combining Approaches

Responsive targeting through coordinated assessment and proactive targeting through data-driven case finding approaches are by no means mutually exclusive, but on the contrary, should be thought of as complementary. Communities can and should combine these approaches and implement them simultaneously to pursue a complete targeting strategy for permanent supportive housing.
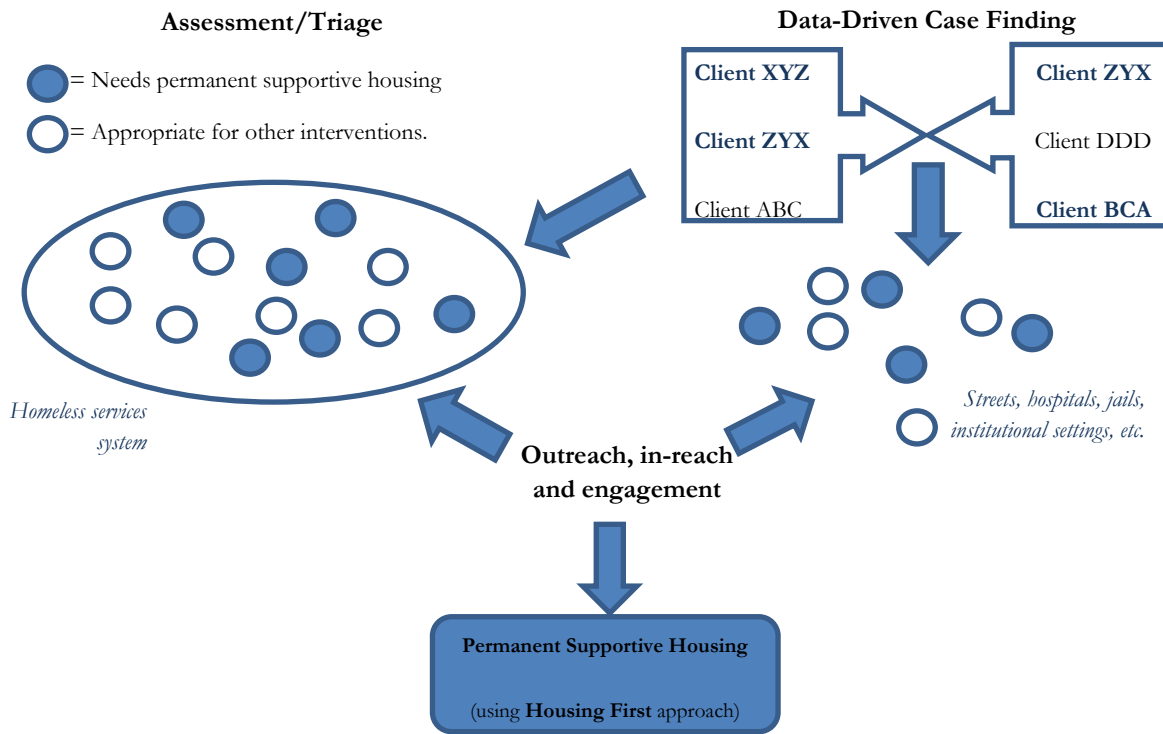
Figure 3. Combining Responsive and Proactive Targeting

Figure 3 illustrates how these approaches can be combined to implement a more comprehensive targeting strategy that distinguishes people who need and do not need permanent supportive housing, and also actively seeks out people who would benefit most from permanent supportive housing.

Community Example: King County, Washington (WA) Client Care Coordination

King County, Washington uses an approach for targeting permanent supportive housing in which individuals are identified, targeted, and prioritized for permanent supportive housing. King County conducts data analysis to identify and generate a list of high utilizers of health, behavioral health and corrections services. Vulnerability assessments of people experiencing homelessness are also conducted to create a separate list. The county then prioritizes people on either list for assistance through permanent supportive housing. Providers receiving county funds must provide housing within 50 percent of their supportive housing units to persons referred from these two lists.

(Client Care Coordination Supportive Housing Outcomes can be found at: https://www.kingcounty.gov/ healthservices/MHSA/MIDDPlan/MIDDCommittees/~/media/health/MHSA/ MIDD_ActionPlan/2011%20Handouts/Client_Care_Coordination_summary.ashx.)

Example: Community Shelter Board's Unified Supportive Housing System (Columbus, OH)

The Community Shelter Board's Unified Supportive Housing System (USHS) serves as the coordinated entry system for permanent supportive housing in Columbus, Ohio. Through this system, eligibility for permanent supportive housing is open to people who meet the HUD definition of chronic homelessness as well as other individuals experiencing homelessness. However, priority is given to people who meet HUD's definition of chronic homelessness. These persons are further prioritized using a numeric score, which is calculated based on a composite of the history and length of homelessness, high services utilization of county public services (determined through data analysis by the county Alcohol, Drug, and Mental Health Board), and vulnerability as assessed through an assessment tool.

(Useful resources related to USHS can be found at: http://www.csb.org/?id=resources.useful.ushs.)

Conclusion

There has been significant innovation in the last several years around the targeting of permanent supportive housing. At the same time, this innovation remains limited to specific communities or programs and inconsistently applied. Communities have pursued targeting strategies as pilots, without community-wide adoption. There has been an increasing emphasis among the Federal government on targeting and prioritization in permanent supportive housing. The U.S. Department of Veterans Affairs (VA) and U.S. Department of Housing and Development (HUD) have been pursuing policies that ensure that at least 65% of HUD-VA Supportive Housing vouchers are targeted at Veterans experiencing chronic homelessness. In its Fiscal Year 2013 Continuum of Care Program competition, HUD included significant incentives to encourage grantees to adopt policies that prioritize people experiencing chronic homelessness and those with more severe needs in permanent supportive housing. In July 2014, HUD also released a Notice providing guidance to grantees on the criteria and approaches to prioritization (available at: https://www.onecpd.info/resource/3897/notice-cpd-14-012-prioritizing-persons-experiencing-chronic-homelessness-in-psh-and-recordkeeping-requirements/).

As targeting practices become more widely adopted, there will likely be a greater array of tools and approaches, as well as greater community-wide adoption of these practices. As these targeting approaches mature and become established, research and evaluation is needed to test these approaches for their accuracy in selecting appropriate persons and their completeness in coverage. *(See Appendix III: Additional Resources for some examples of these tools and approaches.)*

Chapter

8

HUD-VASH OPERATIONS

Background

Homelessness, a significant national problem, has many causes. Individuals suffering homelessness are usually unemployed, unable to work, or have such a low income that they cannot access safe affordable housing. Frequently, those experiencing homelessness have disabling mental health, substance abuse, or physical conditions that lead to, or compound, their homeless situation. Families undergoing homelessness are more frequently seen now than in the past when single individuals were the primary users of homeless services.

In 1992, HUD and VA piloted the HUD-VASH Program, which was revived and implemented nationally in FY 2008. Through FY 2014, HUD has approved funding for more than 68,000 HUD-VASH vouchers. Nationwide, more than 300 Public Housing Authorities (PHAs) have participated in the program. The President's budget request for FY 2015 would fund an additional $75 million in new HUD-VASH vouchers, bringing the total number of vouchers to more than 78,000 in 2014. While VA provides supports and assistance through case management services, HUD provides permanent housing stability to Veteran participants and their immediate families by allocating rental subsidies from its Housing Choice Voucher (HCV) Program. Additionally, provisions are included to allow for some limited Project-Based Vouchers (PBV) for locations with minimal affordable housing options.

VA's case management services, the heart of the program, are designed to support the Veterans' recovery goals and to accomplish stability in safe, decent, affordable, Veteran-chosen permanent housing. HUD-VASH vouchers are targeted to those Veterans who most need the case management and supportive services for successful sustainment; these are the most vulnerable Veterans who experience chronic homelessness, serious mental illness, substance use disorder histories, significant physical disabilities, or co-occurring disorders. Veterans create individualized "Housing Recovery Plans" with their case managers, focusing on the Veterans' long-term recovery and community integration goals. These plans often involve health care, resolving legal and financial issues, and addressing employment and income needs and increasing natural social connections and supports.

In this chapter, you will learn:
- Documentation (in HOMES and CPRS)

- HUD-VASH Program Model
- Outreach
- Assessment
- Case Management
- Ending Case Management
- Workload

Documentation

The initial documentation in the Homeless Operational Management and Evaluation System (HOMES) is important because it documents the Veteran's homeless status. Overall, documentation of all contacts and services is vital to the program and to the quality of the care provided to the Veteran. Documentation must include both submission of completed forms in HOMES and proper documentation of the contact in the Veteran's official medical record, contained in the Computerized Patient Record System (CPRS).

What is the Housing Operations Management and Evaluation System (HOMES)?

HOMES is an online data system that tracks homeless Veterans as they move through VA's system of care. This system streamlines the data collection and provides information to facilities and leadership on program effectiveness. HOMES is one way to measure outcomes in ending Veteran homelessness. HOMES data also allows VA and HUD to compare and communicate on Veterans in HUD-VASH who are matched at the personal identification level, improving the reliability of the data provided to Congress and other stakeholders.

The HOMES Assessment form is the first form that is completed for a new Veteran, starting the HOMES episode of care. The HOMES Assessment is important because effective program targeting and eligibility for VA Homeless Programs relies on the Veteran's homeless status, particularly in response to the questions related to homelessness (where slept last night and 30 days prior) and duration of homelessness. It is important to determine this part very carefully to ensure that the Veteran's actual homeless status is reflected up to the point of the HOMES Assessment. The Veteran will keep this status if they enter Residential Rehabilitation and Treatment Programs (RRTPs), Grant and Per Diem Programs, Healthcare for Homeless Veterans Contract Housing (HCHV- CH), and other VA non-HUD-VASH programs.

Please see the below flow chart for steps in using HOMES.
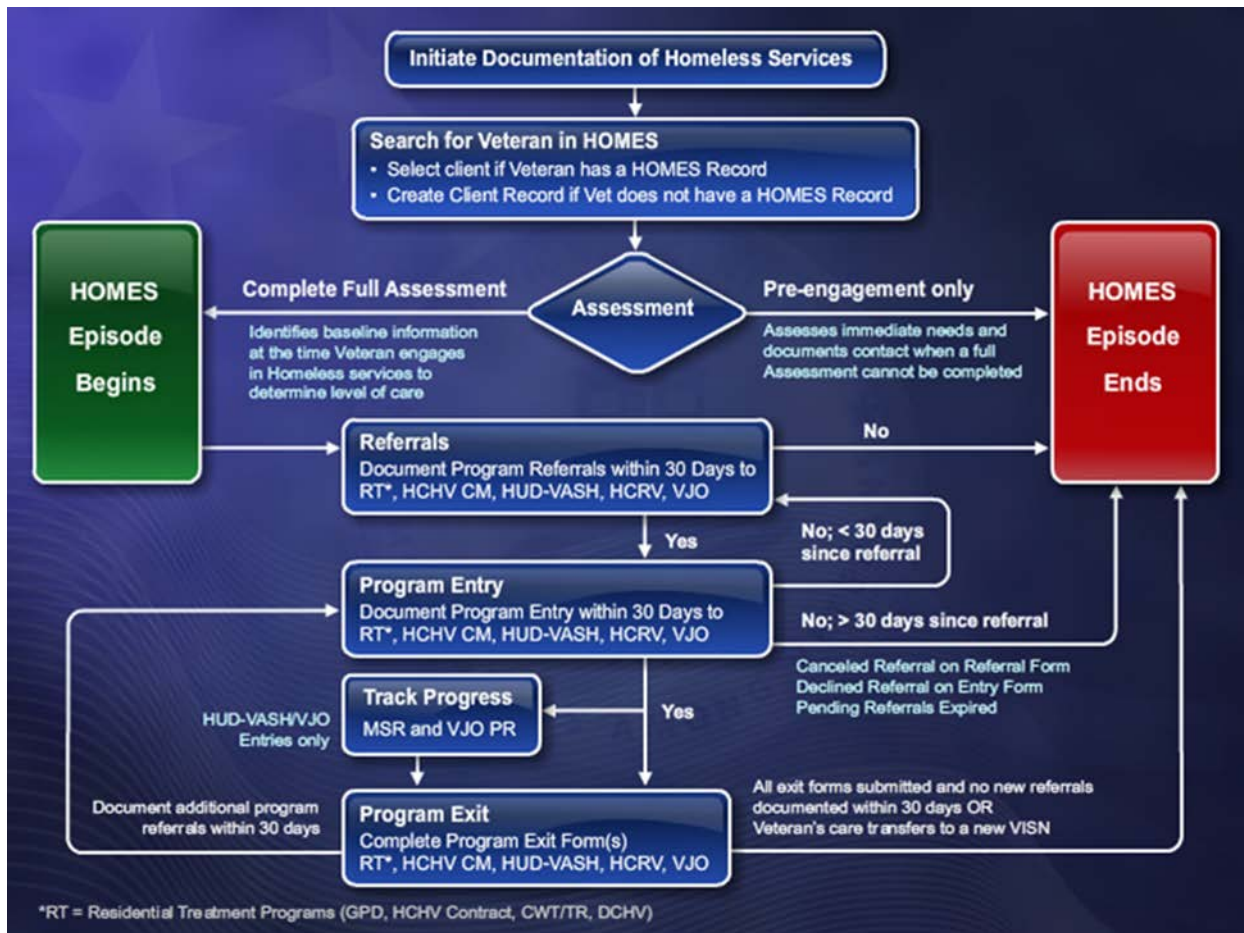
Figure 7. HOMES Flowchart

The number of Veterans discharged from the program, and the reason, must also be entered into HOMES each month. This is closely monitored and analyzed for the presence of any trends requiring further discussion with individual sites to guide potential areas for quality improvement.

Please see the HOMES site, at: https://vaww.homes.va.gov/VAHomes.aspx.

It is strongly advised for each case manager to keep a spreadsheet of the dates different housing steps were completed in order to: 1) reconcile clients' status with the PHA(s), and 2) reconcile HOMES submission errors. Performance Measures are pulled from HOMES data, so timely accurate completion is critical.

Computerized Patient Record System (CPRS) Documentation:

Good documentation is invaluable. Every facility has a documentation process and procedure. Be familiar with the guidelines those provide. The electronic medical record, CPRS, is a legal document, and because of this, it provides as much protection as goes into the documentation. Good documentation provides good legal protection, so always document contacts, and strive to consistently document professionally and completely, particularly in regards to progress on the plan and your risk assessment.

The case manager must seek appropriate consultation with supervisors and the NHC on adverse events to determine the next course of action. Case managers must document with a progress note and in HOMES when a Veteran leaves the program.

Progress notes should be placed in CPRS following all Veteran contacts. Progress notes provide information to other providers involved in the Veteran's care. Progress notes may take different forms depending on your particular facility. Most notes follow one of these formats:

- Data, Assessment, Plan – ("DAP" note)
- Subjective, Objective, Assessment, Plan – ("SOAP" note.)

Additionally, if the contact is not documented in CPRS, you are not getting workload credit for your efforts with the Veteran. This will impact staff funding.

In order to decrease paperwork duplication, HOMES forms can be copied and pasted into the CPRS record, but will require additional content to meet good documentation standards, including an assessment of the contact and a plan. Additionally, HOMES documentation in CPRS is not sufficient for the number of contacts a Veteran is expected to have, especially early in the program. Additionally, documentation includes the Biopsychosocial or other extensive history (depending on your profession) and a housing case management plan with plan updates as goals and objectives are met and new goals are developed. Lastly, changes in level of care must be well-documented as well as reasons Veterans were not appropriate for the program.

HUD-VASH Goals
HUD-VASH provides permanent supportive housing exits from homelessness with high quality case management services to eligible Veterans and their families; the goal is to sustain housing stability, and restore Veteran families to independent lifestyles fully integrated into the communities of their choice through Housing First recovery-oriented practices.

HUD-VASH Model
VA has moved from a treatment-first, "housing ready" model to a Housing First model where the client is first housed and the supportive services and case management are then wrapped around the client to sustain them in housing. Housing First is addressed more specifically in Chapter 2.

Case Management in HUD-VASH is a Veteran-centered, strengths-based approach, aimed to empower and partner with Veterans to effectively meet their individual needs to promote recovery and self-sufficiency. This model involves the use of skills and resources to advance the Veteran's capacity to cultivate natural supports and resources to achieve goals.

A multidisciplinary team model for case management is an evidence-based clinical practice patterned after the Assertive Community Treatment team model. Staff diversification may occur as new positions are funded to provide services for additional voucher allocations, or when there is turnover within the existing staff.

Case management is a care partnership between the Veteran and the HUD-VASH team, with the Veteran determining goals and service desired. The team works with the Veteran to assess the Veteran's status and needs, develop a plan to reach the Veteran's goals using effective strategies to achieve those goals. The team coordinates additional needed services for and with the Veteran, and works to provide the Veteran with information that will help the Veteran to evaluate and obtain the services to meet his or her health and social goals. The case management team communicates with, advocates for and assists the Veteran, with needed resource access. HUD-VASH utilizes established evidence-based practices, such as Housing First and Harm Reduction, to support the Veteran's stable housing and recovery goals.

Outreach

Engaging Veterans who are distrustful of "help," developing working partnerships with other agencies and individuals that have services the homeless Veteran uses, and developing smooth, Veteran-friendly processes are key to Outreach. VA will not be able to end Veteran homelessness alone, so working with, and in, the community is key to achieving that mission. Many communities are developing and using a coordinated entry process to simplify and speed homeless individuals to the services that can best help them. VA must be involved in those processes to ensure the community understands the eligibility requirements for VA homeless programs, and the VA referral process, developed with the community, is clear and efficient. If there is already an established coordinated entry process in your community, you need to learn how that is done and what your role is at your specific facility and in that specific community. VA usually crosses multiple Continuums of Care (CoC), so there may be multiple ways communities do referrals in your catchment area. Keep your local process as accessible, simple and unified with the community as possible.

Once you have the Veteran referral, you must engage with the Veteran. This can best be accomplished by treating the Veteran with respect, being honest and genuine with the Veteran, and by demonstrating a real interest in helping the Veteran to address the issues identified by the Veteran as problems, rather than those that you identify from your assessment of the Veteran. A good way

to frame this in your mind is to use a "what matters to you versus what's the matter with you approach." Peer Support Specialists or Peer Navigators are very helpful in engaging and working with Veterans eligible for VA's permanent supportive housing program, HUD-VASH.

Referrals

Once the HOMES Assessment is done, then the case manager makes referrals to the appropriate resources, depending on the Veteran's identified needs and goals.

As the Veteran's biggest need is usually housing, the first referral is to more stable "bridge" housing unless the local process provides same day permanent housing to the Veteran. As the HUD-VASH program is often unable to house a Veteran immediately into permanent supportive housing with their voucher, short-term safe housing must be arranged for the Veteran and any family living with them until they can be placed in their own permanent supported housing.

If the Veteran agrees to be seen by a primary care provider for a "vesting" physical, then that will need to be scheduled. Many facilities have same day physicals for Veterans so they are able to provide it without requiring a separate trip for the Veteran. Many Veterans have physical concerns and are willing to get the initial physical to get needed health care started. Other referrals and appointments should be arranged as fits with the Veterans goals and concerns unless there is a threat to harm self or others. In that situation, the Veteran does not have a choice and must be taken for a mental health evaluation to determine if admission to the inpatient unit for stabilization is needed.

Assessment

There are many different kinds of clinical assessments used in permanent supportive housing. The first assessment each Veteran will have is a screening for program eligibility, targeting those most in need of the case management and supportive services permanent supportive housing provides. This may be determined during the HOMES assessment or may be done independently. The Veteran's history of homelessness, vulnerabilities, risks, physical and mental health limitations, ability to function independently in the community, develop and utilize support systems, navigate complex systems, and ability to independently exit from homelessness are all factors to consider. Independent tools are available to help determine an objective score for admission, but those instruments need a detailed assessment to understand the Veteran's other immediate needs.

A full clinical biopsychosocial evaluation is required following admission to the program and provides a good starting place for permanent supportive housing services. More than meeting the facility's documentation requirements, a thorough history provides an opportunity to get to know the Veteran better, to identify strengths and challenges, and to find out what is important to the Veteran. It informs on the Veteran's social, economic, physical and mental health and other important history. This evaluation provides a starting point for developing a plan that makes sense to the Veteran because it is rooted in the Veteran's personal and unique history that led to the

Veteran's placement into permanent supportive housing. It is also important to update recent assessments by focusing on prior housing, loss of housing, and risk factors for homeless reentry, as well as protective factors for the Veteran. These will be extremely helpful in identifying risk factors for housing loss and strengths to build on to sustain housing.

The Veteran provides the case manager with his or her goals and priorities, and a plan must be negotiated to achieve those goals. The Veteran may not be able to articulate his or her housing needs well; case managers use what was learned in the assessments to help the Veteran to establish realistic and achievable goals. For example, the Veteran may want to live in an expensive and very much desired location, but this may not be realistic due to the lack of available affordable housing in that location. Focusing on the kind of unit and neighborhood characteristics may be helpful in developing a more realistic housing search plan. The assessment helps inform the case manager to ask the right questions to improve the housing fit and also inquire about other personal goals that the Veteran might like to achieve, or goals to prevent events that might jeopardize his or her housing status. Brief assessments form the backbone of the home visit and the progress note documenting that visit.

Every contact with the Veteran should include a very brief, current status progress note of the salient points, both positive and negative of the visit, including progress made on the plan since the last visit. All progress notes include an assessment of the contact, and indicate next steps in the plan as indicated by the assessment you just made. Thus, if the Veteran was unable to find a housing unit in a certain area, the plan might be to explore other possible locations to search for a unit with the Veteran.

Assessing acuity and risk, in addition to the brief evaluation of the Veteran's housing stability, is critical to the success of the Veteran's exit from homelessness. Frequency of contacts is determined from the assessment of risk factors and acuity. Veterans must be seen as frequently as indicated by their risk and acuity, which will vary over time; they must be continually re-assessed. Increased sensitivity and attention to the Veteran's acuity/risk status helps to prevent sentinel events, such as injury, and death by ensuring supports and resources are promptly available to the Veteran when they are needed.

It is extremely important to assess and document the Veteran for suicide risk at every contact, and enlist the Suicide Coordinator in the action plan if the Veteran has a high risk for suicide. Appropriate actions must follow the assessment of high risk and acuity. Relapse potential and health status must be addressed through discussion with the Veteran; follow-up actions for supports and services are implemented. The goal is to work toward sustained lowered risk through targeted best practice strategies.

Regular assessment of the Veteran's housing stability may take the case manager outside of the home visit to include input from the landlord, family or other care providers, and can be accomplished without a breach of confidentiality. When engaged, the landlord or other informant will often provide the needed information without prompting, and the case manager can listen to the information without comment on the Veteran's care. Evaluating housing stability will help to avert problems before they reach a crisis point, keeps landlords engaged, may prevent the Veteran from returning to homelessness, and keeps voucher turnover low.

Plan

The Housing Plan is not only Veteran-centric, but is Veteran driven. The Veteran determines his or her goals and what he or she will do to reach those goals. The case manager respects and supports the Veteran's housing goals.

VA requires a written plan be developed and reviewed within certain timeframes, using the Mental Health Treatment Plan template. Please be aware of the local policy on treatment plans. The plan will be part of the Veteran's medical record and will be part of the larger facility-wide treatment plan.

The plan is expected to be a dynamic document, developed around obtaining and sustaining housing. Housing First does not require sobriety or treatment to obtain or retain housing. However, to sustain housing, the Veteran must abide by the landlord and PHA requirements. The case manager can discuss the impact of various behaviors on the Veteran's housing status, and enlist the Veteran to solve any that risk housing stability. If the Veteran is not able to make progress on the goals, then a conversation on how to make the Veteran's goals achievable, such as breaking them down to smaller steps or using a Harm Reduction approach.

The case manager provides the Veteran with supports and brokerage to providers who can assist with those goals. As goals are reached, the plan is revisited with new goals chosen by the Veteran. Every progress note should document the status of the plan and the next steps to achieve the Veteran's goals.

> **NOTE:** *Veterans who do not meet the goals and objectives outlined in their housing case management plan must be engaged to determine barriers to reaching those outcomes. The case manager works with the Veteran to eliminate the barriers, especially behaviors keeping the Veteran at risk of losing housing. The case manager is expected to continue efforts to engage the Veteran, following established safety protocols. Veterans do have the right to choose not to participate in HUD-VASH.*

Case Management

Rapid Housing

Case Management and other supportive services provided by the HUD-VASH team will center strongly on ensuring that housing is obtained as quickly as possible, followed by sustaining the

Veteran in his or her permanent supportive housing. The VA and PHA team work together on eliminating barriers that slow the housing process and work to make the experience as user friendly as possible. PHAs in some locations also work to provide same day inspections when a unit is located, again to expedite the process. This is in line with the Housing First model that HUD-VASH follows.

A referral to the Public Housing Authority (PHA) must be prepared and the supporting documentation needed by the PHA must be acquired rapidly. There are some limitations, such as the speed of the Library of Congress to mail a copy of the DD-214, or the ability of a Veteran to get payment stubs from a previous employer. However, HUD's regulations allow for the Veteran to use the registration data from the 1010-EZ once VA has verified it, to be used in place of the DD-214 and the Veteran's birth certificate. In some cases, PHAs will accept a Veterans self-certification regarding income.

If there are other members of the Veterans family that will live with the Veteran, they must also have the appropriate documentation. It is helpful to keep a list of the required documentation for each family member and situation (custody of minor children, for example).

 It is also helpful if the PHA provides HUD-VASH staff with all of their forms so they are always readily accessible to VA staff. Different PHAs will often have widely divergent processes and requirements. For example, "Moving to Work" PHAs usually have fewer requirements than other PHAs. Keeping these processes posted for quick referral will help keep things straight when working with more than one PHA. PHAs won't be able to process anything until all of their paperwork requirements for a particular step are submitted and completed to their requirements.

Even before the voucher has been issued, Veterans can look at housing units, but once the voucher is in hand, it is time to focus on choosing a unit. The case manager has a general sense of the PHA's inspection criteria and will be able to tell the Veteran if the unit looks like it will pass the inspection. "Rolling Housing Fairs" or "Rolling Landlord Fairs" are time efficient because it means looking at a number of units with a group of Veterans seeking housing. One Veteran choosing a unit encourages others to do likewise.

Once the unit has been chosen, the case manager helps the Veteran to obtain the PHA inspection by filing a Request for Tenancy Approval (RFTA).

You can read more about the Housing Choice Voucher Program at the following HUD site: http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/hcv/forms/forms.

PHA staff conducts the housing inspection and it either passes or fails. If the housing fails, a VA team member must help the Veteran to notify the landlord of the deficiencies to be addressed and then schedule another inspection. If the landlord won't fix the deficiencies, a housing search must be re-initiated.

If the unit passes the inspection, then the next step, executing the lease, may occur and will require the VA staff oversight. The lease must be original and must be without any corrections to be submitted to the PHA. The PHA reviews the lease, and when approved, executes the Housing Assistance Payment (HAP) contract, which lets the landlord know that the voucher will pay a significant portion of the rent. At this time, the Veteran may move in (although riskier, sometimes there are situations where the Veteran moves in prior to this, if the landlord agrees to it.)

Veterans sometimes limit their searches narrowly to locations where affordable housing stock is limited. Veterans should be asked and assisted to expand their locations for housing search weekly so timely lease up of their housing can be achieved.

Transition

Once the Veteran and any family have moved into the unit, a new phase of case management begins. Transitions are difficult for everyone, but are especially difficult for our now formerly homeless Veterans. The responsibility of the unit, loneliness, lack of income, and untreated mental health and substance use disorders make it challenging for the Veteran to sustain in that housing. It is important to engage Veterans in their own stated goals to give them the structure and the support to work through these issues.

HUD-VASH intensive case management teams are most similar to that provided by Mental Health Intensive Case Management (MHICM) teams. However, instead of a purely treatment focus, HUD-VASH utilizes a Housing First approach to support the Veteran's housing stability and then wraps services and case management around the Veteran to sustain that housing.

The Veteran's goals become the basis of recovery and housing sustainment. Their goals may be very different from the clinician's goals, but working within those goals the clinician can broach the subjects that impact the goals. For example, if the Veteran is interested in dating, then talking about the impact of substance use, budgeting, mental health symptoms, social skills, hygiene, etc. will be important to realistically achieve the Veteran's goal of dating.

HUD-VASH is a highly clinical program with the case manager exhibiting an extensive breadth of clinical knowledge. HUD-VASH case managers must know how to identify and manage severe mental illness, substance use disorders, crisis and other risks to housing stability. It is important that the case manager is able to provide the linkage or service that the Veteran needs to sustain in

housing and recovery. Harm Reduction strategies, skill building and other "best practices" help the Veteran begin to address those behaviors that lead to loss of housing.

Core Case Management

HUD-VASH case managers plan the intensity of services and supports, based on the stability of the Veteran and the Veteran's ability to live independently. Every contact informs the clinician as to the Veteran's need to be seen more or less frequently. While actively in case management, the minimum contact is monthly (with most of these occurring in a home visit unless there are safety issues), but Veterans who are newly housed, in crisis or clearly struggling will need at least weekly, or sometimes more frequent visits. As the Veteran's stability increases, the Veteran may be seen less frequently and eventually contacts may be extended out to 2 or 3 months, or longer, until eventually the Veteran is discharged from case management. Frequency of contacts always reflects the clinical needs of the Veteran. HUD-VASH uses hybrid models, combining the chosen model with HUD-VASH's overall structure and geographical coverage area. The two main models being used in HUD-VASH are the ACT team model (in HUD-VASH, these are usually called the "Enhanced" or "E-VASH" teams) and an "intensive case management" model, usually following the principles of Critical Time Intervention (CTI).

The Enhanced VASH "ACT-like" Team provides a variety of staff disciplines triaging home visits and services through team case management (discussed in more depth in Chapter 9). The "Intensive Case Management" (ICM) model provides a primary case manager (who may be part of a smaller, professionally diverse team) delivering most of the care coordination and services (also discussed in more depth in Chapter 9).

Large programs will have several teams. E- VASH generally has a greater flexibility to quickly provide diverse service needs in the Veteran's home than the "intensive case management" model. The team model permits the Veteran to form relationships with the whole team, providing different perspectives on the Veteran's status, coordinated care delivery, and crisis management without overwhelming any one case manager. Some programs have an E-VASH team for the most acutely ill Veterans and have the ICM model for the lower intensity Veterans.

HUD-VASH is mandated to use a Housing First approach, focusing on sustainable housing rather than on treatment compliance. However, in HUD-VASH, multiple case management and treatment models may be utilized to achieve the goal of sustaining the Veteran in housing. For example, if something such as substance abuse is threatening housing retention, then that opens up the discussion about the conflict between the Veteran's goal of housing and decision to drink/use. Harm Reduction and Motivational Interviewing are two best practice strategies to help Veterans work on addressing those risks to their housing. Depending on the Veteran's needs, different strategies may be used to find a successful way to address the Veteran's concerns.

Supportive Services and Resource Linkage

It is very difficult to sustain housing without income, so case managers must proactively work to help the Veteran procure legal income. Many of the Veterans in HUD-VASH are interested in and capable of some form of employment. Too often in the program this desire and capability is not recognized and referrals to work programs or assistance with job search is not discussed or offered as part of case management. Work provides numerous benefits by means of structuring time, providing income, utilization of skills and talent, providing a positive identity, and growth of self-esteem. Explore interest in employment in your case management contacts with Veteran participants and assist with the appropriate referrals for those interested in pursuing work.

A major component of case management will involve active pursuit of regular income from a benefit or public assistance resource. Assisting in the application process for VA benefits (service connection or NSC pension), mainstream public assistance (including food stamps) and Social Security are some examples of this help. There are some legal limits to what a VA HUD-VASH team member can do, such as acting as the legal representative of the Veteran, but clinicians can assist the Veteran by helping with completing forms and other technical, linkage and information assistance.

Application for VA funded subsidies may be done by referral to a Veterans Benefits Officer (often set to visit VA homeless programs at regular intervals) or by referral to any one of many local Veterans service organizations, often available at the medical center or regional office. Most service organizations such as The American Legion, Vietnam Veterans of America, Paralyzed Veterans of America, AMVETS, and the Disabled American Veterans to name a few, have Service Representatives available to assist Veterans in filing claims for VA benefits.

SSI/SSDI Outreach, Access, and Recovery (SOAR) Technical Assistance, is a project funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). This national project is designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are homeless or at risk of homelessness and have a mental illness and/or a co-occurring substance use disorder. This mainstream subsidy may be a source for many of the Veterans in our HUD-VASH program. The SSI/SSDI application process is complicated and difficult to navigate, particularly for people who are homeless or who are returning to the community from institutions (jails, prisons or hospitals). Using a 3-pronged approach of Strategic Planning, Training, and Technical Assistance (TA), the SOAR TA Center coordinates this effort at the state and community level. Many communities have a local agency involved with SOAR and can provide direct service to assist Veterans in application for SSI/SSDI. To find SOAR availability in your community, go to the SOAR site [www.prainc.com/soar/] and follow state locator sites displayed on the right side of the home page. The VA case manager can provide much of the information needed for successful application with an appropriately completed VA Release of Information (ROI). SOARS optimizes rapid, successful outcomes.

Budgeting and money management are often concerns for Veterans in HUD-VASH, especially with the very limited incomes in this population. Timely rent payments are pivotal to sustaining housing stabilization. Assisting Veterans to address long standing credit deficiencies and current obligations is crucial to improve fiscal and credit history for future housing options. Fun, social groups on fiscal management must be offered in the HUD-VASH program. A Harm Reduction strategy that can help with meeting fiscal obligations and housing sustainment is helping Veteran participants to plan around the cost of their substance use. Local Credit counseling services may be accessed, or referrals to Psychosocial Recovery and Rehabilitation Centers (PRRC) at the VAMC may be alternative resources for fiscal planning help. Veterans may need additional referrals to negotiate reasonable child support and credit card debt payments.

Engaging groups and classes are an efficient and productive means of providing skill building, education, confidence and social connections to Veteran participants. A catchy name may interest Veterans; calling it, for example, "Stretching your Dollar" or "Financial Independence" may be more palatable than "Money Management" or "Budgeting." Referral to VAMC programs with these programs may be available.

Groups for Veterans are to be developed around the specific needs and interests of your Veteran population. Examples of Veterans' skills groups might include the following areas:

▪ Social interactions ▪ Connection or reconnection with religious/spiritual support ▪ Dating ▪ Shopping ▪ Cooking ▪ House Cleaning ▪ Time management ▪ Computer Skills	▪ Meal planning ▪ Coupon clipping/use ▪ Laundry ▪ Bill Paying ▪ Checking accounts ▪ Parenting skills ▪ Creative writing ▪ Self Esteem Growth ▪ Constructive use of free time

Explore community offerings to promote integration.

Many positive activities available through local adult learning, the YMCA, and community parks and recreation programs may be free or low cost.

Groups may also be indicated to help slow attrition rates by addressing unspoken or unknown concerns of Veterans who are dropping out. Canvas your Veterans regularly to determine if program changes are needed.

Veterans who are homeless or recently housed may find it particularly difficult to address their medical care concerns because it is a lower priority, a complex system to negotiate or nearly impossible to follow medical advice (example: A diabetic that cannot follow the diet and has no place to refrigerate insulin). Concepts of wellness may be introduced through topics such as sleep hygiene, diet, exercise, stress reduction, immunizations and preventative measures (such as flu shots), etc. Medical centers with Homeless Patient Aligned Care Teams (H-PACT) teams support homeless Veterans to address health care (and other care needs) in a clinic environment set up specifically to work with this high needs, complex population. Helping the Veteran to navigate the medical center system, and attend appointments either within or external to the VA, may be vital to addressing untreated, chronic and acute concerns. Coordination with various treatment resources is indicated when the Veteran expresses interest in those services.

Most Veterans come with very few belongings when they enter their new homes. Living in an apartment or house without any furniture or necessities does not constitute having a home. VA case managers are not allowed by VA regulation to solicit for donations to Veterans, but may make presentations about the program and the needs of Veterans to both internal and external groups. Connection with the local VAMC's Voluntary Service may be a source for assistance in procuring these items. Accessing community resources for furniture, cooking items, bedding, hygiene supplies and food also falls under the realm of effective case management. Again Veteran Service organizations, particularly the auxiliary units, may be rich contacts.

Evaluation of the Veterans experience and knowledge of management of a home should be a topic for case management discussion. There may be little or no past experience with what is involved in keeping a safe and clean living space. Food storage, use of disinfectants, schedules for cleaning, laundry, personal hygiene, emptying of trash etc. are areas for discussion, education and structure. Reinforcing the need to keep the rental unit in good repair, and what and when to report structural problems to the landlord is important to address and revisit. Issues of hoarding behavior should be identified and addressed early.

If the Veteran is living with family, there may be a need to arrange for additional supports or assistance for family members. Reunification with children may require additional assistance with communication, parenting skills and school resources.

Assistance through legal aid agencies may be indicated for issues such as visitation with children, custody, divorce, delinquent tax satisfaction, squelching of old legal records, and child support concerns.

Levels of Care

All Veterans in HUD-VASH are in the case management level with the prescribed frequency of visits based on their clinical acuity and needs. Acuity scales are helpful to determine both the frequency of visits and the needed case management intensity. In both CTI and Housing First models, there are essentially three levels of acuity. Those levels are high, moderate and low intensity with corresponding actions based on the acuity levels that placed the Veterans into a particular level.

In CTI, there are time frames for each level that average about 90 days each. However, because in HUD-VASH it can sometimes take 90 days for the Veteran to obtain housing and because the transition period is an especially difficult time, the Veteran needs to be considered high intensity on move in until the Veteran stabilizes and adjusts to the new environment.

In a team model or E-VASH model, the workload is absorbed by the overall team so that different individuals are engaging the Veteran throughout the week or as frequently as they need to be seen. The optimal ratio in the E-VASH team is 12-15 Veterans per staff member. One model might have the case managers with some high intensity, some medium intensity and some low intensity Veterans on their caseloads. Another model has more staff on a high intensity team, fewer on the moderate intensity and fewer still on the least intensive team. Establishing who on the team is responsible for documentation in HOMES and the medical record (such as treatment plan reviews) will be determined by the program manager or coordinator for each Veteran.

A. **High Intensity Case Management**:

Frequency of contact is expected to be a range from multiple times a week to a minimum of once a week, depending on the specific needs of the Veteran each day.

Due to targeting those most vulnerable and in need, HUD-VASH Veterans are all initially high intensity. Periods of change are particularly stressful for clients, so major transitions must involve a higher intensity case management. Veterans in declining health, prior to needing a higher level of care, would be in this group.

Some Veterans, because of the severity of their illnesses and symptoms, need a prolonged high intensity case management program to ensure that the supports and services they need are wrapped around them to sustain them in housing. This is the group most in need of the Enhanced VASH team.

B. **Moderate Intensity Case Management**:

The range for this level of contact is expected to be weekly to a minimum of every two weeks. Veterans who have successfully transitioned to housing, but still are learning and adjusting to the various elements of housing – timely paying rent and other bills, establishing social connections in their community, utilizing care/support providers, etc. would be in the

moderate intensity of case management. The Veteran is more comfortable with housing and is more stable, but still has continuing needs. The Veteran may be having regular small crises until they become comfortable managing the various parts of their housing stability.

C. Low Intensity Case Management:

It is during this least intensive level that clients are to be seen at least every month to ensure their continued progress.

It is expected that most clients by this time are stable and able to manage their housing and community integration independently.

D. Crisis:

At any time, a Veteran may relapse or be in a crisis situation. At that time, the case management intensity would increase to a high intensity level with at least weekly, if not more frequent contact, until the Veteran is able to return to more stability. Once the Veteran stabilizes, the frequency may again be dropped back.

Ending Case Management Services

HUD-VASH lasts as long as the Veteran needs the case management to reinforce the housing stabilization and attainment of Veteran centered goals. The length of time in case management is variable and depends on the Veterans functional and economic capabilities. When a Veteran has attained maximum benefit from the intensive case management there is generally a shared decision between the Veteran and the case manager to begin a transition toward a less intense level of case management and, eventually, to ending case management. A Veteran can exit case management and retain the voucher if financial circumstances are such that the subsidy is still needed to support permanent housing.

As Veterans move through the program and demonstrate increasing abilities, independence and stability, the case manager may begin to talk with the Veteran about ending case management. Contacts would be scaled back over time, and then noted in the housing plan and progress notes.

Veterans who are in this level of case management would have even less contact, perhaps once every two or three months, to ensure that they are continuing to sustain in housing and are managing their responsibilities sufficiently. If the Veteran continues to demonstrate this level of independence, then a decision may be made regarding ending case management with a specific end date in mind. Some facilities, after Veterans who were no longer in case management were evicted, have determined that it is helpful to have yearly contact with the Veteran, just prior to the recertification process, to ensure that the Veteran is aware and engaging with the PHA to complete the recertification.

Veterans must be able to return to additional case management services if needed. Appropriate discharge from case management provides the Veteran with the positive recognition of their persistent stability. A process for returning for help should be developed, and the Veteran should be knowledgeable about it. Veterans should be engaged in services or support systems, such as primary care, mental health, community groups, etc. Fostering active Alumni Groups helps promote Veterans supporting Veterans in the community.

Optimally, the PHA provides a regular voucher to Veteran families that continue to meet the income threshold and return the HUD-VASH voucher for another Veteran's use, but if the PHA does not have a regular voucher, then the Veteran may continue to use the HUD-VASH voucher as long as the Veteran remains eligible for it. If a HUD-VASH voucher is switched to a regular voucher, the family is not subject to the PHA's waiting list because the family is already a participant in the PHA's HCV Program.

The transition from intensive case management may entail changes to the frequency of the contact, change in the focus of the contacts as well as shifting of supports more broadly to the community, friends and family. Exit from case management is a planned, thoughtful process that is titrated rather than occurring instantaneously. There may be a trial, error/success, and processing period for the Veteran as they make efforts to expand their interactions within the community. Ending case management must be about the Veteran's readiness and capability for independence, not to relieve case managers case load sizes.

A major piece of the transition is the development of a plan and resources in the event that the Veteran finds they need assistance. This may include reaching out to resources within the broader VA system, within the community or to alternative self-help groups. The plan should include simple step by step actions to be taken if the Veteran need added support. Warning signs of relapse and relapse prevention are often a part of this plan. Warning signs should be associated with simple actions to be taken to halt decline and gain stability.

During times of improved stability and independence, it is a good time to check in with the Veteran on any changes in readiness to seek employment/volunteer work, start school, reconnect with family and friends, take up old hobbies or start new ones, join action groups in the community for causes important to the Veteran or other new goals the Veteran would like to tackle. The intent is that now that the Veteran has attained the housing stability, addressed existing medical and mental health issues, and is managing potential substance use issues, they may have more time and energy to broaden their interactions with others or other activities

Other Case Management-ending Situations:

In some cases, Veteran participants may be severely ill on admission to HUD-VASH and may need a higher level of care, which the case manager must address with other providers (VA Primary Care,

Geriatrics, Home Health, etc.) for appropriate placement. It also may occur that the Veteran needs to be rehoused in a building with additional supports, such as elder housing.

Discharges from the HUD-VASH Program may be required, when the Veteran abandons the apartment and is lost to contact. Veterans who choose to participate in behaviors that are adverse enough to result in eviction from the unit, or arrest may be terminated from case management and have the voucher revoked by the PHA following the applicable laws and processes.

However, in Housing First, the case manager is expected to rehouse the Veteran whenever possible. Advocating for continued voucher use with the PHA, unless the Veteran is a high risk to harming self or others, rehousing is not legally viable, or a higher level of care is needed, and working to rehouse the Veteran is required to continue with the mission of ending Veteran homelessness.

NOTE: Non-compliance with HUD-VASH does not necessarily lead to loss of the Section 8 HCV voucher. Work with the PHA to explore alternatives they will be willing to do.

Encounters Workload, and Credit Stops

Documentation of workload is how the VA receives funding for its work. Documentation of workload also shows if a staff person has the right level of contacts for their position. The Veterans Health Administration Support Service Center (VSSC) has developed a wealth of information from both HOMES and CPRS in operational reports providing feedback on effectiveness and efficiency in the program, and provides data to guide program improvements. Regular review of program performance measures and monitors will inform quality improvement and systems redesign projects. Familiarity with the data reports is advised for all staff in the program.

Workload is directly related to the number of Veteran contacts; acuity of the Veterans in HUD-VASH and variables such as travel times for home visits impacts workload. Because the acuity level drives the frequency of contacts with the Veteran, ongoing assessment of caseloads is critical. The assignment of cases and division of work by the program manager or team leader ensures the appropriate level of case management is being provided to the Veterans. The higher the acuity, the fewer Veterans on the case load, and the lower the acuity, the more Veterans on the case load.

HUD-VASH Case Managers adhere to VA standards for accurate capture of workload activity to support continuity of care, resource allocation, productivity metrics and identification of staff shortages, and performance measurement.

Stop codes indicate the specific program contacting the Veteran and type of contact (e.g. face to face, group, telephone.) All of HUD-VASH face to face contacts are in the 522 stop code. Please see the HUD-VASH handbook for other stop codes to be used with HUD-VASH.

Current Procedural Terminology (CPT) codes are numbers assigned to an "encounter" (or contact) based on the clinical service (or procedure) performed during the professional contact between the Veteran and Case Manager.

Detailed instructions regarding establishment of Stop Codes and Procedure Codes is available through contact with your local Decision Support Services and is reviewed at the following locations:

- https://vaww.cmopnational.va.gov/CR/MentalHealth/HUDVASH/Forms/AllItems.aspx

- Homeless Program Guidance on Workload Capture - FY 2015 V2 / Quick Guide: http://vhaindwebsim.v11.med.va.gov/hub/app/library/record/visit?id=79
- HUD-VASH Handbook: http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2446

Accurate accounting in CPRS is critical in demonstrating workload for the HUD-VASH program. All programs must have stop codes for individual, group, and telephone HUD-VASH visits and note titles should be assigned and directly tied to the established stop codes. Workload capture must have the appropriate type of documentation tied to it, such as Biopsychosocial Assessment, Progress Notes, Housing and Case Management Plan, etc.

Chapter
9

TEAM-BASED CARE –TYPES OF SERVICE TEAMS: ACT, ICM AND BLENDED

Introduction/Overview

The official policy for HUD-VASH is to use a Housing First model of care, an important shift in service delivery and philosophy that was accepted as VA Homeless Program Policy in 2012. The best method for employing the Housing First model is to utilize a team-based approach for case management.

A team-based model is built on the system of shared caseloads, and includes other strategic practices such as scheduling home visits based on geography, conducting morning huddles, and using other team-based tools or methods of communication to create an efficient and effective team.

Community-based interventions such as Housing First are most effective and successful when implemented with a team-based system of case management. It is important for team members to support the Veteran throughout the housing process, beginning from the street or shelter and continuing to engage as long as needed.

The VA is utilizing team-based approaches across service lines, nationwide. Examples include Patient Aligned Care Teams (PACTs), Behavioral Health Interdisciplinary Program (BHIP) Teams, Mental Health Intensive Case Management (MHICM) and Home Based Primary Care (HBPC).

Service providers within the community also employ team-based models to best serve their clients. The home health movement for Medicaid recipients with complex needs uses multi-disciplinary teams in order to provide their members with more holistic and efficient care. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html.

In this Chapter you will learn:
- Three different models of team-based approaches
  - ✓ Assertive Community Treatment Teams (ACT)
  - ✓ Intensive Case-management Teams (ICM)
  - ✓ Blended teams (a combination of ACT and ICM)
- The operational tools used to facilitate communication when using a team-based approach

After reading this chapter you will be able to:
- Describe the different models of service teams used to implement the Housing First model;
- Create the type of team approach that your program will use or tweak your existing one if needed;
- Be provided with examples of communication and operational tools that you can utilize to effectively implement the team based approach.

Assertive Community Treatment (ACT) Teams

Assertive Community Treatment (ACT) teams will be the first model discussed in this chapter. The ACT model was developed in 1970 by Mary Ann Test, PhD, Len Stein, MD, and Arnold Marx, MD at the Mendota State Hospital in Madison, WI. *(For more information about ACT teams, please visit: http://usich.gov/usich_resources/solutions/explore/assertive_community_treatment)*.

The ACT team was created in response to frustration from inpatient unit staff members who were demoralized about providing significant treatments and preparations for clients moving into the community, only to have these clients return a few weeks later. The staff noticed that the clients of one social worker were not returning to the unit, and that this social worker was providing extensive support within the community after each client was discharged. The support provided by this social worker included transportation to mental health appointments, assistance with obtaining food, and the social worker also gave clients her phone number so they could call her if they ever were in crisis. The discovery of this social worker's successful practices led to the leadership moving the locus of treatment from the hospital to the community, with services in the community provided by a multidisciplinary team (Test, 1998).

1. Target Populations of ACT teams using the Housing First model of service. ACT teams are structured to serve people with the highest level of needs. This includes people dealing with persistent and serious psychiatric disabilities, histories of homelessness, co-morbid addictions, as well as significant histories of institutionalization by hospitals and/or jails. Also, the team is providing services directly in their home and the community verses

brokering or linking people to services. The idea is that people will need more support than a referral based team provides.

2. <u>Team Design.</u> ACT teams are designed to provide services directly rather than referring clients or brokering services. These multidisciplinary teams are comprised a variety of specialists and are managed by a designated team leader – typically a Licensed Clinical Social Worker, Psychiatrist or RN. Other team members can include roles such as: Peer Specialist, Housing Specialist, Mental Health Specialist, and Substance Abuse Specialist, among others. Depending on the needs of the specific population served, ACT teams may benefit from inclusion of the roles of Occupational Therapist, Recreation Therapist, Family Therapist or Criminal Justice Specialist.

3.   <u>S</u> <u>taffing Pattern.</u> In order to provide the level of service intensity and care comprehensiveness necessary for an ACT Team, the Staff to Veteran ratio must be low. A typical ACT Team will operate with a ratio of approximately 10:1 to15:1.

4. <u>Roles of Team Members</u>.

   *It is important to note that all team members are well versed in harm reduction philosophy and techniques.

   a. <u>Team Leader</u>
      The Team Leader role is essential to any ACT team. This role is the hub of the wheel. The responsibilities of the team leader/LCSW include providing clinical oversight, supervising team members, setting priorities for the team and ensuring the flow of work is meeting the Veterans' needs. The leader of the team is primarily responsible for making certain the morning meeting/huddle is done consistently and efficiently. The Team Leader is also expected to lead the team to embrace the philosophy of Housing First and to operate in accordance with its mission and principles.

   b. <u>Psychiatrist or Nurse Practitioner</u>
      The Psychiatrist or Nurse Practitioner supervises the Nurse and other medical personnel on the team. Responsibilities associated with this role include the monitoring of medication for Veterans, and serving as a liaison with other healthcare professionals that are serving the Veteran – both in and outside of the VA. It is extremely important that the Psychiatrist or Nurse Practitioner is willing to work in the community and to make home visits when needed.

c. <u>Registered Nurse (RN)</u>

The RN's role is to assist the Veterans with medical needs. Primary responsibilities for the Team's RN include providing direct care and oversight, monitoring and administering medication, and providing education about health-promoting activities. The educational function of this role may be conducted in one-to-one counseling sessions or in a group setting.

d. <u>Peer Specialist</u>

The role of Peer Specialist is crucial to an effective ACT Team. This team member maintains a working knowledge of resources in the community and within the VA, is active in advocacy, and manages programs such as Wellness Recovery Action Plans, or 'Moving and Moving On' groups.

e. <u>Housing Specialist</u>

The Housing Specialist is responsible for assisting with tenant-related services. This includes locating potential apartment units, assisting with the housing and move-in process, and serving as a liaison with local landlords, Veterans, and team members. Another important role of the Housing Specialist is to work in partnership with and interface with the Public Housing Authority.

f. <u>Mental Health Specialist</u>

The role of the Mental Health Specialist is to provide therapeutic support, lead groups, and assist with general case-management duties.

g. <u>Substance Use Specialist</u>

An ACT Team's Substance Use Specialist is responsible for providing substance use counseling and facilitating groups. It is critical that this team member is exceptionally well-versed in harm reduction techniques.

h. <u>Other Specialists typically seen on Housing First ACT Teams:</u>
   1. Occupational Therapist
   2. Recreational Therapist
   3. Criminal Justice Specialist
   4. Family Therapist

5. <u>Operational Aspects</u>

a. *<u>Morning Meeting/Huddle.</u>* This is a daily meeting that typically occurs in the morning, and all team members are expected to be present for the Huddle. This is not a clinical

meeting. The purpose of the Morning Meeting is to conduct a review of the previous day's activities and to plan for the current day's visits and activities. During the Morning Meeting, the team members are assigned to home visits, other appointments are scheduled and responsibilities that need to be completed are delegated. The Morning Meeting runs quickly and efficiently.

b. *White Boards: Weekly, Monthly, Goals.* Organization is fundamental to operating an ACT Team, and many ACT Teams will utilize white boards to manage and track home visits and other activities. Other ACT Teams rely on an outlook calendar to fulfill this role. Regardless of format, there needs to be one calendar that lists the current week's scheduled home visits. This can be revised or added to throughout the week as appointments are set or home visits for people not currently scheduled are added to the week's plan. These visits and appointments are then categorized by geography. Each day, during the morning meeting it is determined who is going to what location, and said team member is responsible for seeing the people located within that area. The medical professionals will experience an exceptionally varied geographic itinerary each day, as they are typically the team members with the most limited time and may go to several areas during the day to accommodate people's needs for their expertise or specialty.

Intensive Case Management (ICM) Teams

ICM teams work with a population that has less severe needs than those served by an ACT team. Similar to the early ACT teams, ICM teams were originally clinician or practitioner-driven rather than client/Veteran-driven. The ICM structure was developed in the 1980s, and Dr. Charles Rapp from the University of Kansas is credited most frequently with changing the dynamic in case-management to include the strengths-based perspective.

The strengths-based perspective is a cornerstone of the Housing First philosophy, and is comprised of six key principles. Each includes a set of accompanying procedures which operationalize the principles throughout the helping process (Rapp, 1993).

The principles of the Strengths-based approach are:
1. Focus is on individual strengths rather than pathology.
2. The Case Manager – Client relationship is primary and essential
3. Interventions are based on client self-determination.
4. The community is viewed as an oasis of resources, not an obstacle.
5. Aggressive outreach is the preferred mode of intervention.
6. People suffering from severe mental illness can continue to learn, grow, and change.

A. *Target Populations.* ICM Teams are designed to serve Veterans with more moderate needs. These Veterans are often able to manage their own medications with limited support, and make and keep their own appointments without significant assistant from the team. Essentially, these Veterans need assistance to initially link with services and supports and the amount of time this will take depends on the specific Veteran and the specific service.

B. *Team Design.* The structure of ICM Teams was originally based on an individualized caseload model, but this design has since changed and many teams operate with shared caseloads like an ACT team. Staff working on teams that have transitioned to the shared caseload model report feeling a greater level of support because they are backed by the entire team. Staff also benefit from the reliance on other team members to brainstorm ideas and interventions, and report greater efficiency. The Veterans served by shared caseload ICM Teams receive the advantage of multiple specialists on-board to provide their expertise and services as needed.

C. *Staffing Pattern.* The caseload ratio for ICM Teams typically falls around 20:1 or 25:1. The staffing pattern is slightly higher than that of an ACT Team because ICM Teams are serving Veterans with more moderate needs.

D. *Roles of Team Members.* It is very important for ICM Teams to have a designated Team Leader who provides clinical supervision and administrative oversight. Teams often incorporate the support of a psychiatrist to provide consultation, though this may be on a part-time or as needed basis. It is also helpful to include a nurse on the team who can prioritize working with people with significant medical needs. Other specialists typically seen on these teams are a substance use specialist and employment specialist. These positions typically function as consultants or shared between a few different teams.

E. *Operational Aspects.* Morning Meetings or Huddles are conducted three times each week. For ICM Teams employing a shared caseload model, the home visits planned during the Morning Meeting are based on geography and these are done for a couple of days at time depending on how frequently the team meets.

Hybrid or "Blended" Teams

A blended team uses a combination of elements from the ACT framework and the ICM framework, combined so as to provide a range of services.

1. *Target Populations.* Hybrid teams are used to serve populations with mixed levels of service needs – high needs and moderate needs within one team.

2. *Team Design.* Similar to the structure of a typical ACT Team, a Hybrid team will include a Team Leader, as well as a nurse and a psychiatrist or nurse practitioner. There are often fewer specialists included on Hybrid Teams,   though roles may be incorporated on a consultative or bridging role. Blended teams can also be included as sub-parts within established teams. Typical blended team structure may include staff with smaller caseloads of Veterans with more intense needs, other staff members who work with moderate-needs Veterans; and staff that operate in a maintenance capacity for low-needs Veterans. Caseloads are shared within the mini-teams and will increase in size as needs decrease.

3. *Operational Aspects.* Morning Meetings/Huddles are not required on a daily basis, but are typically held between three to five times each week. Home Visits and other appointments are organized and tasked to team members based on geography. Many hybrid teams will have a large over all huddles once a week and then the mini-teams or teams within teams will meet between 3-5 times per week.

In summary, using a team based approach is a very efficient way to provide comprehensive services to a significant number of Veterans. It is very important to match the right dose and duration of services based on the needs of the Veterans. An ACT Team is appropriate for serving Veterans with the highest level of needs, severe and persistent psychiatric disabilities, addiction and very significant histories of homelessness, often but not always with high utilization of acute services. The ACT model also is invaluable for people who need services brought to them in their home; duration of these services is dependent on each individual's process.

In comparison, the ICM structure of service provision is best paired with Veterans who experience more moderate needs. Veterans with the ability to access services with support from Case Managers are great for ICM teams, with the hope that in time the stability of service and work with the team will help them to gain the skills to manage their own care.

A blended team is one that combines both levels of care within one larger team. This design has the advantage of allowing for flow between levels of services depending on the current needs of the Veterans.

Reference

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Chapter
10

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HOME VISITS

Introduction/Overview

Home Visits are an essential component of the Housing First model. Home visits are where the majority of the work takes place. Providing services in an individual's home offers a more comprehensive perspective of the person's life, and allows for deeper understanding of the person and his/her needs. One Veteran explained the value in gaining the at-home context, stating: "I can come into the office and present well, but if you came to my home you would be able to see how much I was struggling with my depression".

The Home Visit is also valuable in that it ensures Veterans are provided with the level of service they require. It is a less effective and oft impractical approach for teams to wait for Veterans with significant needs to make and attend appointments at the office or clinic. It is important to remember that Home Visits are a targeted intervention. Though the atmosphere of a Home Visit is typically warmer than visits in an office or clinic setting, the visit is done by a clinician or other staff.

Home visits should be the norm for all clients in permanent supportive housing and this expectation should be clearly established when conducting orientation for the program.

The overall purpose of the Home Visit is to assist the person to achieve their stated goals – the strategy to meet this objective is the science of the Home Visit. The art of the Home Visit is how staff approaches the visit, and manage to build relationship and rapport while maintaining healthy boundaries.

> **In the following chapter you will learn:**
> - The philosophy of Home Visits
> - The practical approaches and goals of a Home Visit
> - A review of some common dilemmas faced when providing community-based interventions

Home Visit Philosophy

<u>Opportunity for Engagement</u>. Visiting people in their home allows the clinician or support staff to gain a comprehensive sense of how the person is actually doing, as well as learning more about what skills and needs they may have. It also conveys a message of caring and support by the staff's willingness to come and meet the person in his/her home. The Home Visit is one way in which team members enact the concept of meeting a Veteran where they are – literally in this sense – without conditions.

<u>Boundaries.</u> The atmosphere during a Home Visit is friendly, polite, respectful and professional. This is a delicate issue, to know the boundary between friendly and respectful versus fostering a sense of over- familiarity that makes either party feel uncomfortable. When working in an office or clinic-based setting, the sense of professionalism is automatic, and it is important for staff to maintain this professional framework, though, it is less traditional and more flexible when working in someone's home.

One guiding principle for teams to consider is that their work will not be effective if they feel scared or uncomfortable to the point of distraction. In certain instances a team member may feel uncomfortable but not distracted (e.g. Veteran owns a cat, team member does not like cats), in these situations the team member should try to accept the surroundings as-is.

Home Visit: Practical Consideration:

1. <u>Preparation.</u> It is imperative to be adequately prepared before going to see someone. The entire team, especially the team leader, should be aware of where team members will be conducting Home Visits each day. The staff should know the address or location of where the Visit will happen before leaving, and for Home Visits that require travel via car, the staff should ensure there is gas in the vehicle. It is very important that staff remember to carry their phones with them at all times, and therefore important that phones are charged prior to leaving for the Home Visit. Attending to these items will increase the efficiency of the team, and will increase the level of comfort for staff so they can be fully present for the Veterans served.

2. <u>Scheduling of Visits</u>. Visits are scheduled with the Veteran and are planned in advance, often a month at a time. For instance, if Wednesday afternoons are a preferable time for the Veteran, the team may set the schedule so that Wednesdays are the Veteran's regular Home Visit day, though there will be instances where the Veteran may need to be seen more frequently. Other adaptations to the schedule may be for considerations – for example, a Veteran may mention they are experiencing difficulty remembering to take their morning medication, and may agree to have a team member stop by every other morning for the next month to assist them with this. A helpful strategy is to bring a calendar at the beginning of

the month and fill in the mutually agreed upon Home Visits as well as any other appointments, and leave the calendar at the Veteran's house. These appointments and visits should also be added to the master schedule of Home Visits for all Veterans the team is serving.

3. <u>Basic Safety Practices</u>. Safety is important when conducting Home Visits See Chapter 12, "*Safety in the Community"* for more details.

4. <u>Determining the Frequency of Visits</u>. The right frequency of visits will be determined based on the needs of the Veteran. It should be assumed that when a Veteran first moves in they will need to be seen a minimum of once per week. Some Veterans may need to be seen more frequently others can have reduced visits. There is fluidity to the frequency of visits – as a Veteran becomes more stable they may reduce the number of visits, but then will need additional support and visits should they experience a crisis. The team needs to have flexibility to truly provide Veteran-driven services. The use of tools such as an acuity scale or vulnerability index can help guide the process of determining the correct amount and duration of services (examples of such tools can be found on the HUD-VASH SharePoint site: https://vaww.cmopnational.va.gov/CR/MentalHealth/HUDVASH/Forms/ AllItems.aspx.) When establishing the frequency of visits, it is critically important to include the Veteran, their significant others or any other collateral supports that would like to be involved in the treatment planning process.

5. <u>Community and Relationships.</u> During the Home Visit, staff will work with various collaterals and manage relationships with neighbors, Property Managers and Landlords. It is always important to be friendly and courteous with the individuals you meet during visits as they can have significant effects on how the Veteran is received in the building. The confidentiality arrangement agreed upon by the Veteran will determine how much can be shared with these community members and property managers. It is crucial to obtain consent to talk to the landlord, as developing a strong relationship with this person is very helpful. If there is a Housing Specialist on the team, this Specialist can take the lead in connecting with landlords, but it is recommended that all team members have a working knowledge of the landlord. Likewise, the landlord should feel comfortable calling the team or the client and letting each know if there are any concerns before a situation has the opportunity to become a crisis.

In addition, neighbors can play an important role in the Veterans' sense of community. They may either be a great source of friendship and community support, or they may be difficult and be troublemakers. It is important for the team to work with the Veteran on how to build positive social relationships if this is a skill they are currently lacking.

The Goal of Home Visits:

1. <u>Service provision using Veteran-driven goals</u>. The Home Visit is a targeted intervention structured so as to help the Veteran work on the goals they have established. Therefore, goals should be the central point of discussion during the visit. If a team member finds that the same discussion is recurring during each visit and with limited progress, this may be an indication that the goal needs to change. In that situation, Motivational Interviewing can be a very helpful tool to help realize new goals.

2. <u>Assess the person's well-being.</u> While working on the Veteran's goal is the primary purpose of the visit, another priority is to assess the Veteran's well-being. There are many non-verbal clues that provide insight to the person's well-being. For example, if someone is typically quick to answer the door and shows enthusiasm when visited – and on subsequent visits it is taking the person several minutes to answer and they are not making-eye contact or seem despondent, it is clear the support staff should notice that something is going on. Sometimes changes in behavior or well-being are less obvious or noticeable, so it is important to be mindful of anything that seems to be a departure from "normal" or baseline for that Veteran.

3. <u>Assess the person's unit.</u> Likewise, this principle of noticing changes is applicable for assessing the person's unit. The team should try to engage the Veteran as soon as a change is detected – even if the change is small, such as accumulating garbage or extra dishes in the sink. Such small changes could be tied to a myriad of reasons: Is the person becoming depressed, have they had many guests over recently, or perhaps they recently began working and are still trying to adjust to a new routine and figure out the work/life balance. It is important that the team not ignore changes and equally important the team not assume all changes are related to pathology.

4. <u>Community integration.</u> Often a Home Visit will begin in the home but end in the community. A team member might choose to visit the Veteran within their home and then take a walk, go for a coffee, or even attend an AA meeting together. The goal of the work is to assist the Veteran to achieve his/her goals, and joining the Veteran in the community is a helpful practice.

Home Visits: Common Dilemmas

This section will discuss some common dilemmas encountered in a community-based intervention such as Housing First.

- <u>Clutter/Hoarding:</u> When working with Veterans in their home, it is inevitable that this issue will come up for a few individuals, and the intervention used should be based on the specific individual. If it is a true hoarding situation related to a psychiatric condition then it will be important to have a VAMC or community clinician with appropriate expertise evaluate the

person. If the clutter or hoarding seems to be more aligned with poor housekeeping skills or feeling overwhelmed due to physical/aging concerns, then assistance from the Case Manager and in-home health supports are needed. Assisting Veterans with housekeeping or setting up systems for managing their home are tasks well within the scope of practice when employing a Housing First model of service, even for clinically-trained Case Managers.

- <u>Refusal to open the door:</u> If a Veteran is refusing to open the door or is not home for their scheduled Visit, it can be an indicator of issues of the services currently provided. For example, the team may not be offering anything of interest to the Veteran, there may not be enough of a relationship between the Veteran and the team, or it could be that the Veteran is experiencing difficulty that could potentially develop to a crisis. Often Case Managers will interpret this situation as an indication that the Veteran is not interested in services or is non-compliant. However, the correct response needs to be increased contact. It is the team's duty to engage the Veteran to see what needs to change in the relationship, and to find a way to connect so that they can provide services to the Veteran.

  It is also very possible that the Veteran is not home during the scheduled visit because they are becoming more integrated into their community, and perhaps in need of less support. In any situation, it is important to have a conversation with the Veteran and then adjust the schedule accordingly, based on mutual understanding.

- <u>Too many 'guests':</u> Clients tend to have the most difficulty with this situation and are most often evicted from units as a result of too much traffic in and out of the apartment, or having too many people staying with them. Conducting frequent home visits may deter people from coming and going or inhabiting the space. Often the team may need a more significant intervention, such as the Housing Specialist accompanying the Case Manager or two Case Managers conducting the Home Visit together and explaining to the guests that they are not on the lease and need to leave. Such action may not be desired by the Veteran a) because they are afraid or b) because the 'guests' may be there for companionship and it could be a mutually beneficial relationship. If it is a positive relationship then the team should work with the Veteran and the other individuals to find a more suitable unit, paying careful attention so that the Veteran understands the commitment. If the 'guests' pose an exploitative situation, when appropriate you may need to contact Adult Protective Services or law enforcement. It is important to be open and transparent with the Veteran about the actions you are mandated to take if necessary. Of course, any action should be discussed and reviewed by supervisors and other team members. The worst option is to ignore the situation, but a calm and thoughtful approach is needed – not a reactive one. Each scenario will have its own set of circumstances and considerations.

- <u>Evidence of substance use/abuse:</u> In Housing First, Harm Reduction is an essential component. With a harm reduction approach there is not an insistence on abstinence, it is

recognized that the team serves adults capable of making their own choices, and relapse is also accepted as a part of recovery.

However, using a Harm Reduction approach does not mean the team should ignore or avoid discussion if a Veteran is experiencing difficulty with substance use. The issues of substance use are varied and nuanced, and there is a spectrum of possibilities associated with the topic. For example, a Veteran may drink occasionally without any negative consequence on their well-being, and in this instance it is not necessary to address this unless the Veteran wants to or if there is potential of harmful side effects to factors such as medication – in which case the focus should be on education and raising awareness. On the opposite of the spectrum would be a Veteran struggling with addiction and facing severe health consequences. The team has the responsibility to address this concern through increased services or other approaches, but threatening the Veteran's housing is not an appropriate response unless it becomes an issue of competency. If the problem becomes associated with housing, practical approaches should be first considered, such as obtaining a payee for the Veteran. If the Veteran's housing again becomes jeopardized, while the team is doing everything they can it may happen that the Veteran loses their unit. The team should try to re-house the person, but it is very important that the Veteran understands what happened and what needs to be different in their next unit. When eviction occurs as a result of substance use problems, it is most frequently associated with the people with whom the person is using – it is a traffic or noise problem. If this is a recurring problem, it may be a beneficial option for the Veteran if they were to move to a congregate setting in which staff on-site can control who enters the building. Teams that include a Housing Specialist will find it helpful to divide up roles to address problems of substance abuse: the Clinician/Case Manager can address the issue from the perspective of treatment provider and the Housing Specialist will help by ensuring the Veteran is in compliance of their lease.

With Housing First, it is important to remember that the team is not in the role of landlord or probation officer or police, but rather should be focused on supporting the person to achieve their goals.

In summary, housing stability is often contingent on the amount of services the person receives. Teams who have achieved significant and successful outcomes show a positive correlation with more intensive service supports. Home visits should be the norm for most HUD-VASH client contacts as opposed to the traditional case management office visit approach. Housing First is a client-driven model, but it is not a passive intervention. The Home Visit is an invaluable practice for providing intensive services and helping Veterans achieve their goals, yet we need to be artful in service provision and understand that this is truly the person's home.

Chapter
11

MAINTENANCE OF HOUSING AND WORKING WITH LANDLORDS

What's in this Chapter?

Across the country, VA's permanent supportive housing programs, HUD-VASH, are successfully partnering with PHAs and landlords to help end homelessness among Veterans. Creative strategies have been developed to recruit and retain landlords who will rent quality apartments at available rates to households with no or limited income, criminal histories, spotty or poor credit and rental histories and/or physical or behavioral health issues.

In this chapter you will learn:
- To understand landlords' interests and concerns
- To market your program and respond to landlords' concerns effectively
- To understand both the landlords' and tenants' obligations under the lease and the permanent supportive housing program so that you can effectively negotiate a successful partnership
- To help landlords and Veterans to successfully navigate the various components of the leasing process
- To help Veterans identify suitable apartments and succeed at landlord interviews. Effective strategies to maintain good relationships, resolve conflicts that might arise, and help tenants achieve stability and avoid eviction

Understanding Landlords' Interests and Reservations

To help Veterans to quickly find and successfully maintain apartments in your community, you need a substantial network of responsible landlords willing to partner. Like any partnership, the quality of your relationships with those landlords will be dependent on your ability to understand what

motivates their participation and what reservations they have. It is important to recognize that each landlord is a unique individual and that opinions and attitudes can easily be shaped by past experiences – positive or negative. It is equally important to avoid stereotypes that lump landlords together and conceal individual interests, strengths, and concerns. Though each individual is certainly different, generally, landlords' interests are different than yours as a case manager. Landlords are motivated by a diverse range of factors that might include, for example:

- Keeping vacancy rates in their units low
- Minimizing operating expenses such as unit turnover, repair, maintenance and utility costs
- Minimizing legal expenses as a result of evictions and other court proceedings
- Getting paid a fair market rent in a timely manner
- Protecting their investment by minimizing property damage
- Avoiding frustrating and time consuming interactions over things like rent arrears, repairs, and neighbor complaints
- Maintaining their reputation as a good landlord
- Avoiding past mistakes
- Being a good neighbor and acting in ways that support the safety and quality of life in the neighborhood
- If they or people they care about live nearby, they may also be concerned about the safety and quality of life of their loved ones
- Helping people in need
- Helping people who have served our country
- Practicing their faith through participation in charitable or neighborly acts

In addition, like all people, some landlords will be motivated by deeply held biases and misperceptions that can be difficult to shake. Understanding what motivates the individual landlords that you are working to recruit or to retain is essential to facilitating communication in a manner that helps everyone (i.e., tenants, landlords, case management staff, supervisors, and partners from other organizations) to see the needs of each other clearly and work together to create "win-win" situations.

Given the scarcity of affordable units in most communities, landlords, particularly those with well-maintained units, can be very selective. Though they can seem like unnecessary barriers to ending homelessness for your clients, credit and background checks, references, minimum income requirements and interviews are among the limited tools landlords have to try to protect against renting to someone who will not pay their rent, or who might damage their property or disrupt neighbors, and landlords who may have had bad experiences in the past are even more likely to be cautious.

Why might landlords want to rent to Veterans in your program? Many are motivated by altruism. They want a chance to honor those who have served and to be a part of ending homelessness among Veterans, who have sacrificed so much for our country. Others see practical advantages to participation, including:

- Reliable monthly rental payments
- Fair market rent guarantees
- Case management services that provide a safety net and a resource to help resolve issues and protect their property
- A steady stream of potential tenants that reduces vacancies and marketing costs
- Other practical benefits that are sometimes offered by individual programs (see examples below)

Most landlords are motivated by a complex set of personal and business interests that might include a perceived opportunity to contribute positively to their community, while minimizing their personal risk.

Recruiting Landlords

The key to establishing successful partnerships is to listen to each individual landlord, reinforce positive motivation to participate, and explore opportunities to resolve concerns rather than trying to deny or refute those concerns. In all instances, your credibility will be reliant on being honest and trustworthy. Be truthful about what is in your control and what is not and never make promises you cannot reliably deliver. Don't be shy about selling your mission, your program's services and the Veterans you work with, but, of course, always do so in a manner that protects client dignity and confidentiality.

Be clear about the role of the case manager and any other relevant program staff and creative in developing strategies that respond to landlords' most pressing concerns. Consider for example, whether the VA or a partner organization can offer and reliably deliver any of the following:

- Guarantees to respond to urgent landlord calls within a specified timeframe, including at night and on weekends
- Guarantees to make trained staff available within a specified timeframe to mediate and resolve conflicts between the landlord and tenant or tenant and neighbors
- Assistance with labor and/or costs associated with repairing property damage
- Proactive outreach to the landlord, at least monthly, to monitor timely payment of rent and problem solve any concerns that may arise
- Guarantees that you can identify a pool of suitable, potential tenants within a specified timeframe from unit vacancy

- Assistance relocating Veterans voluntarily to other housing to avoid eviction related costs and/or covering eviction related legal fees when issues cannot be resolved
- Assistance covering maintenance and other costs associated with unit turnover
- Regular identification of resources that might be useful to the landlord, e.g. weatherization programs or simple guidance on how to prepare for an HQS inspection
- Forming a landlord damage insurance fund to cover costs associated with property damage

To see a sample MOU from a landlord damage insurance fund, visit http://www.endhomelessness.org/library/entry/example-landlord-damage-insurance-fund-mou-from-the-planning-council.

Create brief marketing materials that highlight the HUD-VASH program's track record in the community, explain the practical benefits you can offer to participating landlords, share inspiring success stories, and dispel myths and stereotypes. Use a broad range of networking strategies to get to know as many landlords as you can and to connect to key community leaders who know landlords. Those strategies might include formal meetings and networking events with community and faith-based groups, developing partnerships with Veteran services organizations, requesting referrals and references from current or past landlords or other partners, mining personal and professional networks of your staff, canvassing target neighborhoods, and cold calls and follow up meetings to potential landlords identified through canvassing, internet searches, and print media advertisements.

It is crucial to think positively and not give up even when faced with setbacks. Staying positive is critical to getting past the expectation of rejection and to cultivating creative ideas to find and market to landlords. Celebrating each success with your team, including your tenants and partners, is an important strategy for maintaining focus and morale. As you develop a track record of success and a reputation for excellent customer service, your accomplishments will breed additional success.

Landlord's Obligations under Lease and Permanent Supportive Housing/HUD-VASH

The lease and Section 8 addendum are legal documents conferring specific obligations that can be enforced in court. For some landlords, their participation in permanent supportive housing may be their first experience with this type of lease. Others may have had similar leases in the past, but without fully understanding the legal rights and obligations that the document confers.

The case manager or housing specialist may need to help ensure that the landlord understands his/her legal obligations, which include, maintaining the unit in compliance with HUD Housing Quality Standards (HQS), promptly making repairs as necessary and/or directed by the public

housing authority (PHA), providing all housing services as specified in the lease, allowing the PHA to inspect the unit at times the PHA deems necessary, ensuring that the unit includes appliances as specified in the lease, and paying the utilities as specified in the lease. In addition, the landlord cannot charge a rent that exceeds that paid for comparable unassisted units, cannot charge additional amounts for items customarily included in rent, must comply with the terms of the Housing Assistance Payment contract with the PHA, and cannot be an immediate family member of the assisted Veteran (unless the PHA has approved the arrangement as a reasonable accommodation). Furthermore, failure of the PHA to pay its portion of the rent is not a violation of the lease and cannot be grounds for eviction, and the landlord can only evict through court action.

In addition, case managers and housing specialists can play an important role in helping landlords to understand the benefits of assertively communicating lease violations, for example, by sending a violation notice to tenants as early as possible and notifying the case manager when such notices are sent. This provides the case manager or housing specialist an opportunity to help the tenant to understand lease obligations and to explore options to meet the expectations. Without consistent enforcement, tenants may not take lease requirements seriously and will miss opportunities to develop tenancy skills and develop a history of positive tenancy. It will also limit the case managers' and housing specialists' ability to intervene, as tenants often seek assistance when there are problems that put their housing at risk. The Corporation for Supportive housing has a Property Management Manual with sample forms that may be helpful to landlords [http://www.csh.org/wp-content/uploads/2011/12/Tool_PropertyMgmtManual1.pdf]. The case manager can also work with landlords to identify, based on local housing laws, the process to resolve lease violations and identify the roles of the landlord and case manager (see Sample Lease Violation and Roles and Responsibilities in the Property Management Manual mentioned above).

Tenants' Obligations under Lease and Permanent Supportive Housing/HUD-VASH

For some Veterans, their participation in permanent supportive housing may be the first time they have ever had a lease in their name. Others may have had leases in the past, but without fully understanding the legal rights and obligations that the document confers. Some may have lost their housing as a result of lease violations, although actually being evicted from housing happens relatively rarely. A primary role of the VA case management team is to help the Veteran to understand her rights under the lease and 'Section 8' addendum to the lease, what she must do to remain in compliance, and the consequences of lease violations. In addition, the case manager and housing specialist can help the Veteran to learn about local tenant laws and programs that offer assistance when landlords fail to comply with their obligations or that can provide free or low cost legal assistance to tenants at risk of eviction.

The lease is a legal document conferring specific tenancy obligations that can be enforced in court. These obligations include paying rent in full by a specific date each month, maintaining living and housekeeping standards that do not pose threats to the health and safety of other residents/PHA or landlord employees or cause damage to the unit or premises, not engaging in criminal or violent activity in the unit/common areas/on the grounds, disposing of garbage and other waste appropriately, keeping utilities current and paid, allowing others the peaceful enjoyment of their homes (e.g., not creating a disturbance and following all provisions related to noise), abiding by occupancy provisions and not allowing people not on the lease to live in the unit, providing access to the landlord and/or landlord's proxies for purposes of conducting necessary maintenance and repairs, and following all other lease provisions (e.g., limitations/prohibitions on pets).

In addition to complying with the lease, as a participant in permanent supportive housing, the tenant has other obligations that she must meet to remain in the HUD-VASH program, including providing accurate information for annual recertification or any interim re-certifications and reporting all changes in income and family composition (e.g., birth, adoption, marriage, domestic partnership, and custody). In all instances other than, birth adoption or court ordered custody, the Veteran family must obtain PHA approval prior to allowing any additional persons to live in their household. In addition, the tenant may not have another residence or sublet or transfer the unit. The Veteran family must not be absent from the unit for longer than 180 days, must notify the PHA before leaving the unit, and must allow the PHA to inspect.

The lease also confers legal rights to the tenant, for example: the right to live in decent, safe and sanitary housing free from environmental hazards; the right to have repairs made in a timely manner; the right to privacy, including reasonable notice in writing of any non-emergency inspection or other entry into the unit; the right not to have the landlord enter the unit for any purpose other than a reasonable business purpose; and the right to have the PHA re-inspect the unit and withhold payment until the apartment meets quality standards. It is essential that the case manager is familiar with all obligations and rights of tenancy, educates the tenant about these obligations, and serves as a resource to the landlord and housing authority to help ensure compliance.

Permanent supportive housing is essential to the national goal of ending homelessness among Veterans. This goal is ratified by the Departments of Veterans Affairs and Housing and Urban Development and supported by the US Interagency Council on Homelessness. Since HUD-VASH offers both long term housing assistance and case management support, it is well suited to meet the needs of chronically homeless Veterans.

It is understood that placing chronically homeless people in housing and supporting them in maintaining that housing is challenging and that many chronically homeless Veterans will face

impediments to entering and remaining in the program. VA case managers and other members of the support team need to be prepared to go to extra lengths to keep Veterans housed and prevent them from violating lease or program requirements.

In some instances, these efforts will not be sufficient and Veterans may leave or be forced to lose their housing, and the PHAs may seek to terminate the vouchers for violations of one or more program rules or requirements. As indicated in the chapter, "Working with PHAs", eviction and/or the loss of a voucher has different consequences in permanent supportive housing than in other settings. It may be that the Veteran needs more support than can be provided in a scatter-site tenant based rental assistance program and access to a project-based voucher could be more beneficial. Or, the VA case management team will need to structure more intensive supports to assist the Veteran to remain housed. After carefully reviewing the circumstances behind the Veteran losing his/her housing, the VA should, in collaboration with the PHA, develop a plan to re-refer the Veteran for a new voucher or to locate an alternative housing opportunity that is more likely to lead to long term stability. Since the national goal is to end all homelessness among Veterans, any individual setbacks along the way should be seen in that context and efforts reinitiated to place and maintain the Veteran in permanent housing.

Helping Veterans to Navigate the Housing Search Process

Landlords' experience with VA's permanent supportive housing program will be affected by each interaction with the case manager, housing specialist, tenants, potential tenants, and PHA staff. Landlords will want the process of meeting and vetting potential tenants to be efficient, pleasant, and result in leases with tenants who consistently meet their tenancy obligations. The case manager, housing specialist, and other members of the team such as peer specialists play an important role in helping to ensure that the housing search process is efficient and effective for both Veterans and landlords.

Assessment

The process of helping tenants to prepare for the housing search begins during the initial service assessment, which should include questions that will help inform the housing search. For example, the assessment might explore: past homelessness and housing experiences, current housing goals, experience as a leaseholder, what the Veteran liked and did not like about previous housing, and ability to complete paperwork and successfully navigate interviews.

A housing needs and preferences checklist can be a useful tool for the tenant, case manager, and housing specialists to vet potential units. The checklist can be individualized according to the unique needs and preferences of each Veteran, and, for each item, the Veteran might specify ideal conditions, acceptable conditions and any factors that are non-negotiable. The case manager and

housing specialist should encourage the Veteran to think about what she would really like in the future and to dream big, while helping the Veteran to simultaneously define what she is willing to accept in the present. The resulting discussions can be an important way to inform the person-centered planning process and to help the Veteran see options currently available as a step towards meaningful longer-term personal goals. (For more information on person-centered planning, see Chapter 1, "Patient-Centered Care", or the Office of Patient Centered Care and Cultural Transformation site: http://HealthforLife.vacloud.us.)

Interviews

In addition, the case manager and housing specialist plays an important role in helping Veterans to prepare for housing interviews. Strategies, including mock interviews, escorting Veterans to their interviews, and debriefing what went well and could have been better following each interview, are all good ways to help Veterans get prepared and learn new skills. Furthermore, when the interviews go well, landlords will be more likely to remain enthusiastic about the program.

Remember that some Veterans may not have ever interviewed with a landlord before or may have had previous negative experiences with such interviews. It can be tricky to avoid assuming that the Veteran knows how best to manage the interview, while simultaneously not providing unwelcomed advice. By asking about past experiences and for permission to offer advice and assistance, case managers and housing specialists can achieve that balance.

As indicated by Veterans' skills and preferences, case managers and housing specialists might, for example offer assistance in these areas:

- How to access and understand a credit and/or criminal background report
- How to correct erroneous information on the reports
- Anticipating what questions the landlord might ask about the reports and developing effective responses with a focus on what has changed
- Anticipating what questions the landlord might ask about the Veteran's rental history and developing effective responses
- Appropriate dress for the interview, including obtaining clothing as needed
- Arranging reliable transportation and planning strategies to ensure promptness.

Rent limitations

The amount of the HUD-VASH subsidy is limited by the 'payment standard' established by the local PHA (see "Working with PHAs chapter for more information). The maximum subsidy that can be provided is the difference between the required tenant rent payment and the payment standard established by the PHA. Additionally, upon initial occupancy of the unit, the Veteran and his/her family can pay no more than 40% of their adjusted income for their housing costs.

As a result there are limits on the housing that is affordable even with the HUD-VASH subsidy. Veterans with no or very limited income, should be seeking units that rent with utilities included and with a total rent that does not exceed the payment standard. Veterans with higher incomes may be able to afford units that are priced slightly above the payment standard.   Prior to visiting a unit, the Veteran, case manager, and housing specialist should review the payment standards and the requested rent to verify that the unit will be affordable prior to investing time in visiting a unit that they will not be able to afford. Often, when the difference between the payment standard and the asking rent is not that great, landlords can be convinced to accept a slightly lower rent in return for the guaranteed payments under the subsidy and in order to assist a homeless Veteran.

With an understanding of rent limitations, a thorough assessment, and advanced interview preparation, the case manager or housing specialist can facilitate good matches between Veterans and potential units/landlord and make the housing search process a positive experience.

> ### *Sidebar: Housing Needs and Preferences Checklist*
> A checklist can be used to vet potential units and can be individualized according to the unique needs and preferences of each Veteran:
> - ✓ Preferred Location(s)/Neighborhood(s)
> - ✓ Excluded Location(s)/Neighborhood(s)
> - ✓ Access to Transportation
> - ✓ Proximity to Significant Others
> - ✓ Accessibility to the VAMC or CBOC
> - ✓ Proximity to Services (e.g., doctors, entitlements offices, employment services)
> - ✓ Proximity to Community Resources (e.g., park, library, grocery store)
> - ✓ Proximity to Employment Opportunities
> - ✓ Unit Size
> - ✓ Housing Density
> - ✓ Building or Unit Amenities (e.g. laundry facilities, elevator)
> - ✓ Special Accommodations
> - ✓ Restrictions on Pets

Working with Landlords in the Leasing Phase

Particularly for landlords that may not have previously participated in VA's permanent supportive housing or similar programs and for those who may have participated but did not have a positive experience, the HUD-VASH case manager or housing specialist can play an important role in helping the landlord to understand and navigate the program. For example, it will be important for the landlord to understand the supports available through the VA case management team. These include:

- Assisting the Veteran to gather documentation required by the PHA
- Working with the PHA to get vouchers issued promptly
- Assisting the Veteran to locate a unit and submit to the PHA for inspection
- Helping to coordinate initial and annual inspections
- Assisting the Veteran to maintain tenancy and prevent eviction including assisting in resolving issues that may arise between Veterans and landlords
- Assisting the Veteran and in preparing for inspections and re-certification

Understanding these supports can go a long way towards increasing landlord confidence in the program.

Preparing for inspections

It is important for landlords to understand the Housing Quality Standards (HQS) so that they can be prepared and avoid the need for multiple inspections. (For more information on HUD's HQS, please refer to the section in Chapter 6.) These general tips from the HUD-VASH Landlord Factsheet [http://www.va.gov/homeless/docs/landlords_factsheet.pdf] are a good starting point to help landlords to understand the requirements and prepare for inspections:

Make sure your unit has:
- ✓ Working smoke alarm(s)
- ✓ Proper ventilation in bathrooms (window or fan)
- ✓ Connected utilities
- ✓ A functional stove and refrigerator
- ✓ A window in every bedroom that can stay open without props
- ✓ A working water heater discharge line and pop/relief valves
- ✓ Handrails for steps
- ✓ Secure railings for porches and balconies

Make sure your unit does not have:
- ✓ Broken or missing locks
- ✓ Broken or missing windows
- ✓ Bugs or vermin
- ✓ Tripping hazards on the floor
- ✓ Exposed electrical wiring
- ✓ Chipping or peeling paint inside or outside

To avoid HQS failures, the case manager or housing specialist can advise landlords to use the HUD HQS Inspection Checklist [https://portal.hud.gov/hudportal/documents/huddoc?id=DOC

_11775.pdf] to pre-inspect the unit. In some cases, as an incentive to landlord participation in the program, the case manager, housing specialist, or another individual from his/her organization might provide pre-inspection services to alert the landlord to needed repairs. In addition, having the landlord or a proxy of the landlord, and/or the case manager or housing specialist shadow inspectors during inspections can help ensure everyone understands the process and is familiar with the most common findings issued by your PHA. In general, these conditions commonly trigger HQS inspection failures: missing or broken smoke detector(s) & carbon monoxide detector(s), missing electrical outlet covers, paint on wall(s) is chipping or peeling excessively, windows are defective, no window stops/broken window balances, and missing or broken window guards if children 10 or under are living in the unit.

Fair Housing and Accessibility

Similarly, it is important for landlords to understand their obligations under the Fair Housing Act. The Fair Housing Act prohibits discrimination in housing on the basis of race, color, religion, sex, family status, national origin or disability. Other than prohibiting the seven bases of discrimination listed above, the Act does not limit the considerations that may be taken into account in making a housing decision, or prevent the adoption of preferences (e.g., a preference for homeless households) as long as those preferences do not violate the rights of one of those seven classes. The Act also permits preferences for persons who are disabled.

Some disabled Veterans may require a reasonable accommodation under Section 504 of the Rehabilitation Act of 1973. PHAs are required to provide reasonable accommodations so that people with disabilities have equal access to housing opportunities. Examples of reasonable accommodations include: the ability to rent from a family member, obtaining a higher rent payment standard enabling the Veteran to rent an apartment at a higher amount than typically allowed, and ability to have a service animal even if pets are not normally permitted in the unit. Reasonable accommodations are not likely to be common, so the case manager or housing specialist should use judgment about when educating landlords about these requirements is necessary. (For more information on this, please see Chapter 6 in this Resource Guide about 'Working with PHAs').

Working with Landlords when Veterans are Tenants

It is inevitable that issues that could threaten Veterans' housing stability will arise after the lease has been signed. Common challenges include rental arrears, conflicts with the landlord and/or neighbors, and violations of occupancy, pet, noise or other provisions in the lease. To maximize Veterans' housing stability and build positive partnerships with landlords, case managers or housing specialists can use these strategies.

Proactively assess lease compliance and practice crisis prevention. By working to establish a cooperative relationship with the Veteran and landlord, in advance of any problems, the case manager or housing specialist will have a solid foundation from which to address lease violations and other challenges. Rather than waiting for a compliant, case managers should do proactive outreach to the landlord, at least monthly, to monitor timely payment of rent, ensure overall lease compliance and problem solve any concerns that may arise. Given resource constraints in most human services programs, it can be tempting to adopt a crisis intervention orientation, in which staff spends the majority of their time responding in the moment to the most pressing emergencies. This approach is challenging for staff and generally less effective than crisis prevention, which requires positive relationships with Veterans and landlords, regular contact with both, frequent home visits, honest and skillful assessment of emerging challenges, and proactive intervention prior to crises.

Establish credibility by demonstrating integrity and reliability. Though it can be tempting to focus on the positive and avoid discussions with the landlord about challenges, this strategy is likely to backfire and undermine your credibility when issues become apparent. The case manager will need to conduct regularly scheduled home visits, intervene promptly when s/he detects a problem, and communicate proactively with the landlord, while protecting Veterans' confidentiality. Furthermore, the service team will need to follow all policies and procedures for after-hours emergencies.

Similar to strategies used during the landlord recruitment phase, the keys to establishing successful ongoing landlord relationships are proactive communication, careful listening, and a creative and collaborative approach to resolving concerns. To establish credibility, case managers will need to be honest and reliable. Be truthful about the situation and about what is in your control and what is not and never make promises you cannot reliably deliver. Demonstrate accountability and integrity by making firm commitments whenever possible, and always following through in a timely manner on the things you commit to doing. As you work to resolve issues maintain proactive communication by always keeping the landlord informed of the actions you are taking and of any changes to the agreed upon plan or situation.

In all communication with those outside of the direct service team, including landlords and PHA staff, the case manager or housing specialist must not reveal confidential health or clinical information. Rather than revealing Veterans' personal information, communication should focus on lease compliance and the steps the service team and Veteran are taking to remedy any violations. The case manager or housing specialist will need to be careful about the level of detail revealed to avoid confidentiality breaches. For example, in response to neighbor complaints about a Veteran with mental illness who frequently screams at night, the case manager or housing specialist should not reveal that s/he is working with the psychiatrist on medication adjustments. Rather, s/he might

explain efforts to make sure that the Veteran understands the related terms of the lease and gets support to prevent future incidents.

Use the lease as a service engagement tool. The case manager or housing specialist can use the lease as a structured and nonjudgmental way to engage tenants in matter-of-fact discussions around sensitive topics. For example, a Veteran who does not wish to discuss her substance use, mental health symptoms or domestic violence issues, may be open to discussions about tenancy rights and obligations. Such discussions tend not to be stigmatizing and can be a good place for the worker to quickly provide useful, concrete assistance, thereby establishing a non-threatening role and an opportunity to build trust and credibility with the Veteran.

When they occur, lease violations can be a natural way to discuss negative consequences of risky behavior with the Veteran and plan ways to reduce harm together. Non-judgmental exploration of ways in which eviction might interfere with the Veteran's short and long-term goals, can be an important opportunity to build motivation to stay housed and plan risk reduction strategies. A clearly defined process outlining the steps that will occur and who is responsible for each can be an important tool to inform matter-of-fact discussions around reducing harm from rent non-payment. (For more information about harm reduction and person-centered planning, see Chapter 4. Also, see the Rent Arrears Flow Chart in the Property Management Manual [http://www.csh.org/wp-content/uploads/2011/12/Tool_PropertyMgmtManual.pdf]).

Adjust service intensity when lease violations occur. For any Veteran that is regularly violating her lease and at risk of eviction, service intensity should increase. Case managers or housing specialists may need to initiate hands-on interventions, such as: accompanying tenants to cash checks, obtain money orders, and make rental payments; regularly assessing the apartment for health and safety violations; and assisting with waste removal, apartment upkeep or repairs. In all instances, services should focus on building tenancy skills and avoid staff doing things that Veterans can learn to do on their own. When the level of service necessary exceeds what is possible for the VASH service team, case managers should assist the Veteran in establishing linkages to other community based service providers, including representative payees, home health, and personal care services.

Use Motivational Interviewing to build effective partnerships. Of course, some Veterans may be reluctant to engage in services and avoid discussions of apparent issues. Motivational Interviewing (MI) is an effective tool to avoid power struggles and build an effective partnership between staff and Veterans. MI is a clinical technique that helps people to identify their problems, resolve ambivalence and build motivation regarding change. The MI counseling style generally includes the following elements: establishing rapport with the client and listening reflectively; asking open-ended questions to explore the client's own motivations for change; affirming the client's change-related

statements and efforts; eliciting recognition of the gap between current behavior and desired life goals, asking permission before providing information or advice; responding to resistance without direct confrontation; encouraging the client's self-efficacy for change; and developing an action plan to which the client is willing to commit.

<u>Seek alternatives to eviction.</u> If lease violations continue despite increased service intensity, the case manager or housing specialist should actively seek alternatives to eviction, which is costly for the landlord and damaging in various ways for tenants. Alternatives might include accessing one-time rental assistance funds and/or anti-eviction legal services and assisting with voluntary relocation.

When issues that could threaten Veterans' housing stability inevitably arise, these strategies will promote both Veterans' housing stability and positive partnerships with landlords.

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Chapter
12

WORKING AND COMMUNICATING WITH MENTAL HEALTH PROVIDERS

What's in This Chapter?

C ase Managers and Peer Support Specialists can provide psychiatrists and other mental health providers with invaluable insights into the daily living of the Veterans they serve. After reading this chapter, you will know how to take a proactive approach to supporting the work of treatment providers working with HUD-VASH Veterans on your caseload.

In this chapter you will learn:
- How to facilitate psychiatric and other mental health services;
- How to support adherence to mental health treatment plans; and
- Tools for avoiding and managing crises.

Importance of the Case Manager

A significant percentage of the Veterans in the HUD- VASH program will be involved in mental health treatment of one form or another. An effective and well-integrated Case Manager can have a profound impact on the Veteran's successful recovery from acute mental health disorders.

Within an interdisciplinary team, it is common for the each member to have a different type of relationship with the client, and each type of relationship will have a different basis for communication. If, for instance, the pain of a service-connected injury is played down to a primary care provider, the Peer Support Specialist might know that this is because this Veteran, who is in active recovery from a narcotics addiction, wants to avoid being prescribed a drug with a street value. Similarly, a psychiatrist who is working with the Veteran on cognitive behavioral therapy for severe depression will have a different understanding of the Veteran's thought processes than, for

example, even a 12-step sponsor. Although the Veteran is the common concern, each member of a treatment team receives different types of information, at varying levels of depth, in a different way.

CASE MANAGER COMMUNICATION CAN ENHANCE THE PROVIDER VETERAN RELATIONSHIP		
TREATMENT OBJECTIVE	**CASE MANAGER'S ROLE**	**OUTCOME**
Support the Veteran's treatment and recovery needs	Communicate important information on behalf of the Veteran when needed	Improve diagnostic database for clinicians by communicating concerns, observations, information
		Allow for earlier recognition of emerging problems by keeping treatment team informed about Veteran's lifestyle, work, education, housing—including goals, achievements, setbacks
Reinforce and inform the Provider's treatment plan	Convey own observations, concerns, information	Extend view and awareness of treating mental health professional
		Improve Veteran's adherence to prescribed treatment strategies
		Help modify intervention strategies

Table 5. Case Manager Communication's Role in the Provider-Veteran Relationship

"The Case Manager's observations and relationship to the Veteran can provide ongoi assistance in achieving the therapeutic goals of the mental health treatment plan…"

At the center of all of these relationships is the Veteran's Case Manager, who will often be viewed by the Veteran as a confidant, an ally, and an advocate. Equally important is the Case Manager's role as an honest broker–serving as a liaison among different members of the treatment team and providing clear, accurate information. By appropriately participating in, and augmenting the relationship between, the Veteran and the psychiatrist (or other mental health provider), the Case Manager can potentially improve the diagnostic database, allow for earlier recognition of emerging problems, modify intervention strategies, and improve adherence to the prescribed treatment regimen. The

Case Manager can extend the view and awareness of the treating mental health professional, and can help convey important information on behalf of the Veteran.

By working as a team, the variety of perspectives and observations can be incorporated into a broader and more complete picture of the Veteran's world than any one clinician alone could formulate.

Obtaining History

The ability to accurately diagnose an illness or understand a situation is directly related to the amount and quality of information obtained through history and examination.

In Mental Health Care, History is Vital
▪ Many symptoms are chronic, but still wax and wane over time
▪ Course of symptoms defines and distinguishes one mental health syndrome from another, yet the course is not always evident or expressible
▪ Symptoms often do not lend themselves to direct examination, verification, etc.

Table 6. Why a Proper Medical History is Vital

Obtaining a good history is essential but not always simple, especially if the only source of information is the patient. Human beings strive for some form of order or understanding. Events are put on timelines, connections are made–and, in some cases, causality is inferred in order to "make sense" out of what is happening. This is one strategy by which an internal sense of mastery, or control, can be achieved. In order to help communicate information to others, it is internally edited and formatted. The connections that are made, the theories that are generated, and the organization that is developed serve clear functions; however, this framework also limits the degree to which a person can provide a truly objective, unaltered, factual history. The Veteran patient will edit and select information based on what he/she perceives as important and relevant and, depending on the skill of the clinician and the Veteran's perception, may also provide history with intent to please or satisfy the interviewer. This can be especially true when the issues are highly personal for the

Veteran, or when he or she feels that there is a lot at stake– in these cases, treatment team members, or even the same clinician on different visits, may receive different amounts of spontaneous information about the Veteran's subjective experiences and opinions. Assumptions on the part of the Veteran concerning the relative role, interest and expertise of the listener also factor into this variance. Time- limited appointments with psychiatrists and nurse practitioners may convey that only certain factual material is to be discussed; this may also positively reinforce certain disclosures and responses, while having the opposite effect on others. This is not to be confused with withholding, malingering, or falsifying information–rather, it is a limitation shared, to some degree, by all historians.

When the challenge of providing unaltered, un-interpreted, factual information is coupled with the inherent subjectivity of many questions and symptoms in mental health, it is easy to see why an account of an illness or problem may sound quite different at different times and to different listeners, and might vary still more from what an outside observer would witness.

As outlined in the table below, seeing the Veteran in his or her home, or in a community setting, can provide information that isn't available in an office visit. Is the home grossly unkempt, suggesting apathy, or is it overly fastidious, suggesting compulsive cleaning? Are beer cans or wine bottles lying around, and is this consistent with reported use? Are windows or the T.V. covered, suggesting paranoid fears?   Not everything is obvious, even when viewed directly, but by noting the condition of the home, of the Veteran, and how he or she seems to be interacting with the environment, the Case Manager can be the eyes of the treating mental health professional and augment the reported history with additional facts and details.

In addition to direct observation, the nature of the Case Manager's interactions with the Veteran can be a vehicle for obtaining information that may be not disclosed to a mental health provider. High anxiety, worsening depression, emerging psychosis, or developing mania can impair insight and judgment, making it difficult for Veterans suffering from these issues to observe themselves and convey their experiences. For example, a person may describe sleep habits very differently when responding to a closed question in a structured interview during a scheduled appointment than when asked about the same issues in a more conversational way.

It is common for a Veteran patient to attempt to conform to the provider's style and needs during a diagnostic interview or medication appointment. Problems and symptoms are typically the focus. In a meeting with a Case Manager, however, the tone is typically more conversational and less formal.

It is more likely for hopes, fears, and wishes to be part of the discussion. It cannot be immediately assumed that one interaction is inherently superior to the other, but if disparate or unique reporting

is identified, additional efforts to gain clarity and accuracy can be pursued. Obtaining information that may vary from that reported to the psychiatrist is not only of potential value to the psychiatrist, but is also of value to the Veteran, as it allows for the most accurate clinical picture and appropriate treatment. The take-home point is not to assume consistency in all reporting and to consult the medical record frequently and maintain open communication with others on the treatment team.

An accurate history is not just important in the early stages of care, but remains vital to the monitoring of stability and treatment effectiveness. The Case Manager's observations and relationship to the Veteran can provide ongoing assistance to the therapeutic goals of the mental health treatment plan. Indeed, in some cases, specific assessment tools can also be utilized between scheduled appointments to improve the disease monitoring process. A number of surveys and questionnaires exist for various psychiatric illnesses which can provide a measure of symptom severity that the primary treatment team may find useful in guiding treatment. One example is an instrument used in depression care management, the Beck Depression Inventory (BDI). It is a Veteran-completed questionnaire that can assist in symptom and response tracking vis-à-vis the treatment course.

While the principal treating provider should be consulted and local policies should be considered prior to administering any specific instrument, when indicated, the Case Manager can help ensure that measures are completed and the results relayed in a timely manner. Field interventions, such as the completion of a questionnaire, can make appointments with prescribing providers more efficient, and, in some cases, can potentially allow for timely interim medication adjustments.

Facilitating Treatment

With adequate information, a mental health professional should be able to generate a diagnosis and prescribe a treatment. At subsequent visits, the success of the treatment is evaluated and, if needed, an adjustment is made to the regimen. Occasionally, a lack of response or a unique response to treatment may trigger reconsideration of a diagnosis. The ability to follow the prescribed treatment plan is, therefore, important for two reasons: it may be of value to the Veteran in light of his or her recovery goals, and it may re-inform the clinician's opinion of the condition itself.

A provider may prescribe medications but also commonly make recommendations and suggestions for lifestyle changes. These may involve exercise, education, hobbies, or volunteer projects, or may center around nutrition plans or a nighttime routine for sleep (sleep hygiene). Apart from issues of more clear resistance to the treatment, which will are covered later, there can be some very real challenges with translating these lifestyle recommendations into actions. The Case Manager should review the provider's recommendations in common language, and should revisit the "new habits" often.

In addition to potential implementation challenges, there may also be barriers in understanding what the treatment recommendations actually are. Memory difficulties, problems with attention, and language barriers are all common in patients receiving mental health care. Some patients may also have very concrete thought process and be unable to generalize or comprehend figures of speech. While most providers try to use appropriate language to ensure that their recommendations are understood by the patient, it is still quite possible for parts of the explanation to be forgotten and certain points "lost in translation." Repeatedly reviewing all recommendations in a non-hurried, concrete manner, using different explanations and examples, if necessary, can be a tremendous help to everyone.

As the Veteran, clinician, and Case Manager reach an agreed-upon understanding of the treatment plan, the recommendations should be reviewed in light of the Veteran's actual environment.

A recommendation to get exercise may be compromised by the lack of a nearby gym as well as by preconceptions about what constitutes exercise. This may not be expressed to the recommending provider at the time of the appointment, and it may fall to the Case Manager to isolate the issue, discuss it, and find a solution. If no alternative can be identified, the Case Manager and the clinician can discuss a timely plan modification.

Along the same lines, providing information about the Veteran's actual environment and lifestyle can be very helpful to the mental health provider, and can allow the clinician to make treatment recommendations that fall within the scope of the Veteran's abilities and environmental limitations. Cooking skills, or lack thereof; disposable income; access to transportation; proximity to community resources; and other realities of the Veteran's habits and behavior are all potentially important. When the Veteran does not or cannot communicate important lifestyle information, the Case Manager can fill in the blanks for the mental health provider.

Frank conversations about what parts of the treatment plan the Veteran is actually implementing, in a manner that does not convey displeasure or disappointment, can provide insight into what elements of the treatment plan are working, and which can be improved. Relating lifestyle changes to potential medication issues is often a critical step in engaging the Veteran. Explaining that it is impossible to determine which symptom is a side effect of medication, and which is a side effect of poor nutrition or poor sleep hygiene, for example, is an important step in facilitating the Veteran's investment in his or her own treatment.

It may also be helpful to explain that most providers begin with the lowest-risk medications and treatments, but often these require more lifestyle changes on the part of the Veteran. If treatment fails due to implementation barriers–for instance, a Veteran's inability to follow a schedule that helps

determine whether or not a medication is disrupting sleep–a second-line medication or treatment strategy, with more potential side effects, may be the result. Furthermore, each step toward treatment compliance is an opportunity for esteem-elevating self-sufficiency.

Case Managers should be proactive in seeking their own understanding so they can be assets to clients and to treatment teams. When Case Managers ask for clarification of words, meanings of certain terms, etc., during joint meetings with the Veteran and the provider, it serves all parties–eliminating both the barrier to implementation and the hesitation of inquiry.

Supporting Adherence

A high percentage of both mental health and general medical patients have poor adherence to a medication regimen as ordered by a treating provider. Poor understanding of risks and benefits from treatment, fear of side effects, actual experience of side effects, forgetfulness, confusion, nonchalance, and, in some cases, a potential secondary gain from medication diversion, are some potential causes for non-adherence. Being aware, being inquisitive, and being responsive can help improve medication adherence and treatment success.

The informed consent process, the risk descriptions in pharmaceutical packaging, advertising, and information from the internet can all make the potential risks of treatment seem overwhelming and out of proportion to the potential benefits. If concerns about potential side effects are an identified issue for a Veteran, it can be very helpful to clarify the concerns, actual risk, and what the response would be. Are the feared side-effects common or very rare? Are they reversible? Are they time-limited? What is the plan if the feared side effects actually emerge? Exploring these items with the Veteran can, at times, alleviate concerns.

Any further issues that emerge, or perhaps a concession to a more informed risk-benefit analysis, that emerges, can be used in follow-up with the prescribing provider so that, if necessary, an alternative agent can be utilized. Many of the same points are relevant when side effects do emerge, and even more so when they limit adherence. Psychiatric medications, especially those that fall into certain pharmacological categories, can negatively impact sleep, energy, appetite, weight, bowel functioning, physical movement, muscle control, and sexual functioning. While this is an incomplete list, it does demonstrate why a Veteran might consider ad hoc treatment discontinuation.

It is good practice for Case Managers to become familiar with the most common and, potentially, the most severe, side effects of their clients' medications. Analysis of medication side effects can be tricky, as many side effects are very similar to the symptoms of the illnesses they are designed to treat. Other effects can be influenced by, for instance, whether or not the medication is taken on a full or empty stomach, or if it is taken in combination with other agents (including other prescribed,

over-the-counter, and/or herbal preparations).   The key point is to be aware that medication discontinuation is a common phenomenon, and the sooner it is recognized, and the rationale behind what it identified, the better. Some Veterans may be reluctant to spontaneously bring up problems such as sexual dysfunction, so tact is necessary in eliciting information that the prescribing provider can use to modify treatment.

CASE MANAGERS CAN HELP SUPPORT MEDICATION ADHERENCE	
PATIENT/CLIENT	OPPORTUNITY FOR SUPPORT
Concerns about potential side effects	▪ Work to help clarify actual risk and potential response ▪ Are feared side-effects common or very rare? o Are they reversible or time-limited? o What is medical plan if side effects to emerge?
Actual experience of side effects	▪ Become familiar with most common and potentially most severe side effects of common psychiatric medications, and of your clients' medications ▪ Introduce reminders for or investigate mitigating factors: full stomach, empty stomach, with food, etc. ▪ Be aware that some Veterans may not bring up problems like sexual dysfunction, etc.; be discreet and tactful ▪ Prescribing provider may be able to adjust dose, modify schedule, add an antidote med, etc.
Abrupt medication stoppage	▪ Check in regularly with Veteran and ask about medication adherence, problems, concerns, etc.
Memory problems, confusion, scheduling problems	▪ Help provide pill boxes and assist with filling if necessary; observe if there are meds whose supplies change abnormally quickly or slowly ▪ Consider bubble-packed medications if there is a higher need for supervision

Table 7. How Case Managers Can Help Support Medication Adherence

By becoming aware of a medication issue, the prescribing provider may be able to adjust the dose, modify the schedule, add an antidote medication, suggest behavioral strategies, or provide education

that can allow the Veteran to continue with treatment. In other cases, the treatment may need to be changed more dramatically, but having information in a timely manner is a key factor to relapse prevention or symptom exacerbation caused by medication non-adherence.

In most cases, a short time off treatment will not trigger an exacerbation, but if the Veteran stops his or her meds soon after having them prescribed–and it is not known for several weeks–serious problems could arise. Similarly, the abrupt cessation of certain meds, including some antidepressants and anti-anxiety medications, can trigger withdrawal symptoms that can, at times, be quite uncomfortable and severe. High rebound anxiety, insomnia, and seizures are some potential complications of abrupt medication withdrawal.

In the case of memory problems or confusion, additional tools may aid the Veteran in adhering to the treatment regimen. Pill boxes can be helpful, but many patients will either struggle with filling the box correctly or may actively defeat the pill box by accessing meds early–or in excess–in order to achieve a desired effect. The latter is more likely to occur with substances of abuse such as tranquilizers and pain medications. Observing the Veteran's supply of medication, and comparing it with prescription instructions, could signal the need for a higher degree of medication supervision. In this case, there are options such as prefilled pill boxes, bubble-packed medications, or other, more secure, medications of medication delivery.

Crisis Avoidance/Management

The treatment prognosis is best when the diagnosis/ diagnoses is/are accurate, the treatment plan is comprehensive and well-developed, the Veteran is adherent and conscientious, and the Case Manager and treatment team are involved and aware. However, even in an ideal situation, decompensation may still occur due to medical conditions or status changes, changes in environmental stressors, or natural progression of an illness.

While symptom control is important as far as mitigating the patient's pain, suffering, or mental anguish, and also because of the variety of possible negative social consequences, there is evidence that, in a variety of conditions, the long-term course and prognosis worsens with each recurrence.

Extended periods of psychosis may reduce baseline functioning; each manic and depressive episode can increase the risk for subsequent episodes. It is also widely known that suicide risk is elevated in a variety of psychiatric conditions.

Remission and recovery are always the goals, and may be realistic outcomes in many cases. However, recovery may not equate to a complete absence of symptoms. In spite of aggressive management of symptoms and conditions, treatment results may be incomplete. If the patient has

adapted to symptoms over time, and has appropriate supports, he or she may still be able to function very effectively, despite symptoms. Lingering paranoia or hallucinations, suboptimal mood stability, or residual anxiety may be realities of daily life for some Veterans.

Recognizing this reality, and working to understand the specifics of the client's condition, are important for optimal functioning and for effective case management. The Case Manager should prioritize communication with the treating clinician and should maintain familiarity with the Veteran's baseline status. The severity of baseline symptoms can impact individual goals and outcomes, but stable symptoms typically do not cause the same level of distress and risk as acutely worsening symptoms–even if the severity appears less pronounced in the latter. Thus, it is clear that effective monitoring for worsening symptoms is dependent upon a good understanding of the Veteran's functioning at baseline and an awareness of several key indicating factors.

While relatively non-specific, sleep is often one of the earliest signs of a declining management of mental illness. Depending on the condition(s) being treated, the threshold for intervention may vary; establishing expectations or guidelines from the clinician can be helpful in addressing sleep difficulties. For certain patients with bipolar illness, even short periods of sleeplessness may quickly lead to severe mania and may warrant a rapid appointment or intervention. Gaining a sense from the Veteran and the provider about the sleep patterns and expectations can be very helpful.

In addition to sleep, changes in appetite, energy, grooming and participation in activities may also be signs of a change in status. A Veteran may report symptoms (loss of appetite, poor sleep, etc.), but there may also be observed signs (e.g. unkempt appearance, talking louder or faster) of which the Veteran is not aware. As a Veteran gets more depressed, he or she may cease certain activities, become more delayed in responses, or become more irritable. In a developing manic episode, a Veteran may become more talkative and energetic. He or she may present as enthusiastic, playful or irritable. More sexual or religious references may be present in speech or behavior, and risky

or frivolous behavior may begin to manifest itself. Psychosis can begin as withdrawal, disorganization, or poor attention as the Veteran responds to paranoid concerns, has difficulty processing information, or is distracted by hallucinations.

A negative change is always a stress that can trigger further worsening. For example, a reduction in income or a new medical problem can lead to worry, sleeplessness, and mood instability, which may precipitate substance misuse or other problems, which can quickly multiply. Although the cause

and effect relationships can often be unclear, when social stressors mount, there is a definite possibility that psychiatric stability is, at a minimum, at risk to deteriorate.

The preceding signs are an incomplete list, but they speak to the value the Case Manager can bring to the treatment process by making observations in the field that might otherwise go unnoticed. In all cases, suicidal thinking can develop and any statements of hopelessness or references to dying should not be ignored and need follow-up. With some Veterans, it may be useful to have candid discussions concerning their past patterns and what tend to be their earliest signs and symptoms. A person may struggle to recognize emerging difficulties during an acute exacerbation of their illness, but may still be able to comment on past experiences and collaborate on an action plan at a time of relative stability.

Not every observed behavior is a warning sign, but vigilance, observance, and communication with the clinical team can facilitate interventions that may halt emerging problems.

CASE MANAGERS CAN HELP DIFFUSE SOME OF THE LIMITATIONS OF FORMAL MENTAL HEALTH HISTORY		
DOMAIN	**DESCRIPTION**	**CASE MANAGER TASKS**
ESTABLISHING AN UNDERSTANDING OF THE VETERAN'S "NORMAL"	Changes in sleep, appetite, energy, social engagement, interest in hobbies, cleanliness, and tolerance of stimuli are but a few items of significance within a typical psychiatric history. While there is some normal variation in all of these areas, they are also prone to disruption and potentially amendable to intervention if they are pieced together and evaluated properly	▪ Note baseline levels ▪ Note changes ▪ In addition to what is reported at intake, the Case Manager can make comments, observations ▪ Ask follow-up questions as appropriate; work to elicit additional information that could be vital to the mental health provider
ACTIVITIES OF DAILY	Seeing the Veteran in his or her home or in a community setting can provide information that isn't available in an office visit	▪ Look for consistency between what is reported and what is observed ▪ Pay close attention even during casual conversations as this is when

CASE MANAGERS CAN HELP DIFFUSE SOME OF THE LIMITATIONS OF FORMAL MENTAL HEALTH HISTORY		
DOMAIN	**DESCRIPTION**	**CASE MANAGER TASKS**
		important details might emerge
SYMPTOM FOCUS	During a diagnostic interview or medication appointment, problems and symptoms are typically the focus	▪ Engage the Veteran on hopes, fears, dreams, goals ▪ Reinforce the value of these, and use them to help the mental health provider give context to the treatment plan
TROUBLESHOOTING	Forgetfulness, embarrassment, concerns about consequences can lead to less-than-accurate reporting clinical appointments. Dangerous medication interactions are a concern, as are undisclosed or inaccurately explained lifestyle habits that lower the certain medications (i.e., between nicotine and antipsychotics)	▪ Explore over-the-counter medication use, use of herbal or vitamin supplements, etc. with the Veteran ▪ Compare observations with history, medication record, etc. ▪ Convey discrepancies

Table 8. How Case Managers Can Help Diffuse Some of the Limitations of Formal Mental Health History

There will be times when a Case Manager is confronted with an acute and unexpected crisis in the field. A clear understanding of the specific local protocols, emergency services and response system is vital in such cases as resources and statutes vary greatly across communities.

The potential benefits a Case Manager can bring to the mental health care of a Veteran are, in many ways, predicated upon good communication between the Case Manager, the Veteran, and other mental health providers. There will be some variation in the particulars concerning the relationship between the mental health provider and the Case Manager, depending on local structure; yet,

regardless of the model, the Case Manager and the clinician should be in close contact.   If the Case Manager can attend appointments with the Veteran, this is a valuable tool.   Joint meetings can reinforce the concept of team-based care, deepen care coordination, and help eliminate miscommunication. In addition to bringing another source of information to the appointment, the Case Manager can also observe the relationship the Veteran has with the mental health provider and witness the Veteran's ability to express him or herself in that setting. If the Veteran is unable, for whatever reason, to articulate issues or concerns, the Case Manager can assist in the moment, but can also work with the Veteran between visits to improve communication and self-sufficiency skills.

Along these lines, it can be helpful for the Case Manager to initiate an open discussion with the client and the clinician around how to best be of assistance during, and in between, appointments. As with all efforts, the goal is for a Veteran-centric approach that matches the intensity of the intervention with the needs of the Veteran, while concurrently moving the Veteran toward increasing levels of independence.

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Chapter

13

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SAFETY IN THE COMMUNITY

Introduction

T he Bureau of Labor Statistics divides occupational injuries due to violence into two categories: fatal and non-fatal. Of note, Healthcare and Social Assistance Industry occupations accounted for 63% of non-fatal injuries each year from 2003-2010, according to Centers for Disease Control (CDC) review of occupational violence. (Centers for Disease Control and Prevention, 2014) Historically, health care professional are at higher risk for workplace violence due to many factors related to the circumstances surrounding the need for health care. Considering that many medical conditions and situations are accompanied by a combined sense of urgency and a perceived loss of control, it can be expected that patients and concerned family members may demonstrate aggressive or hostile behaviors they might otherwise never consider demonstrating under normal social circumstances. Violence is very often the outcome of a person's attempt to regain a sense of control when she/he feels powerless, overwhelmed, or besieged.

Community based care differs from hospital and clinic based care in that patients are typically in a more stable medical condition and are also being seen in environments that are more familiar, thus simultaneously reducing the sense of urgency and perceived loss of control. However, there are several other factors in community based care that provide opportunity for escalation of aggressive, hostile, and violent behaviors from not just Veteran patients and their families, but also other persons and even animals that may be present in community settings.

Programs offered in the community often serve patients with fewer resources or limited access to care. Programs focused on improving living conditions, social functioning, occupational functioning, physical and psychological wellbeing, and legal issues for patients, by their very nature serve Veterans struggling to get basic needs met. A recent study of Iraq and Afghanistan Veterans, "indicates that rehabilitation aimed at improving socioeconomic, psychosocial, and physical well-being has potential promise to reduce aggression and violence among Veterans" (Elbogen, 2014), however, programs aimed at providing those improvements begin providing care at the lowest point of the Veteran's functioning in these areas, presumably at the time of highest risk for violence and aggression when the fewest protective factors are in place.

Special awareness of these patient-specific challenges, as well as to the challenges inherent in environments, situations, conditions, and others present, is vital for ensuring the safety and health of VHA employees providing care in community based settings. In this chapter, we will focus on community-specific workplace violence hazards. Guidance to help reduce the risk of violence and minimize the negative impacts of violence will be provided, as well as information about training, resources, best practice actions, and reporting. It is vital for management and employees to understand that while taking measures to prevent and minimize workplace violence is everyone's responsibility, sometimes violence can happen in spite of all that we do to prevent or minimize it. Violence can happen anywhere, at any time, regardless of how prepared or unprepared we may be. Violence is never the fault of the victim.

Safety as Part of Patient-Centered Care

Given the right set of circumstances, we are all capable of violent or disruptive behavior in order to regain a sense of control or to protect ourselves from real or perceived threat. Few people seek to become violent, aggressive, or hostile and most will only do so when provoked. This is important to understand for two reasons. First, because when we understand that those in our care or others in the environment are violent or disruptive as a method of self-preservation, we can help de-escalation by removing the perceived threat or by helping re-establish a sense of being in control. Second, because we must understand our own ability to become violent or disruptive when threatened and find ways to either avoid getting into a position of extreme vulnerability or to develop responses to threat that are simultaneously adaptive, flexible, effective, and safe for ourselves and others.

With the exception of that small percentage of the population that is sociopathic and enjoys their violent acts toward others, most people feel significant remorse and guilt after acting either disruptively or violently, even when they feel their actions were justifiable. Preventing the conditions that lead to violent and disruptive behaviors and de-escalating Veterans we observe to be escalating toward violence are patient-centered interventions in that they help preserve the dignity and emotional integrity of the person escalating toward an act or behavior that s/he will very likely regret. Preventing violent or disruptive behaviors in ourselves, even when provoked or threatened, is also a patient-centered intervention in that it prevents us from causing emotional distress for, physical injury to, or loss therapeutic rapport with our Veteran clients. A Veteran who perceives VHA employees as dangerous, threatening, easily provoked, or disruptive will be less likely to seek services and care from VHA in the future.

Safety Enhancing Structure and Operations

Safety is a very high priority within VA and systems and processes exist at multiple levels to advance safe practices and reduce the risk of violence.   The Office of Workplace Violence Prevention exists at the national level and develops policies and guidance as well as the tracking of events to better

understand trends and tailor future efforts. The Prevention and Management of Disruptive Behavior is one program under this office which oversees staff trainings and is crucial to reducing risk for all staff. The reader is directed to the PMDB website for more information on specific offerings. The list of other involved parties at the national/Central Office level is long but other notables include the VA's Chief of Police/Senior Security Officer and individual clinical program offices which play an active role in advancing safety.

At the facility level VA police, the Disruptive Behavior Committee (DBC) and others work together to improve the environment of care and preparedness of staff. The DBC conducts risk assessments, oversees the patient record flag system as well as general educational efforts and target risk reducing strategies. The committee reports directly to the facility Chief of Staff and includes membership from a variety of high risk settings. Lastly, safety needs to be a regular topic and priority for all clinical teams and individual staff members. Individual and team level approaches and opportunities will be the primary focus of this chapter.

Key Variables Contributing to Risk of Violence

Safe practice in the community begins with the recognition that violence in any setting stems from a dynamic interplay of the persons involved and the environment. Each component warrants consideration recognizing that the greatest degree of control is over the self, the least over the other person, and a variable level of control over the environment. Where control is limited it can be partially compensated for with good preparation and established response systems.

The community at large is a unique environment of care that poses some different challenges than those encountered in more traditional sites of care such as medical centers (VAMCs) or community based outpatient clinics (CBOCs). In the community the capacity to control or modify the environment is markedly less than in medical facilities. Coupled with this is the absence of an established internal emergency response system. With these realities in mind it is imperative for community based teams and workers to establish solid processes and procedures in order to be as informed as possible in advance of community visits and to have mechanisms in place for communications, monitoring, and emergency interventions.

The Community Environment of Care

A starting place for work is to exercise due diligence in becoming familiar with community being serviced. The more you know about the community you are entering, the better prepared you can be for situations to avoid or appropriate and timely responses to situations. For instance, will you be visiting a neighborhood that is unsafe due to gang activity? Are there known meth labs or drug smuggling operations in the region or community? Are there times of day that are less safe than others in the community you will visit?

Some of this information can be learned from community contacts such as local law enforcement or community service agencies. Learning more about interagency safety trainings in the community and community agency collaborations on safety issues can offer many opportunities to learn more about the locations you will visit and help build bridges that will improve your safety in the field.

Other important information may be available through online search engines, websites, or news articles. Helpful information to have about the areas you will be visiting includes:

- Traffic patterns and several possible routes to and from the location
- Street views from internet mapping programs that allows you to see landmarks and general condition of the location
- Location of nearest emergency services (police, fire, hospital, etc.)
- Location of nearby gas stations so that you can fill up before you arrive
- Cellular coverage within the area. If this is problematic consideration should be given to acquiring a satellite phone or engaging in alternative risk reducing strategies such as working in peers or meeting in another location.

The homework done on the community visited is a foundation for safety but attention to the environment needs to continue throughout any forays outside of medical facilities for outreach, home visits, or other activities. Out in the community an observant eye coupled with thoughtfulness will add to safety. One key time for consideration is at the point of arrival at a site of care.

- Parking options should be surveyed and ideally the vehicle used should be parked in such a manner so as to facilitate a rapid departure if necessary. Avoid head-in parking or situations where the vehicle could get blocked in by another car.
- The path from the parking location to the actual visit location should be noted with attention paid to potential trip hazards or blind areas where a person could conceal themselves.
- The buildings and individuals in the general vicinity also warrant consideration and can provide clues as to the likelihood of criminal activity in the area
- Once inside the home, apartment or other setting a similar analysis should take place
- Note the location of exits and how clear the path is to them if one needed to leave in a hurry
- Meeting places should be chose with exits in mind and internal rooms that would be harder to depart from should be avoided.

- If a situation does develop where an exit to the outside is not convenient a secondary option of a securable internal location such as a lockable bathroom should be identified and utilized in an emergent situation.
- Be aware of the presence of others in building and inquire as to the expected arrival of others during the period of the visit.
- Consider items in the immediate area and their potential to be used as weapons.
- Classic weapons such as guns and knives are obviously important to note and should be secured in advance and no visit conducted if they are loose in the environment. This should be communicated in advance with patients/clients.
- Pets that might bite or scratch should, similarly, be secured in advance of visits.

In addition to adopting a diligent approach to assessing the environment both before and during visits proactive steps must be undertaken to maximize awareness and communication opportunities with others on team and with emergent personnel if needed. Traditional sites of care typically have clear response systems and teams such as panic alarms, security staff, etc. These protective measures need to be replicated as best as possible for community based workers. An initial measure teams should take is the adoption of a clear system for knowing or predicting the whereabouts of staff out in the field.

- Staff doing field work should have a mobile communication device with call and texting capabilities that is charged and in good working order.
- Emergency contacts and response numbers such as 911 should be programmed into speed dial.
- There needs to be a well understood sign-out and return system so others know when staff is out in the field and when they return safely.
- The location(s) of planned visits needed to be noted in order with estimated times arrival/departure times to assist in locating a staff person if communication is lost.
- Any changes that develop in the previously reported schedule need to be reported back to the team at the medical center or CBOC. An example might be the need to work in a new visit based on a phone call or a change in the order of visits.
- For extended periods of time in the community there needs to be regular (every 2 hours) communications back to the home team location indicating all is well. Note: If this practice is well established and a call is not received on time, when coupled with an accurate schedule of visits, the ability to initiate a timely and targeted search is optimized.
- Communications from the field need to go to a live person and not an answering machine. Centralizing this process across programs and case management teams may be a best option at many sites.

The Other Person(s)

A second key component in interactions that could become dangerous is the other person or people encountered. The most obvious person for consideration is the Veteran being served. As noted previously, there may be some baseline risk factors associated with the cohort of individuals served in community based programs and residing in supportive housing. A history of violence, limited coping strategies, chronic pain, certain mental disorders, substance use, and homelessness can all increase the likelihood of disruptive or violent behavior. As with the environment, doing homework in advance and learning as much as possible about the individual being served is an important first step.

- If at all possible conduct a thorough chart review in advance of meeting with the Veteran noting in particular any patient record flags, criminal history, past episodes of violence or threats of violence, or a history of cognitive or behavioral compromise.
- Review notable findings such as flags with the treatment team and the DBCs learning as much as possible about precipitants for violence and best strategies for engagement.
- In some cases, the history may warrant reconsideration for appropriateness of the program or limitations on the location and manner of interaction. In more extreme situations visits may need to be restricted for a time to secure locations where others can present.

Once a background review has been conducted it is preferable to have the first encounter over the phone or at a more structured setting as opposed to the person's residence. During this visit rapport can begin being established, risk further assessed, and ground rules, expectations, rights, and responsibilities reviewed.

- Conduct a thoughtful history taking note of static and more temporal risk and protective factors.
- Emphasize Veteran choice within treatment and your role in supporting his or her goals.
- Avoid any statements that could be interpreted as threatening or demeaning
- Clarify the intent of any community visits and the need to have the setting amenable to such visits with the securing of any weapons and pets as noted above.
- Reiterate the regulations regarding no weapons on VA premises and how this extends to any government vehicle the Veteran may be transported in.
- Demonstrate a respectful demeanor emphasizing your role as a resource.
- Do not make unreasonable promises or create expectations that will not be doable.

Subsequent visitations should build on this approach. With ongoing engagement and successes risk should be reduced but it must be remembered that even with a history of positive encounters acute changes and stressors such as intoxication, impending eviction, or new disability may elevate the

propensity for violence. If an encounter shows signs of escalation the maintenance of a skillful, appropriate stance will lead to the best outcome.

- Recognize defensive or aggressive postures such as crossed arms or finger pointing as well as a change in volume or rate of speech.
- Intervene as early as possible when signs of agitation are observed reiterating your role as a resource.
- Offer problem solving strategies when appropriate but do not make claims you will not possible be able to carry out.
- Do not threaten retaliation or punishment which may further escalate the situation
- Above all else, stay calm but also give yourself the license to quickly evacuate a situation that is deteriorating to maintain safety.

It must be noted that while the Veteran client or patient is the principle person of interest when conducting work in the community they may not be greatest source of risk. Roommates, relatives, neighbors, and passers-by on the street may pose a much greater risk to safety and typically there is not a way to evaluate these individuals in advance nor is there any relationship or expectations to utilize when engaged in an unfavorable encounter. Higher caution should be exercised when encountering other unknown individuals during community work and negative interactions reported as will be discussed later.

Yourself

The final variable in the triad of factors is you. While it is the variable with which you have the greatest degree of control it is none the less important to consider the many nuances involved and opportunities for improvement. Having a role in healthcare does not exclude one from being impacted by the multitude of issues that can lower tolerance, increase irritability, or decrease awareness of mounting risks. When one is struggling with illness, having relationship or work difficulties, experiencing other stressors it can reduce effectiveness in clinical encounters and potentially contribute to escalation of a situation and a higher degree of risk. Doing a regular inventory of one's own health and emotional status is an important component of good, safe service. Coupled with awareness of one's inner state should be an analysis of one's appearance and preparedness for the duties required.

- While professionalism is desired the visibility of lab coats or other medical paraphernalia can draw unnecessary attention from others and potentially present oneself as a person you might have prescription drugs or other items of street value on their person.

- Similarly, wearing expensive jewelry should be avoided as it could increase risk of becoming a target for theft
- Clothing should allow for comfort but also be conducive to the environment and facilitate rapid exit if needed.
- Items such as ties or scarves which could be used as weapons should not be worn
- Car keys should always be kept in a readily accessible pocket and not placed in a bag or jacket that might get separated from you.
- Being organized in advance and leaving unnecessary items or securing valuables in the trunk prior to arrival at a community destination can also reduce attention from predators in the environment and support a timely exit
- Most importantly it is imperative to receive appropriate training in advance on risk identification, verbal de-escalation, and personal safety skills prior to engaging in community based work.

The VA has developed a variety of products to educate and prepare staff for their work. The Prevention and Management of Disruptive Behavior Courses I, II, and III should all be completed by community based workers. Additional material of relevance is contained within a Supplement for Community Based Workers which can be found at: https://vaww.portal.va.gov/sites/PMDB/Pages/CommunityBasedWorkers.aspx.

Crisis Situations

In spite of good preparation and preparedness there may be instances where situations escalate and a true crisis develops. While this should be very rare it is a potentially high impact, dangerous event and warrants some advanced consideration. As a rule, it is safest to stay in parts of the home or establishment open to the public, while at the same time preserving the client's privacy. Living rooms, dining rooms, open-style kitchens, or other such "common" areas often provide the most visibility and routes of escape. It is helpful to both the client's privacy and your general safety to ask that others, except for those involved in the client's care, leave the area where you will be meeting with the client.

Be aware of where you are at all times and avoid becoming isolated or relocated to a less secure part of the home. For instance, basements may be less secure than the main living floor since there may be fewer routes of exits and fewer windows through which passersby could notice if you were in distress or in need of assistance. Avoid relocation to typically intimate parts of the home, such as bathrooms or bedrooms, as these may also be isolated, difficult to escape, and suggest a willingness on your part to change the purpose of your visit.

Finally, stay aware of your feelings and TRUST YOUR GUT. You are born with instincts and intuition that tell you when danger is present. You have also had years of experience and training that can improve these instincts. Your "gut" feelings may clue you in to information you have unconsciously picked up about the environment. If you are feeling uneasy or your gut is warning you that something is wrong, do not hesitate to leave and reschedule your visit at a later time.

If there are others in the area, try to summon help. It may also help to appeal to the individual's sense of right and wrong, without giving a sermon. If you know of factors that may inhibit the person from becoming violent (e.g., compassion for others, what might be lost as a consequence, duty to loved ones, etc.), bring these up gently in a way that encourages the person to de-escalate. Provide the individual with logical and viable solutions or alternatives to escalation. Do not make promises that obviously cannot be kept and do not make threats.

Do NOT permit yourself to be transported. Never leave the initial location of the visit, especially under duress, to go to a different location. The chances that you will be found, assisted, and/or survive all decrease when you are moved from the initial location.

Individuals who do best in any type of crisis, severe or otherwise, are those with "high emotional intelligence." These are people who are most aware of their own feelings and are able to manage feelings in a way that helps them respond effectively to situations with high emotional stakes. By developing high emotional intelligence, you improve the chances that you will be able to set your fear aside long enough to do whatever it takes to survive the current situation. It is important for you to believe that no matter what happens you will survive.

Post Event Reporting:

Once you are safe and have received any care you need following an incident, it will be important to let your facility know what happened. Data from reported incidents are used to inform policies about safety and training plans for employees of the department, it is vital that employees report any and all incidents of sexual assault or disruptive and unsafe behavior in all workplaces, including community-based workplaces. If we don't know, we can't help.

There are many ways to make a report.

- Uniform Offense Report to report the incident to VA Police
- Reports of Contact or Patient Incident Reports to Patient Safety
- Workers Compensation Reports to Occupational Health
- Notification of immediate supervisory and/or supervisory chain and management
- Computerized Patient Records System (CPRS) when appropriate

- Safety Reports or Disruptive Behavior Committee (DBC) reports that may vary by station

It is important to know your station's local policies regarding reporting. Your department chair and supervisor may have additional expectations, and can direct you to the proper protocol. If there are police reports from the community that were filed, these may also be helpful to give to VA Police or the DBC. All reports of disruptive, violent, or dangerous behaviors by patients should ultimately go to the DBC.

The DBC at your facility is responsible for soliciting, collecting, and reviewing all reports of violent or disruptive behavior incidents by patients. The committee conducts comprehensive violence risk and threat assessments, and uses that knowledge to develop a threat management plan. The DBC is also an integral part of monitoring, tracking, and analyzing behavioral risk patterns at the facility and formulating the Workplace Behavioral Risk Assessment.

The work of the DBC informs local workplace violence prevention policies and training plans for employees to help reduce the risk of violence. The DBC chair facilitates the coordination of the Prevention and Management of Disruptive Behavior (PMDB) program at the facility, usually with the assistance of the PMDB Coordinator who is also a member of the DBC.

Benefits

- Staff that feels/is safer will provide better care
- Safety in the community will support growth of that model of care

References

Centers for Disease Control and Prevention. (2014, February 24). CDC Workplace Safety & Health Topics. Retrieved July 7, 2014, from Centers for Disease Control and Prevention: http://www.cdc.gov/niosh/topics/violence/.

Elbogen, EB, et al. (2014). Protective mechanisms and prevention of violence and aggression in Veterans. *Psychological Services*, 11(2):220-8.

Community Based Worker Violence Prevention Checklist			
Checklist Items	Yes	No	Comments
Itinerary Sharing, Contact person on station	☐	☐	
Traffic concerns or issues	☐	☐	
Emergency services near visit location identified	☐	☐	
Gas and services stations near visit location identified	☐	☐	
Emergency numbers programmed into phone	☐	☐	
Phone charged, functional, mobile charger available	☐	☐	
Pre-visit weapons security discussion completed	☐	☐	
Pre-visit pet and visitor security discussion completed	☐	☐	
Patient records, record flags, and DBC input reviewed	☐	☐	
Contact, location, and other information confirmed	☐	☐	
Behavioral treatment issues reviewed and understood	☐	☐	
Weather and environmental conditions for the visit	☐	☐	
Clothing and gear appropriate to visit conditions	☐	☐	

Figure 8. Community Based Worker Violence Prevention checklist

Section 3

Special Populations, Biopsychosocial Challenges & Interventions

VETERANS WITH SERIOUS MENTAL ILLNESS (SMI)

Overview

Mental health difficulties can increase vulnerability of individuals, leading to a compounding of stressors (Burt, et.al, 1999). This compounding is reflected in statistics from the Substance Abuse and Mental Health Services Administration (SAMHSA). Their research indicates that 20-25% of the US homeless population suffers from serious mental illness compared to 4.1% of the general US population (NIMH, 2012). Other studies have shown that mental illness can be a driving factor for risk of homelessness. One recent survey indicated that mental illness is the third largest cause of homelessness for single adults and an important factor causing homelessness for families (United States Conference of Mayors, 2008). In addition, specific mental health diagnoses, including bipolar disorder and schizophrenia, have been shown to be indicators of greater vulnerability for homelessness (Folsom, et al., 2005). These diagnoses are part of a group of diagnoses that are often considered to be serious mental illnesses.

See SAMHSA's Definitions and Terms Relating to Co-occurring Disorders at: https://store.samhsa.gov/shin/content/PHD1130/PHD1130.pdf.

Populations with Limited or Compromised Resources

People with serious mental illness are considered within the group of "vulnerable" populations. "Vulnerable" populations are defined as those whose 1) access to resources and options for resources is severely limited; and 2) ability to make fully informed decisions is diminished due to acute or chronic conditions (Center for Mental Health Services, SAMHSA, 1999).

When homelessness is combined with serious mental illness and/or other difficulties including poverty, older age, racial and/or minority status, disability, high medical needs or substance use or abuse, the health disparities for people with these complex needs from vulnerable populations can be particularly grim (Fleishman & Farnham, 1992; Robertson & Cousineau, 1999; Smereck &

Hockman, 1998; Song, Safaeian, Strathdee, Vlahov & Celentano, 2000; Victor, Connelly, Roderick & Cohen, 1989; Martel, et al., 1992; Viron & Stern, 2010; Zolopa, et al., 1994).

Click on the following links to read about research, US government policy, and other information related to vulnerable populations:

- http://www.hhs.gov/ohrp/policy/populations/

- http://tdi.dartmouth.edu/initiatives/accountable-care-organizations/research/vulnerable-populations

- http://www.urban.org/health_policy/vulnerable_populations/

- http://www.samhsa.gov/samhsanewsletter/Volume_18_Number_6/MentalHealthReport.as px

Serious Mental Illness Defined

The definition of serious mental illness most commonly accepted is described by SAMHSA as 1) a mental, behavioral, or emotional disorder that meets diagnostic criteria within the current version of the Diagnostic and Statistical Manual (DSM); 2) is experienced as either a single unremitting episode of symptoms or a as a frequently recurring and/or prolonged episode of symptoms; and 3) that these symptoms cause impairments in functioning that substantially interfere with or limit major life activities. It is important to note that in the definition of serious mental illness, both the duration of symptoms and the fact that the impairment from symptoms substantially interfere with functioning and life activities are key. More information about serious mental illness can be found at the following websites from SAMHSA and the National Institutes of Mental Health:

- http://www.samhsa.gov/newsroom/advisories/1211273220.aspx

- http://www.nimh.nih.gov/about/director/2013/getting-serious-about-mental-illnesses.shtml

Your Practice: Helping by Understanding Serious Mental Illness, Mental Health Recovery, and Housing

Mental health recovery is defined by SAMHSA as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." (SAMHSA, 2012). Home, having a safe and stable place to live, is one of SAMHSA's four major dimensions of supporting a life in recovery: Home, Health, Purpose, and Community. To read more about mental health recovery see the chapter in this Guide entitled, "Recovery and its Relationship to Psychosocial Rehabilitation (PSR)." Understanding how to help someone with SMI with housing as part of their larger process of mental health recovery is an important part of providing permanent supportive housing.

Because people with SMI often have severe limitations in access to / options for resources and may also have a diminished ability to make fully informed decisions due to acute or chronic symptoms, there are some key points to improving care for these people. These include partnering to improve outcomes, working to obtain a stable environment, and providing increased care with increased need (as well as decreased care with decreased need) (National Mental Health Association, 2006).

Partnering to improve outcomes involves:
- Physical health care access

- Mental health treatment access

- Trauma informed treatment

- Care coordination

- Education and employment support

- Skills training

- Peer support

A holistic approach to working with people with complex needs, including homelessness and SMI, is recommended. Often this vulnerable population has been under- or sporadically-treated for physical and mental health needs, have a complex of amalgam diagnoses and related polypharmacy, have interrupted education, need assistance with income and employment, and have mental health

symptom-related skills deficits (e.g., social skills) (Bauer, Baggett, Stern, O'Connell, J.J., & Shtasel, 2013). This level of complexity requires careful evaluation or re-evaluation of clinical needs and vigilant care coordination between what is likely to be multiple providers with different skills and approaches. Working as a team to partner in the care of someone with complex needs will ensure the coordination of care needed to optimize outcomes for the person.

Working to obtain a stable environment involves flexibility in treatment options. These can include home- or community-based service provision as well as providing choice in housing. Having an array of housing options such as independent apartment, transitional or interim housing, integrated housing, etc., allows for housing choice (Zerger, et al., 2014). The literature indicates that the ability to have choice in housing is a predictor of success in housing retention (Tsemberis, Gulcur, & Nakae, 2004). In addition, providing flexibility in levels of care—or providing increased care with increased need—is another predictor of longer-term stability and success (Tsemberis & Eisenberg, 2000).

VA Partners and Programs for Veterans with SMI
Keys to partnering with providers and programs include understanding availability of and specific contacts for services at your facility and understanding current linkages between services—including the current process for referrals and collaboration. In addition, Veterans with complex needs will benefit when you, as a care provider, construct new linkages (including care coordination) that center around the individual Veteran's needs rather than adapting to an existing service structure. Below is a brief description of potential VA partners and programs that provide care for Veterans with SMI. Note that not all of these programs are available at all VA medical centers, so please consult with your local facility. Your local VA may also have strong partnerships with the community for resources that the VA cannot directly provide. For example, national organizations such as the National Alliance on Mental Illness (NAMI) and SAMHSA have resources that may be beneficial for serving Veterans with SMI who are seeking housing.

Physical Health Care
- Primary Care: VHA primary care gives eligible Veterans easy access to health care professionals familiar with their needs. It provides long-term patient-provider relationships, coordinates care across a spectrum of health services, educates, and offers disease prevention programs.
  - Patient Aligned Care Teams (PACT): The Patient Aligned Care Team (PACT) is VHA's model for delivery of comprehensive primary care. A PACT team is a team of health care professionals that provides comprehensive primary care in partnership with the patient (and the patient's personal support person(s)) and manages and coordinates comprehensive health care services consistent with

 agreed upon goals of care. PACTs for special populations are designated by a specific indicator.

- o <u>Special Population PACT</u> (e.g., GERI-PACT, SMI-PACT, Homeless PACT): A special population PACT is a team designated by specific nomenclature in PCMM that provides comprehensive primary care and additional specialized care to a special population.

- ▪ <u>Home-Based Primary Care (HBPC):</u> The HBPC mission is to provide comprehensive, interdisciplinary, primary care in the homes of Veterans with complex medical, social, and behavioral conditions for whom routine clinic-based care is not effective. The primary focus of HBPC is longitudinal care for complex chronic disabling disease.

Mental Health Care

- ▪ <u>Outpatient Mental Health:</u> VHA outpatient mental health care provides eligible Veterans with coordinated mental health care including evidence-based and recovery-oriented psychotherapies and pharmacotherapies. These therapies and related treatment plan are determined through a collaborative process between mental health providers and Veterans and are designed to help Veterans progress toward their individualized treatment goals.

  - o <u>Behavioral Health Interdisciplinary Program (BHIP):</u> BHIP is a new model of team-based care being piloted within VHA. The model consists of inter-professional teams of mental health providers and administrative/clerical support who provide the majority of outpatient mental health care for a panel of assigned Veterans (i.e., those receiving general mental health outpatient care). The goal of BHIP is to promote continuous access to recovery-oriented, evidence-based treatments through collaborative, Veteran-centric, and coordinated care. This team-based model is consistent with comprehensive, population-based care vs. diagnosis-based care, and Veterans with SMI may benefit from the team's increased emphasis on case management and coordination of care. This team based model is used in the Housing First model of Permanent Supportive Housing.

- ▪ <u>Specialty Mental Health Care</u>

  - o <u>Intensive Community Mental Health Recovery (ICMHR) Programs:</u> These include Mental Health Intensive Case Management (MHICM), Rural Access Network Growth Enhancement (RANGE) and Enhanced RANGE (E-RANGE). ICMHR Services

provide clinical community-based case management services to Veterans with SMI, functional impairment, and high inpatient mental health unit utilization, in coordination with existing community and VA services. Services are individualized, person-centered, and strengths-based and promote hope, responsibility, and personal empowerment. These services are holistic and provide assistance to Veterans across all desired areas of life, including personal wellness and health.

○ Psychosocial Rehabilitation and Recovery Center (PRRC): PRRCs are outpatient transitional learning centers designed to support recovery and integration into meaningful self-determined community roles for Veterans challenged with serious mental illness and severe functional impairment. Programming is curriculum-based and is specifically designed to teach the requisite skills that are necessary for defining and realizing Veteran's self-chosen roles and goals in all domains of health and life. PRRC services are part of the mental health continuum of care and are coordinated with other services in the VAMC and in the community.

○ Peer Support: Peer Support is a fundamental building block of recovery-oriented services. Within the recovery literature, Peer Support is a promising best practice which provides role models for Veteran consumers of the Department of Veterans Affairs (VA) mental health care program to engender hope, demonstrate recovery, and teach advocacy skills among other valuable practices. All Veterans with SMI must have access to Peer Support Services, either on-site or within the community.

o Therapeutic and Supported Employment Services (TSES): The TSES programs are based on a recovery-oriented model and offer a continuum of work restoration services. Veterans are financially compensated for their work and in turn, improve their economic and social well-being as they prepare for community re-integration

▪ Supported Employment (SE): SE is an evidence-based clinical model that helps individuals with serious mental illness or physical impairments co-occurring with mental illnesses engage in competitive employment in the community.

o Substance Use Disorder (SUD) programs: SUD encompass the family of alcohol and other drug-use illnesses that meet diagnostic criteria according to the American Psychiatric Association Diagnostic and Statistical Manual (DSM). They include patients who meet diagnostic criteria for abuse or dependence on alcohol, tobacco products, illegal substances, and prescribed psychoactive medications. The diagnosis of SUD

must be consistent with the criteria of the mental health diagnosis system approved by VA, i.e., the current edition of DSM.

o   Mental Health - Residential Rehabilitation Treatment Programs (MH-RRTP): A MH RRTP provides residential rehabilitative and clinical care to eligible Veterans who have a wide range of problems, illnesses, or rehabilitative care needs which can be mental health, SUD, co-morbid medical, homelessness, vocational, educational, or social.

o   Post Traumatic Stress Disorder (PTSD) programs: PTSD is an anxiety disorder in which symptoms develop following exposure to an extreme stressor. Provision of a PTSD continuum of care (including inpatient, outpatient, and residential PTSD care) implies matching the unique needs of a patient with the level of care required at the time, as well as the potential to move the patient to a higher or lesser intensity level as needed.

Click on the following link to access VHA publications (e.g., Handbooks, Directives, Memoranda) related to the programs described above: http://www1.va.gov/vhapublications/publications.cfm?pub=2&order=desc&orderby=pub_Number

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Chapter

15

CHRONIC MEDICAL CONDITIONS AND COMMON MEDICAL COMORBIDITIES AFFECTING HOMELESS VETERANS

Overview

In many ways, keeping homeless Veterans housed is as challenging, if not more so, than placing them in permanent supportive housing. Drug and alcohol relapses, relationship problems, mental health issues, chronic medical conditions as well as un-diagnosed or un-treated conditions that now get prioritized often define the clinical spectrum of need facing these Veterans. Coupled with difficulty managing finances, and other day-to-day challenges, maintaining housing is a daunting task with the Supportive Housing Team playing a critical role. It is also important that this role not be viewed in isolation of other VA resources and capacities that can also advance the shared goals of stabilizing clients in permanent supportive housing and keeping them healthy.

In this chapter, we review:

- Medical Complications associated with homelessness and how these issues often present and translate into health care needs;
- Chronic care management needs of homeless and formerly homeless Veterans, highlighting a few conditions not always considered in their care;
- Navigating the VA health care system, including programs and initiatives within VA that may serve as resources for case managers and the supportive housing team, such as Patient Aligned

Care Teams (PACTs), Specialty PACTs including Homeless PACTS (H-PACTs), Primary Care–Mental Health Integration, and other Mental Health resources.

- Tips for communicating with the health care team, including key observations, signs and symptoms that might indicate something of clinical significance and the sharing treatment plans that case managers need to be aware of and help facilitate.

Considering the high prevalence of chronic diseases in this population, the often-deferred and/or often delayed primary and preventive care services (O'Toole, 2013a); the unavailability of heath care while homeless; and the ongoing role health care plays in helping individuals stay in permanent housing, the role of the Case Manager is critically important. Community-linked case management provides a unique opportunity to identify risk factors, look for signs and symptoms, raise concerns, and facilitate care of un- and undertreated medical and mental health conditions that could, if untreated, precipitate a return to homelessness.

Medical Complications of Homelessness

The average age at death for a homeless person is between twenty and thirty years younger than their age-matched, housed contemporaries (O'Connell, 2005). Cancer and heart disease are the most common causes of death for the 45-64 year age group–a rate that is three times as high as that of the general population - while homeless in a younger demographic are more likely to die from infections such as HIV/AIDS, trauma or substance abuse-related complications (Hwang, 1999; Baggett, 2013). While there are many conditions, both acute and chronic, that threaten the health and well-being of the homeless population, in general, the relationship between health and homelessness has been described within three contexts:

- Medical issues that precede and contribute to homelessness;
- Medical problems that are complications of homelessness; and
- Illnesses or conditions that are harder to treat or manage because of the patient's homelessness (Institute of Medicine, 1988).

Not surprisingly, homeless persons also utilize acute level health services at very high rates. In one survey, over 40% had used the emergency department at least once for care in the previous year; more disturbingly, 7.9% accounted for 54.5% of all visits (Kushel et al, 2002). In a national survey of homeless persons, one out of four indicated that they had been hospitalized annually (Kushel et al, 2001) and, in a study of homeless persons who accessed New York City hospitals, their average length of stay was 36% longer per admission than non-homeless individuals (Salit et al, 1998).

Unstable sheltering arrangements (i.e. residing in an emergency shelter or in an unsheltered arrangement) are associated with overall higher rates and of inappropriate use of emergency

departments (Kushel et al, 2002; O'Toole et al, 1999a; O'Toole et al, 1999b). In contrast, homeless persons who are able to move into more stable sheltering arrangements are 2.4 times more likely to access and receive care for chronic medical problems (O'Toole et al, 1999b). Case Managers can help Veterans learn to navigate the health system, help them advocate for their own ongoing care needs, and assist them in the transition from relying on acute and emergency services to instead accessing primary care for acute, chronic and engage in preventive care needs.

Chronic Care Management Needs of Homeless and Formerly Homeless Veterans

There are several conditions and clinical scenarios that are particularly relevant to homeless Veterans transitioning to permanent housing arrangements. Often, because of the competing needs and priorities associated with day-to-day survival as a homeless person, signs and symptoms that would otherwise lead to seeking health care are neglected and ignored so that by the time someone does become housed and has the capacity to seek care, the need is often great. Other conditions can pose significant challenges to maintaining housing because of cognitive impairment, effect on Activities of Daily living (ADLs), or often poor decision-making and behaviors that are employed in their self-management. For these reasons it is critically important to see accessing and engaging in care for underlying medical, mental health, and substance use conditions as core to a Housing First agenda and housing retention goals. Some conditions that highlight this dynamic are the following:

- Traumatic brain injury. Prevalence rates of traumatic brain injury (TBI) among homeless persons ranges from 8-53% which are significantly higher than the general population (Topolovec-Vranic, 2012).   More notable is that in one major study, 70% of the brain injuries occurred prior to their homelessness and was associated with significantly higher rates of other medical and mental health co-morbidities and overall poorer health (Hwang, 2008).   It should be expected that the nature of combat injuries among OEF/OIF Veteran populations would place this cohort at significant risk.   Individuals with traumatic brain injuries have higher rates of mental illnesses, cognitive impairments and are often more susceptible to trauma and injury, making independent living often a greater challenge (To, 2014).   Clinical interventions and supports have been developed and concerns about a suspected TBI should be discussed with the Veteran's care team for appropriate evaluation and management planning.
- Chronic Pain Syndromes. Several studies have identified chronic pain as being one of the most common clinical conditions facing homeless persons (O'Toole, 2013, Haley 2011, Hwang, 2011, Fisher 2013). Prevalence rates range in the 36-70% range and are often attributed to orthopedic injuries, arthritis, past traumas, headaches, or chronic disease complications which are all more prevalent in homeless settings.   Management of chronic pain is challenging in most settings and with most populations but is even more so for

homeless Veterans when housing arrangement are unstable, the risk of re-injury/exacerbation great because of exposures, lifestyle and trauma risk, and when the potential for self-medication with drugs and alcohol make prescribing any treatment regimen more difficult. Chronic pain has also been associated with homeless recidivism (Creech, 2014) suggesting a spillover effect on housing and social re-engagement. Pain management typically calls for a multi-faceted and multi-disciplinary approach that includes medications, physical therapy, mental health/cognitive behavioral support and the capacity to rest and rehabilitate, all of which is facilitated by stable housing. It is also a condition that is chronic with acute exacerbations. Patient education and engagement in care management strategies as well as creating realistic expectations is critical. Being part of the care team managing this is an important role for the case manager, both in helping inform the team on functional deficits from their client's pain, functional goals of pain care as well as providing an objective assessment of treatment effectiveness/care compliance.

- <u>Chronic medical conditions/end stage organ diseases.</u> The chronic disease burden of homelessness is significant and likely reflects the combination (1) enhanced risk for chronic conditions resulting from drugs and alcohol use, environmental exposures, etc.; (2) lack of access to primary and [preventative services that could have mitigated this exposure risk; and (3) biologic and genetic factors triggered by the toxic stressors associated with street life that accelerate aging pathways (O'Toole, 2014b). The higher than expected rates of geriatric syndromes at relatively young ages among homeless adults underscores this dynamic (Brown, 2013).   From a clinical perspective, there are two main issues that need to be considered. First, these homeless and formerly homeless Veterans need to be closely monitored for chronic diseases and conditions that may be developing at younger-than-expected ages, and when they are identified, they need to be aggressively treated to clinically indicated targets. It is not clear whether age-specific monitoring needs to be initiated at younger ages but should be considered. Second, medication and treatment adherence needs to be closely followed. This is typically a population that is not accustomed to the treatment compliance needs of a chronic condition and who will often feel greatly restricted by the restrictions care plans often impose on one's lifestyle (Munger, 2007.   Further this is also a population that may not be familiar with the role and expectations of having a primary care provider and source for usual care. Reinforcing the importance of keeping appointments, seeking care when not feeling well, reminding clients of upcoming visits and encouraging them to take medications as prescribed is key. This is particularly the case for psychiatric meds where often noncompliance can trigger poor decisions and behaviors and set in motion a cascade of untoward events (Coe, 2012).

Navigating the Health Care System: The Role of Primary Care

Primary care, and, specifically, primary care tailored to the needs of homeless or formerly homeless persons, provides a unique opportunity to comprehensively address some of the service gaps and vulnerabilities in homeless health care. It also provides a platform from which to engage homeless persons in an array of services over a continuum of time and needs. However, long-term homelessness (>2 years), competing needs, such as food, clothing, and finding shelter, and social isolation are all associated with not having a regular source of care (Gallagher et al, 1997). Additionally, multiple morbidities common among homeless persons, including mental illnesses, substance use, and acute and chronic medical problems, often create a triaging dilemma, whereby care may be fragmented and conditions not prioritized to reflect the priorities and preferences of the patient. This also can override any opportunity to provide preventive care and engage the person in behavioral changes.

As a result, when a homeless Veteran enters into permanent supportive housing, it is possible that he or she has limited or no experience accessing primary and/or non-acute ambulatory care and may not necessarily know what is available or what they need. This is obviously important when considering the high prevalence of chronic diseases in this population; the often deferred and delayed primary and preventive services not available while homeless and; very importantly, the ongoing role health care plays in helping individuals stay in permanent supportive housing. Knowing where to go when advocating for a client, and knowing what clinical resources are available when problems arise, is essential in case management. Aligning the resources and services of VA with the health care needs of the Veteran can advance your shared recovery goals. There are several initiatives within VA primary care that are available, or are being developed, that aim to improve access and coordination of care within VA. These include both general Patient Aligned Care teams and population-tailored care teams (specialty PACTS), integrated Primary Care-Mental Health Care, and the CCHT/Tele-health program (see table 3).

General PACTs are available throughout VA but some facilities have also developed specialty PACTs. One example of a specialty PACT for individuals with serious mental illness is a SMI-PACTs. Like other special population PACTs, the SMI-PACTs assume full responsibility for providing comprehensive healthcare services to assigned patients in addition to serving the specialized mental health needs. SMI-PACTs are recovery oriented and transitional in nature, with a goal of returning patients to regular PACTs as they achieve stability and recovery.

Most facilities do not have SMI-PACTs. In those settings, patients with serious mental illness receive ongoing care from one or more specialty mental health services, often including Behavioral health interdisciplinary teams (BHIP), Substance use disorder teams, Mental Health Intensive Case Management (MHICM) and others. All of these individuals will have an assigned mental health

treatment coordinator (MHTC). The MHTC is a critical resource for care coordination for these patients.

Homeless PACT (H-PACT) may be established to create a collaborative Primary Care-Homeless Program for Veterans who have difficulty accessing care and engaging in VA services. The team focus is on eliminating access barriers and providing integrated, coordinated homeless-specific care and case management. These goals are accomplished by:

- Enhancing access and engaging homeless Veterans in clinical care earlier in their homelessness before complications arise;
- Providing comprehensive medical, mental health, case management and social services, preferably in one setting;
- Tailoring care to the specific medical, mental health and homeless service needs of homeless Veterans.
- Establishing longitudinal relationships that encourage behavior change, engagement in treatment, and address the disproportionate chronic care needs of the homeless population; and
- Providing care management or care coordination services necessary to proactively and preemptively intervene with Veterans at imminent risk of becoming homeless or returning to homelessness.

Facilities typically select an H-PACT model depending upon their local resources and capacity, the volume of homeless Veterans seen and the specific needs being targeted (i.e. reducing emergency department use within a Medical Center, treatment engagement at a Community Resource and Referral Center, care management during high risk shelter transitions).

If available, the Case Manager may consider recommending H-PACT when there are signs that the homeless Veteran's health care needs are not being met, including high no-show rates, poor chronic disease management outcomes, and/or high use of emergency department and inpatient care for non-acute and preventable conditions.

Homeless Veterans often have additional special care needs given their greater complexity and disease burden. H-PACT teams have population adjusted teams and panel sizes along with specialized care providers on the team to help support these challenges. For the homeless population, the Case manager can support the high priorities for the H-PACT, which includes: 1) coordinating and negotiating access to appropriate specialty clinics, 2) addressing transportation and scheduling barriers, 3) encouraging visit-preparedness, and 4) enhancing communication between the Veteran, the Specialty providers, and the H-PACT team.

Communicating with the Clinical Team

Good communication is critical to ensure effective, timely, and coordinated care. Quality documentation in the medical record coupled with regular review of others' notes is foundational for interdisciplinary communication. However, well-written notes with co-signatures are insufficient to ensure team-based care. Provision of integrated comprehensive care to Veterans in supportive housing requires ALL staff providing care for the Veteran to work as a team, regularly communicating with each other. It is critical to have established contacts and connections within the PACT, HPACT, or other clinical service before a crisis occurs. Typically, the RN on the H-PACT or PACT team is a good point of contact (s/he is often more readily available for consult/communication than the lead physician).

There are several ways to establish regular contact with the rest of the clinic team. Meeting with the team as part of their weekly meeting or daily clinic huddle is one opportunity to convey any concerns or update them on a client's progress. Another approach chosen by some Case Managers is to accompany the patient to the clinic visit or have the clinic team accompany you to a home visit. This provides an opportunity for the Case Manager to both advocate for the Veteran and to listen to the primary care treatment plan. When members of the clinic team meet with the Veteran, it also increases the Veteran's sense of treatment unity and cooperation, enhancing trust and conveying the sense that there truly is a team working on behalf of the individual. None of these approaches is exclusive of another, and they should complement each other. The key is to establish what communication channel works best for everyone in advance of a crisis, typically by meeting with the team and asking which approach is mutually convenient.

Finally, it is important to feel comfortable conveying not only direct observations and reported symptoms, but also less concrete concerns. Again, the HUD-VASH Case Manager is in the unique position of being able to observe the client in contexts that are not readily apparent during a clinic visit. Using this vantage point to observe, gather data, and form impressions of the Veteran's functioning that may contribute to the care team's ability to assess symptoms and create treatment plans is invaluable, as it brings to the clinical encounter a perspective not typically available. It is also important to recognize that functional communication is a two-way process and that Case Managers may be asked by the care team to follow up with the patient regarding care plans or assessments, emphasize actions steps or behaviors that were encouraged in the clinic appointment, or facilitate compliance with a given treatment or medication.

Eliciting Clinically Relevant Information–What to Ask your Client

Many behaviors and symptoms can suggest more serious underlying problems that, if left untreated, could lead to worsening mental and physical health, precipitate a relapse, and or ultimately jeopardize one's ability to stay housed. Case Managers are often in a unique position to ask about and observe behaviors that clients might not otherwise find significant or feel comfortable reporting. Some telltale presentations that may warrant a closer examination and discussion with the treatment team include:

- **The client reports feeling down, depressed, anxious, has difficulty with hygiene, or becomes socially withdrawn.** These may all be signs and symptoms of an underlying depression or anxiety disorder that may become more evident when the client becomes more socially withdrawn and isolated in their new living arrangements.
- **The Case Manager might observe the client with pressured speech, report little to no sleep, racing or intrusive thoughts and/or speak in grandiose terms.** These symptoms are suggestive of a manic or hypomanic episode that requires further specialty evaluation.
- **The client complains of pain.** This is particularly common when a Veteran with a long-term drug or alcohol abuse pattern becomes sober and no longer has the effects of substances to mask or block the pain or injury. It is important to be vigilant and responsive, as untreated pain can often lead to relapse, and there are a variety of pain management treatments available, including non-pharmaceutical alternatives.
- **The client skips or stops taking medication.** Many conditions require chronic medication dosing in order be controlled, yet it is often difficult to convey these physiological reasons for compliance. This is especially true when the client may not recognize an immediate or direct benefit from the medication or is worried about side effects or dependency. Some medications must build up in a client's system in order to have a noted effect, particularly anti- depressants; other medications have subtle or unrecognized effects. The client may be cutting back or stopping medications in trying to alleviate medication side effects that have not been communicated (for example, diuretics cause increased urination and may cause erectile dysfunction). Cost may also be an issue, especially if full VA benefits are still pending or means testing has not been completed; when certain drugs are not on the VA formulary, or access to the pharmacy is difficult.
- **The client reports excessive sleepiness, lack of energy, and/or constant fatigue.** While these symptoms can be associated with a depressive disorder or other mental health condition, they can also be associated signs and symptoms for conditions like congestive heart failure, anemia, substance abuse relapse, or endocrine disorders such as hypothyroidism or new onset/poorly controlled diabetes. Often, this will require a medical evaluation, typically including

blood work. The sooner the primary care team is aware of presenting symptoms, the sooner the work-up can begin.

▪ **There are significant changes to eating habits or diet.** When a Veteran locates and receives permanent housing, it also represents a daily lifestyle change with decreased emphasis on walking and transit, sometimes with greater or less food security that is associated with this new autonomy. Weight loss and/or poor appetites, symptoms of hypoglycemia (sweating, weakness, dizziness relived by eating) may all suggest limited availability or access to food and income resources, depression or anxiety, acute conditions such as a cancer, or chronic medical conditions such as liver disease and cirrhosis. While the client may not think much of these changes, a clinical work-up can rule out more serious explanations and to address potential complications.

▪ **The Veteran regularly misses appointments or meetings.** While occasional forgetfulness may be expected, a developing pattern of this may suggest a downward trend in motivation or treatment engagement. This relationship is particularly notable in the context of drug or alcohol abuse relapses, when the client starts missing meetings, avoiding the Case Manager, or ignoring the PCP or other team members. If the Veteran is in the throes of a relapse, he or she may not be fully aware of the threat this poses to their health and housing.

▪ **There is difficulty engaging the Veteran in health maintenance and preventive health care.** For many Veterans, in their "former" unsheltered lives, going to a clinic or hospital is only done in the case of sickness or injury. Primary and preventive care was not a priority, especially in the context of also trying to secure housing, get food, stay safe, etc. Now, with permanent, supportive housing, many homeless Veterans need to rethink what seeking health care means. Preventive care for homeless Veterans is similar to the general population of primary care. Regardless of what PACT team is caring for the Veteran, the case manager should advocate, encourage, and facilitate all preventive care needs including screening for high blood pressure, diabetes and other chronic diseases; screening for tuberculosis, colon, prostate, breast, and cervical cancers; immunizations and vaccinations against seasonal influenza, tetanus, and other conditions with added emphasis to those conditions more prevalent among homeless persons or that are associated with homelessness and risks for homelessness (i.e. tuberculosis screening, Lyme disease for unsheltered homeless in endemic areas, hepatitis C and HIV screening, hepatitis A and B vaccinations, etc.).

CASE MANAGERS: KEY POINTS TO REMEMBER

Availability = Demand	Among permanent supportive housing clients, many medical conditions may have gone untreated for extended periods of time. Unstable shelter, active use of drugs or alcohol, and competing medical needs often obstruct medical care. Once stable housing is obtained, there is often a pent-up demand for medical care.
Limited experience with self- advocacy, self-care and navigating the health system	When a Veteran is overwhelmed by the system and/or physical or mental health issues, medical treatment priorities, as determined by health care providers, may not always reflect the needs and priorities of the Veteran. This may result in fragmented care and dissatisfaction.
Triage dilemma	Many unattended medical needs are associated with not having a regular source of care (Gallagher et al, 1997). When the Veteran then enters into the health care system, these multiple morbidities (mental illnesses, substance use, and acute and chronic medical problems) often create a triaging dilemma.
Unaccustomed to a preventive care lifestyle	Case Managers should take any opportunity to provide preventive care, engage the Veteran in behavioral changes that promote recovery goals, and de-habituate dependence on emergency services for medical care.
Unfamiliarity with health care system in general or with civilian health care providers	When a homeless Veteran enters permanent supportive housing, it is entirely possible that he or she has limited or no experience accessing civilian VA, civilian primary, and/or non-acute ambulatory care. Veterans may not know what to expect, what is available, or what they may need.

Table 9. Case Manager Key Points to Remember

MEDICAL COMORBIDITIES AND HOMELESSNESS

Conditions that precede, **accelerate, or contribute to homelessness (TBI, etc.)**	• Mental illnesses such as depression, schizophrenia, and bipolar disorder have long been reported as precipitants of homelessness (Institute of Medicine, Committee on Health Care for Homeless People, 1988) • Drug and alcohol addictions (Jenks, 1995)
Conditions that are often **related to homelessness**	• Frostbite, trench foot, hypothermia, hyperthermia as results of exposure to the elements; often, these are exacerbated in intemperate zones when shelter demand exceeds capacity • Parasitic infestations (scabies, bed bugs, lice, fleas) • Increased exposure to transmission of airborne illnesses, especially tuberculosis, in overcrowded shelter conditions • Weakened immune system function • Increased risk of trauma (women are particularly vulnerable) (Kushel et al, 2003).
Conditions that are **complicated by** **homelessness**	• Chronic diseases that require continuous monitoring and medication, such as diabetes (managing insulin-dependent diabetes while living in a dusk-to-dawn emergency shelter presents significant obstacles, not only in storing and securing medications, but also in managing multiple injections in the context of an unstable, erratic, and usually suboptimal food availability) • Wound care: wound care is seriously compromised by inadequate hygiene in many sheltering arrangements as well as by the dependent edema that is a result of prolonged standing and walking

Table 10. Medical Comorbidities and Homelessness

WORKING WITH PRIMARY CARE		
RESOURCE / COMPOSITION	**OBJECTIVES**	**REFERRAL / CONTACT**
PATIENT ALIGNED CARE TEAM (PACT) ▪ 1-3 primary care providers (PCP's), a team RN, LPN, health technicians, nursing assistants ▪ Augmented by social workers, nutritionists, pharmacists, behavioralists, etc.	• Provide comprehensive, continuous, and coordinated care to Veterans • Coordinate chronic disease management, improve treatment outcomes • Serve as a first stop for urgent or emergent medical needs, thereby reducing emergency department visits and preventable hospitalizations • Increase patient and staff satisfaction • Engage client in primary care	All Veterans in permanent supportive housing should be linked to a PACT.
It is critical that the Veterans in permanent supportive housing are assigned to one of these PACT teams and that the team is used as a touchstone for engaging a client in primary care, coordinating any chronic disease management, and using it as a first stop access point for any urgent or emergent needs.		
HOMELESS PACTs Care team typically includes primary care provider, RN case manager, social worker, homeless program staff, mental health provider(s), health tech and often peer support	• Intended for homeless and recently homeless Veterans having difficulty navigating traditional care channels within VA • Housing and social supports needs are embedded in the clinic model with a primary focus on addressing housing needs in the context of providing clinic care • Panel sizes are smaller to allow for more intensive care and follow-up • Clinic model incorporates 4 main principles: • Open access/low threshold for accessing care and being • treated • Wrap-around services/care and resources on-site that • are specific to homeless-related needs • Intensive case management/care coordination that is community linked	Access is typically through open-access, "fixed time/place" walk-ins or via the homeless program staff. Check with your local facility on whether a team is in place there.

PRIMARY CARE-MENTAL HEALTH INTEGRATED CARE Care teams typically include social workers, psychologists, and sometimes psychiatrists	• Embed mental health care teams in Primary Care • Increase the accessibility and availability of mental health services within VA, especially for individuals with specific, time- limited, non-severe mental health presentations (depression, anxiety) • Eliminate traditional referral process • Provide an outlet for individuals who feel stigmatized seeking mental health care through traditional channels • Engage treatment-resistant clients • Introduce individual to time-limited cognitive behavioral therapy • Facilitate determination of most appropriate treatment with primary care and mental health team	Accessing this resource can typically be either directly with that provider team or via the assigned PACT team.
CASE MANAGEMENT / **TELE-HEALTH** RN-level case management and home-based tele-health technology	• Use technology to provide ongoing monitoring and assessment of chronic conditions • Intensive monitoring can inform and modify care plans before conditions worsen to the point of needing to go to the emergency department or to be hospitalized. • Equipment conveys health information electronically; RN follows up with patient prior to patient becoming symptomatic or deterioration of	Patients with difficult-to-manage chronic diseases such as diabetes, congestive heart failure, etc.

Table 11. Working With Primary Care

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Chapter

16

VETERANS AND SUBSTANCE USE DISORDERS

Introduction

A clinician working with Veterans in Permanent Supportive Housing (PSH) will often encounter individuals whose transition from homelessness is complicated by substance use disorders, often with co-occurring mental illness. Let us begin with some frequently asked questions.

What's in This Chapter?

There is a high prevalence of substance use disorders (SUDs) among Veterans enrolled in VA's Permanent Supportive Housing (PSH) Program HUD-VASH. In one study of 29,143 Veterans entering the HUD-VASH program between January 2008 and April 2011, 60% had a substance use disorder upon admission (Tsai et al, 2014). With the VA shifting the emphasis from PSH to Housing First and other low barrier homeless programs, prevalence rates are likely even higher along with the acute need for SUD services within the population. When PSH clinicians understand the nature of substance use disorders, the principles of assessment and treatment strategies for SUDs, they can collaborate effectively with Veterans to reach their recovery goals. In this chapter, you will be presented with an introduction to addictive substances, SUDs, evidence-based practices and resources for assessment and treatment of SUDs including:

1. Screening and assessment.

2. Treatment including medications and psychosocial treatments.

3. Treatment of co-occurring disorders

What are substance use disorders?:

According to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), which is the American Psychiatric Association's manual for categorizing mental health conditions into

diagnostic groups, "The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems." (APA 2013) Clinical signs and symptoms can be grouped into five main categories: impaired control of substance use, social impairment, risky use, and pharmacological criteria. (APA 2013) Specific diagnostic criteria for Substance Use Disorders can be found in the DSM-5 available online at: http://dsm.psychiatryonline.org/book.aspx?bookid=556.

	DSM – IV Abuse[a]		DSM – IV Dependence[b]		DSM – 5 Substance Use Disorders[c]	
Hazardous use	X		-		X	
Social/Interpersonal Problems related to use	X	≥1 criterion	-		X	
Neglected major roles to use	X		-		X	
Legal problems	X		-		-	
Withdrawal[d]	-		X		X	
Tolerance	-		X		X	
Used larger amounts/longer	-		X		X	≥2 criteria
Repeated attempts to quit/control use	-		X	≥3 criteria	X	
Much time spent using	-		X		X	
Physical/psychological problems related to use	-		X		X	
Activities given up to use	-		X		X	
Craving	-		-		X	

[a] One or more abuse criteria within a 12-month period *and* no dependence diagnosis; applicable to all substances except nicotine, for which DSM-IV abuse criteria were not given.

[b] Three or more dependence criteria within a 12-month period.

	DSM – IV Abuse[a]		DSM – IV Dependence[b]		DSM – 5 Substance Use Disorders[c]	
[c] Three or more substance use disorder criteria within a 12-month period.						
[d] Withdrawal not included for cannabis, inhalant, and hallucinogen disorders in DSM-IV. Cannabis withdrawal added in DSM-5.						
(Hasin et al 2013)						

Table 12. DISM-IV and DSM-5 Criteria for Substance Use Disorders

Which substances are potentially addicting?

Substance-related disorders involve ten classes of drugs according to the DSM-5. All of these except caffeine are potentially addicting and can lead to the development of substance use disorders. These classes include alcohol; cannabis (including synthetic cannabinoids such as "Spice" or "K2"); hallucinogens; inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants (including cocaine, amphetamines, and cathinones); tobacco; and other (or unknown) substances. (APA 2013)

What makes these substances addicting?

The brain's reward system motivates individuals to pursue adaptive behaviors such as finding food and securing shelter. Under most circumstances, the reward system prioritizes one's attention to those behaviors that are most important for survival. Potentially addicting drugs produce an intense, direct activation of the reward system. Over time, repeated intense activation of these brain reward circuits causes changes such that the addicting drug(s) begin to take priority over other activities that activate these systems. Important activities and adaptive behaviors may be neglected. When an individual continues to use addicting drugs despite knowing that the drugs are causing significant substance related problems, he or she has developed a substance use disorder. This behavior is driven by the brain changes caused by repeated use of addicting substances which may persist long after detoxification (Koob 2006). The behavioral effects of these brain changes may result in repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli. These persistent drug effects benefit from long-term addictions treatment (McLellan, Lewis et al. 2000) as with other chronic conditions including diabetes.

Who needs to be screened for substance use?

Screening and brief intervention may prevent those who use substances from developing substance use disorders and may help to identify and motivate those who need treatment. Because we have

evidence-based screening and intervention tools for alcohol and tobacco, everyone needs screening for alcohol and tobacco use. For those without contraindications to any alcohol use (e.g., hepatitis C), the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has established recommended daily and weekly alcohol consumption limits that are associated with exceptionally low rates of alcohol use disorders (less than 1%)(NIAAA 2009). Screening all Veterans for hazardous alcohol use and providing brief interventions to reduce unhealthy alcohol use improves health and quality of life. All Veterans should be screened for tobacco use and offered evidence-based smoking cessation treatment. (See VA-DoD Tobacco Cessation CPG at: http://www.healthquality.va.gov/guidelines/cd/mtu/index.asp).   At-risk individuals (e.g., those who are homeless) should also be assessed for other substances such as marijuana, cocaine, and opioids.

Why should I be concerned about SUDs among homeless Veterans?

Substance use and co-occurring substance abuse and mental illness represent a major risk factor for both becoming homeless as well as for sustaining homelessness. (Greenberg and Rosenheck 2010) An estimated 41% to 84% of homeless adults have a SUD. (Bassuk, Buckner et al. 1998, Gonzalez and Rosenheck 2002, North, Eyrich et al. 2004) In a pilot program in 17 states, homeless persons with co-occurring mental illness and substance use disorders were worse off clinically and socially at program entry and experienced less improvement than those without co-occuring disorders. However, those with co-occurring disorders who engaged in addiction treatment showed comparable improvement to those without co-occurring disorders after 12 months.(Gonzalez and Rosenheck 2002) Your attention to substance use disorder screening, assessment and collaborative treatment engagement can make a profound positive impact on the lives of the Veterans you serve.

Should SUD treatment be required before entry into Permanent Supportive Housing?

Research suggests that Housing First, which has been adopted by the VA to end chronic homelessness should be offered without any preconditions for SUD treatment. Veterans with SUDs who engage in the HUD-VASH program have similar housing status outcomes six months after entry compared to Veterans without SUDs, provided that they receive substance use disorder services (Tsai, Kasprow, Rosenheck 2014). However, participants with SUDs had a higher risk of substance use and mental illness symptoms than those without SUDs after six months in HUD-VASH. (Tsai, Kasprow, Rosenheck 2014) It is important to collaboratively address SUDs and co-occurring mental illness from the onset of services and throughout program engagement to help Veterans achieve their recovery goals. By building a collaborative, respectful therapeutic alliance and leveraging the power of this alliance to encourage SUD treatment engagement, Veterans may be more likely adhere to and benefit from evidence-based SUD treatments and to retain their independent housing. The PSH Resource Guide chapter on Housing First (insert page #) provides more information on this approach.

General Principles

For some Veterans, substance use disorders can be chronic diseases that respond over time to comprehensive treatment.

1. A strong therapeutic alliance based on mutual respect forms the foundation of effective SUD treatment. Veterans' perception of the quality of SUD treatment strongly correlates with the perception that clinicians are empathic and assist Veterans to achieve recovery goals beyond mere symptom reduction (Blonigen, Bui et al. 2014). (Blonigen, Bui et al. 2014). The principles of shared decision making build the strong therapeutic alliance that is essential for high-quality care for substance use disorders (Barry and Edgman-Levitan 2012).

    Shared decision-making requires a dialogue between the clinician and patient aimed at:

    1) Helping patients better understand their medical conditions and the need to make treatment decisions;
    2) Clarifying the benefits and potential adverse events associated with each option
    3) Soliciting patients' values and preferences; and
    4) Supporting their decision, even if for no treatment.
    5) Providing support while patients implement their decisions. (Légaré and Witteman 2013)

2. In order to make informed decisions, Veterans need accurate information about medications (pharmacotherapy), evidence-based psychosocial treatments (such as Cognitive-Behavioral Therapy for SUD, 12-Step Facilitation, Contingency Management, Behavioral Couples Therapy for SUD, etc.), and community resources (such as Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, etc.).
    The VA-DoD Clinical Practice Guideline (CPG): Management of Substance Use Disorders [http://www.healthquality.va.gov/guidelines/MH/sud/] provides evidence-based guidance for:
    - Screening and initial assessment of substance use disorders (Module A)
    - Management of SUD in Specialty SUD Care (Module B)
    - Management of SUD in Primary Care (Module C)
    - Addiction-focused Pharmacotherapy (Module P)
    - Stabilization and withdrawal management (Module S)(Group 2009)

    In addition, VHA Handbook 1160.01 Uniform Mental Health Benefits outlines the minimum and recommended resources for treatment of SUDs at VHA facilities.

3. Assessment of substance use is a key first step for all patients in PSH.   The Screening and Assessment module of the VA DoD Clinical Practice Guideline recommends screening for

alcohol use using an evidence-based tool such as the AUDIT-C and for substance use in high risk populations such as those with homlessness(VA-DoD CPG Module A). For those with substance use disorders, a thorough biopsychosocial assessment be completed for Veterans in high-risk groups such as homeless Veterans (VA-DoD CPG Module B) The VA DoD Clinical Practice Guidelines for Substance Use Disorders can be found at the following http://www.healthquality.va.gov/guidelines/MH/sud/.

a. Assess current alcohol consumption- Determine the number of standard drinks (14 grams of pure ethanol or 0.6 fluid ounces) consumed by the Veteran in a typical week and the maximum number of drinks per occasion in the past month. Alcoholic beverages vary in alcohol concentration. See figure below from the NIAAA Clinician's Guide   for   Helping   Patients   Who   Drink   Too   Much [http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm] for a guide as to how much of each beverage constitutes one standard drink.

12 oz. of beer or cooler	8–9 oz. of malt liquor 8.5 oz. shown in a 12-oz. glass that, if full, would hold about 1.5 standard drinks of malt liquor	5 oz. of table wine	3–4 oz. of fortified wine (such as sherry or port) 3.5 oz. shown	2–3 oz. of cordial, liqueur, or aperitif 2.5 oz. shown	1.5 oz. of brandy (a single jigger)	1.5 oz. of spirits (a single jigger of 80-proof gin, vodka, whiskey, etc.) Shown straight and in a highball glass with ice to show level before adding mixer*
12 oz.	8.5 oz.	5 oz.	3.5 oz.	2.5 oz.	1.5 oz.	1.5 oz.

Figure 8. Single Serving of Alcohol

b. Determine Whether the Veteran is drinking more than is recommended

Recommended Alcohol Consumption Limits for Healthy Individuals < 65 years	
Men: ▪ ≤ 14 drinks a week; and ▪ ≤ 4 drinks on any occasion	**Women:** ▪ ≤ 7 drinks a week; and ▪ ≤ 3 drinks on any occasion
Standard-sized drinks are: 12 oz. beer, 5 oz. wine, or 1.5 oz. hard liquor.	

Table 12. Recommended Alcohol Consumption Limits for Healthy Individuals Less Than 65 Years of Age

c. Determine whether the Veteran may be using other addicting drugs. The National Institute on Drug Abuse's NMAssist provides an interview tool for assessing substance use (Smith et al, 2010), which can be found at: http://www.drugabuse.gov/nmassist/?q=nida_questionnaire.

d. For Veterans who endorse drinking alcohol above recommended limits or using other addicting drugs, assess whether the Veteran meets criteria for a substance use disorder using DSM-5 criteria.

e. For those with a substance use disorder, conduct a comprehensive biopsychosocial assessment including a history of the present episode (including precipitating factors, current symptoms and pertinent present risks), medical history, physical examination and laboratory tests for infectious diseases and consequences of substance use, a mental status examination, a survey of assets, vulnerabilities and supports and the patient's perspective on current problems, treatment goals and preferences. Use an empathic and non-judgmental style being sensitive to gender, cultural and ethnic differences.

f. Using a structured assessment of current substance use and risk and protective factors, such as the Brief Addiction Monitor (BAM) can help identify targets for treatment goals and objectives. (Cacciola et al, 2013) Follow-up assessments provide a structure to modify treatment plans as indicated.

g. Using principles of shared decision-making (Barry et al, 2012), provide a diagnostic formulation including past treatment response and the patient's perspective on current problems. Express concern about excessive alcohol use and any problems related to alcohol or other drugs. Link your treatment recommendation to the Veteran's health and housing concerns.

     h.   Present and discuss the treatment options with the patient and significant others.

     i.   Deterine whether the treatment plan can be implemented in general health care (including primary care) based on availability of a willing provider, severity and chronicity of the SUD, active involvement with recovery supports in the community, prior treatment response, and patient preference and likelihood of adherence.

     j.   Offer referral to specialty SUD treatment, as indicated.

     k.   Using principles of shared decision-making, assist the Veteran to set recovery goals and support any positive changes toward that goal.

     l.   Continue to provide support for alcohol and drug use goals during future visits.

4. Reduce barriers to SUD treatment by offering a menu of options. Some options may be offered within the PSH program. The VA-DoD CPG provides guidance for treatment in the general mental health setting (VA-DoD CPG Module C), including the Patient Aligned Care Teams for Homeless Veterans (H-PACT) that provide comprehensive care. If a Veteran screens positive for hazardous alcohol use or endorses other substance use, assess for a substance use disorder(APA 2013). Summarize the patient's problems, discuss treatment options, and arrive at a shared decision regarding the treatment plan. If an SUD is present, offer a specialty SUD treatment referral, recognizing that many Veterans will not accept it, at least initially. Also assess for any unstable medical or mental health condition including withdrawal risk from alcohol, opioids or sedative-hypnotics such as benzodiazepines and refer for comprehensive assessment, if needed. Refer for acute withdrawal management or medical/mental health stabilization, if needed. (VA-DoD CPG Module S) when the Veteran is using- alcohol, sedative/hypnotics such as benzodiazepines, or opioids.

> **SUD treatment within the PSH program may be most helpful when:**
>
> ▪ The patient has successfully completed specialty SUD treatment and needs ongoing care closer to home.
> ▪ The patient refuses referral to specialty SUD care, but is willing to accept some services from PSH staff.
> ▪ The patient has been engaged repeatedly in specialty SUD treatment with minimal progress toward abstinence or sustained improvement.

When planing interventions in the general (PSH program) setting, consider evidence-based psychosocial interventions- such as Motivational Enhancement Therapy (Miller et al 1994) or 12-step facilitation (Nowinski et al 1994). Consider the patient's prior treatment experience and respect the patient's preferences, since no single psychosocial approach has emerged as the treatment of choice. Emphasize that the most consistent predictors of successful outcome are retention in formal treatment and/or active involvement with community support for

recovery (including Alcoholics Anonymous, Narcotics Anonymous). Based on locally available expertise (e.g., from competency-based training and consultation initiatives), initiate addiction-focused psychosocial interventions with empirical support. Consider the following that have been developed into published treatment manuals and evaluated in randomized trials:

   a. Behavioral Couples Therapy (O'Farrell et al 1998, O'Farrell & Fals-Stewart 2013)
   b. Cognitive Behavioral Coping Skills Training (Carroll 1998, Litt et al 2003)
   c. Contingency Management/Motivational Incentives (Petry et al 2000, Petry & Stitzer 2002)
   d. Motivation Enhancement Therapy (Miller et al 1994)
   e. Twelve-step facilitation (Nowinski et al 1994)
   f. Community Reinforcement Approach (Budney et al 1998, Smith et al 2001)
   g. Seeking Safety (for PTSD and SUD) (Najavits L.M. 2002, Boden et al 2012)
   h. Concurrent treatment of PTSD and SUD using Prolonged Exposure (COPE) (Back et al 2014)

5. Obtain objective measures of treatment effectiveness. For Veterans with substance use disorders, measuring substance use through urine drug screens, breath alcohol tests or other objective measures (such as liver enzymes tests) is essential for effective SUD treatment ((VA/DoD 2009)). A Memorandum from the Assistant Deputy Under Secretary for Health for Clinical Operations (10NC) on September 5, 2013, outlines the requirements for screening and confirmatory testing that must be available at all VA Medical Centers and Clinics. A copy can be found on the SUD SharePoint site, at: https://vaww.portal.va.gov/sites/OMHS/SUD/SUDfiles/Forms/AllItems.aspx?RootFolder=%2fsites%2fOMHS%2fSUD%2fSUDfiles%2fDrug%20screening&FolderCTID=&View=%7bD11E15C0%2dC0BA%2d4F78%2dBB9B%2d468B35D218D1%7d.

6. Consider addiction-focused pharmacotherapy for all patients with alcohol or opioid use disorders (VA-DoD CPG Module P). For alcohol use disorder, both naltrexone and acamprosate are associated with significant reduction in return to drinking in individuals who have been detoxified (Jonas, Amick et al 2014). Patients may prefer a once daily medication or a monthly injection. Naltrexone and disulfiram can be administered once daily. Naltrexone is also available as a long-acting monthly injection. This option may be especially helpful for Veterans who have difficulty adhering to daily oral dosing or who have a history of relapse outside of a controlled environment. See recommendations for use (RFU) at: https://vaww.cmopnational.va.gov/cmop/PBM/_layouts/OSSSearchResults.aspx?k=Naltrexone&cs=This%20Site&u=https%3A%2F%2Fvaww.cmopnational.va.gov%2Fcmop%2FPBM the Pharmacy Benefits Management Intranet site. In an open-label pilot study of chronically homeless individuals, long-acting injectable naltrexone and harm-reduction counseling were associated with decreases from baseline to 12-week follow-up in alcohol craving, alcohol use

and associated problems (Collins et al, 2014).   Acamprosate is another FDA-approved medication for alcohol use disorders that may be especially helpful for Veterans with liver disease since naltrexone and disulfiram are both associated with a risk of hepatitis and require a functioning liver for elimination of the medication. However acamprosate's three times per day dosing regimen may pose an obstacle for less stable patients. Disulfiram may be highly effective in selected individuals who are medically and psychiatrically stable and willing to engage in monitored self-administration. The risks of a disulfiram-alcohol reaction, which include nausea, vomiting, low blood pressure and potentially death from cardiovascular shock must be weighed against the benefits of support to alcohol abstinence. There are also non-FDA approved medications with moderate evidence of efficacy (Jonas, Amick et al 2014), including topiramate. Pharmacotherapy and care management of alcohol use disorders in VA Primary Care clinics is associated with a five-fold increase in treatment engagement and significant reductions in alcohol consumption (Oslin, Lynch et al. 2014).

For opioid use disorder, opioid agonist therapy (OAT) (methadone, buprenorphine/naloxone) is the first line treatment because of superior efficacy in supporting abstinence and reducing risk of overdose death compared to no medication.   For those Veterans with contraindications or who choose not to accept OAT, long-acting naltrexone injection (see RFU for Extended-release Injectable Naltrexone at: https://vaww.cmopnational.va.gov/cmop/PBM/_layouts/OSSSearchResults.aspx?k=Naltrexone&cs=This%20Site&u=https%3A%2F%2Fvaww.cmopnational.va.gov%2Fcmop%2FPBM) and (see RFU for Naloxone Kits at PBM intranet site https://vaww.cmopnational.va.gov/cmop/PBM/_layouts/OSSSearchResults.aspx?k=Naloxone&cs=This%20Site&u=https%3A%2F%2Fvaww.cmopnational.va.gov%2Fcmop%2FPBM naloxone for overdose prevention should be offered.

For Veterans with Tobacco use disorder, PSH clinicians can follow the 5 A's from *Helping Smokers Quit: A Guide for Clinicians.* More detailed recommendations can be found at the Tobacco Tools SharePoint Tobacco Tools Sharepoint and at the VA Tobacco and Health website: http://www.publichealth.va.gov/smoking/index.asp.

From "Helping Smokers Quit- A Guide for Clinicians" [http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2007] about tobacco use at every visit:
1. Advise tobacco users to quit.
2. Assess readiness to quit.
3. Assist tobacco users with a quit plan.
4. Arrange follow-up visits.

Medications   for   Tobacco   Cessation
[http://www.publichealth.va.gov/docs/smoking/cessationguidelinepart2_508.pdf]
includes the following:

1. Nicotine replacement therapies
   a. Daily transdermal patch
   b. Gum as needed
   c. Lozenge as needed
   d. Nasal spray as needed (non-formulary in VHA)
2. Varenicline - twice daily oral tablet
3. Bupropion - twice daily oral tablet
4. Nortriptyline - once daily oral tablet

Summary

High-risk substance use and substance use disorders pose significant risks to the health and housing status of Veterans. For many Veterans, substance use disorders are chronic illnesses that improve incrementally over time using a variety of evidence-based treatments including psychotherapies, medications and engagement in mutual-help organizations. PSH clinicians are in a unique position to build a strong therapeutic alliance with Veterans to engage them in shared decision-making about how best to address high-risk substance use and SUDs consistent with permanent supported housing.

Veteran's choices regarding participation in SUD treatment while participating in PSH Programs should always be respected. If a Veteran declines treatment services, that choice must be respected and supportive services should never be withheld based on the Veteran's lack of compline with SUD treatment services that have been offered.

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Chapter

17

HOMELESS WOMEN VETERANS

Background

Within the Department of Veteran Affairs, female Veterans are designated as a special population because of their unique needs and relatively low numbers within the Veteran and Active Duty population (Washington, 2004). Female Veterans represent 8% of the Veteran population and 14.6% of the active duty population, with this number expected to increase in future years (NCHV). Many of these women face unique challenges as they reintegrate into civilian life compared to their male counterpart which can increase their vulnerability to homelessness. These challenges can include, raising children on their own, having disabling psychological conditions such as Post Traumatic Stress Disorder (PTSD) and major depressive disorder resulting from Military Sexual Trauma (MST) (Hayes, 2012).

Homelessness among Female Veterans

While the overall number among homeless Veterans is decreasing the number of homeless female Veterans is increasing. Reports have indicated female Veterans may be up to four times greater risk of homelessness than their civilian counterparts (Foster, 2010). Among those women Veterans age 18-29 years of age represent the highest risk of homelessness with the risk declining as age increases (Fargo et al. 2011).

In a report by Hamilton, Poza and Washington in 2011, five experiences had been identified as predominant

> **Homeless Women Veterans Statistics:**
>
> **Females make up 8% of Veteran population and 14.6% of the Active Duty population.**
>
> **Female Veterans may be up to 4 times greater risk of homelessness than civilian counterparts.**
>
> **For women Veterans, the risk of homelessness is highest among the 18-29 year age group and the risk declines as age increases.**

pathways for homelessness among women. The pathways include childhood adversity, trauma or substance abuse in military service; post-military abuse; adversity and/or termination of a relationship; and post-military mental health, substance abuse and/or medical problems. These pathways are identified as interconnected and coined, "a web of homeless vulnerability." A sense of isolation, lack of resources and support and barriers to care has also been indicated (Hamilton, Poza & Washington, 2011).

Trauma

When working with Female Veterans it is important to work within a Trauma Informed framework. Reports have indicated 81%-93% of female Veterans have been exposed to some type of trauma (Zinzow et al., 2007). Post-Traumatic Stress Disorder (PTSD) has been reported as one of the largest mental health challenges for returning Veterans (NCHV). Women who experience Military Sexual Trauma (MST) were nine times more likely to show risk factors indicating PTSD (DOL, 2011). Increased problems with alcohol or drugs, lower economic and educational outcomes and difficulty maintaining relationships can be exacerbated within this cohort (DOL, 2011).

Across a range of studies Veterans with a history of MST also reported (Hayes, 2012):

- More mental health problems (e.g., anxiety and depression)
- More physical health symptoms
- More problems readjusting after discharge
- Mental and physical health conditions that can contribute to difficulties with employment (e.g., problems with concentration, difficulty sleeping, physical pain)

Special Issues of Women Veterans who are Homeless

Outreach

Staff conducting outreach frequently neglect to ask female clients if they have military service because of a common misperception that most Veterans are males. Likewise, outreach staff frequently report that some women Veterans do not self-identify as Veterans when asked if they are Veterans (DOL, 2011). It is imperative that outreach staff be mindful that many women who are homeless may have Veteran status and should routinely inquire by asking the question, "Do you have any military service?" Asking a female client about military service is more likely to elicit Veteran status than simply asking the client if they are a Veteran.

Priority Placement

Living on the street is dangerous for all the homeless, but it is even more dangerous for women who are homeless. Recent studies indicate women experience extraordinary high rates of abuse and victimization while homeless (No Safe Place, 2011). Due to the increased risk for women

experiencing homelessness, it is recommended that women Veterans be given priority for immediate placement in safe, permanent, supportive housing.

Housing Selection and Safety

The provision of Housing Choice vouchers for Veterans has greatly expanded options for all Veterans to find affordable housing and this has been especially true for women Veterans. However, finding safe affordable permanent housing remains very challenging due to the fact that much of the housing available thought this program is frequently in less than desirable communities with high rates of crime and social problems. Women Veterans are also more likely to be accompanied by their children, increasing their concerns about neighborhood safety, safe schools for the children, and access to parks, recreational areas, and child care for their children. Case managers and housing specialists must be especially attentive to these issues when assisting women Veterans in finding permanent supportive housing. Reducing the potential for devastating additional victimization and finding a neighborhood where the Veteran and family feel safe and can have their needs met should be the highest priority, often requiring multiple visits to the prospective neighborhood, the local schools, and community amenities.

Access and Proximity of Specialized Services for Women Veterans

Case managers and housing specialists must also consider the requirements for specialized services for women Veterans and accompanying family members. The ability of the Veteran and family members to have access to these services is likely to be a critical factor in the adjustment to the Veteran's new home. Permanent supportive housing staff are encouraged to work closely with the local VA Medical Center's Women's Program Manager to meet these resource needs.

VA Homeless Programs

VA has recognized without intervention and programs specific to female Veterans the number of women who have served will continue to increase within the homeless population. Currently all VHA Homeless, substance abuse and mental health programs serve both male and female Veterans. Community partners and VHA are working together to provide services that focus on the needs of women Veterans, such as, child care, transportation assistance, wrap around services that address personal safety. Programs that have demonstrated great success with the female Veteran population include, Grant Per Diem (GPD), HUD-VASH, and Supportive Services for Veteran Families (SSVF). For detailed descriptions and current figures on women Veterans being served can be found here: http://www.va.gov/HOMELESS/for_women_veterans.asp.

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**Chapter
18**

ELDERLY HOMELESS VETERANS

Introduction

Aging can be defined as a process of decline in multiple life functions over time. How someone ages is influenced by genetic, lifestyle, and environmental factors, including access to housing. Homelessness accelerates the aging process. Among homeless individuals in their 40-50s, we find geriatric syndromes-e.g. falls, incontinence, cognitive impairment- not seen in the general population for another two decades (Brown et al, 2011). The development of one or more geriatric syndromes among homeless Veterans relates to modifiable risks-chronic illness management, alcohol and substance abuse, educational attainment, and access to care (Brown et al, 2013). Homeless Veterans survive in environments not meant for human habitation by making adaptations to ensure safety, sustenance, and support. Alcohol and drug use, poor sleep, unbalanced diet, isolation, violence, injury and disease are often the results of living under conditions of deprivation. Attention to health and wellbeing is rarely a priority amidst the vagaries of homeless life until they precipitate crises. This accounts for high utilization rates of emergency and inpatient health services and poor health outcomes in this population (Tsai and Rosenheck, 2013).

Housing first in permanent supportive housing has made it easier for older Veterans to establish a foundation of stability. However, housing alone is not sufficient to reduce health risks or promote social integration (Tsai and Rosenheck, 2012). Without active participating in the community, making positive lifestyle changes, engaging with health services and social support, the formerly homeless Veteran is just as likely to persist in their isolation and ignore their health as before. Isolation is linked to further cognitive and functional decline (Caplan et al, 2006). Case managers working with Veterans in permanent supportive housing will encounter many older individuals seeking housing, particularly those from the Vietnam and post-Vietnam era, for years to come. Case mangers serve a crucial role empowering these Veterans to age in place. This chapter is intended to provide case managers the background to distinguish normal aging versus pathological processes, appreciate the impact of comorbid medical conditions on psychological health and functional

capacities, and provide guidance on how case managers can best support the interests of older Veterans.

"NORMAL" AGING:

In the US, average life expectancy for males is 75.6 years and for females, it is 80.8 years. Among homeless Veterans, particularly those with mental health and substance use disorders, those in their 40s and 50s have nearly double the mortality rate compared to housed Veterans and have prevalence of comorbid chronic health conditions similar to housed population 15-20 years older (Kasprow et al, 2011). Physical changes occur at different rate and to different degrees depending on multiple factors as previously mentioned. Table 1 presents a few of these changes commonly found in all older individuals.

Psychological and social changes over the course of aging are marked by cycles of life transitions and individual adaptations to these Transitions. In a conventional life trajectory one might encounter retirement, relocation, losing spouses and friends, greater investment in family, and increased dependence on others for care. Erik Erickson once described middle adulthood-roughly between ages 35-65- as a time of generativity versus stagnation. Those who were able to do socially valuable work and foster the next generation have an easier time coming to terms with themselves, their regrets and achievements, when they pass into the late adulthood stage of ego integrity versus despair. For many of our homeless Veterans, their lives interrupted by poverty, unemployment, divorce, estrangement, addiction, incarceration, institutionalization, and transiency, there may be unrealized life goals from previous stages of their lives Veterans need to accomplish to age successfully and avoid despair.

Cognitive changes of aging occur as well. One's fund of knowledge- learned facts, practiced skills, vocabulary, reading ability, syntax, and quantitative capacities are relatively preserved over time. Older individuals do have more difficulty learning and incorporating novel information. In part this is related to a decline in attentional capacities-sustaining, dividing attention, retrieval, holding, and manipulating new information. Executive functions- e.g. the capacity to organize, plan, and self-monitor-also declines over time- affecting ability to carry out complicated projects. Changes in vision and hearing acuity, coupled with slowing of sensory-motor processing speed may make driving and other activities requiring quick response difficult. Though the key determinant of cognitive function is genetic inheritance, healthy, educated, self-directed, active and curious individuals tend to retain their cognitive faculties longer (Jeste et al, 2010). Abnormal cognitive changes and their impact will be discussed later in the chapter.

Body Systems	Age Related Changes	Consequences of These Changes

Cardiovascular	Reduced heart muscle mass and elasticity; blood vessels harden	Less efficient filling and pumping; higher blood pressures, less stamina
Respiratory	Reduced elasticity and capacity to hold air	Less efficient gas exchange
Digestive	Reduced absorption and motility	More prone to diarrhea, constipation
Genitourinary	Reduced bladder elasticity, capacity, weaker sphincter muscles	Increased urinary urgency, incomplete bladder emptying, more urinary incontinence
Musculoskeletal	Reduced muscle mass, degeneration of joints from increased wear, less lubrication, more calcium deposition, less bone density	Loss of strength and stamina, increased risk for developing arthritis, osteoporosis, postural changes (e.g. "hunchback")
Immunological	Reduced number of new white cells being formed	More susceptible to cancer and infections
Sensory/motor	Decreased visual acuity, loss of hearing, diminished sense of smell and taste; increased motor response time, loss of fine motor skills	Disorientation, loss of appetite; Functional limitations (e.g. driving, self-care, eating, dressing)
Homeostatic	Postural instability, swallow reflex slows, regulation of temperature and thirst less efficient, less response to low oxygen	Increased risk of imbalance and falls, choking or aspiration, dehydration and heat/cold intolerance, and apneas (i.e. when sleeping)

Table 13. Physical Changes of Aging

Geriatric Syndromes and Psychological Aspects of Medical Illness

Geriatric syndromes develop in older adults when there are one or more interrelated medical issues leading to functional limitations. Geriatric syndromes often have multiple causes related to chronic disease conditions such as diabetes, arthritis, osteoporosis, cardiovascular disease and access to appropriate care (Brown et al, 2013). Alcohol and substance use as well as prescription polypharmacy can contribute as well to some geriatric syndromes. Sensory impairments-vision, hearing, taste-present additional functional challenges and are sometimes considered geriatric syndromes in themselves. Cognitive impairment such as delirium and dementia (now termed neurocognitive disorders)-will be considered separately. Geriatric syndromes can negatively impact psychological and social spheres of life if not diagnosed and managed. There are many types of

geriatric syndromes, for a more comprehensive listing, see A Guide to Geriatric Syndromes from the Foundation of the American Geriatrics Society (http://www.healthinaging.org/files/documents/tipsheets/geri_syndromes1.pdf). Here we will concentrate on a select few common and disabling syndromes that may disrupt housing tenure and community reintegration efforts.

Falls: One-third of individuals 65 and over fall annually. Of those who fall, 1 in roughly 16 will suffer a fracture-most commonly hip fracture, and 1 in 4 of those who suffer a fracture will die within 6 months. Those who survive may live with limited physical mobility and develop anxiety and depression due to fear of falling again. These individuals are at risk for becoming more isolated and dependent on care for others. Multiple risk factors contribute to fall risk: >65, female gender, osteoporosis, sensory and cognitive impairment, polypharmacy, sedative use, cardiac disease, neurological diseases (e.g. Parkinson's disease, stroke) and environmental hazards in the home. Fall risk can be assessed in the home using simple clinical assessment tools. To assess mobility, case managers can use the Timed Up and Go Test (http://www.fallpreventiontaskforce.org/pdf/TimedUpandGoTest.pdf). Individual starting in a seated position is asked to get up, walk to a marked point 10 feet away, turn around and sit down again. Taking greater than 20 seconds to complete this task is rated as impaired mobility. The Tinnetti Balance and Gait Assessment Tool (see http://www.geriu.org/uploads/applications/Tinetti/tinetti.htm for tutorial) is a more nuanced assessment of fall risk. There are separate scales to measure various aspects of balance and gait. Of a possible 28 points, those scoring 19-24 have risk for falls, those who score >19 are at high risk for falls. Home safety assessment should be completed for those Veterans with risk for falls. This can be completed by home based nursing, physical therapy or occupational therapy. The purpose is to observe how Veterans navigate the home environment and to identify potential trip hazards-e.g. cords, rugs, steps, shower, toilet, poor lighting-to be eliminated. Structural and individual accommodations-e.g. grab bars, non-slip bath mats, toilet booster seats, grabbers, walkers- can be added. Referral to primary care is recommended for medication review to eliminate medications with impairing side effects contributing to falls. A thorough clinical/lab work-up may be called for to identify associated medical conditions. A program of physical and occupational rehabilitation may be indicated for individuals to strengthen muscles, improve balance, and develop compensatory strategies to prevent and recover from falls. Case managers may also consider obtaining a medical alert system for those with ongoing fall risk. Bed with railing could be advantageous for nighttime fall prevention. Ongoing falls warrant additional in-home caregiver service for monitoring. When individuals have serious cardiac disease causing fainting, develop neurocognitive disorder (dementia), or movement disorders like Parkinson's disease, Case managers should discuss with Veteran the eventual need to transition to a higher level of care.

Incontinence: urinary and fecal incontinence are the leading cause of homebound elderly and the number one cause of nursing home placement. Urinary incontinence can result from stress- where increased abdominal pressure from coughing, sneezing, laughing overcomes weakened sphincter muscles, from increased and spontaneous contraction of bladder muscles, from incomplete emptying and overflow of urine, and for functional reasons like the inability to make it to the toilet on time or neglecting to make the effort to use the toilet. A host of underlying conditions ranging from cognitive impairment to severe depression to alcohol intoxication and over-medication can contribute to urinary incontinence. Fecal incontinence is most commonly related to chronic constipation and damage to intestinal muscles or nerves controlling motility of colon and rectum. Those at particular risk include individuals with history of intestinal and rectal surgery, radiation treatment, history of inflammatory bowel disease, and other bowel infections. Those who suffer from incontinence are at higher risk of immobility, developing pressure ulcers, infections, and hospitalization. They may be embarrassed by the condition, avoid from public settings and activities for fear of incontinence, resulting in isolation and further anxiety and depression. Case managers may be the first to identify these issues from home visits with the Veteran. Referral to primary care for initial clinical and laboratory workup is the first step. Referral to specialty care may be indicated for more sophisticated diagnostics and management. Therapies for bladder and bowel training exist. Veterans may need to use absorbent undergarments in order to have more mobility. Supportive counseling may be provided by the case manager or other qualified MH counselor to address anxiety and self-esteem issues around incontinence.

Chronic Pain: Chronic pain is pain lasting greater than 1 month. There are usually multiple causes- e.g. from traumatic injury, arthritis, diabetic neuropathy, or diffuse pain syndromes like fibromyalgia. New onset pain and or functional change suggest underlying condition and should be evaluated by medical professional. Estimates of between 25-50% of community dwelling older adults live with pain (Hanks-Bell et al, 2004). Chronic pain can lead to sleep deprivation, which can decrease pain thresholds, and limit daytime activity and mobility. Chronic pain may lead to self-medication with alcohol or other drugs, increase incidence and severity of depression and mood disturbances as well as other geriatric syndromes- e.g. falls. Veterans living with chronic pain may have a diminished quality of life, Societal consequences of pain include increased financial and caregiving burdens placed on families and friends as well as the increased utilization of health care services. All of these consequences of pain further diminish quality of life by isolating individuals from social engagement and amplify emotional isolation. Case managers may help Veterans identify and rate their pain level. Multiple brief pain rating scales can be employed, e.g. numerical rating scales, Wong-Baker FACES pain scales, Brief Pain Inventory which also assesses functional impact of pain are some examples (http://www.partnersagainstpain.com/measuring-pain/assessment-tool.aspx).

Depression commonly overlaps with chronic pain and can worsen perception of pain. Case manager may wish to screen for depressive symptoms using PHQ-9 (http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf) or Geriatric depression scale, Short Form (http://web.stanford.edu/~yesavage/GDS.html). Additional assessments should be accomplished by home nursing or primary care providers. Though an estimated 1 out of 5 adults over 65 use pain killers three times a week, it must be that chronic pain is rarely completely resolved and chronic use of any substance to manage pain tends to lose efficacy and cause additional health problems over time. Steroids may cause mood swings and psychotic symptoms, Nonsteroidal anti-inflammatory drugs (NSAIDs) like ibuprofen may interfere with kidney function, acetaminophen may cause liver damage, and opioid pain meds can suppress respiratory drive, cause cognitive impairment, imbalance and falls, lead to constipation, and create dependency. Case managers may help reframe Veteran goals from elimination of pain to living despite pain. Referral to multidisciplinary pain clinics through the VA can help develop the Veteran multimodal treatments and strategies to cope with pain that do not rely exclusively on pharmacological treatments. Referral to counseling and medication management for treatment can improve both depressive symptoms and pain levels.

Failure to Thrive: this is a state of decline with multiple causes. Common symptoms that define the syndrome include loss of >5% of baseline weight, decreased appetite, poor nutrition, inactivity, dehydration, impaired immune function, low cholesterol levels, and depression/apathy (Institute of Medicine, 1991). This can affect up to 35% of community dwelling individuals over 65 and has a mortality rate of close to 16% for hospitalized patients (Verdery, 1997). Common causes include infection-UTI, dehydration/electrolyte imbalance, malnutrition, anemia, depression, cognitive impairment, physical immobility or disability due to underlying medical illness, and polypharmacy. Here a multidisciplinary team approach to assessment and treatment is most helpful. This includes primary care and mental health providers, dietician, PT/OT, nursing, speech therapy and case manager. There should be a comprehensive history and mental status examination and review of medications to eliminate offending agents. Routine lab work should be conducted to check for kidney and thyroid function, nutritional status, urinary infection, anemia and other blood born abnormalities, liver function, hormonal deficits-e.g. testosterone, and other infectious or cancer marker. A review of illicit substance or alcohol use should be part of the clinical and home assessment as well as depression, cognitive, and functional screenings. We will discuss these in more detail in the next section. Treatment should be limited to interventions that have few risks because of the frailty of these patients- this may include resistive and strength training, nutritional supplementation, ensuring access to food and hydration, and treatment of depressive symptoms (Robertson and Montagnini, 2004). Care delivery in home versus a residential or hospital setting should be considered by the team.

Polypharmacy: The average adult over 65 is taking 7 or more prescription medications. Medications frequently prescribed for older adults tend to have the high risk of drug-drug interactions. This occurs when one drug changes the nature, magnitude, or duration of action of another drug. This is further complicated by changes in the aging body causing differences in drug distribution, metabolism, and elimination. Polypharmacy is a serious problem, leading to nearly 100,000 deaths annually (Phillips and Bredder, 2002). It can present with reported adverse effects of medications, poor tolerance leading to non-adherence with treatment or ineffectiveness of treatments, worsening of the treated disorder, or emergence of new symptoms. Case managers who encounter these issues with their Veteran can refer to primary care or mental health provider to review and streamline medication regimen. Pharmacists may also be consulted. For a list of medications that may be inappropriate to use in older adults, see the AGS Beers Criteria (http://www.americangeriatrics.org/files/documents/beers/2012AGSBeersCriteriaCitations.pdf).

Psychiatric and functional disorders may result from medical conditions affecting the elderly.

Cardiovascular disease: is the most common cause of death in adults over 65. Nearly a quarter of individuals who've had heart attacks have major depressive disorder, and more develop adjustment disorders after MI. Depression constitutes an independent risk factor for having additional cardiac events. Treatment with antidepressant such as sertraline may reduce overall morbidity and mortality rates (Glassman et al, 2002). Motivational interviewing can be employed to help Veterans make lifestyle modifications in diet, exercise, smoking cessation. VA offers smoking cessation classes as well as medications and nicotine replacement therapy to support quitting.

Diabetes: especially Type II diabetes which develops later in life in the setting of obesity and insulin resistance, can lead to multiple negative consequences. Individuals who do not control their blood sugar may have cognitive impairment from too high or too low blood sugar levels. Chronic, uncontrolled diabetes lead to microvascular disease that can cause visual impairment, kidney dysfunction, cardiac disease, and stroke. Immune functions are impaired in the setting of uncontrolled diabetes, rendering the individual more susceptible to infection and leading in some cases to limb amputation. Neuropathic pain and loss of sensation in limbs associated with diabetic neuropathy can increase the risk of injury and falls. Diabetes increases the risk of developing depression (http://www.diabetes.org/living-with-diabetes/complications/mental-health/depression.html), and could lead to worsened diabetes self-care. Treatment of depression with certain antidepressants like duloxetine may help both depressive mood and neuropathic pain. motivational interviewing done by case managers and peer support specialists to help the Veteran take charge of diabetes self-care, engage in weight loss programs like the VA's MOVE! Program, and work with nursing and primary care providers on diabetes education, monitoring, and management.

Thyroid Dysfunction: also has overlap with psychological and functional issues. Hypothyroidism, more common in elderly, is linked to symptoms of fatigue, confusion, depression, weight loss, cold intolerance. Diagnosis is based on clinical evaluation and simple laboratory testing. Sometimes replacing the deficient thyroid hormone is enough to reverse symptoms of depression, though in many cases, additional treatment using antidepressants are necessary. Hyperthyroidism is rare and presents as palpitations, weight loss, fatigue and weakness in the elderly. Vets with hyperthyroidism may present as restless, anxious, and agitated. Initial assessment is through PCP but may require specialty care and procedures to correct the underlying cause. Beta-blockers and low dose benzodiazepine are used in some cases to control anxiety and agitation symptoms in the short term as thyroid function is restored.

Cancer: 60% of new cancer cases and two-thirds of cancer deaths occur in 65 and over. Cancers themselves may cause psychiatric symptoms- induce mania, psychotic symptoms, anxiety and depression, particularly small cell lung cancer and brain tumors (Benros et al, 2009). Cancer treatments- surgery, chemotherapy and radiation can also induce depression as either a direct result of treatments or cause psychological distress related to life interruption, body-image and self-esteem issues, role changes, money and legal concerns. Depression develops in 15-25% of individuals with cancer diagnosis. Treatment with medication management and therapeutic counseling is warranted for symptom relief. Case managers can be provide some basic support and education about normal psychological reactions to diagnosis and can facilitate referrals to appropriate resources, which may include spiritual services and hospice care.

HIV/AIDS and Hepatitis C: may be overrepresented in this cohort of aging Veterans with chronic homeless history. This can be related to the high rates of IV drug use, alcohol use, and other risky behaviors. Untreated, HIV can progress to AIDS, cause "failure to thrive" syndrome, and lead to a rapidly progressive dementia. Hepatitis C and some of its treatments can lead to neuropsychiatric symptoms-mood disturbance, anxiety, cognitive symptoms (Dieperink E et al, 2000). Case managers may be able to help coordinate care between primary care, mental health, and substance use and specialty services to support the Veteran.

Sleep Disturbances

Older adults experience common changes in their sleep cycle. They take longer to fall asleep and spend larger amount of time in the night in light sleep so wake frequently. Other issues like chronic pain, urinary urgency may also contribute to poor sleep quality. Primary sleep disorders include dyssomnias, which are disturbances in amount, quality, or timing of sleep like insomnia, obstructive sleep apnea, and Circadian rhythm sleep disorder. Parasomnia, or abnormal behaviors or events during sleep like nightmares, sleepwalking, and Rapid Eye Movement (REM) behavior disorder may occur in overlap. Sleep disturbances are also associated with a host of other conditions like

depression, mania, post-traumatic stress disorder, alcohol and drug use, anxiety, neurocognitive disorders and physical health issues like heart failure, chronic obstructive pulmonary disease, and gastric reflux among others. Obese men between 18-60 years of age with thick necks, who have diabetes, hypertension, and who smoke and drink, are at risk for obstructive sleep apnea (OSA). Left untreated, OSA can increase the risk of having abnormal heart rhythms, heart attack, and stroke. Daytime fatigue and lack of energy may lead to cognitive impairment, low or irritable mood, and micro-sleeps-unintended episodes of loss of attention that are potentially dangerous. Case managers may attempt screening sleep health. This is to establish sleep routine and sleep hygiene practices. sleep logs to record time to bed, sleep latency, number of awakenings, time of awakening, restfulness, daytime naps, use of stimulants like caffeine and nicotine may be helpful to establish patterns and areas for improvement. History of nightmare symptoms related to PTSD should be assessed and if appropriate, refer to mental health treatment. Screening tools, such as the self-administered Epworth Sleepiness Scale (http://epworthsleepinessscale.com) can establish a person's average propensity to sleep in daily life. Sleep disturbances should be referred for full medical assessment. The definitive diagnostic study is a polysomnography, or sleep study. Treatment for obstructive sleep apnea involves the use of continuous positive airway pressure therapy (CPAP). The Veteran may need to have a period of habituation to wearing the CPAP mask but have options to select from for maximal comfort. Positive outcomes are seen with consistent use of CPAP. Sleeping medications can be used in the short term to induce sleep but long-term use is associated with loss of effectiveness, tolerance, and rebound insomnia. Case managers may also support Veterans by motivating them to develop good sleep hygiene practices (http://www.byui.edu/Documents/health-center/wellness/Sleep.pdf), stop smoking and alcohol use, and lose weight through VA programs like MOVE! Sleep therapy groups are available at VA, including Cognitive Behavioral Therapy for Insomnia (CBTi) and PTSD Sleep Therapy Groups (http://www.mirecc.va.gov/visn16/docs/Sleep_Therapy_Group_Therapist_Manual.pdf/) may be available at your local VA.

Neurocognitive Disorders (Dementia), Delirium, Depression
Neurocognitive disorders: previously known as dementias, neurocognitive disorders are organically caused impairments in cognition and function that typically progress over time. There are no known cures or interventions that arrest disease progression. The disease prevalence is 10% in ages 65 and over. Among the various forms, those with Alzheimer's disease make up two-thirds of all diagnosed cases. The risk of developing Alzheimer's disease doubles every 5 years from the 6th decade on, to where ½ of all those in their 90s will be at risk for Alzheimer's disease. Alzheimer's disease is notable for its "insidious" onset, presenting first with subtle short-term memory loss and progresses to affect long-term memory, language functions, ability to execute coordinated movement, to loss of self-awareness and inability to perform basic activities of daily living in later stages. Alzheimer's disease is highly associated with neuropsychiatric symptoms-including depression and apathy,

delusions and hallucinations, sleep-wake cycle disturbances leading to the phenomenon of "sundowning". In later stages of Alzheimer's disease repetitive purposeless behaviors may occur like pacing, wandering, picking, vocalizations that cannot be controlled by medications. Individuals with Alzheimer's disease may become agitated or aggressive, though this often indicates some underlying medical complication like pain, constipation, or urinary tract infection. The next most common cause of neurocognitive disorder is Lewy Body Disease, making up about 20% of the cases. Patients with Lewy Body disease presents first with Parkinson's like movement symptoms- resting tremors, shuffling gait, slowness of movement, and rigidity of muscles- and formed visual hallucinations- e.g. of little people and animals- before the onset of cognitive impairment. Those with Lewy Body Disease are exquisitely sensitive to antipsychotic medication, which tends to worsen their movement symptoms. Individuals with Lewy Body disease will have visuospatial impairment preceding memory loss. The severity of cognitive impairment follows a fluctuating course, though the trend is towards greater decline. Neurocognitive disorder due to vascular disease makes up about 15-20% of all cases. It is caused by cardiovascular disease, major strokes, or an accumulation of smaller vascular insults. This type of neurocognitive disorder progresses in a stepwise fashion where cognitive and functional decline plateaus following a vascular event until the next event occurs. There is often loss of executive function and emotional/social disinhibition seen in these individuals. Depression is a common co-morbid condition. Other forms of neurocognitive disorder make up the remaining 20%. There is often overlap between causes of neurocognitive disorder- e.g. mixed neurocognitive disorder with Alzheimer's and vascular disease or Alzheimer's and Lewy Body disease. In the Veteran homeless population, there may be higher rates of neurocognitive disorder due to traumatic brain injury and alcohol use. In the former, we may see a loss of executive function, impaired attention and learning, and mood swings. In the case of the latter, the individual may demonstrate significant imbalance and incoordination on neurological exam and exhibit profound memory loss with relative preservation of language and other cognitive domains in cognitive testing. Please see Table 14 below for a summary of these and other notable forms of neurocognitive disorders.

Neuro Cognitive Disorder Due to	Age of Onset	Progression	Most Common Presenting Symptoms	Associated Neuro psychiatric Issues
Alzheimer's Disease	Typically 65+	Slow and gradual	Memory loss	Paranoid delusions, sundowning
Multi Infarct Disease	60s & 70s	Stepwise	Executive dysfunction	Mood lability, apathy, behavioral disinhibition
Lewy Body Disease	60s & 70s	Rapid, fluctuating	Visual hallucinations	Formed visual hallucinations, sensitivity

Neuro Cognitive Disorder Due to	Age of Onset	Progression	Most Common Presenting Symptoms	Associated Neuro psychiatric Issues
			fluctuating cognition	to antipsychotics, Parkinson like motor symptoms
Fronto-temporal Lobar Degeneration	40s & 50s	Rapid	Language vs executive dysfunction variants; Personality changes, hyperorality, compulsions	Disinhibition, impulsivity, disorganization
Alcohol induced	Variable but usually 50s+	Gradual	Short term memory loss-confabulation,	Executive dysfunction, imbalance and incoordination
Traumatic Brain Injury	Variable	Can be static	Executive dysfunction	Mood lability, impulsivity, inattention
Parkinson's Disease	Variable, approximately 10 years after onset of Parkinson's disease	Gradual	Extrapyramidal movement symptoms, 50-80% progress on to develop neurocognitive disorder	Visual hallucinations, paranoid delusions, depression, REM sleep disorder
Huntington's Disease	40s & 50s	Motor symptoms precede cognitive problems	Uncontrollable "dancing" or chorea movements, loss of sensory motor speed and dexterity	Depression prominent, anxiety, psychosis, obsession, apathy possible
Cruzfeldt-Jacob Disease	Bimodal depending on variant, onset >40 is most	Very Rapid-months to a year from diagnosis to death	Memory lapses, , slowed movements, slurring speech	Loss of dexterity, coordination, gait disturbances, muscle twitching and tremors, with rapid progress to apraxia

Neuro Cognitive Disorder Due to	Age of Onset	Progression	Most Common Presenting Symptoms	Associated Neuro psychiatric Issues
	common			and mutism.
Delirium	Variable, more common in elderly	Acute onset, waxing and waning course, reversible	Distubances in consciousness and attention, global cognitive impairment	Visual hallucinations, disoriented delusions, "sundowning", mood lability, associated with gait and balance problems. hypoactive vs hypoactive forms
Depression (pseudo-dementia)	Variable but well demarcated	Short but rapidly progressive course	Depressed mood, awareness of cognitive deficits	Mood congruent delusions, poor effort on cognitive testing

Table 14: Summary of Neurocognitive Disorders

Assessment of neurocognitive disorders need to account for both cognitive and functional domains as well as co-morbid neuropsychiatric symptoms. Common cognitive screens that can be done in patient homes include the Montreal Cognitive Assessment (MoCA-www.mocatest.org) and St. Louis University Mental Status Examination (SLUMS-medschool.slu.edu/agingsuccessfully/pdfsurveys/slumsexam_05.pdf). A geriatric depression scale, short form can be used to assess for co-morbid depression. Table 15 shows the cognitive domains, changes seen in neurocognitive disorder, and how each is assessed. In addition, functional assessment of basic activities of daily living and instrumental activities of daily living can be used to evaluate impact of functional domains. Commonly used assessment scales are presented in Table 4. Clinical assessment includes full history and physical exam including neurological and cognitive exam. Standard lab works are done to rule out reversible causes of cognitive impairment-e.g. thyroid dysfunction, B12/folate deficiency, electrolyte imbalance, infection. Further psychometric testing and neuroimaging may help clarify and support clinical diagnosis.

Cognitive Domain	Examples of Symptoms/Observations	Examples of Assessment
Complex attention (sustained, divided, selective, processing speed)	Major: increased difficulty in environments with multiple stimuli, easily distracted, unable to attend unless other stimuli removed, Difficulty holding new	Sustained/Selective Attention: reading random alphabet letters and tapping only when a certain letter is read out

Cognitive Domain	Examples of Symptoms/Observations	Examples of Assessment
	information in mind, difficulty with mental manipulations- calculation, all thinking take longer and must be simplified to one or few components. Mild: Errors in routine tasks, easier to focus in low stimuli environments. Normal tasks take longer	loud Divided Attention: doing two tasks at once, tapping while learning a story being read.
Executive function (planning, decision making, working memory, responding to feedback, overriding habits, inhibition, mental flexibility)	Major: abandons complex projects, Needs to focus on one task at a time, dependence on others to plan IADLs or for decision-making. Mild: Increased effort to complete complex projects, difficulty resuming after interruptions, Difficulty following multiple conversations as during a party	Planning: finding exit to a maze, outlining steps to solving a problem "what do you do if your water mane broke and it's flooding your kitchen?" Decision-Making: weighing of risks and benefits and alternatives as it pertains to personal relevance-e.g. in informed consent Working Memory: repeating a sequence of digits or list of words forwards and backwards Overriding habits/inhibition: go-no go test Mental/Cognitive Flexibility: alternating sequences, Trails B test
Learning and memory (immediate or working memory, recent memory, long-term memory)	Major: Frequently repetitive, difficulty keeping track of recent conversation, short lists, requires frequent reminders to focus on tasks at hand	Working Memory: repeating a sequence of digits or list of words forwards and backwards Recent memory: free or cued

Cognitive Domain	Examples of Symptoms/Observations	Examples of Assessment
	Mild: difficulty recalling events and need cues, relies on memory aides, lose track of bills paid	recall of words, information from a narrative, multiple choice recall for recognition Long-Term Memory: check autobiographical details against collateral information, ask to explain or demonstrate learned skill
Language (expressive and receptive)	Major: use generalized phrases in place of specific signifier "that thing". Difficulty recalling names of close friends and family, idiosyncratic word choices, substitutions, made up words, grammatical errors, less spontaneous speech, echoing and automatic speech utterances Mild: subtle omissions or incorrect grammar, word substitutions or circumlocutions	Expressive Language: confrontational naming, Verbal fluency-naming animals or words starting with the same letter in the span of a minute Receptive: testing comprehension-performing actions according to verbal and written commands
Perceptual-motor (visual perception, visuospatial construction, praxis, gnosis)	Major: significant difficulties with previously familiar activities and learned skills, getting lost in familiar environments Mild: rely on maps and others for directions, may feel disoriented to task at hand after brief distraction, greater effort to complete spatial tasks- building, sewing	Visual Perception: bisecting lines, matching figures Visuoconstructional: clock drawing, copy figure, block assembly Perceptual-Motor: inserting pegs into a slotted board Praxis: integrity of learned movements-pantomiming use of objects "show me how you brush your teeth" Gnosis: integrity of perceptual awareness and recognition-

Cognitive Domain	Examples of Symptoms/Observations	Examples of Assessment
		faces, color, tactile-identify coin or other object in hand without looking
Social Cognition (recognition of emotions, theory of mind)	Major: clearly socially unacceptable behavior, immodesty of dress, neglect of social cues, impulsive decision-making with low situational awareness or concern for safety, lack of insight Mild: subtle changes in personality, less aware of social cues decreased empathy, inhibition	Recognition of Emotions: identify emotions in images of faces Theory of Mind: ask patient to describe mental state of other in a particular scenario.

Table 15: Cognitive Domain Changes in Neurocognitive Disorders

Activities of Daily Living (ADLs)*	Instrumental Activities of Daily Living (IADLs)**
Bathing/Hygiene (Regularity, thoroughness etc.)	Ability to use Telephone (and other appliances)
Dressing (dressing for weather, buttoning, zippers, cleanliness)	Shopping (remembering items)
Toileting (accidents, urgency, impairments)	Preparing meals (burn food? Leave stove on and unattended?)

Activities of Daily Living (ADLs)*	Instrumental Activities of Daily Living (IADLs)**
Transfers (up and down from chair, bed, etc.)	Using telephone and appliances
Grooming (combing hair, shaving, etc.)	Driving and public transportation (directions, planning route)
Feeding (difficulty chewing, swallowing, choking, remembering to eat)	Housekeeping
	Financial management

Table 16: Functional scales *Katz Index of ADLs, ** Lawton Instrumental Activities of Daily Living Scale

Medication management of neurocognitive disorders is limited to delaying progression and symptoms management of Neuropsychiatric symptoms like mood disturbances, hallucinations and delusions, agitation and aggression. Appropriate psychotropic medications like low dose antidepressants, mood stabilizers, and antipsychotics may be used to target symptoms. Notably, antipsychotics carry an FDA black box warning for increased mortality rates when used in Elderly. The relative risk of death from all causes is doubled with the use of antipsychotics, but in absolute terms the increase is relatively small and long-term mortality risk beyond 10 weeks is not known due to the limitations of existing data. The focus of psychosocial interventions is to support Veteran's continued day to day functioning. Veteran's home environment should be modified to ensure safety-adequate lighting, bath and bed rails, temperature-control installed, fall hazards eliminated and precautions taken. Signs with written and visual cues should be clearly posted, as well as digital clocks with large number displays. Emergency contacts may be pre-programed into a phone with speed dial associated with visual cues. Microwave meals or a delivery services like Meals-on-Wheels may be arranged. Home health nurse may monitor medication adherence on a regular interval. An automatic pill dispenser can be preloaded to prevent misuse of prescription medications and provide alarmed cues to promote adherence. In early and middle phases of neurocognitive disorders, individuals may be able to participate in structured activities designed to promote physical activity, mental stimulation, and emotional support. These include recreational and art therapy, pet and music therapy, reminiscence groups, and life-skills groups. VA offers many of these services and the community support senior day program activities. Cognitive rehabilitation and retraining may be possible for individuals with more stable cognitive deficits (e.g. TBI). In home caregivers are usually necessary as neurocognitive disorders advance. These caregivers may be family members or professional services. Particularly with family caregivers, there is a high financial and emotional burden associated with providing care to loved ones. Most states will reimburse family caregivers through Medicaid. The VA and the Alzheimer's Association offer caregiver education classes and support groups. VA may also have respite programs for caregivers where the Veteran can be placed

in a residential facility for a brief period. Case managers must be aware of the possibility of elder abuse-which can range from financial exploitation to verbal, emotional, and physical abuse. Suspicion of abuse may be reported to local adult protective services for independent investigation. Individuals with progressive neurocognitive disorder are unsafe to drive. However, this is a particular area of contention because driving is often deeply associated with a sense of independence and the individual suffering from neurocognitive disorder does not recognize the extent of their impairment. If there is significant cognitive and functional impairment, history of accidents and near accidents while driving, and collateral informants corroborating marginal or unsafe driving ability, is usually sufficient to report the impaired individual to the DMV. Some VAs and DMVs offer driving simulations as a further assessment to confirm impairments prior to revocation of driver's license. Given most neurocognitive disorders are terminal illnesses, individuals should be given the chance while sufficient decision-making capacity is intact, to draw up an advance directive for end-of-life care and name a health care power of attorney to make decisions when he becomes incapacitated from advancing illness. A voluntary payee or an appointed conservator may be necessary to manage Veteran's finances as financial capacity is one of the first functional domains to be affected. This also safeguards against financial exploitation. Public or private guardianship may be designated by court to direct health and housing decisions if the Veteran is found to be incompetent and without designated health care power of attorney or advance directive. Guardianship processes usually cost money in legal and court fees. The VA does not provide guardianship services and clinical decision to recommend guardianship should be communicated to the local VA privacy officer. Case managers should be considering placement in specialized foster care, assisted living, or nursing care facility with memory units designed specifically for individuals with neurocognitive disorders as their cognitive and functional capacities diminish over time in housing.

Delirium: Delirium is a transitory state characterized by disturbances of consciousness, attention, perception and memory. Delirium can be induced by a variety of medical conditions, substances, sensory and sleep deprivation, and polypharmacy among other factors. Delirium can co-occur with neurocognitive disorders but can be distinguished from them by its abrupt onset, waxing and waning course, short duration-on the order of day to weeks, impairment of attention, and reversibility when underlying causes are identified and treated. Delirium can present as agitated and hyperactive or hypoactive and quiescent. The latter form is more common in elderly but is often misdiagnosed as depression. There is frequent sleep/wake cycle reversals associated with delirium, also called sun-downing, where patients are more active and agitated at night. Delirium is associated with visual and tactile hallucinations and bizarre delusions and labile moods. Delirium carries a high mortality rate. On cognitive assessment there is usually difficulty with orientation to time, place, and situation, patients are distractible and do poorly with attention measures, visuospatial construction. Treatment is typically done in the hospital and is based on identifying and treating the underlying cause. Antipsychotic medications are used to control hallucinations, delusions, and agitated behaviors.

Benzodiazepines like Ativan can be used in cases where delirium is due to alcohol or benzodiazepine withdrawal. Environmental management is a key part of treating delirium. This includes verbal and non-verbal cues to orientation, maintaining consistent staffing, normalizing sleep wake cycles using bed restriction and natural light exposure, correcting any sensory impairment, and adhering to routines. About one-third of those who've recovered from delirium have persistent cognitive deficits. This makes environmental management all the more important in the home setting.

Depression: This is the most common psychiatric disorder in older individuals. As we've already discussed, depressive symptoms accompany a host of medical conditions and psychosocial transitions and is associated with other psychiatric, substance abuse and neurocognitive disorders. Among older homeless Veterans, depressive disorders are often underdiagnosed and undertreated. Factors associated with poor recovery include comorbid persistent depressive disorder (formerly dysthymia), poor social supports, functional limitations and cognitive disorder. Depression increases mortality rates through potentiating mortality risk of medical conditions such as heart disease and through completed suicide in the older population. Presentation of depression in elderly is different from younger adults. There is often a focus on somatic complaints-e.g. fatigue, pain, dizziness, loss of appetite, headaches, increased psychomotor disturbances, psychosis, and suicidal behavior. Depressed Veterans isolating in their housing can exhibit observable behavioral regression with self-neglect, social detachment, inactivity, and cognitive symptoms that present like neurocognitive disorder. New onset depression in the elderly should raise concern about underlying causes-stroke, heart disease, neurocognitive disorders, Alzheimer's disease, Parkinson's disease, tumor, thyroid dysfunction, and other general medical conditions. Initial assessment by the case manager may combine home observations, noting onset and duration of impairments, and screening for depressive symptoms. The Geriatric Depression scale is a commonly used and validated instrument for the older population. Positive screens should trigger referral to mental health professional for full diagnostic work up that includes medical, lab, and imaging studies in some cases to rule out underlying and reversible causes. Antidepressants are first line for treatment of major depressive disorder, though attention should be paid to drug-drug interactions. Starting dose and therapeutic dose is generally lower than in younger adults. Medications should be gradually tapered after a prolonged period of remission to avoid a withdrawal syndrome. Depression with psychotic features may benefit for addition of an antipsychotic medication or in severe, nonresponsive cases, electro-convulsive therapy can be used. Relative contraindications for ECT are recent heart attack, recent stroke of increased pressure in the brain, severe COPD. Psychosocial interventions include evidence based therapies such as cognitive behavioral therapy, interpersonal therapy, and supportive therapy. Case managers can help Veterans suffering from depression to develop stress management strategies and behavioral activation plans that includes regular exercise, shown to improve has been facilitate recovery from depression. Case managers may also help Veterans coordinate socialization effort in the form of structured group activities, recreation, volunteer services, and vocational pursuits.

Because middle aged and older individuals account for the majority of completed suicides, case managers may help Veterans draw up a suicide safety plan in case of mental health crisis. Guns and other weapons in the home should be identified and removed if possible.

Other Psychiatric Disorders

Post-Traumatic Stress Disorder: PTSD in the older homeless Veteran population may be attributed to a variety of causes besides combat-exposure. Traumatic exposures during childhood, sexual trauma, and traumatic experiences during incarceration or homeless episodes may be explored at the Veteran's readiness. Case managers may gather additional information of core symptoms of PTSD-intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity on their own. The VA National Center for PTSD provides access to brief PTSD screens appropriate for the field-e.g. SPAN and SPRINT - found at http://www.ptsd.va.gov/professional/assessment/screens/index.asp . Positive screens should be referred on to mental health for structured diagnostic interviews and treatment. VA provides specialized PTSD residential and outpatient treatment programs that employs evidence-based practices like cognitive processing therapy and exposure therapy. Because of the intense nature of these treatments, Veterans are typically stabilized with psychiatric medications prior to entry into PTSD focused therapy. Is should be noted that PTSD is highly co-morbid with alcohol and drug use and active substance use should be screened for and referred to treatment.   Many older Veterans with PTSD and homeless histories report mistrust and suspicion when it comes to Privacy and confidentiality discussing details of their traumatic past. Mistrust reinforces avoidance and isolation behaviors, which stands in the way of community reintegration and social networking. Here, motivational coaching and association with a peer support specialist who themselves have lived experience and shared Veteran culture may be able to help the Veteran create a safe environment to engage in services. Combat Veterans and those who suffered military sexual trauma can access counseling services through Vet Centers (http://www.vetcenter.va.gov/About_US.asp). There they can have access individual and group counseling, family therapy and bereavement services usually delivered by counselors who were Vets themselves. The treatment records at Vet Centers are not directly accessible by the VA and so afford Veteran service users some additional privacy protection. All HUD-VASH workers should be familiar with principles of trauma informed care when supporting formerly homeless Veterans. Its basic tenets focus on creating physical and psychological safety, establishing trust and mutuality between provider and client, focusing on Veteran strengths, empowerment of Veteran voice and choice towards making positive change (http://www.samhsa.gov/traumajustice/traumadefinition/approach.aspx). VA offers trauma informed care training.

Substance Use Disorders: The baby boomer generation has higher rates of substance use than previous generations. The most commonly abused substance is alcohol, followed by prescription

benzodiazepines and opiates. Among Veterans of this generation with homeless histories, there is also a greater than average rates of cocaine, amphetamine, heroin, and cannabis use, often times in combination. Housing may be used as a safe haven to continue alcohol and drug use which threatens housing tenure and criminal justice engagement and complicate the treatment of other medical and mental health conditions. Case managers can observe for evidence of ongoing alcohol and drug use at Veteran's home. A substance use history can be taken that includes duration, frequency, intensity, and consequences of use. Brief screens like CAGE or AUDIT-C can be employed to assess alcohol use. Rule of thumb is that more than 2-3 drinks a day for 2 weeks or greater than 4 drinks in a sitting is considered at-risk drinking. Comorbid psychiatric disorders like PTSD or depression and geriatric syndromes like chronic pain should be assessed and referred for treatment if indicated. Methamphetamine, cocaine, and cannabis use are also known psychogenic agents that may induce psychotic symptoms; symptoms may persist beyond cessation of use and warrant treatment. Withdrawal from alcohol and benzodiazepine may be fatal. Those with a history of seizures and delirium tremens or severe autonomic instability-fluctuation blood pressure, palpitations, sweating-should be medically detoxified in a treatment facility or hospital. Several relapse prevention medications exist for alcohol and opiate addiction. However these medications work best when combined with a psychosocial treatment program. Various programs for substance abuse exist at the VA, including outpatient treatment, methadone maintenance programs, and residential treatment. A variety of recovery support groups like AA, NA, Cannabis Anonymous, Dual Diagnosis support groups exist in partnership with the VA and in the community. Engagement and retention in substance treatment is a perennial problem. Motivational Interviewing is an evidence based practice that can facilitate change talk and improve participation in services. Peer support specialists and substance use specialists may assist the case manager in motivation the Veteran to engage with treatment services. The development of clean and sober support networks and social activities is important to sustaining sobriety.

Psychotic Disorders: Primary psychotic disorders such as schizophrenia are usually considered neurodevelopmental disorders and have its onset in one's 20s-30s. Late onset schizophrenia, after the age of 40, occurs in about one-fourth of cases and actually carries a favorable prognosis for recovery. Very late onset of schizophrenia, that is first psychotic episode after 60, may raise concern for an underlying condition such as neurocognitive disorder, strokes, and tumors. Schizophrenia has three core symptoms clusters-there are what was once called "positive symptoms"-e.g. delusions, hallucinations, disorganized speech and behavior, and "negative "symptoms which includes flattening of emotions and expression, poverty of speech, and avolition, or passivity. The third cluster consists of a cognitive syndrome that impact complex attention, visual and verbal learning, fluid reasoning, and social cognition. Schizophrenia is an extremely disabling disease-because of the burden of illness itself, the side effects of the treatments available, and the stigma associated with the diagnosis. Despite the odds, one-third of individuals living with schizophrenia have worked, and

three-fourths live independently. Medication management is usually a key part of what's gives the individual diagnosed with schizophrenia their stability but comes with major side effects. Older antipsychotics like haloperidol and perphenazine can cause involuntary movement disorders called extrapyramidal symptoms (EPS) and a subjective sense of restlessness called akathisia. These side effects can persist even after the antipsychotic is discontinued. Newer antipsychotics such as risperidone and olanzapine have less risk for inducing EPS but are associated with developing metabolic syndromes- high cholesterol, insulin resistance, weight gain. Clozapine, the most efficacious medication for treating schizophrenia, has the rare but deadly side effect of bone-marrow suppression, which disrupts the production of immune and blood cells and requires weekly monitoring of bloodwork when first starting the medication. For side effect and practical reasons, clozapine is reserved for difficult to treat schizophrenia. Both older and newer types of antipsychotic medications can disrupt heart rhythm and in Elderly lead to an increase in all causes mortality. Antipsychotics, particularly older antipsychotics, can cause a rare but potentially fatal condition call neuroleptic malignant syndrome (NMS)- characterized by fever, alterations of consciousness, autonomic instability, and muscle rigidity. Muscle rigidity can lead to muscle breakdown. The CPK, a marker for muscle tissue breakdown is usually elevated. NMS is a medical emergency. A thorough physical and neurological examination, with baseline lab work, EKG, and weight should be obtained prior to initiating treatment and routinely thereafter. Starting doses in elderly are usually lower than starting doses in younger adults. Psychosocial interventions, in the treatment of schizophrenia, include milieu or day treatment programs focused on psycho-education, peer support, supported employment and recreational activities. Veterans living with schizophrenia should also be encouraged to quit smoking as smoking induced liver enzyme activity and may lower the blood level of the drug. Motivating and creating a behavioral activation plan can help Veterans be more active in the community and stay in shape.

Bipolar Disorder: Bipolar I and bipolar II disorders have a combined prevalence of 3% in the elderly population. They are primarily distinguished by the duration of symptoms and intensity of impairment, with episodes lasting greater than a week considered manic and those lasting less than a week hypomanic. Core symptoms include elevated or irritable mood, increased pleasure seeking and risk taking orientation, decreased need for sleep, increased goal directed activity, distractibility, racing thoughts and flight of ideas, grandiosity, expansive and pressured speech. The Young Mania Rating Scale is one of the screening instruments available for bipolar disorder. The disorder is highly associated with co-morbid substance use which needs to be screened for and treated. Bipolar disorder is also associated with psychotic features including perceptual disturbances and delusions of a grandiose or persecutory nature that responds to antipsychotics. As one ages, the frequency of manic episodes diminish and episodes of bipolar depression increase, though mixed episodes featuring both manic and depressive symptoms do occur. It is possible to have late-onset of bipolar disorder, first manic episodes occurring in old age should raise suspicion of some underlying cause,

e.g. medications such as antidepressants and steroids, or drugs of abuse such as alcohol, cocaine, and methamphetamines can induce manic like state. Brain tumors, seizure disorders, right sided strokes, traumatic brain injuries, central nervous system infections, and mood/behavioral disinhibition associated with frontotemporal degeneration and other neurocognitive disorders can have a manic-like presentation. Older Veterans exhibiting manic symptoms should be referred to mental health professional for further assessment and medical/lab work up for underlying causes. There is a high morbidity and mortality rate associated with bipolar disorder. By some estimates 15-20% of individuals diagnosed with bipolar disorder commit suicide. Treatment with lithium in classical cases of bipolar is known to reduce suicidality. However, lithium can cause hypothyroidism and interfere with kidney function. Lithium toxicity can be fatal so Veterans on this medication need adhere to prescribed regimens and present for routine lab work to monitor drug levels and kidney function. Other mood stabilizing agents such as valproate, lamotrigine and second generation antipsychotics all carry potential side effects that could lead to non-adherence with treatment. Electroconvulsive therapy may be considered for difficulty to treat cases. Psychosocial interventions should focus on establishing a structure to daily life. One of the most important factors in this is regular sleep. One model for this is interpersonal social rhythm therapy (arch Ven Psychiatry: 2005;62:996-1004).

Anxiety Disorders: Generalized anxiety disorder is the most prevalent anxiety disorder among the elderly. OCD most evenly distributed bet male and females. Worry is a short term response to uncertainty and there are benefits to this-reduced uncertainly, increased vigilance, sense of mastery. In anxiety disorders like GAD or OCD, the core anxiety symptoms cause significant functional impairment. The key here is an understanding that avoidance is a core feature of anxiety-avoidance may take on the form of intrusive and ruminative thoughts in GAD, or being in a situation without the possibility of escape in agoraphobia, or having disturbing and intrusive thoughts that must be neutralized by a ritualistic compulsion in OCD. Anxiety is more often associated or caused by another condition. Anxiety is highly comorbid with mood and substance use disorders, medical conditions such as COPD, pulmonary embolism, congestive heart failure, thyroid dysfunction, adrenal tumors, and epilepsy to name a few. A full medical workup may be necessary to identify and treat underlying causes. Anxiety is chronic, waxing and waning. Case managers may provide Veterans with the Geriatric Anxiety Inventory, a 20 question, self-administered questionnaire well validated in older populations to assess recent severity of anxiety symptoms (http://www.gai.net.au/page7.html). First-line Medication management for anxiety disorders is with an antidepressant medication, typically a serotonin reuptake inhibitor. Benzodiazepines have limited use in the elderly because of sedation, cognitive disinhibition, and development of drug tolerance. Other non-benzodiazepine anxiety adjunct medications may be considered, such as gabapentin and buspirone, which is FDA approved for generalized anxiety disorder. Psychotherapy tends to work well against anxiety disorder, particularly cognitive behavioral therapy for GAD and exposure and

response prevention therapy for panic disorder and OCD. Case managers can deliver CBT once they have the training or refer to another provider.

Ethics and End of Life Care

There are four foundational ethical principles to clinical practice (Beauchamp and Childress, 1990?): Autonomy-client self-determination, non-maleficence - "do no harm", beneficence - the clinical relationship benefits the client, justice-basic right to access and fair allocation of resources.

Informed Consent

There are three important components to valid informed consent: 1) Voluntariness-that is consent must be given by an individual free from coercion, manipulation, or other undue external influences, 2) Disclosure-where the researcher or provider, in lay language, give sufficient, valid, and reliable information about the intervention to support an individual making an informed decision, and 3) Capacity-this last element pertains to the ability of the individual to both understand the information provide and form a reasonable judgment based on the potential consequences of his or her decision. For an individual to have the capacity for informed consent, he or she must have the ability to communicate a choice, have a factual understanding of the issues-can give a description of the pertinent elements of the intervention, its benefits, risks, alternatives in their own words, be able to show appreciation of the situation and its consequences in relation to himself, and have the ability to rationally manipulate the information, i.e. reason.

Determining decisional capacity is a particularly relevant issue in the elderly population given increased prevalence of cognitive impairment - particularly decline in fluid reasoning, and the high stakes of decisions. Decisional capacity must be distinguished from competency- which is a legal determination with defined, enforceable consequences. General competency determinations address individual's ability to adequately carry out all of one's affairs and can lead to conservatorship and guardianship. Specific competency determination- e.g. to write a will, drive a car is more focused to the task. Decisional capacity is a clinical concept but it is not monolithic. Rather we should talk in terms of decisional capacities depending on the situation at hand. What to have for breakfast requires a different level of decisional capacity than determining whether to have surgery. Our clients may need some extra support during clinical consultations or understand clinical information to make a decision. This is particularly difficult if the Veteran has low literacy or comprehension difficulties, misplaced expectations or distortions about the nature and purpose of the intervention, or become distractible due to situational anxiety being in the doctor's office. Case Management (CM) or peer supports in permanent supportive housing may help in these cases by helping the Veteran identify concerns and/or assumptions.

<u>Medical advance directives and mental health advance directives</u>: Anticipation of loss of decisional capacity in the case of a physical or mental health crisis warrants discussion about completing an advance directive. Advance directives help individuals, in a lucid state, to record their preferences for treatments/withdrawal of treatment when they become incapacitated and unable to communicate their choices. Typically advance directives allow for written "living will" that directly reflect an individual's health care preferences and/or designation of a health care proxy who can make decisions for the incapacitated individual in situations when preferences are not clearly expressed. For medical advance directives, there's typically not a prerequisite of clinical determination of decisional capacity of the individual filling it out to make the document valid. An individual, as long as they can communicate their wishes, can revoke their medical advance directive and health care proxy. Though it carries legal weight, there are exceptional situations where providers can act to contest individual/proxy decision-making-e.g. in an emergency situation, in the case where expressed preferences is inconsistent with basic standards of care, or if there is suspicion of coercion, maleficence on the part of a healthcare proxy. Filling out a medical advance directive can be a challenging process. CM can review the document (VA has a national document, "[VA Form 10-0137 - VA Advance Directive: Living Will & Durable Power of Attorney for Health Care](http://vaww.va.gov/vaforms/medical/pdf/vha-10-0137-fill.pdf)" at: http://vaww.va.gov/vaforms/medical/pdf/vha-10-0137-fill.pdf) with individuals. Referral can be made to medical providers, home nursing for discussion of specific treatment preferences. Documents are to be witnessed by two individuals not directly involved in clinical care of the individual. Most often these are family members or friends. In the permanent supportive housing population, there could be difficulty coming up with willing designees and witnesses. In these cases a notary may be useful, or a colleague not involved in the direct care of the individual could serve as witness.

The VA healthcare advance directive has a section for mental health care preferences. Separate mental health advance directives or the ability to express MH preferences in a combined health advance directive is available in about half of the states (National Resource Center on Psychiatric Advance Directives. http://www.nrc-pad.org/). Mental Health advance directives came about in the 1990s as a measure for individuals with history of mental illness to have some choice in how they are treated in a mental health crisis. There are some differences between MH advance directives and medical advance directives. Firstly health care advance directives were initially conceived for end of life care. Mental health advance directives, on the other hand, are a document for ongoing chronic care. The incapacity associated with mental illness is episodic while loss of capacity in the case of end of life care can be permanent. The requirements for a valid MH advance directive can be different-some states require prior clinical assessment to ensure capacity to fill out the form. Other states require that MH advance directives be updated periodically. Still other states require what's called a Ulysses clause, that is an individual with expressed MH preferences or have designated a decision-making proxy cannot revoke those preferences or that proxy's decision-making authority

when he or she is incapacitated by mental illness. MH advance directives also allow for treatment against protestation- that proxies or care providers can decide for involuntary hospitalization and retention in hospitals without the agreement of the individual if they are incapacitated due to mental illness and hospitalization or treatment is indicated for restoration of capacity. The VA uses a combined form healthcare advance directive that includes section to express mental health preferences. However, in its current form, this section does not provide guidance or specific areas to address the individual noting preferences. More detailed MH advance directive forms/supplements are being developed and piloted in various VA's across the nation. In the meantime, it may be useful to access state issued MH advance directives or have link Veterans to MH provider to discuss expectations, standard care in cases of crisis, and clarify individual preferences. The expressing MH preferences for treatment are not only pertinent to those with preexisting mental health issue. As our permanent supportive housing population ages, they are more susceptible to developing neurocognitive disorders, delirium, and other psychiatric conditions 2/2 to medical illness. In these cases, having an understanding and expressing preference for treatment of behavioral/psychiatric symptoms related to those conditions is crucial to patient-centered care.

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Chapter
19

COMMUNITY INTEGRATION AND SUSTAINMENT

Introduction/Overview

Most of the work of assisting Veterans in permanent supportive housing begins after the Veteran moves into their new home. While obtaining their own apartment provides a stable foundation, it is only the first step in helping Veterans reclaim their lives. As Veterans adjust to their new home, most will begin to think about next steps as they move forward in their lives. For many, this will mean thinking about goals such as enrolling in school, obtaining a job, or reuniting with family. Working on these goals will allow Veterans to have a meaningful life in the community. It will also encourage them to be involved with the activities and people that they enjoy and value, which promotes housing retention, health, well-being, and recovery. During this time, service providers will help support Veterans to identify and achieve these goals.

> **In this chapter, you will learn:**
> - What community integration is and why it is important
> - The different domains of community integration
> - Potential barriers and strategies to assist Veterans with community integration

Community Integration

Engaging in this type of work means supporting Veterans with community integration. Community integration reflects the ability and opportunity for Veterans to live, work, socialize, and participate in their communities as any other individual without a disability. Because Veterans face a host of factors that can lead to social isolation – including psychiatric disability, physical health problems, and experiences of trauma – it is especially important to help them develop meaningful connections to other people and to their communities. Too often, Veterans' identities have been reduced to being a "patient" or "homeless" and service providers must support them in developing or reclaiming valued social roles. These may include becoming an employee, taking an active parenting role, caregiving for relatives, or supporting others through the recovery process as a peer. The long

tradition of Veterans helping other Veterans can be an asset for many. Just like for support services, the driving force of community integration should be a Veteran's own goals. Service providers should work collaboratively with Veterans to help identify the Veteran's interests, skills, strengths, resources, risks, and barriers when it comes to community integration.

Barriers & Strategies

Some barriers may be related to Veterans' apprehension about their ability to take on new roles or feeling a limited sense of hope. Veterans also often have an identity of being the protectors of others and so it may take more time to engage them in receiving support services and pursuing integration activities. Issues with physical health or limited mobility may also make it difficult for Veterans to participate in various activities. Other barriers may include Veterans' limited incomes: having little disposable income can make participating in many activities (e.g., eating at a restaurant, attending a concert) much more difficult. Still other barriers may be at the community level. For example, stigma or prejudice may make it harder for Veterans coping with mental illness, addiction, or homelessness to find acceptance; or communities with few options for public transportation may make it difficult to get around. Finally, barriers can also arise from the existing treatment system: providers may have limited beliefs about the capabilities of Veterans to pursue certain goals and/or may be more narrowly focused on more clinical outcomes as opposed to taking a more holistic approach. Further, program funding may be limited or too restricted for helping Veterans with their community integration needs. Service providers and Veterans should be prepared to address these and other barriers to community integration with persistence, flexibility, and creativity.

Veterans who are hesitant to pursue greater engagement may benefit from participating in peer support services. Because of limited finances, ensuring that Veterans are receiving all benefits to which they are entitled may help Veterans have money for expenses beyond basic housing needs. Developing a list of affordable community activities and resources, and encouraging Veterans to contribute and take ownership of such guides, can be a useful tool. In communities where transportation and local resources are a challenge, providers may facilitate access to the internet so that Veterans can become connected to virtual communities and resources. When stigma is a challenge, helping Veterans to become involved in advocacy roles may be helpful. Creating venues where Veterans can share and celebrate their success stories with providers may also help shift the perspectives of clinicians and other support workers.

While some Veterans may be familiar with the neighborhoods into which they have moved, a basic neighborhood orientation can be helpful. Service providers can walk around the neighborhood with the Veteran, identifying essential community resources for everyday living (e.g., grocery stores, pharmacies, etc.) as well as resources that may be tied to the Veterans' personal interests or needs (e.g., basketball court, movie theatre, AA meetings). Walking around the neighborhood may also

inspire Veterans with new ideas for community integration (e.g., spotting a gym may encourage them to join). Welcome packets may also be helpful that map out community resources, offer transportation options, and list possible local activities.

Some Veterans may also need assistance with various community activities or with transportation. This might include helping them practice riding public transportation so that they can then independently make their way around. It might also include modeling or role-playing how to respond to others in certain scenario; for example, how to resolve potential disputes with neighbors or how to approach a potential employer. Providers might assist Veterans with developing routines in the community and establishing casual connections with others in the neighborhood (e.g., pizza shop worker, newspaper vendor) that can further promote a sense of familiarity and belonging.

The amount of direct support that service providers need to deliver will depend on the needs and level of comfort of each Veteran. Some Veterans may just require assistance with identifying possible interests and activities, and are prepared to make the actual connections on their own; for others, however, service providers may need to directly help broker relationships: accompanying Veterans to introduce them to a school advisor, to pick up a job application, or attending a neighborhood community event for the first time.

Domains of Community Integration

Employment & Education:
Employment not only helps Veterans boost their income, it can also lead to increased social participation, positive self-image, and improved mental health. Others may be interested in pursuing educational opportunities. Service providers can help Veterans with all aspects of employment and educational pursuits from identifying potential employers or schools to completing applications to supporting Veterans in their new roles. Evidence-based practices such as Supported Employment, which offer job development and personalized support in obtaining work, have been especially effective in helping Veterans to obtain employment.

Social Relationships:
Veterans are likely to have experienced many events that have disrupted their social relationships – homelessness, psychiatric disability, trauma, and substance use, to name a few – and most identify the need to develop close relationships based on trust and reciprocity as a top priority. Facilitating access to other opportunities for community integration (e.g., employment, leisure, and spiritual activities) may help Veterans to develop new relationships. Re-connecting with members of their social network with whom they had previously had positive relationships can also be beneficial and Veterans may need support in re-establishing or repairing these relationships. Utilizing social media resources can also help Veterans locate and reconnect with family or friends. Interventions such as

Trauma-Informed Care could also help Veterans with mitigating the impact of trauma on their ability to engage with others. Many Veterans may also be parents and so parenting support and/or education classes can be helpful. Because some social relationships may be strained or expose Veterans to certain risks, supporting Veterans to assess and negotiate relationships, and effectively manage social boundaries, can help them derive the benefits of social involvement while minimizing potential stress.

Recreational/Leisure Activities:

Participating in recreational or leisure activities can improve Veterans' satisfaction with how they spend their time and their overall quality of life. It can also positively impact their health, well-being, and sense of connection to others. These activities can range from physically active pursuits, such as sports and exercise to artistic and creative activities, such as playing music or writing, to various entertainment activities, such as attending a movie or comedy show. While some Veterans may be able to readily identify activities that they want to get involved in, others may need more support in discovering new interests by experiencing a new activity for the first time with the help of the program (e.g., fishing, gardening, hiking, attending a cooking class,). Online sites that help organize groups to participate in local activities can also help Veterans find others who share their interests.

Religion/Spirituality:

Spirituality can be an important factor in helping Veterans move forward in many aspects of recovery, including both substance use and mental health recovery. It can offer hope and meaning as well as facilitate connections to other individuals in the community. For some Veterans, religious/spiritual activities may be carried out in solitude; for others, actively participating in religious groups or attending religious events may provide access to important activities and social networks.

Civic and Cultural Activities:

Having received housing and service support, many Veterans are interested in pursuing activities that provide an opportunity for them to contribute and "give back." Providers can help connect Veterans to community groups and events, political activities, volunteer opportunities, or organizations that may be associated with key elements of a Veteran's identity (e.g., cultural heritage). Veterans' groups in the community, in particular, can provide positive opportunities for Veterans to participate. Becoming involved in advocacy also provides Veterans with an opportunity to play an active role in addressing broader system and community challenges, including those surrounding Veterans' issues, stigma around mental illness, or the need for affordable housing.

Community Integration Specialist Training

Effective and sustainable community integration is essential for the long term success of Veterans in permanent supportive housing. In recognition of this fact, VHA Homeless Programs began utilizing peer counselors as Community Integration Specialists (CIS). Additionally, the VA's National Center on Homelessness among Veterans collaborated with the University of South Florida (USF) to develop an online Community Integration Specialist (CIS) training to enhance the skills, abilities, and knowledge of peers and other staff performing community integration services.

The CIS training was designed to:
1.) Serve as a basis for new employees to work as a CIS serving Veterans to end and prevent homelessness, and to assist in their recovery;
2.) Supplement VA employees' mandatory training, with the intent to be complimentary to other new employee orientations;
3.) Enhance the effectiveness of peers working with Veterans in permanent supportive housing programs; and
4.) Provide a user-friendly forum on a variety of detailed issues related to homelessness and housing.

The CIS training consists of online modules which contains videos, lectures, interviews, quizzes, and discussions by subject matter experts from the VA, the University of South Florida (USF), and the community, as well as from national leaders and Veterans themselves. Once the CIS training package has been completed, the viewer receives a certificate from USF certifying that they are trained as a Community Integration Specialist, or certified in Community Integration.

The training is available at: http://vatrainer.cbcs.usf.edu/.

Sample Questions to Open a Conversation

What types of activities do you enjoy or are you interested in?

Are there activities that you've always wanted to do but never had a chance to?

Are there activities that you used to do that you miss?

What do you like about [activity]?

What makes it hard for you to participate in [activity]?

What concerns do you have about participating in [activity]?

What would have to be different for you to participate in [activity]?

What unique qualities do you have that can help you achieve [activity]?

How can we help you to participate in [activity]?

Key Points
- Obtaining a home is only the first step! Service providers should support Veterans to identify and achieve their goals, such as community integration.
- Community integration is the ability and opportunity for Veterans to live, work, socialize, and participate fully in the community as anyone else.
- Greater community integration can provide meaning and purpose, as well as improve quality of life, self-efficacy, a sense of belonging, recovery, and well-being.
- Veterans' experiences with homelessness, psychiatric disability, addiction, trauma, medical issues, and poverty can make community integration challenging.
- Community-level barriers, such as stigma, prejudice, and inadequate transportation, as well as the legacy of a disempowering treatment system must also be addressed.
- Service providers can help Veterans take on valued social roles and pursue employment and education, social relationships, recreational/leisure activities, religion/spirituality, and civic and cultural activities.
- The amount of direct support that service providers need to deliver depends on the needs and preferences of each Veteran.

Conclusion

For Veterans, increasing community integration can provide a sense of meaning and purpose, as well as offer belonging, social support, and connection to others. Involvement in various activities and social roles can also promote self-esteem and self-efficacy. It can help Veterans feel more at home - in their apartments and in their communities - and ultimately lead to more satisfying and fulfilling lives.

Chapter

20

COMMUNITY-BASED EMPLOYMENT FOR HOMELESS VETERANS

Introduction

Your commitment to supporting Veterans to maintain housing stability should include the plan for living independently and fulfilled lives. Employment is a key area to accomplish this fulfillment among homeless and formerly homeless Veterans and serves as a protective factor. In addition to income, studies have found that employment leads to improvements in quality of life, confidence, and independence, while also increasing opportunities for socialization, and decreases reliance on institutional care (Bryson, Lysaker, & Bell, 2002; Van Dongen 1996; Bond et al. 2001). Moreover, employment has been found to improve substance abuse and mental health treatment outcomes (SAMHSA, 2001).

As a homeless services provider, you have the unique opportunity to promote the community integration of homeless Veterans by delivering an array of supportive services, which includes income and financial planning, and the development of skills that are directly related to obtaining and maintaining employment. Regardless of whether you take the lead on supporting each Veteran's employment goals or whether you primarily link them to needed employment-related services, the guiding principle remains the same: Veterans who want to work should be encouraged and supported in achieving these goals, and you should draw on available VA and community-based resources to help you in providing that support. This chapter is intended to be a helpful resource for homeless service providers as they assist Veterans in obtaining and maintaining community-based employment.

What's in This Chapter?
- Why employment is an important component of recovery.
- Ways to support the employment goals of Veterans.
- Available resources to address employment obstacles.

- Specific VA and community-based programs that assist with employment.
- The principles and practices of Supported Employment.

Setting the Stage

As the Veteran becomes more comfortable with his/her housing placement, s/he may likely show an increase in their readiness to return to work. When this happens, a homeless services provider can do a number of things to can create an environment which encourages Veterans to seek employment or work towards achieving their educational goals. By virtue of having a job yourself, you may be able to find some common ground with the Veterans you are working with by describing your own experiences looking for work, being turned down for a job, or overcoming an obstacle in your own career. Without sharing too much personal information, targeted self-disclosure can increase a Veteran's self-confidence and lead to a sense of empowerment regarding his/her own ability to return to work. What sometimes appears to be a lack of motivation, and may in fact be a lack of self-confidence resulting from prior unsuccessful work experiences. Finding ways to instill a sense of hope and possibility may be an important first step on the road to employment.

Exploring the advantages of employment with each Veteran you are working with may increase their motivation to look for work. For example, increased income is not only important in meeting basic financial needs including paying for rent, food, and utilities, but may also allow the Veteran to engage in an activity s/he enjoys; going to a movie, having a meal at a restaurant, or buying a gift for a friend or family member. Helping the Veteran to identify activities which they find enjoyable may not only serve as a motivator for employment, but is also likely to result in improved mood, increased social interaction, and better community integration.

Finally, discussing the types of jobs the Veteran may have held in the past and/or any current vocational interests may assist you and the Veteran in identifying attainable employment goals. All of these subtle interventions can ignite or spark the idea of returning to the workforce. Visit http://www.onetonline.org/ for job search and career ideas.

As you begin to think about ways to support the Veteran's employment goals, it will be important to address potential or perceived obstacles to employment as they present themselves.

Addressing Common Challenges:

Veterans who have experienced homelessness are often hesitant to pursue their employment goals for a variety of reasons. This section provides some basic "how to" ideas for mitigating some of these perceived barriers.

- **Poor work history** – For Veterans who have gaps in their employment history and/or may have been terminated from jobs it may be useful to develop a "functional" as opposed to

"chronological" resume. Functional resumes focus on the skills, training (including military training) and experience the individual has rather than listing previous jobs and the time frames. A variety of user friendly guides to resume writing and job search strategies are also available at www.lifeskillsed.com and can be customized for your program. Strategizing with the Veteran on ways to answer questions form an employer about gaps in work history is also helpful. For example, did he/she take time off to care for a family member or go to school? Any job seeker will perform better in an interview if they have prepared responses to questions that may arise based on employment history. Jobs from which the Veteran may have been fired do not necessarily need to be listed on the resume. Finally, obtaining a work history from the Social Security Administration (SSA) can also be useful in verifying employment dates and providing an overview of work history (www.ssa.gov).

- **No identification** – Typically two forms of identification are required to obtain employment. You can assist the Veteran in contacting the local DMV and/or Social Security Office to obtain "Right to Work" documents. ([www.**dmv**.org](http://www.dmv.org) and www.ssa.gov)

- **Lack of transportation** – Being able to get to work consistently and on time is critical especially for individuals who may be re-entering the workforce after a period of unemployment. Before starting a job, it will be important for the Veteran to develop a reliable transportation plan and to even take practice runs.   www.511.org provides nationwide travel and transit planning. You can contact local transit authorities to determine whether clients may be eligible for discounted public transportation passes and also become familiar with local agencies, including non-profit organizations that may provide financial assistance for public transportation.

- **No permanent address or phone number** – The lack of a permanent address or access to a telephone does not need to preclude a homeless Veteran from going back to work. Most employers rely on e-mail for communicating with perspective employees and free e-mail accounts can be set up which can be accessed from any computer including mobile phones.

- **History of justice involvement -** Having a history of justice involvement can make finding employment more difficult, but there are a number of strategies that may help to overcome this potential barrier. The websites below provide strategies for re-employing ex-offenders and updated information on the federal employment law.
    - http://www.eeoc.gov/laws/guidance/arrest_conviction.cfm
    - http://csgjusticecenter.org/reentry/posts/strategies-for-improving-reentry-and-employment-outcomes-highlighted-at-conference-workshop/

- **Limited or no appropriate clothing for job interviews and work-** Locate community agencies and non-profits who offer clothing and support for people entering the workforce. For example, Dress for Success and Career Gear provide professional clothing free of charge ([www.dressforsuccess.org,](http://www.dressforsuccess.org) for women; [www.careergear.org,](http://www.careergear.org) for men). Career Gear even has a

retention program focused on maintaining job skills and continuing professional development. Additionally, the program will provide suits that can be worn for interviews.

- **No computer skills -** Many employers require the completion of an on-line application prior to an interview. Clients may need assistance with both the technology and completing the application questions. Completing a mock application or template may be helpful for use in completing future applications. In addition, Career One Stop (sponsored by the Department of Labor) regularly offers basic computer skills training and help with applications and resumes. (http://www.servicelocator.org/).

- **Concerns about the impact of employment on VA and non-VA benefits** – Many homeless and formerly homeless Veterans are hesitant to return to work for fear that income from employment will jeopardize the financial benefits that they are receiving. Be knowledgeable about the impact of employment on benefits from different sources in order to help the Veteran understand his/her options. You can review the impact of employment on VA benefits at http://www.benefits.va.gov/COMPENSATION/types-compensation.asp. and/or encourage Veterans to schedule appointments with the Social Security Administration (www.ssa.gov).   Remember, not all benefits are impacted by employment in the same way. Part-time, intermittent and seasonal work can also provide many of the social and financial rewards of full-time employment while the Veteran is transitioning back into the community.

VA Employment Programs and Resources

In the last thirty years, great strides have been made in the development and application of interventions that contribute to successful work outcomes and the VA has embraced many of these practices in the development of their vocational and employment services programs (Leddy, Stefanovics, & Rosenheck, 2014; Rosenheck & Mares 2007).   Homeless service providers can make referrals to these VA programs when a Veteran may need specific or more intensive services to achieve their goal of obtaining community-based employment and can also request consultation from VA employment staff.

Homeless Veteran Community Employment Services:

In 2014, each VA medical center received funding to hire a Community Employment Coordinator (CEC) for homeless Veterans. The role of the CEC is to help improve employment outcomes for homeless, chronically homeless and at-risk of homelessness Veterans. The CEC serves as the local point-of-contact for both VA and non-VA employment services and insures that a full range of employment services is available and accessible to all homeless Veterans with employment as a goal. The CEC also engages employers in order to develop new employment opportunities for homeless Veterans.

Therapeutic and Supported Employment Services (TSES)

The mission of Therapeutic and Supported Employment Services (TSES) is to provide Veterans living with mental illness or physical impairment with support in addressing barriers to employment and also in securing and maintaining community-based competitive employment.

Transitional Work (TW) is a vocational model that assists Veterans with disabilities and barriers to employment to successfully return to community-based competitive employment. Services may be provided at VA Medical Centers or in the community to allow Veterans to gain valuable work experience, work skills, and income while enrolled in VA Compensated Work Therapy (CWT)programs that will prepare Veterans for community-based competitive employment. Defining features of CWT/TW include:

- CWT/TW is a time-limited service designed to assist the Veteran in achieving competitive employment through a focus on development and use of effective work behaviors.
- The CWT/TW program has a contract or MOU with an employer (either the VA or community businesses, including other Federal agencies) to provide the agreed-upon work.
- Veterans are participants in treatment and are not considered employees.
- The entity using TW provides funding to the program to remunerate the Veteran. The financial aspects of the service agreement are incorporated into the contract/MOU.
- Payment of the remuneration to the TW Veteran is processed by CWT/TW using the funds provided by the entity using the service.
- Compensation is no less than federal minimum wage.

Supported Employment (SE) is an evidence-based model that helps Veterans with significant psychiatric or physical disabilities obtain and maintain competitive employment in the community. Defining features of SE include:

- Employment services that are provided within the context of individualized treatment and are highly integrated with the Veteran's clinical treatment team.
- Competitive jobs are developed for specific Veterans; Veterans are provided individualized employment opportunities/placements.
- Veterans receive unlimited follow along support to assist them in maintaining their employment.
- Veterans are paid wages and are directly supervised by the employer, not the CWT/SE program (although a Vocational Rehabilitation Specialist may provide additional support).

Eligibility Criteria for CWT Programs:
- Mental or physical impairment

- ▪ Current goal of obtaining community competitive employment
- ▪ Consult to CWT required by a VHA licensed privileged provider

For more information visit http://www.va.gov/health/cwt/.

Vocational Rehabilitation and Employment (VR&E)

After an assessment and determination of an employment handicap, VR&E Vocational Rehabilitation Counselors (VRCs) can assist Veterans who have service-connected disabilities find meaningful, sustainable careers. Vocational rehabilitation and employment services can help with job training, employment accommodations, resume development, and job seeking skills coaching. In addition to the direct services provided by VR&E Vocational Counselors the *eBenefits*- Employment Center website (https://www.ebenefits.va.gov/ebenefits/jobs) provides useful self-help employment tools. Some of these tools include a resume builder, military skills translator, and other job seeker resources and services. Homeless service providers can refer Veterans to this site and/or assist them in utilizing this web-based tool.

Supported Employment

As a homeless service provider, you will be left with a choice of whether to directly assist the Veteran in achieving their employment goals or make referrals to other VA and community-based programs that deliver supported employment. Regardless of the level of support you offer, it may be helpful for you to have some working knowledge of the evidence-based Supported Employment principles. For those delivering Supported Employment services or for those, who want more information on Supported Employment, below is a table with the Seven Core Supported Employment Principles and Practices. These principles are adapted from Swanson, Becker, Drake and Merrens (2008), Supported Employment, A Practical Guide for Practitioners and Supervisors (Dartmouth Psychiatric Research Center). Additional detailed information on Supported Employment can also be found in the recently released Toolkit by the Substance Abuse and Mental Health Services Administration (SAMHSA), on "Supported Employment: Training Frontline Staff" http://store.samhsa.gov/shin/content/SMA08-4365/TrainingFrontline%20Staff-SE.pdf (SAMHSA 2009).

CORE SUPPORTED EMPLOYMENT PRINCIPLES AND PRACTICES	
PRINCIPLE	**PRACTICE**
1. Zero exclusion. Research has not been able to reliably distinguish those who will or will not succeed in employment. Anyone who has expressed a desire to work is deserving of help to achieve this goal irrespective of their current clinical status or past work history.	Homeless service providers should embrace the Veterans' desire for employment and support.
2. Integration of vocational and treatment services. Frequent communication is needed between employment specialists and the health care treatment team in order to apply a consistent, hopeful message about work and to problem solve clinical issues that may relate to work success, such as timing of appointments, or control of psychiatric symptoms or dealing with side effects of medication when on the job.	Connect the Veteran's primary care provider (PACT team, MH caseworker, social worker) and their work program. If there is no work program available, serve as the liaison between the Veteran and the primary care provider to help with managing meds, interruptions in work due to appointments, etc. Additionally, be encouraging and work with the team to troubleshoot issues: a unified treatment team that stands behind the Veteran is a huge asset, and promotes self-worth and motivation.
SUPPORTED EMPLOYMENT IN PRINCIPLE AND IN PRACTICE	
PRINCIPLE	**PRACTICE**
3. Competitive employment. Jobs should be obtained in the competitive economy (not sheltered work or segregated placements for people with disabilities) and pay at least minimum wage.	Veterans are recovering from homelessness. They have faced formidable challenges and they are survivors. Don't let past difficulties limit them.
4. Benefits planning. Veterans and their support team must think through and obtain reliable information on the potential impact of income on any disability benefits, many people with serious mental illness will restrict their work for fear of losing health insurance or having benefits reduced.	Candid conversations about milestones in income achievement and what they mean for benefits may be necessary. At those junctures, homeless service providers should help clients determine their own goals: how do they want to live in society? What is their income potential? What might change down the road?

5. *Rapid job search.* Job search based on Veteran preferences should begin shortly after or within a few weeks of determining the Veteran has a goal to work. Veterans can seek jobs without pre-employment training or formal assessment, or job readiness skill development. The job search should be tied to a simple vocational profile that may specify the Veteran's preferred industry sectors, the type of job skills s/he has and/or the number of hours per week desired.	Strike while the iron is hot! Use the Veteran's enthusiasm to maintain momentum. Don't wait.
6. *Follow-along supports.* Veterans with mental illness or substance abuse may need support of varying intensities for a very long time in order to succeed. Per the Supported Employment model, "cases" can remain open indefinitely.	Continue to coordinate with the PACT/MH teams, and continue to monitor the Veteran's progress. You are in this together and for the long haul. Continue to get updates on employers and new employer contact information, encourage updates to resumes,
7. *Veteran preferences.* Key tenets of SE are recovery, choice and self-determination. Client preferences are always taken into consideration and given primary value when making decisions about what jobs are sought, how many hours are worked, how SE services are provided and whether or not to disclose one's disability on the job.	Facilitate the Veteran's goals. Opening the door to stable housing may, in turn, open the doors to other life changes, but the Veteran's goals are our first priority.

Table 17. Supported Employment In Principle and In Practice

When homeless service providers do not have a full Supported Employment team to assist, the table below includes some resources that may help them tackle these problems.

Helping Veterans with Co-Occurring Disorders Obtain Employment

The principles of Supported Employment apply equally to Veterans with co-occurring substance use disorders in addition to their mental health diagnoses. However, some special considerations may be needed for these Veterans. For example, the Veteran's job profile should take into account information about his/her substance use disorder (e.g., Will the Veteran be around others who use substances? What is the status of their recovery and recovery stability? Account for the presence or absence of supports in their recovery from addictions, relapse triggers, etc.) It will be important to

choose jobs that support recovery (some jobs, for example, in drug stores or restaurants, may provide greater temptation to relapse to substance use).   Communication with the Veteran's treatment team can be essential to arranging for sufficient supports and interventions to prevent relapses. Ongoing supports may require special attention to prevent and appropriately respond to any relapse-related issues. Like treating anyone with a mental illness, take setbacks in stride while continuing to take note of any accomplishments or gains. Share your belief and hope that the Veteran can get more out of life.

HELPFUL JOB SUPPORT RESOURCES

- Job accommodation network: http://askjan.org
- Boston University Center for Psychiatric Rehabilitation: http://www.bu.edu/cpr
- Supported Employment at the Dartmouth Psychiatric Rehabilitation Center: http://www.dartmouth.edu/~ips/
- Benefits counseling: http://www.ssa.gov/work/WIPA.html

Table 18. Helpful Job Support Resources

Education as a Goal

Besides employment, many Veterans, especially young Veterans who served in the OIF/OEF conflicts, will have an interest in pursuing additional education prior to returning to employment. This is particularly applicable to those who can take advantage of their GI Bill benefits to further their education. The recent "Post-9/11 GI Bill" provides increased tuition benefits, housing stipends, and payments for books and computers for Veterans who meet certain eligibility criteria: http://www.benefits.va.gov/gibill/   for additional information on the GI Bill). Additionally, educational benefit programs exist for Veterans from prior wars and for those who wish to transfer their benefits to dependents or other family members.

There may also be scholarships and other benefit programs available from local or state institutions, such as the state Department of Veterans Services or local colleges and universities, and Veterans Service Organizations such as the American Legion and other Veteran-centric non-profit organizations.   For example, the Wounded Warrior Project offers on-campus support, employment services to Veteran students. As there are numerous campus resources targeting Veterans, we believe that a good place to start identifying available resources geared towards Veterans is the Office of the Dean of Students or the college counseling center at local colleges and universities in your area. Linking Veterans to representatives from these departments can make a big difference in assisting Veterans in achieving their educational goals.

Summary

We hope that this chapter was helpful in assisting you in helping the Veterans you work with in achieving their employment (and educational) goals. In this chapter, we discussed the importance of employment, ways to support Veterans directly or through linkages to employment supports, ways to address obstacles to employment, and described a number of available VA, state, and community-based programs and services available to assist Veterans in obtaining employment. We also introduced the principles of Supported Employment, an evidence-based practice with an available toolkit. For each Veteran on your caseload, a key factor in decision making and treatment planning will be whether you deliver employment supports yourself or offer employment (or education) support by linking the Veteran to specialized employment services. However, it is important to note that the two are not mutually exclusive, so you might decide to offer some ongoing support, while simultaneously linking the Veteran to a specialized employment specialist. Whichever you choose, supporting your Veterans in their efforts to obtain employment (or pursue educational goals) will be a key component of their recovery and community reintegration process.

Chapter
21

STAGES OF CHANGE AND THE ROLE OF MOTIVATION IN VETERAN CARE

Summary

Processes that embrace Mental Health Recovery principles and Patient-Centered Care philosophies have become the backbone of VA's official healthcare delivery policies. This change signifies a shift from an autocratic healthcare delivery model, where clinicians set treatment expectations and goals, to a collaborative model, where Veterans drive their treatment plans and clinicians support them on their road to Mental Health Recovery and healthy living. Laudable in its intention, these Mental Health Recovery/Patient-Centered Care-based policies can be challenging to effectively implement and sustain during each clinical encounter. One source of this challenge is the Veteran not exhibiting healthy behaviors that the clinician thinks the Veteran should exhibit despite the clinician using such tools as Motivational Interviewing. As a result, clinicians may become disillusioned with these policies and disengaged with Veterans seeking care from them. One way to address this potential negative consequence of policies, whose evidenced-based principles have been shown to be effective in improving outcomes, is to utilize these principles within the Stages of Change model. This model provides a realistic approach to facilitating behavioral change: people are capable of change, the degree of change is dependent on where an individual is in the spectrum of being motivated to change, and people's position in this spectrum oscillates. Specific tools exist per stage of change that can be used to facilitate change or maintain healthy behaviors. It would be remiss to not acknowledge the impact of countertransference (clinician's unconscious thoughts, emotions, and reactions to the Veteran) on the effectiveness of this model or any other model that involves people seeking care from another person (Gabbard, 1999).

In this chapter you will learn:
- Impact of countertransference

- How people change
- History of Stages of Change model
- Behaviors associated with each stage of change
- Practical tools to address behaviors associated with each stage of change
- Foundational principles of Motivational Interviewing

Aim of the Chapter

The main purpose of this chapter is to explain how Stages of Change principles can be incorporated into everyday clinical encounters to support productive change. The context of using Stages of Change principles is cultivating awareness of how clinicians' countertransference can potentially impact care delivery to the homeless population.

Countertransference

Clinicians' unconscious thoughts, emotions, and reactions to a person in care originate from each clinician's personal experiences and history, and are influenced by social factors, including culture. Countertransference runs the gamut of responses from being positive to negative. Because countertransference is an unconscious process, clinicians need to make a conscious effort to self-assess their emotions, thoughts, and behavior in the context of their personal attitudes towards people experiencing homelessness. One reason for clinicians to be mindful of their countertransference is that countertransference impacts the manner which the clinician processes a clinical encounter. This filtering of "reality" through the clinician's eyes has the potential to cause clinicians to incorrectly assess the clinical encounter and to influence their empathy towards the Veteran.

A way to accomplish this self-assessment is for clinicians to ask themselves such questions as:

- What stereotypes about people experiencing homelessness did my family of origin and society in general hold true?
- What have I taken away from my past interactions with people experiencing homelessness?
- What personal experience do I have with homelessness? How has this impacted me?
- What personal experience do I and/or people close to me have with the illness that the person seeking care from me has? How has this impacted me?
- What is my gut reaction to the specific person seeking care from me? Why am I having this reaction?
- What is my comfort level in providing care to people experiencing homelessness and to the specific person seeking care from me? What triggers my discomfort in providing such care?
- What are the beliefs I hold that might interfere with my effectiveness in providing care to people experiencing homelessness?

An objective self-assessment might uncover inaccurate beliefs that have the potential to interfere with care delivery because the beliefs hinder the clinician's effectiveness in engaging the Veteran. Below are some inaccurate beliefs and associated clinical vignettes where these inaccurate beliefs negatively impact care delivery.

- People choose to be homeless.
  - Despite multiple attempts, a clinician is unable to motivate a Veteran living on the streets to accept shelter housing. The clinician concludes that this Veteran is choosing to remain homeless without being open to the possibility that s/he has had a bad experience at the particular shelter and finds living on the street safer than living at the particular shelter, but would potentially consider housing at another establishment.
- Stable housing is something people have to earn.
  - A Veteran relapses on alcohol. His/her clinician discharges the Veteran from the housing program given that the Veteran is no longer earning his/her housing since s/he was unable to maintain his/her sobriety.
- People experiencing homelessness do not want to work.
  - A Veteran's clinical team does not assess the Veteran's interest in working or install hope in the Veteran's potential ability to work by referring the Veteran to *Therapeutic Supported Employment* Services, or to other resources available to Veterans.
- People become homeless because they are lazy.
  - After being street-homeless for 20 years, a Veteran has become housed and lives in an apartment. His/her clinician's finds the Veteran lounging around his/her home all day and the clinician's immediate reaction is that the Veteran is lazy. In reality, the Veteran is not leaving his apartment out of fear of becoming incarcerated. While homeless, the Veteran experienced multiple incarcerations and believes if he stays home his chances of becoming incarcerated is less than if he ventures outside his home.
- Homelessness motivates people with mental health disorders who are homeless to address their problems.
  - A Veteran with post-traumatic stress disorder is not engaging in treatment, has lost his job, and is about to become homeless. His/her clinician's response is that homelessness will be good for the Veteran because "bottoming out" will motivate him to change his behavior.
- Homelessness is caused by a personal shortcoming since everyone has the same chance of becoming homeless.

     o A clinician, who has never been homeless, speaks down to a Veteran experiencing homelessness because the clinician believes s/he is smarter, is a harder worker, and has a higher moral fiber, etcetera than the Veteran experiencing homelessness.

- Veterans experiencing homelessness with mental health disorders are unlikely to obtain Mental Health Recovery.
  - A Veteran with chronic suicidal ideation is not admitted to a housing program because housing program clinicians' perspective is that the Veteran will be unable to obtain Mental Health Recovery. They do not consider supports that potentially will aid the Veteran in achieving Mental Health Recovery.

Clinicians should perform these self-assessments on a routine bases given the complexity and intensity of care provision related to serving the homeless population (Substance Abuse and Mental Health Services Administration, 2013). Some common clinician reactions that have the potential to negatively impact the clinician's and Veteran's lives include:

- Anxiety about Veteran's unsafe living situation causing clinician to feel a compulsion to protect the Veteran
- Disengagement in context of clinician's frustration about Veteran's non-productive behaviors
- Urge to flee in context of feeling overwhelmed by Veteran's frustration and hopelessness
- Ignoring clinical boundaries in order to lessen Veteran's suffering (such as giving Veteran clinician's own money)
- Spending less time with Veterans whose exhibited priorities do not match those of the clinician
- Doubting clinical skills in context of not seeing an immediate, measurable change
- Feeling guilty about having a richer life than the Veteran who is living on the streets and who does not have a supportive social network

In brief, countertransference distorts "reality" to mold it into a reality that conforms to the clinician's perspective. However, if clinicians are able to bring their unconscious thoughts, emotions, and reactions to Veterans to their consciousness, then clinicians will be able to more effectively address their own potential care-inferring behaviors and strengthen their productive care-delivery behaviors. This awareness is especially important when trying to incorporate Stages of Change principles into care delivery because these principles rely in part on the clinician being able to see the world through the Veteran's eyes.

How People Change

There is a direct relationship between level of motivation and a successful behavioral change outcome; the more motivated the person, the more likely their change will be successful (Miller and Rollnick, 1991). Therefore, motivation is the key factor to successful behavior change. However, as clinicians, how we help someone become motivated is very important. We can help someone to be successful or, despite our best intentions, we can inadvertently demotivate people, disempower people, and stop them from achieving their potential. Therefore, in addition to motivation being a key factor to successful behavior change, the process in which clinicians help people change is also a key factor.

Clinicians have traditionally considered motivation as a personality trait; either the person is motivated or they are not. Treatment failures are blamed on the person's motivation: 'he wasn't ready to change.' This leaves the clinician safe from any uncomfortable reflections that result from asking the question, 'could I have done anything more to help this person to be ready to change?' In this traditional view, the clinician may try to externally apply motivation to a person who is lacking motivation; 'if you aren't sufficiently motivated, then I will try to motivate you.' Clinicians often try to increase someone's motivation to change by challenging and confronting their behavior (Cofer & Appley, 1964; Sorrentino & Higgins, 1996). This is often attempted by informing the person of the consequences of their behavior, offering well-informed advice, punishing their behavior, or confronting their behavior directly. However, exerting external pressure to change can create a paradoxical decrease in the desire to change (Arkowitz and Miller, 2008).

One of the most common interventions when someone doesn't appear to want to change their behavior is to inform them of the consequences of not changing their behavior. This type of educational intervention makes an assumption that the person does not know this information; they have a knowledge deficit. It is assumed that providing this information will result in a change in the behavior. This is a false assumption. It is futile to just give people information to change their behavior. Evidence from research suggests that educational interventions increase knowledge but do not result in behavioral change (Gray, 2000; McCluskey and Lovarini, 2005). As a clinician, it is also a poor use of your time and energy to try to fill knowledge gaps that are not there.

Another strategy is to share wisdom with the Veteran. You have spent many years training and working in the field; you have seen many people with problems like this before. You may have been through something like this yourself. You are in a great position to offer your advice about what they should do. Regardless of your intention, this type of intervention tells the Veteran that you know better than they do and your opinion is more valuable than theirs. This is disempowering of the Veteran and fails to engage their own capacity to find solutions. People are far more likely to

make a successful behavior change if it is attributed to one's own choice rather than those attributed to external sources (Davidson, Tsujimoto, and Glaros, 1973).

We can often be under the mistaken assumption that punishing people for behavior we perceive to be bad will reduce that behavior. Perhaps a Veteran uses marijuana or has a few drinks whilst out on leave. You take away the Veteran's leave privileges in the hope that this action will stop the Veteran from engaging in these behaviors again next time. We can even rationalize this clinical intervention as being in the Veteran's best interests. However, does this type of intervention result in the desired change when it is quite natural to become defensive when confronted, demeaned, disrespected, or threatened (White and Miller, 2007)? What happens is that any relationship you do have is quickly ruined. This resultant strain makes it very difficult to achieve anything meaningful. The aim is to get people to talk themselves into changing or utilizing "change talk" (Miller and Rollnick, 2002). Amrhein, et al, (2003) found a positive correlation between change talk at the end of a therapy session and sustained behavior change.

Finally, we could confront the problem behavior by challenging it. Like offering advice, this type of intervention tells Veterans that you know better than they do, but this time there is more energy behind it. It is no longer an offer, but a demand; "Your behavior is a problem. You need to change it or you will be discharged!" You are in a position of greater power and this intervention aims to use this power to exert influence over the Veteran so that s/he changes. Like the use of punishment in the example above, this intervention is likely to do more damage than good. Anderson and Funnell (2000) argued that techniques using direct questioning, persuasion, education, and advice have limited effectiveness in helping people change their health behaviors. Brehm and Brehm (1981) found that if a person perceives an infringement or challenge to their personal freedom s/he is likely to increase the behavior that is causing them problems. This intervention, like advice giving, informing, and punishing, are authoritative interventions (Heron, 1990). They tend to result in poor therapeutic relationships and high dropout rates from treatment (Rollnick and Miller, 1995). The ideal state is referred to as "optimal frustration" (Kohut, 1971); sufficient frustration with the current behavior exists to motivate towards change, yet not so much that it evokes resistance.

Motivation, then, is a product of the relationship between the clinician and the Veteran. Veterans will be motivated if the clinician engages them, remains non-judgmental, and maintains a supportive stance. Miller and Rollnick (2013) stated "People seem to have an impressive capacity to change themselves if you believe in them; if you tell them they can and give them some help in doing so." We need to build a good therapeutic relationship if we want people to be able to change.

The importance of the relationship in any helping context holds intuitive appeal. We are motivated by people we respect and hold in regard. We are demotivated by people we do not value or respect.

Therefore, the role of the clinician is critical to enhancing the motivation of Veterans in their care. There are a number of studies that support the idea of a strong relationship between therapist empathy and health behavior outcomes (Miller, Benefield, and Tonigan, 1993). For example, Miller and Baca (1983) found a strong negative correlation between therapist's empathy and client's alcohol consumption at 6, 12, and 24 months; the higher the therapist's empathy, the less the clients drank. This is the starting point from which we can start to consider how people go about changing.

History of Stages of Change Model

James Prochaska, a cofounder of the Stages of Change model, was impacted when his father was unable to change his behavior which resulted in him dying from depression and alcohol abuse. His father did not change his behavior through seeking treatment because he did not believe he had these problems and had a mistrust of therapy. Studying to become a psychotherapist, Dr. Prochaska evaluated existing psychotherapies to determine how they foster change in an individual (Prochaska, Norcross, and DiClemente, 1994). In 1979, Dr. Prochaska wrote "*Systems of Psychotherapy: A Transtheoretical Analysis.*" He labeled his analysis as "transtheoretical" because it is based on identifying the key components that propel change associated with 18 psychotherapies, including Freudian consciousness raising, Skinnerian contingency management, and Rogerian helping relationships, and integrates these components into one model. He and a doctoral student Carlo DiClemente then evaluated whether these identified key change components were utilized by people self-motivated to change. They found that regardless of the problem, people progress through the same stages of change to address a problem. They also noted that people used the same tools, specific for a stage of change, to advance through the stages of change. Furthermore, they observed that successful behavioral change was dependent on identifying the person's current stage of change and utilizing tools associated with that specific stage of change (Prochaska, Norcross, and DiClemente, 1994).

Concurrent with the development of the Stages of Change model was Drs. William Miller's and Stephen Rollnick's creation of Motivational Interviewing (Miller and Rollnick, 1991). Motivational Interviewing's assumption is that the person has the ability to enact the desired change and that the person's ambivalence to change is the obstacle to change. Thus, Motivational Interviewing targets this ambivalence to motivate change. The Stages of Change model delineates the processes of change that need to occur for change to happen. The Stages of Change model incorporates Motivational Interviewing techniques to assist the person in progressing through the stages of change.

Since its creation, a plethora of articles, mostly in the field of health, have been published about the Stages of Change model. This large body of literature has supported its popularity and provides a relatable means to describe and conceptualize the process of behavioral change. For example, creators of the Kelly Hotel Transitional Living Community's programming based their design on the

Stages of Change model (Barrow and Rodriguex, 2000). In 1997, the Kelly Hotel Transitional Living Community opened its 40-bed transitional housing in West Harlem, New York City. Its eligible population was people with mental illness who had spent at least 730 days in a shelter over the previous four years or people with mental illness living on the streets. Using the Stages of Change principles in its approach to the residents of Kelly Hotel, this transitional housing program filled its beds within five months of opening its doors. Within 13 months of reaching capacity, it was able to meet its goal of securing long-term housing for 42% of the first shelter group, in the context of limited supply of supportive housing for individuals dually diagnosed. However, critics of the Stages of Change model contend that studies do not exist that validate the description of the specific stages of change (Sutton, 2007) and that the model does not account for such forces as external drivers, social drivers, and the automatic decision-making processes (Verplanken, 2010). Counter arguments to this criticism are that the model was never intended to be predictive or all-inclusive in nature.

Stages of Change Model

The desired change is often a health behavior, such as stopping drinking or drug use, but it can be about other aspects of people's lives. The model describes a series of stages that are both cognitive - "I want to change", and behavioral - the person changes how they act. Figure 1, below, depicts the six stages; each will be detailed next.
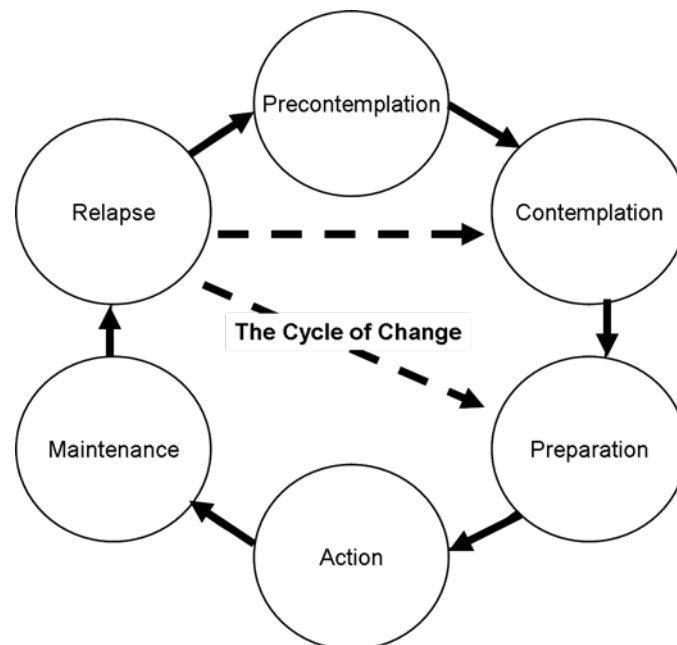
Figure 9: The Stages of Change (Prochaska and DiClemente, 1983)

Behaviors Associated with each Stage of Change

Pre-contemplation

Pre-contemplation is the first stage of the model during which the person is unaware their behavior is a problem or is causing problems. In this stage, the person has no awareness of a need to change their behavior and may be happy to maintain the status quo: "I am OK. I don't need to change." This is often labelled as 'denial' or 'lacking insight.' Veterans often present to services in the pre-contemplation stage. It can be very frustrating for clinicians working with Veterans in this stage as it is clear what the problem is to the clinician, but the person can't, or won't, see it. Later in the chapter, we will discuss strategies that can be used to help this Veteran move on to the next stage of change: contemplation.

Contemplation

The contemplative stage is when the person begins to recognize a problem with their behavior. This may be prompted by an external event, such as deterioration of health, or it may be prompted by a desire to be healthier. The person may believe that they are in control and are able to change their behavior when they are ready to do so. It is important to recognize that the person is thinking about changing but has not yet changed. It can be frustrating to work with Veterans in this stage; they have recognized they have a problem but aren't doing anything about it. It is important to empower Veterans to make changes on their own time.

Preparation

The preparation stage is when the person explores possible solutions to change their behavior. This testing of the water is often stimulated by a greater awareness of the potential consequences if they do not change. This may be seeking out possible resources and actions to help support a change, such as seeking support from clinicians or seeking additional information.

Action

The action stage is when an individual changes their behavior. They may experience heightened feelings of empowerment and self-esteem, but this behavior may be short lived. Perhaps they had a week without alcohol or stopped smoking for several days, but it has not changed in general. It is, therefore, important for the person to continue this newly learned behavior and maintain patterns that support the change process.

Maintenance

Anyone who has tried to change their behavior will know how difficult this behavior is to achieve and maintain. Changing a health behavior is like creating a new path through thick undergrowth when the old behavior is like an old well-trodden path. It takes time and energy to change a

behavior. It can be very difficult to maintain a behavior change particularly when feeling stressed or overwhelmed. These times are when we often lapse back into old familiar ways of behaving.

Relapse

The most common outcome of any behavior change is relapse (Rollnick and Miller, 1995). A person may have given up smoking or stopped drinking; a stressful week may result in picking up a cigarette or a 6-pack of beer. Old behaviors are familiar and comfortable. New behaviors require hard work and repetition for them to take hold through becoming familiar and trusted. Once the person relapses, they may experience feelings of helplessness and guilt for having failed; they may re-enter the cycle at any stage, but most commonly as pre-contemplative ("There isn't a problem"), contemplative ("I know there's a problem, but I'm not yet ready to do anything about it"), or preparation ("I have slipped and I want to make sense of it and get back on with my Recovery"). Helping a person learn from a relapse can help to stop a slip or lapse from being a full blown relapse.

The Stages of Change model is sometimes reported with 'relapse' as a specific stage, whilst other versions leave it out of the model. This may be because some clinical programs use the model without relapse to avoid the risk of making relapse an 'acceptable' outcome in the eyes of the service users. However, accepting that relapses happen is not the same as saying they are OK. Instead, it can be useful to include it in the model as it helps to normalize the relapse process. Understanding that relapse is normal may take some of the guilt and shame away from the person who has "failed" in actualizing their desired behavioral change. This normalization may make it more likely for the person to seek help rather than feel that they have to hide their relapse.

Stages of Change: Summary

There are several things to keep in mind when using the Stages of Change model. The first is that people can spiral around the stages a number of times before making any lasting change. This outcome is quite normal and should be treated as such. The Motivational Interviewing approach avoids seeing this outcome as a failure and suggests that the clinician has yet to find the right approach, i.e. hope continues to exist for sustained, productive change in the future.

Another aspect of Stages of Change is that people can be at different stages of change with different behaviors. For example, a person may be contemplative about their smoking, pre-contemplative about their drinking, and in the maintenance stage regarding their medication usage. Each of these behaviors should be considered separately, starting with the behavior the person wants to change first or the one the person finds easiest to change.

Stages of Change is a useful model for understanding the process of change. It can be helpful to draw the model out for Veterans as it can help normalize the change process. Normalizing the change process may reduce the negative feelings that are evoked after relapsing. Helping Veterans understand their own process will facilitate the change process. Finally, Stages of Change helps match the type of intervention to the Veteran's stage of change. Each stage suggests a particular way of working.

Practical Tools to Address Behaviors Associated with each Stage of Change

How can you use the Stages of Change model to guide how you work? These stages help us identify which strategy to use. It is important to ensure that the right type of intervention is utilized at the right time or resistance will be evoked.

In the pre-contemplative stage, Veterans aren't ready to acknowledge that they have a problem. Therefore, any attempt to give information, discuss, or think about the problem is going to be met with resistance. At this stage of change, the best approach is to engage with the Veteran; find out what it is that the Veteran would like to achieve. You could complete an assessment of the Veteran's history in order to get to know the Veteran better and start to understand how the Veteran got to be where s/he is. Just finding out how a Veteran got to be where s/he is now can be a useful way of gently building the relationship and potentially raising the Veteran's awareness of his/her problems. Helping Veterans solve some of their practical problems, such as helping them with their bills or with their grocery shopping, may help move Veterans towards thinking about their problem. Perhaps, when some trust has been established or some of their other difficulties get resolved, they may begin to talk about changing; they may become contemplative.

The contemplative stage is when Veterans have become aware that they have a problem. The aim now is to help them move towards preparation and action. If this move is done too quickly, it will result in resistance. This movement is achieved by raising their awareness of the difficulties. Remember that interventions that provide information alone do not result in behavior change. Explore with Veterans their difficulties; get a clear sense of the Veterans' problems. Help them to explore their uncertainty about changing, perhaps by doing a pros and cons balance. Use their responses to redress the balance. For example, if a good thing about drinking is that it relieves boredom, help the Veteran find alternative things to do. This exercise moves the balance slightly closer towards changing.

During the preparation and action stages, the emphasis is on helping the Veteran to be sufficiently resourced to be able make the change. Help equip the Veteran with the information, skills, and contacts to be able to manage the behavior change. Use Problem Solving to explore and plan for

more complicated problems; use Functional Analysis to explore complex situations; Explore Beliefs and Concerns if there are things that may impede sustained, positive behavioral change; start thinking about Looking Forward and Relapse Prevention to plan ahead for when the change is made. Help the Veteran make a backup plan in case their first plan is unsuccessful.

During the maintenance stage, there are two main tasks: minimizing the risk of relapse; and promoting independence and sustained, positive behavioral change. Use Relapse Prevention techniques for reducing the risk of relapse. Help the Veteran generalize the lessons from the clinical encounter into everyday life to promote sustained, positive behavioral change. Your role with the Veteran should be reducing whilst their independence is increasing. Help them explore options outside of traditional treatment services; help them to think about educational or occupational activities that encourage personal development.

If the Veteran relapses, then the Veteran will enter another stage, usually pre-contemplation, contemplation, or preparation. Help the Veteran learn what they can from the relapse. Avoid blaming or punishing the Veteran for the relapse and focus on what needs to be adapted for another attempt. Veterans frequently talk about being back at stage one after a relapse. This thought process fails to account for the learning that has occurred whilst they have been well. The Veteran hasn't lost the experience of doing well, regardless of how long or short the Veteran was in the maintenance stage. Normalize relapse and support the Veteran in your care to use it as a learning opportunity.

These stages have been presented as clearly distinct stages. The reality is that Veterans can fluctuate between stages from time to time. If you are finding it difficult to know what to do, or you are feeling stuck with the Veteran in your care, the best way to deal with this situation is to talk with this Veteran about it. There is no harm in showing that you don't know. In fact, it may give you credibility to be open about your uncertainty. Reassure the Veteran that you are here to support him/her; you are happy to work with the Veteran to find a path through, but you don't have all the answers.

Foundational Principles of Motivational Interviewing

There are some very useful principles worth knowing about when you are supporting people with behavior changes. They include the principles of Motivational Interviewing:

- Expressing empathy
- Developing discrepancy
- Rolling with resistance
- Avoiding argumentation

- ▪ Supporting self-efficacy

Expressing Empathy

Empathy refers to the clinicians' skill of being able to immerse themselves into the Veteran's world. This is an 'as if' position; to imagine what it is like to be in the Veteran's shoes. This allows the clinician to experience what it is like to be the Veteran. This understanding is then conveyed through empathic statements that show the Veteran that the clinician understands. Being understood allows someone to begin to change (Rogers, 1957). Reflective listening is an effective way of conveying understanding. Reflective listening can be mistaken for repeating back what the Veteran has just said. This is a misunderstanding of what active listening and conveying empathy means. The below table contains different examples of active listening.

In simple terms, expressing empathy can be summarized by asking open-ended questions, listening to Veterans' experiences, and reflecting back the emotional component of what they said. Let the Veterans do the talking. You just have to listen and support the Veterans in their process of changing.

Active Listening		
Veteran statement: "Even though nothing has changed, I've been feeling more depressed lately"		
	Definition	Example response
Repeat	Repeating an element of what has been said	"You've been more depressed lately"
Rephrase	Staying close to what the Veteran has said with some rephrasing	"So your sadness is getting worse and you don't know why"
Paraphrase	Inferring the meaning of the Veteran's statement and reflecting this back	"You would like to understand why your mood changes like that"
Reflect	Emphasizing the emotional content through empathic responding	"It's scary not to be able to understand these feelings"

Table 19. Examples of Active Listening

Developing Discrepancy

Discrepancy describes when a Veteran holds two contradictory beliefs at the same time. Take for example a Veteran who smokes. Most people hold the belief that they will live a long pain-free life. However, the evidence on smoking is clear; it generally reduces people's life expectancy and contributes to a painful death. People who smoke typically will hold both of these beliefs simultaneously but separately. By holding these two ideas next to each other shows there is a discrepancy between them. This discrepancy creates dissonance - a feeling of discomfort - motivating the Veteran to want to reduce these feelings.

If the clinician attempts to create discrepancy in a way that creates too much dissonance, by directly challenging or confronting the behavior, the Veteran will become resistant and withdraw. We will discuss managing resistance in the next section. It is important to develop sufficient discrepancy to increase the Veteran's motivation whilst ensuring that the dissonance doesn't become too great or the Veteran will become resistant.

Developing the discrepancy in the Veterans' thinking allows them to weigh the positions, come to a conclusion about the potential consequences of their behavior, and decide what they want to do about it. This process allows Veterans to reach a conclusion without the clinician having to tell them. This action avoids confronting or challenging the behavior. Keeping resistance low, or rolling with resistance, is a key principle of Motivational Interviewing.

Rolling with Resistance

We have already touched upon the concept of resistance in considering several types of intervention. Resistance is most easily understood in terms of interpersonal dynamics. Resistance is evoked when there is a disconnection between the clinician and the Veteran. It occurs when the clinician and Veteran are not working together effectively. Typically, this happens when the approach taken by the clinician does not match the Veteran's stage of change. Essentially, if the change is too much or too fast, then the most likely response is resistance. Resistance is the Veteran's way of saying, "slow down. I don't agree. I'm not with you." It is important that the clinician manages resistance so it does not become a barrier (Miller and Rollnick, 1991).

There are a number of different ways resistance can arise between a clinician and Veteran. The Veteran may argue with the clinician. This arguing is not the constructive discussion of ideas but more likely to be centered upon more personal aspects, such as the clinician's expertise or integrity. The Veteran may deny their situation or be unwilling to recognize problems, cooperate, or accept responsibility. Finally, the Veteran may resist by not coming to the session, being inattentive, not responding to communications, or actively side-tracking a conversation.

Whilst resistance arises out of the interpersonal interaction, it is the clinician's responsibility to manage. Resistance suggests that the strategy being used is not appropriate for that Veteran. Therefore, the – clinician must find alternative strategies. If the clinician persists using the same strategy, the Veteran is likely to become more resistant. However, it is important to bear in mind that resistance does not suggest that the Veteran is unwilling to change. Change is difficult so resistance is normal. Avoiding arguments with Veterans is a key to maintaining a good therapeutic relationship.

Avoiding Argumentation

Arguments can result out of the frustration that is evoked by unmanaged resistance. The clinician is using interventions that are not appropriate to the Veteran's stage of change. The Veteran is expressing resistance to this intervention. Rather than rolling with the resistance and managing this appropriately, the clinician increases the pressure and tries to force the intervention. Like fighting fire with fire, the two escalate their own positions and fail to hear the other. This is the clinician's responsibility to manage. Should this begin to occur, the clinician would be better served by backing off and coming alongside the Veteran: "I'm sorry. I misunderstood you there. Perhaps it would be a good idea if we went back to look at what it is that you want to achieve."

Supporting Self-Efficacy

Self-efficacy refers to a Veteran's perception of their own competence (Bandura, 1977) and increases with successful performance. When Veterans experience success, their feelings of confidence and competence increase. However, when Veterans experience failure, they may lose confidence in their ability. At this point, it is important for clinicians to help build the Veterans' confidence back. This action is not accomplished by telling them how good they are but by encouraging Veterans to evaluate their own performance. This way Veterans retains control over their performance and is not reliant on others for evaluation.

Ambivalence

Before we leave Motivational Interviewing, it is worth making a point about ambivalence. Ambivalence is frequently misinterpreted as apathy, as a lack of motivation. This interpretation is not the case. Change, of any type, requires energy, commitment, and comfort with taking a risk given the desired change may not work out. Ambivalence means that the person is uncertain, or has mixed feelings, about changing. Most people have mixed feelings about change even when the change is desired. Helping Veterans in your care to resolve their ambivalence is vital to achieving change (Rollnick and Miller, 1995).

To help Veterans explore and resolve their ambivalence, take some time to help them think about the pros and cons of their behavior. It can be helpful for the clinician or the Veteran to write these

ideas down. Seeing this list can often be quite motivating. Remember, this technique should only really be done with Veterans who are contemplative or further along in the Stages of Change model. It is likely you will be met with resistance if you raise exploring the pros and cons of their behavior with Veterans who are pre-contemplative.

Keeping Resistance Low

Resistance is important to manage because it is difficult to have a collaborative conversation where resistance has been evoked. It is the clinician's role to work with resistance through selecting approaches that will keep it to a minimum. If you feel that you have to work hard with the Veteran in your care, you are probably working against the resistance. Simply being aware that you can increase or decrease resistance can help conversations about difficult issues flow more easily.

There are three useful strategies for dealing with resistance. They are emphasizing personal choice, backing off and coming alongside, and reassessing the Veteran's goals. Emphasizing personal choice is when you make a statement that reinforces the Veteran's ability to choose. Telling Veterans that they have no choice is likely to increase resistance and giving choices decreases resistance. For example, "At the end of the day, the choice to use drugs is yours. I wonder if it would be ok to spend a little time thinking about how this may impact on you?"

Backing off and coming alongside refers to a change of tactic when you get too much resistance. Rather than insisting on maintaining your position, this strategy aims to back off and try again. For example, "I'm sorry I misunderstood you there. How would you like to spend this time?"

Reassessing the Veteran's goals may be required if the Veteran becomes resistant. Sometimes a goal can seem like a good idea when it is far away. As it gets closer, it can become anxiety-provoking. This anxiety can cause people to get 'cold feet' and want to slow things down. Thus, they become resistant. For example, a Veteran wants to utilize his/her housing voucher. However, as the date to find an apartment gets closer, Veteran stops coming for sessions and doesn't engage as well as before. It can be helpful to name this behavior with the Veteran and review the Veteran's goal and strategy to get there.

Exchanging Information

The process of communication between Veteran and clinician should be a two-way exchange of information. The Veteran should not be the passive recipient of the clinician's wisdom nor should the Veteran be continually answering yes/no questions. The entire treatment process is about sharing information. The clinician should be using information from the Veteran to assist in the treatment process. The Veteran should be gaining information in order to make informed decisions about their health and lifestyle.

The process of exchanging information should begin by asking the Veteran what they already know about the subject in question, be it their illness, medication, or health information. Once this has been established, ask the Veteran if they would like any more information and explore ways the Veteran could obtain this information. It can be very empowering for the Veteran to gather information, rather than the clinician to provide it all. Where possible, negotiate who will retrieve the information. Any information should be provided in a neutral way. It should be factual rather than personal opinion.

Once the information has been given, ask the Veteran what they think about the information or how the information has affected them. It is a process of integrating information that will help people make informed decisions about their treatment and sustained, positive behavioral change. When information is exchanged, it should be at a level appropriate for the Veteran. The clinician should spend time checking the Veteran's understanding of the information. Where possible, should be repeated in later sessions with understanding re-checked.

Examples of Exchanging Information
Scenario #1:

> Clinician: "It sounds like you want to know more about the effects of marijuana."

> Veteran: "Yes, I think that would be helpful".

> Clinician: "Tell me what you already know about marijuana."

Scenario #2:

> Clinician: "Where could you go to get some information about obesity for the next session?"

> Veteran: "Well, I don't know. I could get a leaflet from my physician."

> Clinician: "Okay, good. Would you like me to bring some information that I have, and we can look over it all next week?"

Scenario #3:

> Clinician: "What do you think about the information we have read today?"

> Veteran: "I have experienced some problems with seeking a job, but I am concerned about being able to write a good resume".

Clinician: "Would you like some time to work on this together?"

Conclusion

One of clinicians' greatest tools is being aware of their thoughts, emotions, and reactions to a Veteran. With this awareness, they can more objectively evaluate how they are impacting their delivery of care. Another method to provide effective delivery of care is to use the appropriate engagement approach depending on the particular stage of change the Veteran is currently at and realizing that this approach will need to be continuously evaluated and potentially modified as the Veteran moves through the continuum of Stages of Change typically in a non-linear fashion.

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APPENDIX I: ELEMENTS OF RECOVERY

VA STAFF:
- Actively protect veteran's rights
- Listen carefully to the veteran's concerns
- Assist veterans in communicating their needs and hopes
- Provide information to assist in decision making

VETERAN:
- Consider a new path for the future
- Be open to new ideas about therapy
- Develop a support network
- Be an active participant in your care plan

VA STAFF:
- Maintain a positive approach
- Focus on the person's abilities, not disabilities
- Create service options and support
- Believe in the goals of recovery

VETERAN:
- Talk about your success
- Open up to new possibilities
- Develop a fine-tuned plan to cope with stress
- Believe in the goals of recovery

VA STAFF:
- Pay attention to the veteran's basic needs
- Share sources of support with veterans and families
- Reach out to colleagues in the community to extend care plans

VETERAN:
- Join therapeutic sessions regularly
- Involve at least one special person in your plans
- Volunteer to help others

VA STAFF:
- Encourage veterans toward greater independence
- Provide models of coping skills and wellness plans
- Assist veterans in locating community resources

VETERAN:
- Monitor your symptoms
- Ask for help when needed
- Create wellness and crisis plans
- Maintain a healthy diet, exercise, sleep and have fun

VA STAFF:
- Share information
- Answer questions clearly
- Provide choices and suggestions

VETERAN:
- Ask questions until you understand
- Think about the change you want to make
- Learn new ways to make decisions
- Learn about the resources in your hometown

VA STAFF:
- Recognize that the illness is only one facet of a veteran
- Learn about each veteran as a unique individual
- Learn what veterans need most for recovery

VETERAN:
- Share information about yourself
- Think about the change you want to make
- Be open to new possibilities
- Review information about recovery

VA STAFF:
- Encourage individuals to share their experiences
- Search for social support in the community
- Organize group sessions
- Provide information on the VA Peer Support Program

VETERAN:
- Listen respectfully to the views of others
- Offer ideas and understanding to each other
- Share your recovery story with others

VA STAFF:
- Use a pleasant, caring voice
- Provide personalized care to each veteran and family
- Listen to ideas on how to improve our services
- Set aside labels and assumptions

VETERAN:
- Ask for the information you need
- Make your personal needs known
- Talk about what works for you and what doesn't
- Speak with a pleasant voice

VA STAFF:
- See a hospital stay as a recovery step, not a failure
- Respect the current situation of each veteran
- Develop a partnership with veterans, families and friends
- Share ideas for next steps

VETERAN:
- Think: "It's important to keep trying."
- Be open to reviewing and revising your care plan
- Learn a new coping skill and share it with a friend

VA STAFF:
- Ask about personal preferences, interests, and skills
- Include the veteran's strengths and talents in their care plan
- Search for community connections to match veteran's interests

VETERAN:
- Participate in a variety of therapies: art, music, recreation, etc.
- Look for chances to learn new skills
- Share your experiences and interests with others

FOCUS ON RECOVERY

HOPE · HOLISTIC · SELF-DIRECTION · RESPONSIBILITY · EMPOWERMENT · PERSON CENTERED · PEER SUPPORT · STRENGTH-BASED · RESPECT · NON-LINEAR

Poster originally created by Psychiatry Department, University of Iowa Health Care and adapted by Mental Health Service Line, Iowa City VA Health Care System.

APPENDIX II: MH RECOVERY LANGUAGE

Recovery Language

Words have power. They have the power to teach, the power to wound, the power to shape the way people think, feel, and act toward others.
                                                                -Otto Wahl

Our language reflects our beliefs and the way we view people. We are often unaware of the impact that the words we choose can have on our own attitude as well as on those around us.

The way we speak to and about people is a window into what we are really thinking. Communication is a highly complex thing. With the words we choose we can convey the fact that we truly value people, which we believe in them, and that we genuinely respect them. Or, the words we choose can make it clear that we do not.

People living with mental illness tend to be put down, discouraged, demoralized, and marginalized. We can either reinforce that with the language that we choose or we can fight it.

None of us should be defined by our problems or diagnoses, or by a single aspect of who we are; we are people first and foremost.

Consider this…

DON'T portray successful persons with mental illness as super humans. This carries the assumption that it is rare for people with mental illness to do great things. It is also patronizing to those who make various achievements.

DON'T sensationalize a mental illness. This means not using terms such as "afflicted with," "suffers from," "victim of," and so on.

DO put people first, not their labels. Say, for example, "person with schizophrenia" rather than "schizophrenic."

DO emphasize abilities, not limitations. Terms that are condescending must be avoided.

DO focus on <u>what is strong </u>instead of what is wrong

What should we call people?

What's the best label to use?

How about not using labels at all!

The most respectful way to refer to people is as people.

Whenever possible, use the person's name.

There are times when other language has to be used, particularly when putting things into writing. Some options you can use that still convey respect include:

To refer to a group of people:

Think about what you're trying to say about the group, who it is you are defining?

Are you referring to people with mental illnesses?

- Individuals living with mental health issues
- People with mental illness
- Folks in mental health recovery
- Individuals with a mental health diagnosis

Are you referring to people who are utilizing mental health services?

- People receiving mental health services
- People being served by the mental health system

Are you referring to people who are utilizing your program?

- The people in or program
- The individuals we serve
- The folks we work with

To refer to an individual:

Again, what is it you are trying to convey?

That someone has a mental illness?

- Ian is working on his mental health recovery
- Cathy has a mental illness
- Lucy is living with mental illness

That someone receives services at your agency?

- Joshua receives services at our agency
- Natalie is one of the people we serve

That someone has a specific diagnosis?

- Alice lives with bipolar disorder
- Nick has depression

Samples of Recovery Language

The following are some of the terms that we have traditionally used to describe people and/or their behaviors. These terms place judgment and blame on the individual and generalize their actions. It is much more helpful to describe the specific situation that a person is facing than to use generic and punitive clinical terms

Worn Out Language	Language that Promotes Acceptance, Respect & Uniqueness	Comments
Max is mentally ill Max is schizophrenic Max is a bipolar Max is…	Max has a mental illness Max has schizophrenia Max has been diagnosed with bipolar disorder Max is a person with…	Avoid equating the person's identity with a diagnosis. Max is a person first and foremost, and he also happens to have bipolar disorder Very often there is no need to mention a diagnosis at all It is sometimes helpful to use the term "a person diagnosed with," because it shifts the responsibility for the diagnosis to the person making it, leaving the individual the freedom to accept it or not
Alex is an addict Alex is in recovery from drug addiction	Alex is addicted to alcohol	Put the person first Avoid defining the person by their struggles

Worn Out Language	Language that Promotes Acceptance, Respect & Uniqueness	Comments
Rebecca is brain injured/damaged	Rebecca has a brain injury	Put the person first Avoid defining the person by their struggles
Jane is disabled/handicapped	Jane is a person with a disability	Put the person first Avoid defining the person by their struggles
Mark is normal/healthy	Mark is someone without a disability	Referring to people without disabilities as normal or healthy infers that people with disabilities are not normal and not healthy
Sarah is decompensating	Sarah is having a rough time Sarah is experiencing…	Describe what it looks like uniquely to that individual—that information is more useful than a generalization Avoid sensationalizing a setback into something huge
Mathew is manipulative	Mathew is trying really hard to get his needs met Mathew may need to work on more effective ways of getting his needs met	Take the blame out of the statement Recognize that the person is trying to get a need met the best way they know how

Worn Out Language	Language that Promotes Acceptance, Respect & Uniqueness	Comments
Kyle is non-compliant	Kyle is choosing not to… Kyle would rather… Kyle is looking for other options	Describe what it looks like uniquely to that individual—that information is more useful than a generalization Does Kyle even agree with the plan you've developed?
Megan is very compliant	Megan is excited about the plan we've developed Megan is working hard towards the goals she has set	Being compliant means that someone is doing what they were asked or told to do. The goal of recovery-oriented services is to help the person define what they want to do and work towards it together. Someone being compliant does not mean that they are on the road to recovery, only that they are following directions.
Mary is resistant to treatment	Mary chooses not to… Mary prefers not to…	Describe what it looks like uniquely to that individual—that information is more useful than a generalization Remove the blame from the statement

Worn Out Language	Language that Promotes Acceptance, Respect & Uniqueness	Comments
Allie is high functioning	Allie is really good at…	Describe what it looks like uniquely to that individual—that information is more useful than a generalization
Jesse is low functioning	Jesse has a tough time taking care of himself Jesse has a tough time learning new things Jesse is still early in his recovery journey	Describe what it looks like uniquely to that individual—that information is more useful than a generalization Avoid defining the entire person negatively based on the fact that he struggles in some areas
Michael is dangerous	Michael tends to become violent when he is upset Michael sometimes strikes out at people when he is hearing voices	Describe what it looks like uniquely to that individual—that information is more useful than a generalization Remove the judgment from the statement
Harry is mentally ill chemically abusing (MICA)	Harry is a person with co-occurring mental health and substance use/abuse problems.	Put the person first Avoid defining the person by their struggles

Worn Out Language	Language that Promotes Acceptance, Respect & Uniqueness	Comments
Sam is unmotivated	Sam doesn't seem inspired to go back to work Sam is not in an environment that inspires him Sam is working on finding his motivation Sam has not yet found anything that sparks his motivation	Describe what it looks like uniquely to that individual—that information is more useful than a generalization Avoid defining the person by the behavior Remove the blame from the statement
Andy is manic	Andy has a lot of energy right now Andy hasn't slept in three days	Describe what it looks like uniquely to that individual—that information is more useful than a generalization Avoid defining the person by the behavior
Kate is paranoid	Kate is experiencing a lot of fear Kate is worried that her neighbors want to hurt her	Describe what it looks like uniquely to that individual—that information is more useful than a generalization Avoid defining the person by the behavior

Worn Out Language	Language that Promotes Acceptance, Respect & Uniqueness	Comments
Hailey is a cutter	Hailey expresses emotional pain through self-harm Hailey hurts herself when she is upset	Avoid defining the person by the behavior Recognize the reason behind the behavior
Jordan has a chronic/persistent mental illness	Jordan has been working towards recovery for a long time Jordan has experienced depression for many years	Avoid conveying a prognosis It is difficult to accurately predict an individual's prognosis and it only impedes their progress to define them as someone who will not recover (or will not recovery for a very long time) There is no need to address prognosis in describing a group of people or an individual
Tom is very difficult	Tom and I aren't quite on the same page It is challenging for me to work with Tom	Avoid making a judgment, which may be based on your dissatisfaction with the fact that the person has not met your expectations (which may be different from what he wants for himself)

Worn Out Language	Language that Promotes Acceptance, Respect & Uniqueness	Comments
Manipulative Grandiose In denial Passive aggressive Self defeating Oppositional	These are often people's ineffective attempts to reclaim some shred of power while being treated in a system that often tries to control them. The person is trying to get their needs met, or has a perception different from the staff, or has an opinion of self not shared by others. And these efforts are not effectively bringing them to the result they want.	These are labels for strategies and perceptions we all have about ourselves, although possibly more subtle and effective. We all present information to achieve a desired result to some degree (manipulation). Or have an inflated opinion of ourselves, or are unable to see or agree with something presented to us by another.

Table 20. Samples of Recovery Language

APPENDIX III: ADDITIONAL RESOURCES

Name	Description	Website / Link
100K Homes Vulnerability Index	A tool designed to assess mortality risk factors associated with homelessness.	http://100khomes.org/resources/the-vulnerability-index
Assertive Community Treatment (ACT) Association	Information about the ACT model and teams	http://usich.gov/usich_resources/solutions/explore/assertive_community_treatment
Case Management Society of America	A website for the leading membership association providing professional collaboration across the healthcare continuum to advocate for patients' wellbeing and improved health outcomes by fostering case management growth and development, impacting health care policy, and providing evidence-based tools and resources.	http://www.cmsa.org/
Client Care Coordination Supportive Housing Outcomes	A document developed by King County, Washington to demonstrate outcomes from Client Care Coordination, their system that uses a Vulnerability Assessment Tool to prioritize placement of individuals into vacancies in permanent supportive housing projects to assure that individuals in greatest need of the limited housing resources available are those who are prioritized for entry.	https://www.kingcounty.gov/healthservices/MHSA/MIDDPlan/MIDDCommittees/~/media/health/MHSA/MIDD_ActionPlan/2011%20Handouts/Client_Care_Coordination_summary.ashx

Name	Description	Website / Link
Coordinated Assessment Toolkit: Assessment and Referrals	Multiple tools from the National Alliance to End Homelessness (NAEH) that can help communities develop assessment and referral processes that identify households' barriers to re-entering permanent housing, give households a chance to succeed with minimal assistance, and lead to informed and appropriate referral decisions.	http://www.endhomelessness.org/library/entry/Coordinated-Assessment-Toolkit-assessment-and-referrals
Example Landlord Damage Insurance Fund MOU from The Planning Council	An example document from the National Alliance to End Homelessness (NAEH) - a Memorandum of Understanding used by The Planning Council in Norfolk, VA for a landlord damage insurance fund utilized by a number of rapid re-housing providers in the community.	http://www.endhomelessness.org/library/entry/example-landlord-damage-insurance-fund-mou-from-the-planning-council
Frequent Users Systems Engagement (FUSE)	A website describing FUSE, an evidence-based model, developed by the Corporation for Supportive Housing (CSH), which is based on: 1.) Data-Driven Problem-Solving, 2.) Policy and Systems Reform, and 3.) Targeted Housing and Services.	http://www.csh.org/fuse
Health Homes	A document from the Centers for Medicare & Medicaid Services.	http://www.medicaid.gov
Housing and Urban Development (HUD)-Department of Veterans Affairs Supported Housing (VASH) Program	VHA Handbook 1162.05	http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2446
Housing First Checklist: A Practical Tool for Assessing Housing First in Practice	A document from the U.S. Interagency Council on Homelessness.	http://usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf http://usich.gov/usich_resources/fact_sheets/the_housing_first_checklist_a_

Name	Description	Website / Link
		practical_tool_for_assessing_housing_first_in
Housing Location Solutions Brief	A document from the National Alliance to End Homelessness (NAEH).	http://www.endhomelessness.org/library/entry/housing-location
Mental Health Guidance on Workload Capture: Homeless Programs	An internal VA document.	http://vhaindwebsim.v11.med.va.gov/hub/app/library/record/visit?id=79
National Alliance to End Homelessness (NAEH)	The National Alliance to End Homelessness (NAEH) website.	http://www.endhomelessness.org/
National Coalition for Homeless Veterans	The National Coalition for Homeless Veterans (NCHV) website.	http://nchv.org/
Prioritizing Persons Experiencing Chronic Homelessness in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status	Notice CPD-14-012 from the U.S. Department of Housing and Urban Development (HUD).	https://www.onecpd.info/resource/3897/notice-cpd-14-012-prioritizing-persons-experiencing-chronic-homelessness-in-psh-and-recordkeeping-requirements/
Unified Supportive Housing System (USHS)	Useful resources related to USHS from the Community Shelter Board (Columbus, Ohio).	http://www.csb.org/?id=resources.useful.ushs
VASH Landlord Factsheet	A document from the VA's website.	http://www.va.gov/homeless/docs/landlords_factsheet.pdf
VHA Homeless Programs Operational Planning Hub	A VA website with links to multiple data sources and resources for staff in VHA homeless programs to: organize planning activities, share strategies & best practices with other VA Medical Centers, and gain awareness of community partnerships & operational improvements.	http://vhaindwebsim.v11.med.va.gov/hub/index.html
Vulnerability Assessment Tool	A document developed by the Downtown Emergency Service Center.	http://www.desc.org/vulnerability.html

Table 21. Additional Resources