Manual for Engaging Homeless Mentally Ill Chemical Abusers in a Modified TC Shelter Program[‡]

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[‡] This manual describes the program in place from August 1998 through August 2001

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Executive Summary

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This manual is a guide to the development of a modified therapeutic community (TC) for the engagement and retention of homeless mentally ill chemical abusers (MICAs). The Salvation Army operated the modified TC described, *A New Beginning*, from August 1998 to August 2001 in the Kingsboro 80-bed homeless shelter located in Brooklyn, NY. Designed for MICA men who are seeking shelter rather than treatment, *A New Beginning* uses principles and methods of a modified TC combined with special strategies that motivate and engage these men in treatment while preparing them for housing. This manual describes the planning, development, and implementation of the program in a shelter.

Conceptual Framework. Homeless MICA persons have a dual disorder of both mental illness and substance abuse/dependence. The fundamental problems are their maladjusted pattern of thinking, feeling, behaving, and living, their lack of understanding and self-awareness, and their inability to manage symptoms and behavior. Many individual and situational factors underlie the disorder; treatment must relate to these factors, and must foster fundamental change in the whole person. *A New Beginning* incorporates this conceptual framework in the clinical interventions and TC management.

Review of the Literature. Effective treatment models are needed to serve homeless MICA clients entering shelters, a population that continues to grow. Literature on homeless MICA individuals in community residence settings shows that: **1)** they have multiple impairments requiring multifaceted treatment (Sacks *et al.*, 1997a; 1998a; 1998b); **2)** residential modified TC treatment produces significantly more positive outcomes for drug use, illegal activity, and psychological depression than treatment-as-usual (De Leon *et al.*, 1999a; 1999b; 2000); **3)** TC-oriented supported housing stabilizes the gains from the residential program (Sacks, 1997; Sacks & Staines, 1997; Sacks *et al.*, 2002); **4)** modified TC treatment costs no more than less effective treatment-as-usual (TAU) approaches (French *et al.*, 1999; McGeary *et al.*, 2000); and **5)** modified TC treatment produces $13 benefit for every dollar spent (French *et al.*, 2002). These studies demonstrate the effectiveness of the modified TC approach and provide the empirical foundation for the development of the modified TC program in a shelter.

History and setting of the intervention. The Salvation Army has a long history of operating shelters for needy persons (including men, families, and war veterans) in New York City, and for the assessment of new applicants. The Kingsboro facility for men operated as a shelter until 1998 when the modified TC program was initiated. The development of this program represents a unique collaboration of shelter services (Salvation Army), medical/mental health services (Brookdale Medical Center), and modified TC programming (National Development & Research Institutes, Inc.), to engage shelter-seeking MICAs in treatment as a potential permanent solution to the problems presented by their homelessness and disaffiliation.

Description of the client population. The program serves men with co-occurring psychiatric and substance abuse disorders. Their mean age is 32, and over half are African-American (65%). Most have completed high school or a GED (64%), and have never been married (74%); over one-third of the men have dependent children (40%). Few have worked during the last year (9%), yet only one-third (35%) receives income from welfare, SSI, or SSD. The average of length of time these men have been homelessness is between two and three years. In general, they are non-English speaking, and have significant involvement with the criminal justice system.

Description of the structure and the intervention. The core principles and methods of the TC that are especially relevant to the treatment of MICAs include a structured daily regimen (introduced

gradually), personal responsibility and self-help in addressing life difficulties, peers as role models and guides, the peer community as the healing agent, and a strategy of community-as-method (the community provides both the context and mechanism for change). Change is a gradual, developmental process; clients progress through treatment stages. Work and self-reliance are stressed through the development of vocational and independent living skills, and prosocial values are promoted within a healthy social network to sustain recovery. The program goal is recovery from homelessness, mental illness, and substance abuse, and to assist in finding supportive housing for participants.

Description of the process of the intervention. The treatment process has three stages: *admission & engagement* (Stage One), *beginning treatment* (Stage Two), and *preparation for Re-Entry* (Stage Three). The program adapts to the individual, and incorporates client-specific goals with general goals for each treatment stage. Interventions are grouped in four categories; community enhancement, therapeutic-educative, community and clinical management, and vocational.

Significance. The program has the potential to have a positive impact on the New York City shelter system and the mental health and substance abuse treatment fields. *A New Beginning* offers an innovative and unique treatment model for engaging, stabilizing, and motivating homeless MICA clients in treatment. Overall, *A New Beginning* has the potential to inform policy decisions concerning engaging, sustaining, and modifying the behaviors of homeless MICAs in order to return them to mainstream society.

SECTION I

Conceptual Framework

Introduction

This manual is based upon therapeutic community (TC) principles and methods from the drug treatment field as adapted for homeless mentally ill chemical abusers (MICAs). The new model, represented in this manual by *A New Beginning* modified TC program at the Kingsboro shelter for men, treats both mental illness and substance abuse disorders in the context of recovery and community. (For a full description of the TC see De Leon, 2000; for the modified TC see Sacks *et al.*, 1998a.) The conceptual framework for the modified TC stems from the TC perspective and approach as modified for the homeless MICA client.

Perspective

Four interrelated "views" define the modified TC perspective and guide the treatment approach for MICA individuals, [the view of] the disorder, the person, recovery, and right living.

View of the Disorder

The homeless MICA person has a dual disorder of both mental illness and substance abuse/dependence. As such, their problems stem neither from the mental illness and psychiatric symptoms alone, nor from the substance abuse/dependence disorder and the drug using behavior alone. Their maladjusted pattern of thinking, feeling, behaving, and living, their lack of understanding and self-awareness, and their inability to manage symptoms and behavior are constituent components of the problem; MICA individuals often use drugs to cope with their feelings, thoughts, and behavior. Treatment must relate to the many individual and situational factors underlying the disorder, and must foster fundamental personal change.

Kingsboro shelter residents have extensive histories of multiple psychiatric hospitalizations, substance abuse, involvement in the criminal justice system, and co-existing medical problems (*e.g.*, HIV, hypertension, TB, STD, high blood pressure, *etc.*); approximately 90% are identified as *Seriously and Persistently Mentally Ill* (SPMI). These men are treatment failures, and use services and support systems only as a last resort. *A New Beginning* fosters fundamental change, and provides comprehensive and integrated treatment for mental and physical health and substance abuse, coupled with case management and housing placement services to help these men get their lives back on track.

View of the Person

Homeless MICA persons are more similar than dissimilar; all exhibit psychiatric symptoms and substance abuse behaviors, with cognitive, social, and psychological impairments accompanied by deficiencies in educational, vocational, and social living skills. Antisocial personality features are present in all homeless MICA individuals; a subgroup shows antisocial personality disturbance characterized by poor frustration tolerance, poor impulse control, and problems with authority. MICA persons differ in the specifics of their mental illness diagnoses, the severity of their disorders, the level of cognitive impairment, and the degree of problems in adaptive daily living. They must learn to manage their mental illness, their substance abuse disorder, and related social and psychological impair-

ments. Contrary to commonly held beliefs, homeless MICAs have substantial potential for achieving abstinence and personal integration. Treatment must reduce symptoms and impairments, must provide a sound foundation, tools, and skills to prevent re-occurrence, and must foster personal growth and development.

The homeless MICA men who enter the Kingsboro shelter are transient, disaffiliated, and alienated from family and others. They are not seeking treatment, but are unmotivated, affecting a helpless, hopeless state, and their behavior often verges on destructive. Most are non-English speaking, and have significant involvement with the criminal justice system. They have been undomiciled on average between two and three years; many have been in and out of the New York City shelter system. Their mean age is 32, over half are African-American (65%), and a similar number have completed high school or equivalency exams (64%). Three quarters have never married (74%), yet over one third have dependent children (40%). Few worked during the last year (9%), yet only one third (35%) received income from welfare, SSI, or SSD.

View of Recovery

The recovery perspective (Prochaska, DiClemente & Norcross, 1992; De Leon, 1996) has two main features; that recovery is a long-term process of internal change, and that recovery proceeds through various stages characterizing internal change. The recovery perspective generates at least two main principles for practice; a plan for a course of treatment over time, and the design of treatment interventions appropriate to the stage of recovery. The former relates to the development of continuity of care treatment systems, and the latter to the use of a variety of strategies including outreach, motivational enhancement, and treatment stages. Recovery implies adoption of a prosocial lifestyle, transformation of values and identity, and a commitment to foster change in oneself and others. In the recovery formulation, the individual progresses through the stages of recovery with characteristic indicators of change. At each stage, the client's motivation for change (awareness of the need for change) and readiness for treatment (willingness to undertake the actions necessary for change) are critical determinants of outcome. This deepening self-awareness is the cornerstone of the recovery process.

Recovery is not necessarily a goal for the men who come to Kingsboro; their primary objective is to find shelter. About 90% of those entering the program are not motivated, nor are they receptive to treatment. During the early stages of treatment (and beyond), some continue to use alcohol and other drugs, and do not adhere to psychiatric medication regimens. As noted, most have failed in other treatment programs, either before or during their homelessness. Many have attempted dual recovery before, only to have substance and psychiatric related relapses. Thus, the recovery process at *A New Beginning* is arduous, demanding more patience and tolerance from staff than in other settings.

Participants use the rigorous assessment, engagement, and stabilization features of the program to initiate change. Staff members from the psychiatrist to the housekeeper adopt hands-on methods to engage, stabilize, and motivate program participants. Some participants do not develop a commitment to treatment until they near placement in housing; others leave before being placed and their outcomes are unknown.

View of Right Living

Participants enter *A New Beginning* with a decreased sense of personal responsibility and proper conduct. Most have a street or prison mentality, and exhibit behaviors that can be modified only through a system of guidance, mentoring, education, and role modeling. TCs (and modified TCs) adhere to certain precepts of healthy personal and social living. Personal responsibility (accountabil-

ity for one's behavior), proper conduct (adherence to program rules and the codes of good citizenship), and values (truth and honesty, the work ethic, self-reliance, earned rewards and achievement, social manners—respect for others reflecting self-respect—and community involvement) are emphasized. Members of TCs are encouraged to identify with their "brothers" and "sisters," to display compassion, empathy, and responsible concern. Homeless MICA individuals (and members of other TCs) organize themselves around these moral standards and ethical values. Internalizing the view of "right living" gives meaning to their lives, which provides motivation in recovery and guides their reentry to mainstream society.

Consistency in the application of program rules and guidelines, being genuine and fair, and showing respect for the person, are all key factors in helping to ensure that program participants invest in the principles of right living. Those entering the program begin the transition from a negative peer culture, gradually adopting values of good citizenship, honesty, responsible concern, empathy, and compassion, all of which are virtues of the positive peer culture at *A New Beginning*.

Approach

Treatment Structure

The structure of the *A New Beginning* is similar in most respects to that of a traditional TC. The daily regimen, role of the staff, peer work hierarchy, and peer self-help opportunities are predictable and active within a 24-hour treatment environment. The treatment structure encompasses a variety of groups, including community meetings (morning meeting, concept seminars, and house meeting), psychoeducational classes, therapy groups (most notably the Conflict Resolution Group), and a peer work hierarchy that assists in the operation of the program. Beyond supplying active treatment, the structure provides a predictable environment with well-defined boundaries that creates a pattern and rhythm to the day. Program participants learn consistency, reliability, responsibility, and accountability. In following the daily program structure, program participants acquire the skills necessary for independent living, internalizing the attitudes necessary to sustain and to generalize those skills in independent functioning.

As in traditional TCs, the Kingsboro modified TC staff members serve as role models and guides; they share past experiences, provide examples of appropriate behavior and behavior change, and guide program participants through a set of events to facilitate change. The standard TC peer work structure is in place, with a variety of work departments (maintenance, food service, *etc.*). Each department has a hierarchy, including a peer department head, assistant department head, and crew. Besides the work structure, participants help one another in a variety of ways, sharing information, discussing personal matters, monitoring one another's behavior, and showing "responsible concern" for all community members. "Big brothers" are designated to shepherd new members into the program, helping them to understand and navigate the program by providing counsel, guidance, and additional coaching.

Modified *versus* Traditional TC — Differences in Structure

The structure of *A New Beginning* differs from that of a traditional TC in several ways. Meetings and activities are of shorter duration. Staff members guide the implementation of activities; many activities remain staff-assisted for some time. Information is broken into small units, presented gradually, and discussed in detail. Greater emphasis is placed on helping clients to understand their psychiatric problems and to anticipate and avoid triggers for psychiatric relapse. Staff members have expanded responsibility for acting as role models and guides, providing instruction, practice, and assistance. More staff time and energy is spent on individual counseling to enable clients to absorb and accept the TC experience. The peer work hierarchy is flatter (fewer levels) and task assignments are more individualized. Frequent breaks and more immediate individual counseling punctuate work tasks, and extra instruction assures that clients are successful in their work assignments. Hands-on staff involvement in peer work hierarchy activities encourages full participation of clients. Like all TCs, client ownership of the community is evident—clients manage the facility, take pride in its appearance and ambiance, welcome guests and visitors to the "family," govern facility policies and procedures, and assist staff in continuing program development.

Treatment Process (Stages and Phases)

As adapted for MICAs (Sacks *et al.*, 1998a; 1997b; 1999) and further refined in the Kingsboro program, treatment is a process defined by stages and phases (*cf.* De Leon, 1984; 1996; De Leon & Rosenthal, 1989), a format widely accepted in the drug treatment and mental health fields. The three stages of the program are *Admission & Engagement* (**Stage One**), *Beginning Treatment* (**Stage Two**), and *Preparation for Re-Entry* (**Stage Three**).

The stage and phase format mirrors the program participant's movement through the program, describing program and participant goals, objectives, methods, and expected outcomes, and providing broad criteria for progression from one stage to the next. The modified TC stage and phase format for homeless MICAs, as implemented at *A New Beginning*, differs from other formulations in that:

a) more time and effort are spent on engaging and stabilizing the individuals in the community;
b) the rate of advancement is tailored to the individual to allow for developmental level, diagnostic differences, and variability in rates of learning; and
c) the phase criteria contain sufficient flexibility to permit even lower-functioning program participants to move through the program stages and phases.

The program adapts to the program participant without compromising its integrity by maintaining core minimum standards for stage movement, with other standards adjusted to the participant's level of functioning.

Key Modifications

Central TC features are retained; the modified TC at the Kingsboro shelter, like all TC programs, seeks to develop a culture where program participants learn through a self-help process to foster change in themselves and others. Most of the essential elements, structure, and processes of the modified TC model are found in *A New Beginning*; the traditional TC approach is adapted to each

participant's impairments and deficits, to be responsive to their psychiatric symptoms, health care needs, cognitive impairments, reduced level of functioning, short attention span, and poor control of urges. In general, three fundamental alterations are applied: **1)** increased flexibility—clients progress through program stages at their own rate; **2)** decreased intensity—confrontation is reduced, and the conflict resolution group replaces the encounter group; and **3)** greater individualization—the amount and type of individual participation in the program considers client functioning.

As compared to modified TCs in other settings, *A New Beginning* uses fewer sanctions, more affirmation for achievements, greater sensitivity to individual differences, and greater responsiveness to the special developmental needs of the program participant. Confrontation is reduced, while orientation, education, practical instruction, and training are all increased. Staff uses hands-on methods to motivate participation in scheduled program activities, particularly the peer work hierarchy. Implementation within the New York City shelter system required additional modifications; for example, program participants can come and go as they please, provided they sign out and return to the facility before the 10 PM curfew. Groups and program activities are not mandatory (exemplifying the program's flexibility), but participation is linked to eventual housing placement, which provides incentive to attend. Medication adherence, health care follow-up, and securing entitlements receive special emphasis as these lead to stabilization and readiness for housing. At earlier stages, participants are included in the program's token economy to increase motivation and to reinforce positive behavior. In short, *A New Beginning* is even more flexible, less intense, and more individualized than earlier modified TCs designed for other settings. Greater emphasis is on engagement, stabilization, and affiliation with the TC community to counter the client's multiple deficits, and the fact that program participants come from a population that is seeking shelter, and not necessarily treatment.

Comprehensive and integrated

Services at *A New Beginning* are comprehensive, integrated, and coordinated, and include case management, medical, psychiatric, vocational/educational, and substance abuse services in the context of recovery and community. Major aspects of service delivery are engagement, motivation/readiness for treatment; important outcomes are stabilization, referrals, and placement, along with medical and psychiatric follow-up, medication adherence, and overall progress in the program. Service provision at *A New Beginning* requires, on average, 6 to 9 months, with the first three months focused on engagement and stabilization, and the remaining 3 to 6 months focused on community affiliation and housing readiness.

Community–as–method

The Kingsboro TC community comprises all program participants, staff, the shelter environment, and their interactions. Community-as-method provides both the context and vehicle for change; the community is the healing agent. The program elements and components are community-building activities to reinforce community affiliation that facilitates change. In individual and group counseling sessions and seminars, staff uses TC concepts and the language of community to encourage, motivate, and guide participants to heighten awareness and change behavior. Affiliation with the Kingsboro TC community endures from admission to placement in housing or another residential program, and provides the foundation for personal growth and positive lifestyle changes. The TC community is the source of empowerment and motivation to maximize self-actualization.

SECTION II

Literature Review

The Problem of Homelessness & Substance Abuse— Homelessness continues to be one of our most intractable and complex social problems. The National Law Center on Homelessness and Poverty (1999) estimates that approximately 700,000 persons are homeless on any given night—up to 2 million annually. In New York City, homelessness affects an estimated 100,000 annually (Coalition for the Homeless, 1998). Despite these alarming statistics, our understanding of the diversity of this population and their service needs is incomplete, and treatment options are still limited. Homeless people suffer from various medical problems (Institute on Medicine, 1990), HIV (Schutt & Garett, 1992), criminality (both as victims and participants; Rahav & Link, 1995), alcohol and drug use (Fischer & Breakey, 1987), and mental illness (Rossi, 1990).

The primary health issue associated with homelessness is substance abuse (McCarty *et al.*, 1991). Approximately 40% of homeless adults are abusing drugs or addicted to alcohol (National Law Center on Homelessness and Poverty, 1999). Approximately 70% of participants in recent NIAAA demonstration projects identified alcohol/drug problems as the primary reason for their homelessness in both the first and most recent episodes (Stevens *et al.*, 1993; Leaf *et al.*, 1993). Among those in shelters, almost 90% are estimated to have alcohol problems and over 60% to have problems with other drugs (Fisher & Breakey, 1991; Interagency Council on the Homeless, 1992; NYC Commission on the Homeless, 1992). The ability to maintain housing is profoundly affected by substance abuse (Hurlburt *et al.*, 1996). Effective programs must address the interrelated issues of substance abuse, homelessness, and collateral problems.

The Problem of Homelessness, Substance Abuse & Mental Illness— The co-occurrence of psychiatric and chemical abuse problems has been reported from 20 to 50% among mental health clients (Davis, 1984; Drake & Wallach, 1989; Hasin *et al.*, 1985; Regier *et al.*, 1990; Richard *et al.*, 1985; Safer, 1987; Wolf *et al.*, 1988; Zimberg, 1993), and from 50 to as much as 90% among drug treatment clients (Ross *et al.*, 1988; McLellan *et al.*, 1983; Rounsaville *et al.*, 1985; De Leon, 1988a; Jainchill, 1994). Homeless MICAs are a problematic subgroup, and place unique demands on the homeless, mental health, and drug treatment systems. The prevalence rate for co-occurring mental illness and substance abuse disorder among the homeless has been estimated at 25 to 30% (US Department of Health and Human Services, 1998); the number of homeless MICAs has been estimated to range from 85,000 to 168,000 in any given week (Rahav *et al.*, 1995).

Regardless of problems in classification and estimation, substance abuse and mental health disorders are highly prevalent in the homeless population and require effective ameliorative approaches. The treatment community has responded with several models for treating co-occurring mental and substance abuse disorders, with and without elements that address homelessness (*cf.* Sacks, 2000a). *A New Beginning* refines one of these models—the modified TC—to address the special needs of homeless MICAs in shelter settings.

TCs & the homeless/homeless MICAs— TCs have always served drug abusers with histories of homelessness, estimated by program administrators at 30%, and the successful outcomes associated with TC treatment included these homeless individuals (De Leon & Galanter, 1995). Over the past ten years, TC programs for homeless addicts, many of whom have co-occurring psychiatric problems, have been developed and evaluated, with positive outcomes found for drug use, illegal activity, and psychological functioning (Leaf *et al.*, 1993; Stevens *et al.*, 1993; Liberty *et al.*, 1998).

The Problem of Motivation & Readiness for Treatment— Homeless MICA persons entering shelters (like Kingsboro) are hard-to-reach, and difficult to engage in treatment and service system. Often actively using drugs and mentally unstable, they are alienated and disaffiliated from society.

Recognizing that they are in the denial (De Leon, 1996) or pre-contemplation (Prochaska *et al.*, 1992) stage of recovery, various strategies have emerged, such as Motivational Enhancement (Miller & Rollnic, 1997) and Assertive Community Treatment (Deci *et al.*, 1995; Kontos & Essock, 1995; Bond *et al.*, 1991; Drake, 1998; Drake *et al.*, 1998). The former is designed to increase client receptivity to treatment; the latter employs outreach strategies that bring services to the client in the community. In developing *A New Beginning*, several strategies for increasing client motivation have been integrated to improve client engagement in, and receptivity to, treatment and services.

Evaluation of the modified TC— A systematic series of studies on homeless MICA clients in community residence settings found that: **1)** these individuals have multiple impairments requiring multifaceted treatment (Sacks *et al.*, 1997a; 1998a; 1998b); **2)** residential modified TC treatment produces significantly more positive outcomes for drug use, illegal activity and psychological depression than treatment-as-usual (De Leon *et al.*, 1999a; 1999b); **3)** TC-oriented supported housing stabilizes the gains from the residential program (Sacks, 1997; Sacks & Staines, 1997; Sacks *et al.*, 2002); **4)** modified TC treatment costs no more than less effective treatment-as-usual (TAU) approaches (French *et al.*, 1999; McGeary *et al.*, 2000); and **5)** modified TC treatment produces $13 benefit for every dollar spent (French *et al.*, 2002). These studies demonstrate the effectiveness of the modified TC approach and provide the empirical foundation for the Kingsboro program.

Adaptability of the modified TC— The modified TC model has been successfully adopted in mental health agencies (Sacks *et al.*, 1997a; 1997b; 1999b), general hospitals (Galanter *et al.*, 1993) and drug treatment programs, both nationally (Argus Community, 1998) and internationally (Challis, 1996). The model is currently being employed in a prison (Sacks, 1998b) and a TC facility for those with HIV/AIDS and co-occurring psychiatric and substance abuse disorders (Sacks, 1998a), and has been initiated in the shelter system (*A New Beginning*; Sacks, 2000b). The author and an investigative team have developed a technology transfer model that ensures the quality control of these new applications (Sacks *et al.*, 1999). The model consists of a treatment manual (Sacks *et al.*, 1998a); training curriculum (Sacks, 1998c; 1999a; 1999b), implementation guide (Sacks *et al.*, 1999), and technical assistance protocol (Sacks, 1999a). These materials guided the development of *A New Beginning* and provided the tools for refining the program.

SECTION III

Program Description

Rationale— Previous observations and studies of homeless MICA clients provide the rationale for *A New Beginning*, the modified TC program at the Kingsboro men's shelter, and its special elements for engagement (Sacks, 2000a; 2000b; Sacks *et al.*, 1997b; 1998a; 1998b; De Leon *et al.*, 2000). MICA clients typically have lower tolerance for the structure and demands of treatment, deficits in social functioning, accompanied by discouragement, mistrust, disaffiliation, psychological impairments, and active substance abuse. The core principles and methods of the TC that are especially relevant to MICA treatment include a structured daily regimen (introduced gradually), personal responsibility and self-help in addressing life difficulties, peers as role models and guides, the community as the healing agent, and a strategy of community-as-method (the community provides both the context and mechanism for change). Change is viewed as a gradual, developmental process; clients progress through treatment stages. Work and self-reliance are stressed through acquisition of vocational and independent living skills, and prosocial values are promoted within a healthy social network to sustain recovery. Finally, the need to strengthen engagement and improve retention derives from previous work in the field, which has identified engagement and retention as fundamental issues (Condelli & De Leon, 1993), particularly when working with a MICA population (De Leon *et al.*, 1999a). *A New Beginning* extends previous work that developed special engagement techniques for TC admissions (De Leon, 1988b), methadone patients (De Leon *et al.*, 1993), and other homeless MICA populations (Sacks *et al.*, 1998a; 1998b; De Leon *et al.*, 1999a).

History & Setting— The Salvation Army has a long history of operating shelters for needy persons (*e.g.*, men, families, and veterans) in New York City, including the men's shelter at the Kingsboro facility in Brooklyn. In 1998, the Salvation Army enlisted National Development & Research Institutes, Inc. (NDRI) to respond to a New York City *Request for Proposal* to establish a shelter program for the city's homeless MICAs, based on NDRI's track record with homeless MICA treatment (De Leon, 1993; De Leon *et al.*, 1994; 1999a; 1999b; 2000; Sacks *et al.*, 1997a; 1997b; 1998a; 1998b; 1999). A contract was awarded, and *A New Beginning* was launched on August 1, 1998. The program represents a unique collaboration of shelter services (Salvation Army), medical/mental health services (Brookdale Medical Center), and modified TC programming (NDRI), to engage shelter-seeking MICAs in treatment as a potential permanent solution to the problems presented by their homeless, disaffiliated status.

Project Staff—The Kingsboro modified TC was created through an integrated, collaborative effort of people representing a variety of professional affiliations, interests, and skills, and reflecting diversity in age, gender, racial/ethnic and other characteristics. To ensure minority representation, staff recruitment and hiring followed a strict protocol that included guidelines for advertising and interviewing. Staff training was especially responsive to cultural, language, and gender variation, using special didactic material on responsiveness and communication skills to interview MICA clients, with supervision to strengthen rapport and resolve emergent issues.

Program Philosophy & Activities—*A New Beginning* uses participation in the community of recovering individuals to promote relevance, sensitivity, and integration. The cultural sensitivity and competence of the program is exemplified by several characteristics. Minority members, some of whom are graduates of *A New Beginning* or another similar program, staff the Kingsboro modified TC. The program emphasizes pride in oneself and in one's heritage and respects all ages, looking to the older clients to provide counsel. Individual differences, including those of sexual orientation and impairments in functioning, add to the diversity and richness of the program. All cultural, language and other traditions are honored and incorporated with various meals, celebrations, and events, as

well as in everyday program activities. Staff members and clients are part of one community, working together on the problems of the homeless MICA.

Client Profiles—The client profiles illustrate the inclusiveness, relevance, and representative features of the program participants of Kingsboro. The mean age is 32, and the majority is African-American (65%). Most have completed high school or a GED (64%), and have never been married (74%); over one third or the men have dependent children (40%). Few have worked during the last year (9%), yet only one third (35%) receives income from welfare, SSI, or SSD. The average of length of time these men have been homelessness is two to three years, with multiple episodes and frequent moves. Virtually all have psychiatric disorders (97%), most frequently schizophrenia and bipolar mood disorder, and the vast majority are on psychotropic medication (90%). Virtually all have substance abuse/dependence disorder (97%); most abuse more than one substance, with cocaine most often cited as the primary drug of abuse (55%), followed by alcohol (24%), and marijuana (20%). Nearly three quarters (72%) have a history of arrest and incarceration, exposure to trauma/abuse, and HIV/AIDS risk behavior. Over half (55%) suffer from a variety of chronic medical problems, including TB, diabetes, hepatitis C, sexually transmitted diseases, liver problems, and HIV related infections; invariably regular medical attention has not been received.

SECTION IV

The Interventions

As noted previously, treatment is a process defined by stages and phases (*cf*. De Leon, 1984; De Leon & Rosenthal, 1989; De Leon, 1996) as adapted for MICAs (Sacks *et al.*, 1997b; 1998a; 1998b; 1999) and further refined in the Kingsboro program. The three stages in *A New Beginning* (Table 1) are *Admission & Engagement* (**Stage One**), *Beginning Treatment* (**Stage Two**), and *Preparation for Re-Entry* (**Stage Three**). The stage and phase format is widely accepted in both the drug treatment and mental health fields. The modified TC program adapts to the individual, without compromising integrity, by maintaining core minimum standards for stage movement and allowing other criteria to be adjusted to the individual's level of functioning.

The Approach to Engagement—A successful engagement program helps the clients to view the treatment facility as an important resource. To do so, the program must meet basic needs; ensure psychiatric stabilization; build trust and affiliation; increase motivation; provide education on homelessness, mental illness, and substance abuse; reinforce positive accomplishments; encourage, build hope, and help clients to think productively about the future.

The engagement interventions of *A New Beginning*, shown in Table 2, begin on entry to the shelter, and continue (with decreasing intensity) for an average of three months of shelter residency. Over the next three months of shelter residency, the focus shifts to treatment issues and preparation for living in the community. Although particular activities are dominant in certain phases, some overlap occurs and attention continues to be paid to fundamental aspects. For example, "building trust and affiliation," a dominant activity of *Active Outreach & Continuous Orientation* (Item 3) is present in virtually every intervention and activity.

The interventions described in Table 2 reflect a planned amalgam of TC-oriented methods (Items 1, 3, 5-7) used in other studies (De Leon *et al.*, 1993; 1994; 1995; 1997a), and strategies employed and found clinically useful in programs administered by Brookdale Medical Center (Item 2, *Assertive Community Psychiatry*) and the Salvation Army (Item 4, *Token Economy*). Incorporation of these complementary components further adapts the TC to the particular needs of the MICA population in shelters, and holds promise for expanding treatment protocols in both TC and non-TC programs. The table describes the interventions for engagement and how each is made consistent with TC programming to optimize services for this difficult population.

Table 2—Engagement Strategies

Item	Element	Description
Item 1	Client Assistance Counseling	***Need/Rationale—***The essential first step in the engagement process is to meet the basic needs of the client by providing essential services such as shelter, food, medical care, social/family & legal counsel, and referrals. The Salvation Army provides the structure, management, services, and activities to meet these basic needs.
		Program Element—The program incorporates Client Assistance Counseling to meet basic needs. As distinct from case management, commonly employed in the human services field, Client Assistance emphasizes client responsibility, coaching and guiding the client, and using the client's senior peers to provide assistance.
		TC Congruency—The features of Client Assistance Counseling that are consistent with TC methods include the reliance on peers in conjunction with demands for client's self-assessment, and the availability of staff guidance.
Item 2	Assertive Community Psychiatry	***Need/Rationale—***The clients in this project are substance abusers with a history of mental illness. Almost all are psychiatrically unstable at the time of admission. Most should be taking psychiatric medication but are not. Stabilization of psychiatric symptoms is a precondition for engagement and is best undertaken actively.
		Program Element—The program employs the Assertive Community Psychiatry approach of Brookdale Medical Center, which begins with psychiatric assessment and prescription of needed medication, and then monitors medication compliance. This approach combines the best principles of psychiatric practice and applies them to this difficult setting and population. Assertive Community Psychiatry includes direct provision of psychiatric services in the shelter, assignment of a psychiatrist dedicated to the setting, and emphasizes rapport and trust between the psychiatrist and the client. Also included are regular contact and review of medication, coupled with careful monitoring of medication compliance, recorded daily, by a full-time nurse and an interdisciplinary team.
		TC Congruency— Assertive Community Psychiatry is gradually integrated with more traditional TC methods of self-management to meet the special needs of this psychiatrically impaired population and to facilitate client responsiveness to TC treatment services.
Item 3	Active Outreach & Continuous Orientation	***Need/Rationale—***Although residents are living in the shelter, engaging them as clients in the program requires special outreach and orientation strategies within the facility.
		Program Element—The essential features are Active Outreach, in which staff makes multiple contacts with the resident to build the staff-client relationship and enhance comprehension and acceptance of the program, and Continuous Orientation, with a formal weekly orientation group (the main activity) to strengthen affiliation with peers and to provide concrete information on the program structure and activities. Also incorporated are informal drop-in conversations to examine individual attitudes, and to individualize explanations of the program in an effort to increase motivation for change.
		TC Congruency—The TC's customary use of peers to support program understanding and engagement is extended and modified to adapt to the shelter population.
Item 4	Token Economy	***Need/Rationale—***The rationale for using a token economy is that, while clients are in the early stage of recovery, external reinforcement can help to establish successful behavioral patterns before the development of a more internal commitment to change.
		Program Element—The program uses a Token Economy, successfully employed in other Salvation Army programs, which provides immediate and systematic reinforcement for an array of behaviors during the engagement phase. Points are awarded for the successful accomplishment of a standard list of behaviors, including medication compliance, abstinence, attendance at program activities, follow through on referrals, completing assignments, and various other activities essential to the development of commitment. Points are tallied weekly and tangible rewards (phone cards, treats, toiletries, *etc.*) are distributed commensurate with the earned point totals.
		TC Congruency—Token Economy features are employed to strengthen client's participation in Stage 1 of the program. Integration of the Token Economy with the modified TC community involves the participation and input of the senior peers in the development of the Token Economy protocol for the list of selected behaviors, assigned points and rewards.
Item 5	Pioneers—Creating a Positive Peer Culture	***Need/Rationale—***Strong affiliation with the peer group is essential to engaging clients in the program and, therefore, in the overall success of the program. Continued affiliation with the peer group on re-entering the community is a key to sustaining gains made in the shelter portion of the program.
		Program Element—A potent intervention is the use of the residents to create the culture of change in the shelter. In this approach, selected residents form part of the initial group to launch the treatment program. The key to this strategy is assembling a "seedling group" whose members are designated "pioneers" in a new endeavor. They are trained to function as facilitators in the transmission of the peer self-help culture to other clients. Thus, a group of successful homeless MICA clients will be available as role models to encourage the involvement of newly admitted clients in making use of the program.
		TC Congruency—This approach has been amply demonstrated in community-based TCs developed for methadone (De Leon *et al.*, 1994; 1995; 1997) and MICA clients (Sacks *et al.*, 1998a), and conforms to the fundamental TC tenet of community-as-method.

Item 6	**Client Action Plan**	***Need/Rationale—***Goals and services need to be established to accompany and define progress through program stages and phases, but the diverse and multiple impairments of this population require traditional TC practices to be modified. The Client Action Plan (CAP), an individualized plan of goals and services, is a key modification; this tool reflects the emphasis upon individual differences in level of functioning, readiness for change, and rates of change seen as necessary to work effectively with psychiatrically impaired clients. The CAP for Stage 1 identifies basic needs (housing, entitlements, childcare, ***etc.***). Similar sets of objectives, methods, and expected accomplishments for each client are established for the next and subsequent stages and phases.
		Program Element— The purpose of the Client Action Plan (CAP), determined by clients and staff, is to specify, monitor, and document client short-term goals. An underlying assumption is that the client is capable of substantial accomplishments; however, the path to these accomplishments involves attaining smaller objectives, building incrementally (week by week) on accumulated successes, and accommodating the inevitable uneven progress, relapses, and psychiatric instability. This approach is especially important to the homeless MICA client because it sustains the hope for a successful future despite a long history of past failures and a present profile of considerable dysfunction. Moreover, the attainment of each objective reinforces the sense that the client is on the road to recovery.
		TC Congruency— Successful completion of periodic CAPs makes a positive contribution to client progress through program stages and phases
Item 7	**Preparation for Housing**	***Need/Rationale—***An obvious goal of the program is to see the participants establish permanent housing within the community.
		Program Element— The preparation for obtaining and maintaining permanent housing begins at program entry. Imparting an understanding of the critical relationship between abstinence and housing is most important. Preparation for Housing involves obtaining entitlements, filing a Section 8 application for housing, exploring available treatment and housing options, developing work readiness skills, and learning household management skills. These activities are mediated though a weekly group, the Housing Preparation Group.
		TC Congruency— The structure and activities of this group mirror those of traditional TCs, again with modifications for the multiple impairments and deficits of the population.
◎	**Managing the Non-Participant**	***Need/Rationale—***Some undetermined number of admissions in Stage 1 may participate little, if at all, and may not establish relationships with others.
		Program Element— Although non-participation decreases the likelihood of a successful outcome, it is not in and of itself the basis for discharge. All participation is voluntary; non-participation in any treatment or educational activity has no punitive or negative consequences. Those not fully participating in the program will still receive all of the medical and social services needed during their stay in the shelter, will participate in the study, and will be placed in appropriate housing. As part of this project, the number and characteristics of non-participants will be tracked.
		TC Congruency—The protocol follows TC practice & philosophy, modified for special populations.

TC Program Elements

Table 3 displays the engagement and other elements of the modified TC. All program activities and interactions, singly and in combination, are designed to produce change. Interventions are grouped into four categories; community enhancements (to promote affiliation with the TC community), therapeutic/educative initiatives (to promote expression and instruction), community / clinical management strategies (to maintain personal and physical safety), and vocational efforts (to operate the facility and prepare clients for employment). Although each intervention has specific individual functions, all share community, therapeutic, and educational purposes. The program interventions emphasizing engagement and retention are the five items on black backgrounds in Table 3, plus Items 2 and 4 from Table 2.

Table 3—Modified TC Residential Interventions (Stages One through Three)

Community Enhancements	
Morning Meeting	increases motivation for the day's activities and creates a positive family atmosphere
House Meeting	reviews house business for the day, outlines plans for the next day, & monitors the emotional tone of the house
Program Seminars	address issues of particular relevance (*e.g.*, concept, alcohol & other drug education, medication management)
Orientation Seminar	orient new members and introduce all new activities
General Meeting	provide public review of critical events
Pioneers	promote peer self-help culture through role-modeling and facilitation of groups and activities
Therapeutic / Educative Initiatives	
Client Assistance Counseling	staff guidance and coaching to meet immediate and basic needs; emphasis on self-reliance and peer support
Client Action Plan	establishes individualized, flexible goal plan with attainable objectives
Individual Counseling	incorporates both traditional mental health and unique modified TC goals and methods
Psychoeducational Classes	dominate, in a format to facilitate learning among MICAs, and include topics such as relapse prevention, entitlements/money management, housing and aftercare, triple trouble group, and feelings management
Conflict Resolution Group	modified encounter groups designed specifically for MICA clients
Caseload Group	assists clients to engage and affiliate with the TC program
Health & Medication Management	provides education on psychotropic and other medications.
Men's Group	focus on matters related specifically to men's issues (*i.e.*, sexuality, relationship skills, mental health, and recovery)
Community & Clinical Management Strategies	
Policies	a system of rules & regulations to maintain the physical & psychological safety of the environment, ensuring that resident life is orderly & productive, strengthening the community as a context for social learning
Urinalysis/Breathalyzer	a policy that is designed to assist clients in maintaining a drug-free lifestyle and maintaining and safe, secure, and drug-free environment
Social Learning Experience	a set of required behaviors prescribed as a response to unacceptable behavior, designed to enhance individual and community learning by transforming negative events into learning opportunities
Token Economy	provides immediate and systematic reinforcement for successful accomplishment of assignments and activities
Vocational Efforts / Other	
Peer Work Hierarchy	a rotating assignment of residents to jobs necessary to the day-to-day functioning of the facility, serving to diversify and develop clients' work skills and experience
Peer Advocate Training	a program for suitable clients offering group facilitator training
Department Head Group	provides training and peer support re management skills and supervising others
Housing Preparation Group	focuses on locating and acquiring housing through financial, emotional, and skill development activities

Community Enhancement

Perspective and Approach

The community enhancement activities of *A New Beginning* facilitate the participant's assimilation into the community and reaffirm his commitment to recovery. Most community enhancement meetings occur regularly, and afford each person the opportunity to process their daily experience within the modified TC. Everyone attends, and all other house activities cease for the duration of community enhancement meetings.

Morning Meeting

Purpose

The *Morning Meeting* is the mainstay of the TC, and begins the day with a group reading of the program philosophy that reaffirms each participant's affiliation to the community and commitment to recovery. A variety of activities follow to increase motivation and positive energy. The meeting ends with the program theme song to energize participants as the day's activities begin.

Content

1. reading the program philosophy
2. reading the positive affirmation (word and concept) and current events (news and sports) of the day, horoscope, jokes, songs
3. reminders of daily activities and schedules
4. group song

Goals

1. to reaffirm commitment to recovery
2. to uplift the mood of the individual and the community
3. to increase motivation for the day's activities

Methods

1. active participation
2. individual presentation
3. various community related announcements
4. end with good feelings

Frequency & participation

1. meets at the start of the program day for 30 minutes
2. all members of the community participate

Leadership

Led by upper level peer with staff guidance

House Meeting

Purpose

The *House Meeting* reinforces the idea of community as family—everyone gathers at the end of each day for thirty minutes to discuss family business. Providing a specific time and forum to communicate information pertinent to all community members also allows staff and other community members to observe and assess the appearance and attitudes of all residents. Held at the conclusion of the day's activities, the meetings discuss house business and increase community awareness, with participants again reaffirming their commitment to recovery and community.

Content

The house meeting agenda includes announcements of:

- any changes in the next day's schedule
- late and overnight passes
- planned participant business appointments (with appropriate escorts for newer members of the community)
- in-house psychiatric/medical appointments
- level promotions and job changes

Other agenda items increase community awareness and the sense of the program community as family, such as:

- a resident raises the awareness of the group by standing and speaking about any items of general concern that affect the entire community. For example, a resident can report that "too many lights are being left on in the facility and that we should attempt to be more responsible." The individual's observations foster a sense of community, heightened awareness of the environment, and a ownership, both in himself and in others. House awareness encourages residents to improve their accountability as well as the accountability of other residents.
- a resident who has received a "learning experience" as a consequence of self-defeating behavior is encouraged to stand and describe his experience to the entire community. This public declaration of behavior and the community sanction/learning experience promotes personal growth, helping both the speaker and the audience to develop positive attitudes and behavior.

Goals

1. to communicate house/community business
2. to promote and foster growth
3. to build a sense of community and heightened awareness
4. to end the day on a positive note

Methods

1. active participation
2. individual presentation
3. various community related announcements

Frequency & participation

1. meets at the end of the program day for 30 minutes
2. all members of the community participate

Leadership

Led by an upper level peer with staff guidance

Program Seminars

Purpose

Program Seminars provide both general and program-related information, involving the entire community. Relevant to each member in much the same way, *Program Seminars* are a form of community-enhancing meeting, but with an educational format.

Content

Program Seminars provide education and information on a variety of topics (entitlements, money management, housing, aftercare, housing preparation, health, medication management, *etc.*). Material accentuates the critical contributions that knowledge and understanding make to successful community re-entry, and to living independently or in supportive housing.

Goals

1. to create feelings of community
2. to provide information of general interest
3. to review the concept of the day (concept seminar)
4. to address issues of particular relevance (entitlements and money management or housing preparation)

Methods

1. verbal instruction
2. written resource material
3. participation
4. individual presentation

Frequency & participation

1. meets once each week in the middle of the day
2. all members of the community participate

Leadership

Staff led except for concept seminar, which is led by an upper level peer with staff guidance.

Orientation Seminar

Purpose

The *Orientation Seminar* provides special instruction to explain the modified TC program. The community-as-method approach places increased emphasis on orientation as a special accommodation to MICA individuals' cognitive learning impairment, reduced tolerance for intensity, and lack of basic information and skills.

Content

The material in *Orientation Seminars* is disseminated in small increments. Written outlines of the orientation materials become part of the participant's folder, which allows gradual assimilation of the information, and periodic review to help participants achieve a basic understanding of program concepts presented.

Goals

1. to introduce and explain all new program elements, activities, and procedures
2. to provide basic program information to the new members of the community

Methods

1. verbal instruction
2. written resource material
3. participation

Frequency & participation

1. meets as needed
2. all members of the community participate

Leadership

Led by upper level peers with staff guidance

General Meeting

Purpose

The *General Meeting* is used to address critical issues and correct problems that threaten the integrity of the community (*e.g.*, drug use, breaking cardinal or house rules, acts of violence). *General Meetings* can also be called to transmit information that needs to reach the entire community (*e.g.*, new staff, changes in policy, staff resignations), to convey congratulations on a job well done, or to commend efforts towards ensuring a safe and secure environment conducive to recovery and right living.

Content

Planning and preparation should occur before the meeting is convened, but the nature of the shelter environment at times requires that meetings be called quickly, without prior planning. As opposed to the *House Meeting,* the *General Meeting* has a serious tenor; humor and lightness are discouraged. Participants are to remain silent unless asked to speak, and no one is expected to leave the room.

Goals

1. to identify and correct negative conditions and peer culture
2. to reaffirm motivation and reinforce positive behavior

Methods

1. staff directed
2. participation as requested

Frequency & participation

1. as needed
2. all clients and staff attend

Leadership

TC Coordinator and Director of Social Services convenes and leads the meeting

Pioneers

Purpose

The purpose of establishing a pioneer group is to use successful homeless MICA clients to build community and a positive peer culture. Pioneers provide a role model, and are trained to encourage newly admitted clients to engage in, and take advantage of, the program. In this case, pioneers were identified from the shelter program that existed prior to the initiation of the modified TC. These pioneers helped to launch and implement *A New Beginning*.

Content

The challenge was to develop and implement the modified TC program, transforming the existing system, structure, service delivery, and staff. Unlike most modified TC programs where developers and planners have the flexibility to interview and screen new admissions, *A New Beginning* was implemented with a group of clients and staff who belonged to the old shelter program. Forming a pioneer group proved to be an effective strategy to create a culture of change in the shelter. The key to this approach was assembling the "seedling group," or pioneers, and engaging, empowering, and motivating them to take ownership of their environment.

Goals

1. create a positive peer culture
2. encourage engagement and participation
3. strengthen the use of community-as-method

Methods

1. selecting successful program participants to form a seedling group
2. training these clients to facilitate new members' engagement, orientation, and participation
3. teaching the pioneers to transmit the peer self-help culture to others

Frequency & participation

1. pioneers contribute to, and assist with, the beginning stages of new groups and activities and during program launch
2. clients who can be role models are asked to join the pioneer group

Leadership

TC Coordinator and Director of Social Services trained the pioneers in their role as facilitators in the transmission of the peer self-help culture.

Perspective and Approach

Therapeutic/educative interventions consist of various group program activities, as well as some individual counseling. The groups promote self-expression, divert acting-out behavior, and resolve personal and social issues. Communication and interpersonal skills are increased, behavior and attitudes are examined and confronted, and instruction in alternative modes of conduct is offered.

Client Assistance Counseling

Purpose

Client Assistance Counseling is designed to help clients manage concrete problems and demands, emphasizing self-reliance and peer support. The intent is to help clients become capable of managing their own day-to-day life, using their peer support system and calling on additional community services when needed.

Content

This is a therapeutic group that focuses on topics of importance to individual clients ranging from information (legal, child care) to interpersonal or emotional (feelings management) difficulties. The group provides information, support, and encourages discussion.

Goals

1. promote and foster personal growth and empowerment
2. encourage affiliation with peer community
3. build confidence and self-esteem

Methods

1. active participation
2. individual presentation

Frequency & participation

All residents participate in groups of 12 to 15 that meet once each week.

Leadership

The group, guided by counseling staff, emphasizes individual participation and peer support.

Client Action Plan

Purpose

The *Client Action Plan* (*CAP*) establishes individualized, flexible goals with attainable objectives for each resident. The *CAP* is reviewed periodically to adjust to each client's progress and particular needs, which may well change over time.

Content

The *CAP* encompasses all defined areas in which treatment is required to enhance the individual's personal growth. These include such categories as substance abuse treatment, and planned movement through the program. The *CAP* describes the personal goals to be attained to facilitate progress through program levels and stages.

Goals

1. active participation of each client in the development of his own personal treatment plan
2. promote self-empowerment and personal growth
3. increased problem-solving abilities

Methods

1. individual sessions
2. instruction
3. participation

Frequency & participation

All residents work one-on-one with staff to develop a *CAP* on their entry to the program. The *CAP* is reviewed at least once each quarter thereafter (more frequently if warranted).

Leadership

Counseling staff direct this activity.

Individual Counseling

Purpose

Individual Counseling as a part of the case management activities offered at *A New Beginning* provides both traditional mental health case management and assistance. In the early stages of the resident's rehabilitation, individual counseling aids engagement and stabilization in the treatment program.

Content

The MICA client requires greater individualized attention to affiliate with the program. Such clients often connect first to one individual, then to others in the community. Later in treatment, *Individual Counseling* can assist the MICA individual to make the transition from living in a residential treatment setting to living in community-based housing. The most typical and important use of *Individual Counseling* is to encourage the use of the community by clarifying personal issues to be shared with the group, and suggesting ways of approaching and using the group. The Case Manager acts as a guide or a coach to assist the individual to identify issues to be share.

Goals

1. develop a plan of service
2. meet concrete service needs
3. facilitate engagement and stabilization
4. provide guidance in use of the community
5. assist in making transitions

Methods

1. counseling
2. case management (case assistance)
3. monitoring and management of symptoms
4. monitoring and management of medication
5. assistance with skills development

Frequency & participation

1. scheduled twice per month or as needed
2. all clients participate individually as needed

3. occurs informally throughout program day

Leadership

Generally speaking, one-to-one counseling is led by staff who encourages a resident to use the time to address case management and other issues pertinent to their care.

Psychoeducational Class—*Relapse Prevention*

Purpose

The purpose of the *Relapse Prevention* class is to focus on the biological, psychological, and spiritual impact of alcohol and other drugs. Particular emphasis is placed on the effect of alcohol and other drugs on MICA individuals.

Content

In this class, residents learn about chemical dependency, its physical, mental, social, and spiritual features. Various methods of establishing and maintaining abstinence are taught, and issues around psychotropic medications and recovery are discussed. Considerable time is spent on relapse prevention, including relapse as a process, the progression of relapse, post acute withdrawal (PAW), and the phases and warning signs of relapse.

Goals

1. to learn about the adverse physical effects of psychoactive substances
2. to learn about the physical, mental, environmental, and social factors that contribute to the development of substance use/dependence disorders
3. to learn about the physical, mental, and spiritual features of chemical dependency
4. to become aware of the impact of alcohol and other drugs on MICA persons
5. to become familiar with relapse prevention techniques and processes, and the phases and warning signs of relapse

Methods

1. verbal instruction
2. written resource material
3. participation
4. role-playing

Frequency & participation

1. the class is held once a week in 12-week cycles to accommodate the curriculum sessions; at least ten sessions must be attended to receive a certificate of completion
2. all participants

Leadership

The substance abuse specialist leads this group.

Psychoeducational Class—*Entitlements and Money Management*

Purpose

The focus of this group is on entitlements (Medicaid, Public Assistance, Social Security Insurance, *etc.*) and money management skills, and related feelings, thoughts, and behavior.

Content

As residents progress through the program and develop more independent status, money management issues multiply. More money becomes available, accompanied by more responsibility, with more opportunity to mismanage and misuse money. The community-as-method approach is to de-

velop both the skills and the character necessary for wise money management. Each group session makes explicit the connections among housing placement, entitlements, and money management—residents cannot be placed in housing unless entitlements are secured, which underlines the importance being actively involved in the process. Residents are encouraged to work closely with the entitlement specialist and their case manager, keeping and following-up on all entitlement-related appointments.

Goals

1. to examine feelings, thoughts, and behavior concerning money matters
2. to learn techniques of self control and wise spending habits
3. to establish a relationship between spending, saving, and self-esteem
4. to distinguish between wants and needs
5. to learn budgeting and banking skills
6. to make explicit the connection between housing and entitlements, underscoring the importance of working closely with staff to secure entitlements, keeping and following-up on all entitlement-related appointments.

Methods

1. verbal instruction
2. written resource material
3. worksheets
4. participation
5. role-playing
6. monitoring
7. case assistance

Frequency & participation

1. once each week for 45 minutes
2. all community members

Leadership

Case management staff led this group.

Psychoeducational Class—*Housing & Aftercare*

Purpose

The purpose of the *Housing & Aftercare* class is to examine a variety of supportive and independent living alternatives, and to explore the various available housing levels (*e.g.*, Community Residences, Single Resident Occupancy, combined CR/SROs, adult homes, independent and supportive/intensive supportive apartment programs).

Content

Each session provides an overview of a specific housing level that is appropriate in terms of placement and continuity of care. Particular emphasis is placed on the connection between psychiatric stability, securing entitlements (Medicaid, Public Assistance, Social Security Insurance, *etc.*), and clean time requirements in order to be placed. Attention is drawn to the New York City (NY/NY Human Resources Administration) supportive housing application, and the need to begin the application process early.

Goals

1. to prepare individuals for the transition back to the community

2. to assess individuals needs (ability to complete activities of daily living or ADL, money management skills, *etc.*)
3. to encourage individuals to use the available support systems
4. to heighten awareness of available and appropriate levels of care in the community

Methods

1. verbal instruction
2. written resource material
3. participation

Frequency & participation

1. once per week for 45 minutes
2. all community members

Leadership

The housing and entitlements specialist leads this group.

Psychoeducational Class—*Triple Trouble*

Purpose

The purpose of the *Triple Trouble* class is to examine how the interrelationship of homelessness, mental illness, and substance abuse acts as a trigger for relapse.

Content

In this group, residents are encouraged to discuss, rather than to act upon, impulses; for example, a resident might talk about his desire to drop out of the program, his psychiatric symptoms (*e.g.*, hearing voices), and urge to use alcohol and other drugs. *Triple Trouble* is more than a group—it is a permanent system of assessment, analysis, and planning. The MICA individual develops a perspective of the interrelated nature of homelessness, mental illness, and substance abuse, and comes to look at his behavior within this framework.

Goals

1. to identify triggers for relapse
2. to discuss, rather than act upon, impulses
3. to develop perspective of the interrelationship of homelessness, mental illness, and substance abuse

Methods

1. verbal instruction
2. written resource material
3. participation

Frequency and Participants

1. once per week for 45 minutes
2. all community members

Leadership

Peer-led with staff guidance.

Psychoeducational Class—*Feelings Management*

Purpose

The *Feelings Management* class is to provide a forum for residents to learn how to identify, control, and manage feelings that trigger relapse.

Content

The *Feelings Management* class provides cognitive relapse prevention methods, such as techniques for feelings identification and specific training in feelings management skills. By design, feelings management and triple trouble groups overlap considerably. Both focus on feelings; triple trouble groups highlight feelings as triggers for relapse, whereas the feelings management group teaches skills that prevent the recurrence of old patterns. The overlap between these two program elements allows varied opportunities to identify, examine, understand, and correct patterns of behavior.

Goals

1. identification and management of feelings, especially anger, that interfere with personal and interpersonal functioning and that trigger relapse
2. explanation of drugs used to control and mediate feelings
3. development of appropriate skills and behavior to tolerate and express feelings, thus facilitating both problem-solving and individual growth

Methods

1. verbal instruction
2. written resource material
3. participation

Frequency & participation

1. once per week for 45 minutes
2. all community members

Leadership

Peer-led with staff guidance.

Conflict Resolution Group

Purpose

The purpose of the *Conflict Resolution Group* is to teach residents how to manage and resolve conflict in a healthy and productive way, rather than through the use of violence, intimidation, or other inappropriate means. The *Conflict Resolution Group* is a modified encounter group designed for MICA individuals to resolve inter- and intra-personal conflicts. As compared to a standard encounter group, the conflict resolution group has a shorter duration, reduced intensity of interaction, more emphasis on instruction, and increased modeling by staff and more experienced clients.

Content

The interactions of the *Conflict Resolution Group* are guided by the central interpersonal tenets of the TC, "empathy," "responsible concern," "compassion," and "identification." Consistent use of this group process increases the self-esteem of program participants while giving them a forum to resolve problems and issues with each other, and to address self-defeating behavior. Each confrontation has three phases, known as the 3-Cs—confrontation, conversation, and closure.

Confrontation— First, the resident expresses his concern to the other resident involved, speaking directly to that person, and not through staff or another resident. Once the first resident has stated the issue and his concerns and feelings, the group is asked to articulate any other concerns to the person being confronted. [No more than three residents should be allowed to confront one person.]

Conversation— After the confrontation phase has concluded, the residents discuss the issues of concern. The person being confronted is given an opportunity to respond to each issue. Each resident has an opportunity to talk to the other in an attempt to understand the part that each person played.

Closure— Feedback and suggestions are given to the resident about ways to change his self-defeating behavior. The resident makes a commitment to change or acknowledges the need for help.

Goals

1. identify and modify self-defeating patterns of thinking, feeling, and behaving
2. identify and resolve interpersonal conflicts
3. facilitate self-discovery through personal disclosure and direct interpersonal interaction

Methods

1. verbal instruction
2. confrontation
3. introspection
4. resolution of interpersonal conflict
5. conflict resolution approaches
6. positive feedback

Frequency & participation

1. all community members, depending on psychiatric stability
2. the group meets once per week

Leadership

The conflict resolution group is led by at least two staff members skilled in the art of leading and facilitating this specialized group.

Caseload Group

Purpose

The *Caseload Group* assists residents in identifying and gaining access to needed community and governmental support services and resources (*i.e.*, financial, residential, educational, and social). The caseload group also assists residents to engage and affiliate with *A New Beginning*.

Content

The *Caseload Group* is a vehicle for residents to express feelings and to prevent the recurrence of old patterns of behavior. This forum enables staff to assess psychiatric stability and signs and symptoms of alcohol and other drug use. Group participants assist one another in identifying needed resources, provide responsible concern, constructive feedback, and empathy.

Goals

1. to assist residents in assessing their needs and in identifying appropriate community and government resources
2. to assist residents in the identification and management of feelings (especially anger) that interfere with personal and interpersonal functioning, and that trigger relapse

3. to assist residents in developing the appropriate skills and behaviors to tolerate and express feelings, which facilitates both problem-solving and individual growth
4. to encourage medication compliance and engagement in community-as-method
5. to assist residents in identifying obstacles that prevent them from achieving goals in their independent living plan

Methods

1. counseling
2. interpersonal interaction
3. instruction
4. role playing

Frequency & participation

1. all community members
2. once a week for one hour

Leadership

The caseload group is staff led.

Health & Medication Management

Purpose

The purpose of the *Health & Medication Management Group* is to provide education on psychotropic and other medications prescribed to residents, and to provide information on the need for continued health maintenance (nutrition, immunization, sexually transmitted diseases, tuberculosis, *etc.*). The group also identifies and educates participants on behaviors that may compromise physical well-being.

Content

The focus of this group is on side effects, adverse reactions, contraindications, and other treatment expectancies, engaging residents through education and verbal support. The program psychiatrist and nursing staff consider each resident's total health picture; the group highlights the importance of this approach. The nursing staff coordinates psychiatric and medical aspects of a resident's treatment, and serves as an advocate and educator *vis-à-vis* other health services.

Goals

1. to maintain clients' psychiatric and medical well-being
2. to educate community members on psychotropic medications, their side effects and adverse reactions
3. to impart the need for continued health maintenance

Methods

1. observation and feedback
2. verbal support
3. advocacy
4. engagement in treatment

Frequency & participation

1. all community members
2. once a week for 45 minutes

Leadership

The nursing staff and/or program psychiatrist leads the group

Men's Group

Purpose

The purpose of *Men's Group* is to focus on gender-specific topics associated with mental health and recovery.

Content

Members of the group determine the form and focus of topics to be discussed. In general, the group concentrates on masculinity, identity, mental health, and ADL, incorporating ideas of responsibility, self-expression, relationship skills, and self-esteem.

Goals

1. orientation to gender relationships
2. integrate healthy gender relationships into community living
3. discuss and work to resolve key male-related issues

Methods

1. counseling
2. interpersonal interaction
3. instruction
4. role playing
5. exercises

Frequency & participation

1. all community members
2. once per week

Leadership

A male staff member knowledgeable in the subject matter generally leads the men's group.

Perspective and Approach

These activities maintain the physical and psychological safety of the environment, ensuring that a resident's life is orderly and productive by protecting the community as a whole and solidifying a context in which social learning can take place.

Policies

Purpose

TC clinical and administrative management of *A New Beginning* is supported by *policies* that create a system of rules and regulations to maintain the physical and psychological safety of the environment. These policies ensure that resident life is orderly and productive, and strengthen the community as a context for social learning.

Content

This is a system of rules and regulations that govern community behavior and the environment.

Goals

1. maintain the physical and psychological integrity of the environment

Methods

1. codification of rules and regulations
2. public display and dissemination
3. monitoring and enforcement

Frequency & participation

Policies are in place and enforced at all times, and apply equally to all.

Leadership

Policies are determined by the agency and its staff, with input from the residents.

Urinalysis/Breathalyzer

Purpose

Regular *urinalysis/breathalyzer* testing supports recovery by helping to maintain an environment free of alcohol and drugs.

Content

Urinalysis/breathalyzer testing identifies those clients who are using drugs or alcohol, and early intervention is initiated. This policy assures that residents meet the New York City housing application requirement of 3 to 6 months of sobriety, prerequisite to housing placement. Residents sign an agreement giving their consent to be randomly tested for alcohol and drugs, and confirm their compliance with this policy.

Goals

1. to maintain an alcohol and drug free environment conducive for recovery
2. to identify those who are using to facilitate early intervention
3. to act as a support for sobriety and a deterrent to substance use
4. to educate individuals on the dangers inherent in combining medications, other psychoactive substances, and alcohol

5. to qualify residents for housing placement by establishing their abstinence

Methods

1. orientation and instruction (seminars, various groups, case management, *etc.*), with a focus on the relapse prevention features of this policy
2. urine specimen submission and on-site testing
3. alcohol breath testing using the ALCO Sensor Intoximeter

Frequency & participation

1. random and periodic
2. all community members

Leadership

Testing is initiated and directed by staff.

Social Learning Experience

Purpose

A *Social Learning Experience* is a response to an unacceptable behavior, wherein a set of behaviors are prescribed to enhance individual and community learning, reframing a negative event as a learning opportunity. The *Social Learning Experience* is a mechanism used to redirect a resident's self-defeating behavior and promote positive change.

Content

A violation of a program boundary, rule, or procedure, which may be identified by any member of the community, leads to a social learning experience (a modification of a traditional TC contract). The social learning experience gives the resident the opportunity to gain insight about how and why undesirable patterns of behavior persist. Designed to help residents learn from their mistakes, specific to the identified problem, and time-limited, the *Social Learning Experience* should not be viewed as punishment. Each social learning experience corresponds to the seriousness of the infraction, the client's program stage and level of functioning, and may range from a "talking to," to a public apology, to a brief loss of privileges (typically for one week). In designing the social learning experience, staff spends time behind the scenes to prepare the individual, then to make adjustments based on the client's input. Once agreed upon, the *Social Learning Experience* becomes public and is announced to the community, which then has the responsibility to monitor compliance, evaluate reactions, and affirm completion.

Goals

1. to heighten the awareness of self-defeating behaviors
2. to develop insight to how and why self-defeating behaviors persist
3. to help residents learn from their mistakes

Methods

1. orientation and instruction
2. specific social learning experiences designed for each situation (*e.g.*, written assignment, interpersonal discussion, work activity)

Frequency & participation

1. as needed
2. all members

Leadership

This activity is staff guided and peer led.

Token Economy

Purpose

The *Token Economy* provides a tangible recognition of behaviors, participation in activities, and accomplishment of assignments, reinforcing the positive and discouraging the negative. The *Token Economy* uses behavioral modification techniques to motivate the unmotivated, and to reinforce positive behavior. Client participation in program activities (particularly the peer work hierarchy), ADL (*i.e.* grooming/appearance, making beds, dressing appropriately), medication compliance, adherence to rules and program policies, and assignment completion are encouraged through awarding points (tokens) that can be redeemed for personal items (soap, deodorant, shampoo, toothpaste, underwear, *etc.*), candy, metro cards, and clothing in the Kingsboro store.

Content

A participant earns tokens by acting in a desirable manner and participating in program activities—positive behaviors and program participation are rewarded with tokens given; negative behaviors are penalized with tokens taken away. Clients who have been "written up" for negative behaviors are not able to redeem tokens until their case has been favorably reviewed by the case manager and the social services team. Negative behaviors that violate a cardinal rule (using drugs in the facility, stealing, fighting, threats of violence, *etc.*) revoke all token economy privileges until further review, and residents may be suspended or transferred from the program.

For the program to be effective, all staff members must feel that they can help create a positive and motivating tone, using the *Token Economy* to bring about desirable behavior changes. For this reason, all staff members (including security staff, maintenance personnel, social service and medical staff, house managers, and administrative personnel) are authorized to award tokens for positive behaviors. Staff instruction is needed to ground the concept and philosophy of motivation, and to ensure consistent application at all levels of the program. Care must be taken that the integrity of the Token Economy program is not compromised—tokens should only be awarded to recognize or to initiate positive behavior, not out of favoritism. Since the token economy is designed to solicit positive behavior changes, residents cannot:

- give away tokens or lend points to or borrow points from another resident
- exchange tokens for money
- purchase items on credit

Staff can award tokens for behaviors or activities that are not generally listed. In such cases, the approval of the Director of Social Services is needed.

Goals

1. to reinforce positive behavior
2. to assist residents in money management by teaching how to budget tokens in much the same way they will budget money once they leave the program
3. to motivate and encourage residents to participate in the program's peer work hierarchy and other program activities

Methods

1. uses behavioral modification to motivate the unmotivated
2. ensures newcomers are oriented to the *Token Economy*
3. creates a positive and motivating tone
4. instructs staff to ground the concept and philosophy of motivation, and to ensure consistent application at all levels of the program

5. preserves the integrity of the *Token Economy* by rewarding fairly, not out of favoritism

Frequency & participation

1. always in effect
2. all residents participate, and all staff members (including security staff, maintenance personnel, social service and medical staff, house managers, and administrative personnel) are authorized to award tokens

Leadership

The TC coordinator and the assigned case manager orient new program participants to the *Token Economy*, explaining what it is, and encouraging questions.

Vocational Efforts / Other

Perspective and Approach

Work is an integral part of *A New Beginning*, and is essential to perpetuating "community," the single element most necessary to support growth and change in its members. Work assignments are not simply a therapeutic activity, but define one's ability to contribute to the life of the community.

Peer Work Hierarchy

Purpose

The *Peer Work Hierarchy* is a major community-as-method vehicle for engagement in the community and for the development of community affiliation. The status, role, and function of the work assignment fortify all other aspects of the community affiliation process.

Content

Members are assigned the job of running the community. At designated times during the day, residents are engaged in their work assignments—some clean the interior while others police and clean the exterior and grounds, some prepare meals, some prepare special educational materials, and others monitor the whereabouts of residents and staff. The *Peer Work Hierarchy* provides MICA individuals with an opportunity to develop and explore skills in relation to work. The *Peer Work Hierarchy* focuses on personal attitudes, behaviors, feelings, and interpersonal skills in the work setting—such characteristics as demeanor, interest and energy, response to criticism, consistency of daily performance, rate of improvement, and relationships with others. Residents work at specific jobs, develop work-related skills, and examine those personal characteristics and approaches that affect job performance.

Goals

1. to facilitate community affiliation
2. to develop work skills
3. self examination in relation to work and its performance

Methods

1. job assignments and duties
2. on-the-job supervision
3. instruction
4. counseling

Frequency & participation

1. daily
2. scheduled segments of the day
3. all residents according to assignment

Leadership

The House Coordinator leads the work hierarchy, with staff guidance.

Peer Advocate Training

Purpose

The larger purpose of *Peer Advocate Training* is to expand the MICA workforce by enabling former MICA clients to become MICA counselors, parallel to the manner in which the original TC movement developed the majority of its counselor staff. Peer advocates accrue benefits in self-esteem, knowledge, and viable employment skills, while other clients benefit through the example the peer advocates present and their reinforcement of community-as-method and TC methods.

Content

Peer Advocate Training is a pre-employment program in which senior residents work as staff aides. In order to qualify for *Peer Advocate Training*, senior residents must demonstrate a commitment to recovery, psychiatric stability, and be a positive role model in the community, exemplifying and providing testimonials to the values of the TC culture. The training teaches peer advocates to facilitate various program groups and to assist with other program activities while serving as mentors to lower-level residents.

Goals

1. to strengthen the MICA workforce
2. to reinforce TC precepts
3. to strengthen the peer community
4. to enable MICA clients to become counselors to help other MICAs

Methods

1. didactic and practicum elements are used
2. briefing and debriefing sessions
3. supervision of performance
4. a monthly written evaluation
5. tangible rewards (trainees are paid a stipend from agency funds)

Frequency & participation

1. briefing and debriefing sessions occur before and after each group and activity, scheduled daily or several times per week.
2. the modified TC Supervisor or Program Director provides weekly supervision and a monthly written evaluation
3. weekly peer advocate group meetings are conducted by other staff members (assisted by senior trainees)

Leadership

TC Coordinator and Director of Social Services lead the training and provide supervision.

Department Head Group

Purpose

The *Department Head Group* provides support for department heads who are responsible for the work done in the peer hierarchy that contributes to the operation of the TC program. The group is intended to address challenges and issues of the position in the context of the resident peer work hierarchy.

Content

The heads of the various departments (expeditors, laundry, kitchen, medical, service crew, grounds, *etc.*) of the peer work hierarchy meet with the TC Coordinator to discuss and review scheduling, conflicts between department heads, and problems with crew members. An essential feature of the meeting is that department heads have an opportunity to provide feedback on the progress of crew members, and strategies on how to manage people.

Goals

1. to create a team-building atmosphere
2. to strengthen the peer work hierarchy structure
3. to help department heads to be good role models and leaders

Methods

1. mediated discussion

Frequency & participation

1. once per week
2. department heads

Leadership

The TC Coordinator leads the group.

Housing Preparation Group

Purpose

The purpose of the *Housing Preparation Group* is to develop the basic independent living skills that are essential for obtaining and maintaining housing.

Content

All group participants have submitted an application for housing; some have been assigned housing and are waiting for placement, while others are at some intermediate stage of the approval process (waiting to be interviewed or assigned). The group addresses basic daily tasks and skills needed for a more independent life, and provides support for the anxieties and fears that emerge around making the move back to the community after years of homelessness. Particular emphasis is given to the importance of continuing to seek support once housed, to maintain sobriety and mental health, and to be involved in outside community support service (day treatment programs, mental health clinics, self-help programs, *etc.*). The group learns how to navigate a new living situation, from adapting to a different residence, to using mass transit, orienting to a new neighborhood, etc.

Goals

1. to obtain appropriate housing based on the needed level of care by assisting clients through the approval process, and preparing them for more independent living
2. to heighten awareness of the responsibilities of independent living, and to become self-sufficient and relatively independent
3. to develop and explore the independent living skills needed to function more independently (*i.e.*, personal care, food preparation, nutrition and socialization)
4. to expand financial management skills (*i.e.*, entitlements, employment income, and expenses), and to develop and monitor a written budget
5. to orientate individuals to new living quarters, neighborhoods, transportation, and systems clients need to access once they make the transition from homelessness to housing

Methods

1. verbal instruction
2. written resource material
3. participation

Frequency & participation

1. once per week for 45 minutes
2. clients who are waiting for housing assignment or placement

Leadership

The housing and entitlements specialist leads this group.

The Program Schedule

The program schedule captures the day-to-day activities and provides a snapshot of the week's timetable to make it easy for program participants for follow the sequence of the various groups and activities. The program schedule at Kingsboro consists of all of the elements listed in the intervention section above and is described below.

Weekday	Monday	Tuesday	Wednesday	Thursday	Friday	weekend	Saturday	Sunday
6:30-8:00	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	8:00	Breakfast	Breakfast
6:30-9:00	News/ Current Events	News/ Current Events	News/ Current Events	News/ Current Events	News/ Current Events		Saturday Morning TV	Sunday Morning TV
9:00-9:30	Morning Meeting	Morning Meeting	Morning Meeting	Morning Meeting	Morning Meeting	10:30 –11	Morning Meeting	
9:30-10:30	JOB FUNCTIONS	JOB FUNCTIONS	JOB FUNCTIONS	JOB FUNCTIONS	JOB FUNCTIONS	11:15 – 12	House Clean-up	Fellowship
10:45-11:30	Concept Seminar	Fellowship And Housing Seminar	Conflict Resolution Group	Drug Education Group	DTR		Men's Group	Structured Recreation/ Free-time
12:00P	Lunch	Lunch	Lunch	Lunch	Lunch	12:00P	Lunch	Lunch
1:00-1:45	Structured Free-Time	Structured Free-Time	Structured Free-Time	Structured Free-Time	Structured Free-Time		Structured Recreation/ Free-time	Structured Recreation/ Free-time
2:00-2:45	Orientation And Money Mgt.	Relapse Prevention And Orientation	Caseload Group	Orientation And Housing Prep.	Feelings Management/ Triple Trouble		Structured Recreation/ Free-time	Structured Recreation/ Free-time
3:00-3:45	JOB FUNCTION	JOB FUNCTIONS	JOB FUNCTIONS	JOB FUNCTIONS	JOB FUNCTIONS	3 -3:30	House Meeting	
4:00-4:45	House Meeting	House Meeting	House Meeting	House Meeting	House Meeting		Free-time	
5:00-6:30	Dinner	Dinner	Dinner	Dinner	Dinner	5:00	Dinner	Dinner
7:00-8:00	Structure Recreation/ Free-time	Structure Recreation/ Free-time	Relapse Prevention	Health and Medication Mgmt.	Structure Recreation/ Free-time			

Peer Work Hierarchy

Program participants are charged with the responsibility of assisting in the operation of *A New Beginning*, working closely with staff organized into departments such as maintenance, food service,

laundry, office management, medical, and expediting. All program participants have a work assignment, with upper-level residents assuming department head positions, while lower-level residents perform line duties. What follows is an outline of the peer work hierarchy structure as it is implemented at *A New Beginning*.

Peer Work Hierarchy Structure

		House Coordinator		
		Assistant House Coordinator		
		Chief Expeditor(s)		Trouble Shooter
		Senior Expeditors		
		Expeditors (8)		
Grounds Crew	**Kitchen Crew**	**Service Crew**	**Education Dept.**	**Laundry Crew**
DH	DH	DH	DH	DH
ADH	ADH	ADH	ADH	ADH
Crew Members (10)	Crew Members (5)	Crew Members (10)	Dept. Members (5)	Crew Members (3)
Office Crew				**Medical Dept.**
DH				DH
ADH				ADH
Crew Members (2)				Crew Members (2)
Special Project (2)				

Staff meetings

Clinical Rounds

Clinical rounds are not normally associated with modified TCs, but form a critical element in the coordination and integration of the program in a shelter setting. Held every weekday morning about 9:30, clinical rounds ensure communication across program areas (*i.e.*, social services, house management, medical/psychiatry). The goal is to underscore critical communication (documented in the communication logbook), and to distribute programmatic information—census, discharges (*i.e.*, placements, transfers, *etc.*), curfew violators, concerns (social service, house management), and information critical to service integration (*e.g.*, medical/psychiatric appointments at Brookdale Hospital and in-house medical and psychiatric evaluations).

Clinical rounds are usually chaired by the director of social services, and are brief (generally not over thirty minutes). The meeting's agenda is concise, and discussions are limited to salient points. Those in attendance are expected to view the meeting as a means of keeping informed of incidents, special events, and clinical and house issues. Moreover, communication from clinical rounds is applied to follow-up, planned interventions, coordination of services, and further consultation with key staff. Clinical rounds participants include the director of social services, clinical nurse manager and other medical staff, social service staff (*e.g.*, case managers, social workers, CASAC, and housing and entitlement specialist), TC coordinator, and the program administrator.

Clinical Management Meeting

Chaired by the TC coordinator and held every other week, the meeting facilitates the clinical management of a modified TC program within a shelter setting. All social service staff and representative staff from all house departments (i.e., house keeping, maintenance, kitchen, laundry, and house management) participate. Bringing these staff members together to discuss TC programmatic issues helps to integrate and coordinate the modified TC program within the shelter environment. TC program topics include, but are not limited to, peer work hierarchy (job functions), level movement, token economy, room changes, bed changes, and reviewing and deciding upon social learning experiences.

Clinical Team Meeting

The clinical team meeting was developed to address the social service needs of the residents in the context of integration and coordination. Held weekly for ninety minutes to two hours and chaired by the director of social services, the meeting includes all social service staff, the TC coordinator, nursing staff, and representatives for house management and/or security. Some of the agenda items reviewed and discussed are the case manager's caseload breakdowns, movement in the program (*i.e.*, hospitalizations, curfew violators, and placements), reports on intake and admissions, entitlements and housing, and other house issues. The clinical team meeting is also the forum for client case conferences, in-service training, and presentations from outside service providers.

Program Planning

Most modified TCs use program planning meetings to provide consultation and guidance while the modified TC is evolving, from program launch until all activities are in place and fully operational. Program planning ensures development, implementation, coordination, and integration of all program elements. Consistent with this structure, weekly program planning meetings were chaired jointly by the NDRI consulting team of Drs. JoAnn and Stan Sacks and the Program Administrator. Participants included the NDRI consultants, the TC Coordinator, Director of Social Services, the Brookdale hospital Clinical Nurse Manager, Salvation Army Department of Homeless Services senior staff, and the Program Administrator.

Discharge Planning & Entitlements

The criteria for placement into most housing programs is **(1)** an approved New York City housing application, **(2)** SSI and/ or Public Assistance (entitlements) in place, and **(3)** at least 3 months clean and sober time. Discharge planning and entitlements are significant features of *A New Beginning* organized around these three criteria in the service of the fundamental program goal, which is to see residents successfully established in community housing.

Discharge Planning

Discharge planning begins at within two weeks of admission with the assessment (by the assigned case manager and the housing specialist) of new residents for housing. This assessment includes determining whether residents have completed the New York City housing application, if they have entitlements, and how long they have been clean and sober (the prerequisites to placement in a housing program). Of equal importance are the psychiatric and medical stabilization of the resident, which includes TB clearance and recent psychiatric and medical evaluations. Psychotropic medication adherence is another factor of note—before successful housing placement, residents must adhere to their medication regimen and be self-medicating.

Process

The primary goal of *A New Beginning* is to move residents out of the shelter system and into supportive housing; this goal makes the quick assessment and completion of New York City housing applications a priority. The program's housing specialist and/or the resident's case manager complete these applications for all program entrants who do not already have an approved application, ensuring that the medical team fills out the medical information section (page 4) and that the medical doctor signs off. The application packages are submitted to the New York City Department of Homeless Services Program and Housing Placement unit within the first thirty days. Application responses (approved or denied) are generally received in three weeks.

Discharge Planning Essential Elements

In an effort to help residents make a successful transition to independent living, the modified TC uses its groups and activities to provide skills training and other psychoeducational seminars that prepare residents for housing placement. All residents are expected to participate in a housing and aftercare group and in the housing tours to familiarize themselves with the various levels of housing and the supportive housing living environment.

Purpose & Rationale of Housing & Aftercare

The purpose and rationale of the housing and aftercare groups is to reduce anxiety, address myths and misconceptions, and to educate group participants on the various levels of housing available. Homeless MICA individuals often have a pejorative view of supportive housing; many associate supportive housing with being institutionalized and having their lives controlled, while others are concerned with the stigma attached to participation in a program that provides supportive housing for the mentally ill. Still others have strong biases in favor of Section 8 housing— many residents equate this type of housing with being "normal" and independent. The few residents who enter the program with Section 8 approvals and certificates can attain this goal, but Section 8 housing is not a realistic option for most—typically, homeless MICA individuals require a more treatment-involved housing program, as offered by municipal government sponsored housing. The housing and aftercare group endeavors to instill the message that housing options must be identified early to accommodate completion of the application and placement process within the 6 to 9 months of residence at *A New Beginning*.

The housing and aftercare group addresses the reluctance of residents to share an apartment or room. For a majority, living alone is not a realistic expectation, given the level of functioning they will be able to achieve. Many residents will need intensive support and aftercare long after they leave the program, while others may manage with minimal support and progress to more independent settings. The housing and aftercare group educates participants on all levels of housing and provides the answers for many of their questions.

Purpose & Rationale of Housing Tours

Housing tours help to eliminate the residents' myths and misconceptions by allowing them to see various levels of housing for themselves. Similarly, the housing tours help to dispel the supportive housing agencies' myths and misconceptions about homeless MICA persons. On average, two housing tours are scheduled each month, and are arranged so that residents can meet with the housing agency's staff and tenants, and ask questions along with their tour the facility. This experience provides Kingsboro residents with a different perspective, and helps to motivate and empower them to follow through on their goal of housing placement. Housing agencies also come to the Kingsboro shelter to meet with residents, conduct presentations, and interview residents for housing.

Purpose & Rationale for Housing Preparation

Residents who are approved for New York City sponsored housing begin to participate in the housing preparation group; their participation continues through the interview, acceptance, and placement process.

The housing preparation group provides a forum for residents to address the fears and anxiety that accompany the move to housing within the community. The transition is difficult for many of the Kingsboro residents partly due to their inability to manage themselves outside of an institutional setting and their lack of experience with independent living. The housing preparation group instructs participants in daily living activities, addressing their deficiencies in such areas as money management, budgeting, cleaning, personal hygiene, shopping (*i.e.*, food, clothing, and general household items), ironing, cooking, laundry, *etc.* Participants share their experiences and feelings

with having lived independently—or never having lived independently—and their fears and concerns around moving out of the shelter system and into housing

Entitlements

Just as discharge planning begins at admission, so does entitlement assessment, an important component of the provision of social services at *A New Beginning*. Entitlements can include, but are not limited to Supplemental Security Income (SSI), Public Assistance (PA—case benefits/food stamps), and Medicaid. Securing these entitlements is critical to the continuity of medical and psychiatric care, medication, and housing preparation. For example, residents cannot move into housing unless entitlements are in place, regardless of the entitlement (*i.e.*, SSI or PA).

Process

When new residents are admitted to the program, an intake interview is completed and their entitlement status is assessed. If a new admission enters the program with no entitlements, the assigned case manager helps to secure entitlements quickly so as not to impede housing placement or medical/psychiatric services process. The entitlement and housing specialist collaborates closely with case managers and other social services staff to expedite securing entitlements for clients, and to handle systemic problems and roadblocks in the process.

Supplemental Security Income (SSI)

Given their extensive psychiatric histories, many of the Kingsboro residents are eligible for SSI; some enter the program with SSI already in place, while others need help to secure the entitlement. For those who are entitled to, but not receiving, SSI, the entitlement/housing specialist completes an SSI application that is then submitted to the DHS SSI outreach unit. This unit works collaboratively with all DHS shelters, scheduling visits to shelters every other month to meet with SSI applicants and review applications in an effort to expedite the submission and approval process. The SSI outreach team works closely with the entitlement and housing specialist in gathering supporting documentation, which includes an evaluation, completed and signed by the psychiatrist. The SSI approval rate is at about 35% for first time submission, 45% for second time submissions, and about 65% for third and fourth time submissions.

Medicaid/Public Assistance

A New Beginning incorporates a comprehensive Medicaid management and monitoring process because Medicaid is critical to the continuity of medical and psychiatric services, including pharmacy services. The Salvation Army absorbs the costs of psychotropic and non-psychotropic prescriptions until Medicaid is secured for the resident. A number of steps are followed to ensure that residents are quickly assessed and evaluated for Medicaid:

- Residents are assessed at intake.
- If residents report that they have Medicaid but lost their Medicaid card, they are referred to the Kings County Hospital Medical Assistance Program (MAP) in the T-building to be issued a replacement card.
- If residents report that they have neither Medicaid nor any other entitlements, they are referred to the DHS Riverview Assessment Center, where the entire Public Assistance application process is completed in one day at one location.
- If residents report that they have SSI, but do not have Medicaid, they are referred to the Kings County Hospital MAP office in the T-building to apply for Medicaid.
- The entitlement/housing specialist completes Medicaid applications on-site and can schedule appointments to expedite the Medicaid application process at the MAP office servicing *A New Beginning*, and the MAP main office located at 34th street.

- Mail related to entitlements is opened and reviewed by both the resident and case manager, to ensure the timely receipt of entitlement related mail by social services.

The entitlement/housing specialist works closely with case managers and other social services staff, providing technical support and consultation on matters relating to Medicaid and other entitlements. Trained as a Medicaid pre-screener, entitlement/housing specialist tracks each client's Medicaid status (in place, application needed, disallowed, pending, or threshold notices/restrictions) and prepares weekly reports for the program administrator.

Cultural Competence

As a pluralistic, egalitarian micro-society that teaches compassion, empathy, and responsible concern, the modified TC epitomizes an integral feature of the program— the central message is one of a community of "brothers" and "sisters" working together to foster change in themselves and others. Tolerance for differences in age, race/ethnicity, culture, language, sexual orientation, and gender is embedded within the program principles and is a fundamental part of the teaching. The staff matches the socioeconomic and demographic characteristics of the population; many staff members are themselves in recovery, becoming role models who facilitate the treatment process. The program has the distinctive feature of employing formerly homeless MICA individuals in key program roles and as coordinators on the project. Unique approaches are used to include clients in the program implementation process as described along with other implementation guideline principles.

Medical Psychiatric Procedures

Available from Brookdale Hospital

SECTION V

Implementation Guide

Build a Positive peer Culture

Goals. A positive peer culture provides role models and guides within a structured environment that emphasizes personal responsibility and self-help to manage life's challenges. The first goal is to put in place a core group of residents who convey a message of recovery and right living, and who take responsibility for creating an environment which is safe, secure, drug-free, and conducive to recovery. This message must be transmitted to current and, particularly, new residents entering the program. A second goal is to counteract the existing negative peer culture, which strives to maintain the status quo—old behavior and attitudes that are antithetical to the modified TC model. As mentioned, half or more of the old program residents were resistant to a drug-free lifestyle, a shelter environment that emphasized community, family, psychiatric stabilization, and improving patterns of behaving, thinking, and feeling. They wished to continue as they were, using alcohol and other drugs, coming and going as they pleased with no structure, focus, or purpose.

Role of Pioneers. Unlike most modified TC programs where developers and planners have the flexibility to interview and screen new admissions to a program, *A New Beginning* was implemented with a group of clients and staff who were from the old shelter. The challenge was to develop and implement a modified TC program, making radical changes to the Kingsboro system, structure, service delivery and staff. A key strategy was to use a group of Kingsboro residents as pioneers to help launch the modified TC by working to engage existing residents and to build community and a positive peer culture, creating a culture of positive change in the shelter. The key to this approach was assembling the "seedling group" of pioneers, then engaging, empowering, and motivating them to take ownership of their environment. The pioneers were trained by the TC Coordinator and Director of Social Services to function as facilitators in the transmission of the peer self-help culture to other clients.

The Initial Cohort. Identifying those to constitute the seedling group that would provide peer leadership and be a voice of the community was a challenge. Program and strategic planning informed the decision that the seedling group of pioneers would be formed from residents who were vocally supportive of a drug-free environment and who helped the staff to implement program elements. Program staff watched for residents who would echo statements describing how the changes to the program would ultimately improve the quality life and the environment at the shelter. These residents tended to support the ideas of becoming drug-free, of developing work skills through a peer work hierarchy, of acquiring independent living skills, and of promoting prosocial values. They publicized that support in community meetings, and put themselves in a position to role model positive behavior. In addition and with staff support, several made attempts to be drug-free.

Within the first four months of the program, a cohort of some twelve residents formed a seedling group with a mission to support a positive peer culture and to counteract negative forces (by being role models of positive behavior, addressing and confronting negative behavior of other residents in support groups and program activities). Once this positive peer culture was in place, planning focused on strengthening the positive culture and building community as the main healing agent, a core strategy of community-as-method.

Key Points

1. The success of the seedling group is grounded in the identification and selection of pioneers.
2. Potential pioneers are those residents who are clean and sober (or struggling with sobriety), willing to change, and motivated to participate in the activities of the modified TC.
3. The core group of pioneers needs orientation and training in TC philosophy, essential elements, principles, and structure of the modified TC.
4. Pioneers become allies in the development of a positive peer culture and the launch of the modified TC.

Employ Strategic Planning

The basis of successful programming was the development of a participatory strategic planning group consisting of key staff from the Salvation Army, Brookdale Medical Center, and the NDRI consulting team. "Strategic planning provided a mechanism for active learning, for the discussion of central issues, and for the immediate program modification appropriate to the current situation" (Sacks *et al.*, 1999, p.26).

The Goal of Strategic Planning. The strategic planning group was composed of all those with a key role in the program, plus senior management staff with decision-making authority. Their main goal was to design, develop, and implement the modified TC. The group monitored program development, quickly identifying and addressing any issues that could impede progress or affect the program.

The strategic planning process needed to achieve systems coordination, integrating and responding to both professional and non-professional staff from disparate systems, evolving means of bridging any gaps in professional orientation and training, while complying with regulations of government agencies (*i.e.*, NYC DHS and, NYC DMH), the Salvation Army, and Brookdale Medical Center. Individual issues confronted were training and integrating staff, timing programmatic changes, expediting the application process for receipt of entitlements, facilitating housing placement, stabilizing medication, and absorbing the costs of medication for residents waiting for Medicare/Medicaid benefits.

How to Develop a Strategic Planning Team. The unique nature of *A New Beginning* and its systems and subsystems demanded that the strategic planning team consist of senior representatives (administrators, managers, and clinical staff) with the authority to make decisions. Strategic planning meetings should focus on the "big picture" of issues, concerns, and plans of action, leaving program planning to put those plans into action. The monthly strategic planning meetings monitor the progress of program planning, and handle critical issues as they arise.

Key Points

1. Strategic planners are key management staff (senior administrators, managers, and senior clinical staff) who represent the various systems involved in establishing and maintaining the program.
2. Strategic planning focuses on macro level issues, concerns, and plans of action, coordinating systems and integrating staff.
3. Strategic planning should be scheduled at least once a month.

Apply Strategic Planning

Gain Administrative and System Support

Administrative and system support was central to the successful development, implementation and integration of *A New Beginning*, illustrating the need for administrators and planners to work together within the existing system[s], conforming to its policies and guidelines. Programs are implemented in existing systems and planning must, therefore, be responsive to the policies and guidelines of those systems (Sacks *et al.*, 1999). The Kingsboro program needed a team that would forge an active and collaborative relationship with the New York City Department of Homeless Services and the Brookdale Medical Center to provide a foundation of support from which to launch the program. Without this collaborative effort and close working relationship, the Salvation Army would not be successful in developing a modified TC program in the Kingsboro shelter. Similarly, the subsystems (Brookdale Medical Center and NDRI) would be unable to work successfully within the larger system of service without strong administrative support. Agency participation at all levels is paramount, and demonstrates its commitment and dedication to program development and implementation.

Traditionally, the shelter system has responded to basic client needs (*e.g.*, shelter, food, clothing, medical care, case management and housing), often ignoring other pressing needs that contribute to their homeless status (*e.g.*, mental illness, alcohol and other drug use, physical ailments, a lack of work skills and education, communicable diseases, family issues, and other deficits). Over the past seven years or more, the NYC shelter system has worked diligently to create specialized shelter programs in collaboration with outside service providers and experts in the field of mental health and substance abuse to address some of these issues. At the time *A New Beginning* was implemented, the shelter system was in need of a safety net program for the underserved population of homeless with histories of substance abuse, mental illness and criminality. The key to the success of the Kingsboro program was its ability to work within the shelter system, conforming to the policies and procedures of the primary service system.

Integrate Shelter, TC, and Medical Expertise

Because the shelter, modified TC, and medical/psychiatric models have separate systems, philosophies, and approaches to working with homeless MICA clients, integration was a main focus of the strategic and program planners from the outset. The challenge was to create a new and innovative model that was an amalgam of best methods from each.

Medical Expertise. Brookdale Medical Center provided invaluable medical expertise that enhanced the level of medical and psychiatric services on-site, and offered a timely, comprehensive, and systematic approach to the treatment and stabilization of homeless MICAs. These services include medical and psychiatric evaluations, medication dispensing and monitoring, nursing, referrals to medical follow-up appointments, and pre and posttest counseling for HIV. Enhanced medical and psychiatric services were applied to the core system of service, and are now integrated with the overall scope of services of the modified TC. Since the medical and psychiatric needs of homeless MICA clients are diverse and challenging, innovative approaches and strategies evolved to ensure follow-up, and compliance.

How to Integrate the three Models (Shelter, TC, and Medical). Bringing the three models together began with the strategic and program planning groups, whose representative constituents allowed solutions and a collective will to emerge. The Salvation Army provided expertise in running shelters, NDRI supplied state-of-the-art capabilities in the design, development, and implementation of modified TCs, and Brookdale Medical Center offered expertise in medical/psychiatric services.

Staff training takes a central role in achieving integration, serving as model for both initial and continued training and technical assistance. At the program level, the Director of Social Service and the TC Coordinator share responsibility with the Shelter Administrator to plan and coordinate all program interventions and clinical activities with integration of staff and services as a focal point. For example, staff meetings, clinical team meetings, and other activities encompass staff from both the Salvation Army and the Brookdale Medical Center. The Shelter Administrator and the Director of Social Service ensure that, while the program model is a modified TC, the shelter is still a NYC shelter that follows all prescribed regulatory guidelines (*i.e.*, referral, screening, administrative procedures, policies, discharges, transfers, *etc.*).

Key Points

1. Work within the core system, conforming to its policies and procedures.
2. Integrate medical/psychiatric and substance abuse treatment approaches, without compromising the core system.
3. Garner administrative support, which is central to the successful development of the modified TC in a shelter.
4. Work within existing systems and policies.
5. Formulate active and collaborative relationships across systems.
6. Enlist agency participation at all levels.
7. Ensure that representatives from all systems actively participate in the strategic and program planning processes.
8. Incorporate staff training as a central feature of integration.
9. Maintain training and technical assistance to enhance and strengthen integration.
10. Use program level senior clinical and administrative staff to plan and coordinate all interventions in the context of integration.
11. Integrate all program level meetings (*e.g.*, staff, clinical, *etc.*).
12. Integrate the modified TC (model, philosophy, principles and essential elements) and medical services within the context of the shelter system.

Provide Continued Training and Technical Assistance

Training. Program staff received both didactic and experiential training in modified TC philosophy, principles, and methods during the first year of the program's existence. Training focused on the unique features and challenges of a modified TC in a shelter setting. The didactic presentation was delivered at NDRI over a two-week period; special arrangements were made to ensure that all staff involved in the program was scheduled to attend and participate in the training. The modified TC training curriculum consisted of the history and background of the TC approach; a review of the structure, including the daily regimen, role of staff, role of peers, peer work hierarchy, and social learning experiences; and treatment process, including a description of the stages and phases of treatment. The experiential aspect of the training involved role-playing activities such as morning meeting, concept seminar, and evening house meeting.

Technical Assistance. Training goes hand-in-hand with technical assistance and takes place in the program environment. The Kingsboro staff, which included Brookdale Medical Center personal, learned exactly how to carry out the program activities by participating in those activities. Their years of professional experience in the development and implementation of modified TCs allowed the TC Coordinator and the Director of Social Services to play a key role in the delivery of technical assis-

tance. They briefed and debriefed staff after each group or activity, using role-modeling techniques to transmit the appropriate clinical skills and approaches that helped staff to build a strong clinical foundation for working with homeless MICA clients in a modified TC. The NDRI consulting team provided overall supervision along with guidance and support.

The NDRI consulting team, the TC Coordinator, and the Director of Social Services continued to monitor staff performance until competency in modified TC approaches and methods was demonstrated. Strategic and program planning meetings reviewed staff competency and fidelity of the program elements to TC principles and methods (Sacks *et al.*, 1999) to sustain program quality, initiating refresher training and intervention delivery adjustments as needed.

Balance Staffing

Developing a new program model for a particular population in a specific setting creates unique staffing demands, and candidates with experience with both TC methods and MICA clients may not be available. The critical position is the TC Coordinator who leads and monitors program implementation. In the case of the Kingsboro modified TC, Salvation Army staff included case managers, a housing/entitlements specialist, a recreational counselor, a TC Coordinator, and a Director of Social Services, while Brookdale Medical Center staff included nurses, a social worker, CASAC, medical doctor, and psychiatrist; of these, only the TC Coordinator and Director of Social Services had both TC and MICA expertise.

The strategy and approach used to modify the existing administrative and clinical structure differed from those used with the clients. The modified TC staff was comprised of a variety of people representing numerous professional affiliations, interests, and skills, and reflecting diversity in age, gender, racial/ethnic, and other characteristics. Staff recruitment and hiring followed a strict protocol that included guidelines for advertising and interviewing to ensure minority representation. Staff training focused on the modified TC philosophy, conceptual framework, essential elements of the TC, and the unique features and characteristics of the homeless MICA client. Staff training was also responsive to cultural, language, and gender variations, using special didactic material on responsiveness and communication skills to interview MICAs, with supervision to strengthen rapport and resolve emerging issues. The Director of Social Services, the TC Coordinator, and other clinical staff made a concerted effort to engage and orientate existing Kingsboro staff on the benefits of reshaping the program as a modified TC. The TC Coordinator and Director of Social Services (with over two decades of combined professional and personal shelter, community-based treatment, TC, and modified TC experience) provided clinical leadership in the development and implementation of the modified TC program.

SECTION VI

Case Studies

Cedric

Cedric is a 39-year-old African-American male with a history of substance abuse and mental illness, which prevented him from living independently. Cedric came to the Kingsboro Men's Shelter in May 1999, having spent nearly 10 years in the shelter system. He entered the program with a desire to accomplish his goals, and worked closely with his assigned case manager and the housing/entitlement specialist to explore housing alternatives that would meet his needs. At the same time, Cedric was engaged in the modified TC program and adjusted quickly to the daily regimen of the structured TC program, adopting the idea of community and family. Cedric participated fully in the program and soon became one of its visible leaders and a role model.

Cedric took his medication as prescribed and maintained his sobriety throughout his stay at *A New Beginning*. Shortly after his admission to the program, Cedric's New York City housing application was submitted, receiving approval in August 1999. His first housing interview was a success; he was accepted into the supportive housing program at St. Anthony's Residence and moved in September 1999. Soon afterwards, Cedric was referred to a vocational program for porter/maintenance training.

Kingsboro staff maintained contact with Cedric's assigned case manager at the St. Anthony Residence to follow his progress. Cedric often visited the Kingsboro facility to have meals and to socialize with his peers and staff. One year after Cedric came to Kingsboro as a resident, he was hired as a housekeeping/maintenance staff member. Both Cedric and the Kingsboro staff are excited about his return as an employee. His success speaks to his motivation for improving his quality of life, and to the effectiveness of the modified TC program with its innovative approach to engagement and psychiatry at the shelter level.

Earl

Earl is a 47-year-old African-American male with an extensive history of homelessness and substance abuse. Because of the length and severity of his homelessness and substance abuse, Earl became isolated in every setting he entered, and soon alienated himself from his family and society. Earl's alienation was so severe that he would not speak, apart from the rare times that he wanted something.

Earl came to *A New Beginning* through outreach efforts from another shelter, and was uncooperative during the interviewing and screening process. He was admitted to the Kingsboro modified TC in November 1998 with an unspecified psychiatric diagnosis. Initially Earl was non-compliant and could not be engaged, making the completion of his intake and psychiatric evaluation difficult. He remained isolated from his peers and staff despite attempts to engage him in the modified TC. Earl would not speak and often presented as angry and intimidating to other peers. Staff's daily attempts to communicate with Earl often ended with him yelling to be left alone.

After almost 3 months, Earl began to come around. As an intervention early in the program's development, cigarettes were distributed daily to reward active participation in the program and to motivate residents. Earl responded to this reward, so each time his turn came to receive his cigarettes, the director of social services would ask Earl to say "hello," or to describe how he was feeling that

day. Coupled with the constant proactive engagement from both case management and medical staff, he began to talk openly and to respond to staff.

In February of 1999, Earl began to seek out staff for house incentives and other requests. Staff used this as an opportunity to engage him around his needs and orientated him to the program. After weeks of limited dialogue, Earl began to trust and feel comfortable, and agreed to be evaluated by the psychiatrist. He was placed on medication and developed a relationship with the medical staff. By April 1999, a marked improvement had occurred, compared to when he arrived at Kingsboro in November 1998. He showered daily with staff supervision and was fully compliant with psychiatric follow-up and medication.

After several months, Earl was completely involved in the program and began to co-facilitate groups and activities with staff. Earl's ADL skills had improved and he began working with staff to apply for entitlements and housing. Earl completed the New York City housing application and was approved for placement. At the time of this writing, Earl is pending housing placement, receives SSI benefits, and continues to participate in the program.

Gary

Gary is a 27-year-old African-American male with a long history of homelessness, psychiatric illness, and substance abuse. He was a treatment failure in other systems (*i.e.*, mental health and substance abuse treatment) and eventually became homeless due to his chronic crack cocaine use. Gary resided at Kingsboro from June 1999 through April 2000.

On arriving at Kingsboro, Gary was resistant to the modified TC, primarily because of its insistence on medication adherence. He continued to use alcohol and other drugs while attempting to participate in groups and other social service activities. Gary was constantly engaged around his substance abuse; however, he was unsuccessful in getting clean during the first several months of his stay at Kingsboro. Gary's case manager continued to engage Gary and was involved in a number of interventions to convince him to enter a detoxification program.

Gary was constantly confronted and engaged around his drug use (chronic drug use resulted in his suspension from the shelter system). His compliance to medical and psychiatric medication was poor, and he had to be consistently prompted to follow through on medical and psychiatric appointments. Several incidents occurred that implicated Gary in theft and using drugs on the promises, behavior which prompted his referral to another shelter.

After several short-term detoxification hospitalizations, Gary engaged with the TC program, and became compliant with use of his prescribed medications. He was approved for Social Security Disability, but found that his benefits were contingent on his sobriety. Gary successfully completed a rehabilitation program, stayed at Kingsboro for a short time afterwards, and was placed in a three-quarter house. He returned to Kingsboro in April of 2000, but only to collect the rest of his belongings, and to thank the Kingsboro staff for their help.

SECTION VII

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