



Project RISE

(Recovery through Information, Support and Engagement)

A model of family-focused, integrated, and trauma-informed outreach, engagement, brief counseling and care coordination for homeless families

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Integrated Care for Homeless Families:
Reports from two IHR Homeless Projects

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Outline of Presentation

1) Project RISE (I)

- a) Reminder
- b) Outcomes

2) Project RISE (II)

- a) Transition/Changes
- b) Outreach and Engagement as an Early Intervention/ Treatment Model
- c) Successes and Challenges

3) Moving Forward



Project RISE (I)

- Three-year SAMHSA/CSAT-funded *Homeless Addictions Treatment* Grant (2001–2004)
- 282 North Shore DTA families in motels & family shelters
- Services: SUD/COD & trauma
 - Outreach, Screening, Engagement, Assessment, Care Coordination
 - Child care & transportation
 - Consumer coordination
 - Follow-up for one year
- Evaluation



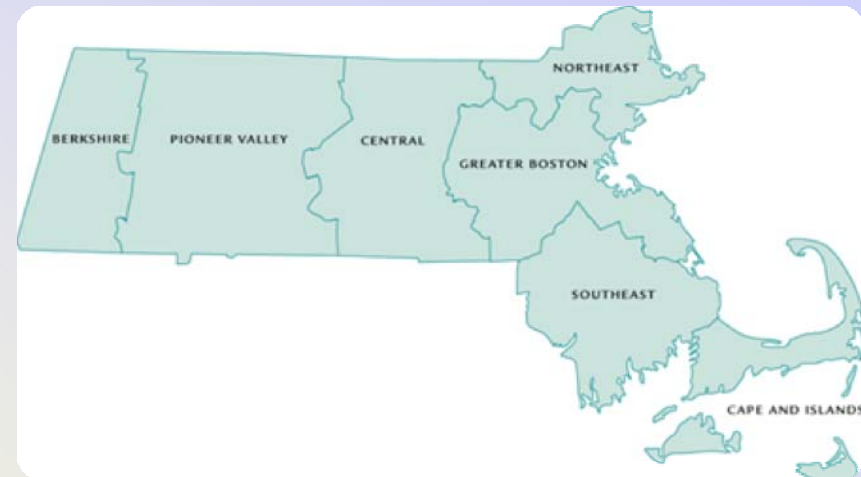
Project RISE Effectiveness

- Evidence
 - Statistically significant outcomes:
 - Alcohol use, marijuana use and trauma symptoms decreased at 12-months
 - Mental health symptoms decreased at 6- and 12-months
 - Interpersonal safety & health-related quality of life increased.
 - Project RISE succeeded in engaging homeless women for 12 months, and residential stability improved.
- CSAT Endorsement of Effectiveness
 - Project RISE was named an exemplary program by CSAT.



Project RISE (II)

- Project Director
- Clinical Supervisor
- Family Care Coordinators
 - Boston, Metro-West (2)
 - Northeast (1.5)
 - Southeast (1)
 - Central Mass (2)
 - Western Mass(3)



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Original Transition Planning Group

- Support for project design & implementation
 - DPH: BSAS/FOR Families/Domestic Violence
 - DTA: Housing/Domestic Violence
 - DCF
 - DMH
 - Medicaid
 - IHR





RISE's Current Population

- Homeless families – adult(s) struggling with SUD/COD
 - Work with many young parents at risk
- Homeless pregnant women, partners, children
- Temporarily housed in DHCD-funded shelters, including scattered-sites and motels
- DHCD Transitional Housing Programs
- DHCD/Housing Authority/Housing First Programs



Intervention

Service Level

- Outreach: early identification
- Screening:
 - Stress, family instability, “problems”
 - Alcohol & Other Drugs (Indicators)
- Assessment: treatment needs & readiness
- Engagement
 - Stages of Change
 - Psycho-education
- Brief Counseling: Evidence-based practices



Interventions

- Care coordination
 - SUD/COD/trauma linkages
 - Assisted referrals to clinical services
- Advocacy
- Crisis Intervention
- Three-months post shelter stay enabling follow-up
- Graduation





Systems Interventions

Agency Level

- Regional cross trainings
 - SUD, COD, Trauma-informed services
 - Motivational Interviewing
 - Impact on family & housing stability
- TA, support & consultation on families impacted by SUD/CODs, treatment & recovery
 - Emergency family shelter staff, Transitional Housing, Housing First
 - DHCD Homeless Coordinators,
 - DTA Domestic Violence Unit
 - DCF workers from local offices
- Work closely with FOR Families



Four Phases of Intervention

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Phases of the Intervention

- **Phase One:** Referral
- **Phase Two:** Engagement
- **Phase Three:** Counseling and Care Coordination
- **Phase Four:** Graduation



Phase One: Referral

Indicators Used:

- Behavioral implications of possible use
- Partner with current or hx of SUD/COD
- Broken rules or not completed tasks on their Re-Housing Plan
- Open DCF case that may have to do with SUD use or related behavior
- “Bad” CORI (Criminal Offender Record Information)
- No explanation for their inability to save money based on income and expenses



Phase One: Referral

- Reluctant to meet with yet another provider
 - “Only meet with them once”
- Arranging the first meeting
 - Confidentiality Release
 - Who is there (children)?
 - Where do they meet?
 - No shows
- Two parent participants
- Prioritizing us vs. housing?



Phase Two: Engagement

- Assessment – whole person, family-based, resiliency approach
 - Person-centered assessment
 - HMIS
 - ESM
- Children
 - When children are present during assessment
 - Children's needs
- Transitional Age – Engagement
- Manage fine line with basic needs
- Telling the SUD/COD story or rather their partner's story



Treatment – Change Plan (Based on MI)

- The changes I want to make (or continue making) are:
- The most important reasons why I want to make these changes are:
- The steps I plan to take in changing are:
- The ways other people can help me are:
- Some things that could interfere with my plan are:
- I will know that my plan is working if:



Phase Three: Early Recovery Counseling and Resource Coordination

- Family-based, “home visiting” interventions
 - Going to where the family is located
 - Driving the family to appointments
- Taking control in a controlled environment
- Tools integrated from:
 - MI, Stages of Change, CBT, Care Coordination, psycho-education, Seeking Safety, & Nurturing Program



Phase Three: Early Recovery Counseling and Resource Coordination

- Matching dreams/hopes with unrecognized skills
- Develop new ways of problem solving and coping
 - Measuring stages of change
 - MI tools (ruler/matrix/cards)
- ID impulsive decision skills, tools to address depression and anxiety



Phase Three

- Develop and maintain “safer” atmosphere within the family
- Expectations & Boundaries are clear
 - The “talk on the drive”
 - Modeling positive provider relationship





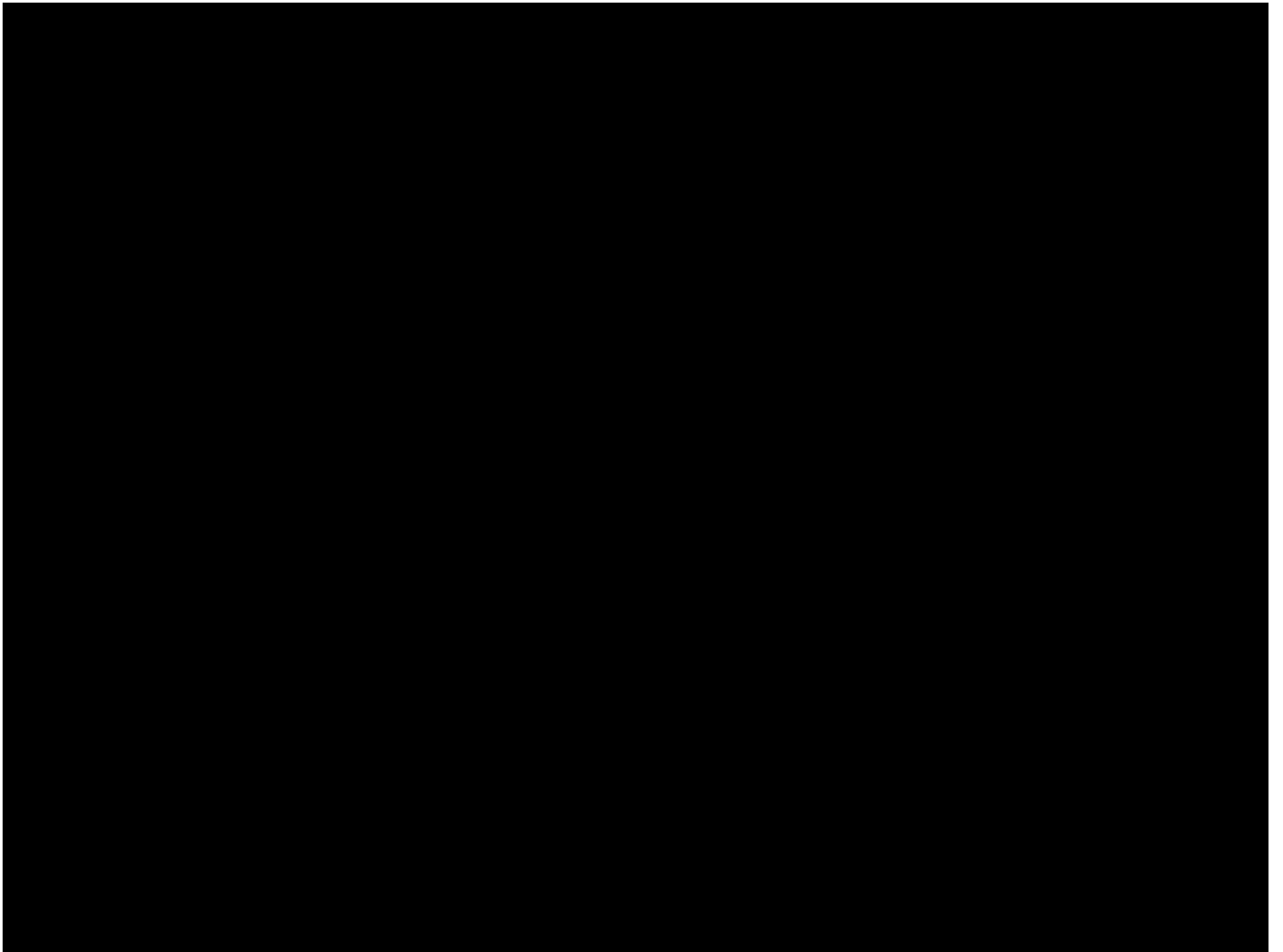
Phase Three

- Sharing, teaching and model life management skills
 - Parenting
 - Better reactions, better results
 - Motivate to take action around job and/or education
 - Housing/tenancy skills
- Relapse Responsive
- Treatment retention issues



Phase Four: Graduation

- Graduation
 - Determine when is a good time to end RISE services
 - Mutually agreed closure
 - Evaluate services provided
 - Talk about maintaining changes
 - Do something together that marks the success and hard work
 - Satisfaction Survey
- Unplanned endings





Discharge Outcomes: July 2008–October 2009 (n=313)

Change in Treatment Health	Percent
Increased MH Tx	52.9%
Decreased MH Symptoms	45.5%
Decreased Substance Use	38.5%
Increased adherence to the Re-Housing Plan	34.6%
Increased Recovery Support	30.8%
Attended Sub. Use Tx	24.4%
Attended 12-step or other Recovery related group	23.7%
Increased consistency with training/employment	15.4%
If applic., Increased adherence to MH meds	14.4%
Decreased Calls to DCF	14.4%
Decreased Legal involvement	7.7%
Saving Money	7.7%

Source: Discharge Summaries



Discharge Outcomes: July 2008–October 2009 (n=313)

Housing Information	Percent
Family Emergency Shelter	25.0%
Subsidized Housing	15.4%
Unknown	14.1%
Market Rent	10.9%
Family/Friends	9.6%
Public Housing	9.6%
Residential Tx	3.8%
Program-based Section 8	3.5%
Section 8	2.9%
Jail	1.9%
Community Housing	1.3%
Street	0.0%

Source: Discharge Summaries



Discharge Outcomes: July 2008–October 2009 (n=313)

Discharge Type	Percent
Graduated	43.9%
Lost to Follow Up	23.1%
Dropped-Out	21.5%
Moved out of Area	7.4%
Jail	1.9%
Other	1.9%

Source: Discharge Summaries



Project RISE — Moving Forward

- Final Outcome Measures
 - BASIS – 24
- Concurrent Documentation
- Work with DHCD to refer families prior to terminations
- Conduct Wellness and Recovery Groups
- Integrating Seeking Safety and Nurturing Program (individually)
- Expand to DHCD Families in Housing Stabilization Phase
 - Recovery and Tenancy Support
- Continue to provide excellent standard of care including systems integration