



# Re-housing Homeless Veterans in Reno: *Using Empirically Grounded Clinical Interventions to Assist in the Transition Out of Homelessness*

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NCHV 2019 Annual Conference, May 29-31, Washington DC  
HCHV Case Manager, Healthcare for Homeless Veterans Program  
VA Sierra Nevada Health Care System, Reno, NV

Photo credit: Dave Griffiths

# Agenda

- Setting: About VA SNCHS & HCHV Program
  - Case Study: Mike
  - Conceptualizing veteran homelessness
  - Theoretical frameworks
  - Clinical approaches w/ case scenarios, exercises & practice activities
  - Q&A
  - Wrap-up/evaluations
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# Learning Objectives

- Participants will become familiar with clinical interventions and strategies shown systematically to have positive impacts on housing status of homeless veterans served
  - Participants will be able to describe potential applications of clinical skills with clients in their professional practice
  - Participants will develop knowledge of evidence-based practice that support veterans, who are homeless, while they move through the stages of change & establish housing and long-term recovery
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# Presenter Introduction

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HCHV Case Manager at VA Sierra Nevada Health Care System (Reno, NV)

LGBT Veteran Care Coordinator

Pronouns I respond to: he/him/his and they/them/theirs

## Conflict of Interest Disclosure:

- Receive compensation from the VA for the provision of professional social work practice.
  - The opinions expressed by this presenter are solely those of the presenter and do not necessarily reflect the opinions of the Department of Veterans Affairs or an endorsement by VA Sierra Nevada Health Care System.
  - The theories and clinical strategies referenced in this presentation are based on findings from best available empirical evidence and are cited accordingly. The content of this presentation is not original source data of this practitioner or the VA. Primary & secondary sources are named at the bottom of the slides and credit is provided in the references section.
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# About VA Sierra Nevada Health Care System

- The VA Sierra Nevada Health Care System (VASNHCS), Reno, Nev., provides primary and secondary care to a large geographical area that includes 20 counties in northern Nevada and northeastern California.
- In addition to our main facility in Reno, we offer services in four community-based outpatient clinics and one rural outreach clinic. These clinics are located in —
  - VA Sierra Foothills Outpatient Clinic (Auburn, CA)
  - VA Carson Valley Outpatient Clinic (Minden, NV)
  - Lahontan Valley VA Clinic (Fallon, NV)
  - VA Diamond View Outpatient Clinic (Susanville, CA)
  - Winnemucca Rural Outreach Clinic (Winnemucca, NV)



# Health Care for Homeless Veterans (HCHV) Program

- HCHV programs serve as the hub for a myriad of housing and other services that provide VA with a way to reach and assist homeless Veterans by offering them entry to VA care.
- Outreach is the core of the HCHV program. The central goal is to reduce homelessness among Veterans by conducting outreach to those who are the most vulnerable and not currently receiving services and engaging them in treatment and rehabilitative programs.
- Another aspect of HCHV is the Contract Residential Treatment program, which places Veterans with serious mental health diagnoses into quality, community-based, supportive housing.

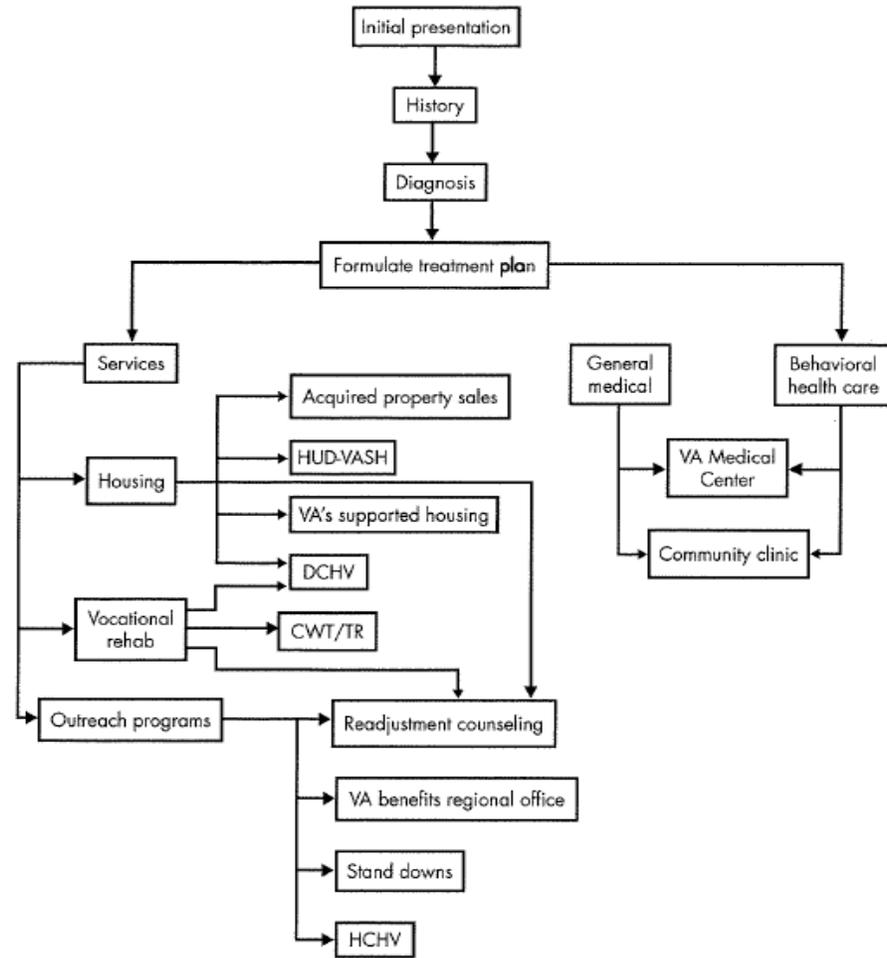
Source: VHA Handbook 1162.09

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TWO  
HOUR  
PARKING

Department of Veterans Affairs  
Greater Waterville  
Health Care System  
Area 40  
Veterans Outpatient Center



**FIGURE 13–1. Flowchart: treatment and services for homeless veterans.**

CWT/TR=Compensated Work-Therapy/Transitional Residence; DCHV=Domiciliary Care for Homeless Veterans; HCHV=Health Care for Homeless Veterans; HUD-VASH=Department of Housing and Urban Development-VA-Supported Housing; VA=Department of Veterans Affairs.

# Mike turned his life around with VA programs for homeless Vets.



Source: <https://explore.va.gov/video/homeless-mike>

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# Conceptualizing the nature and causes of veteran homelessness

The extent of the problem of homelessness among the VA patient population is very large and may be related to premilitary experiences as well as military service itself.

According to national PIT estimates, on a single night in January 2018, 37,878 veterans were experiencing homeless in the U.S., accounting for just under 9% of all homeless adults

# Conceptualizing the nature and causes of veteran homelessness

Veterans' homelessness usually results from the same interrelated economic and personal factors that cause homelessness for other Americans including, but not limited to:

lack of availability of affordable housing, old age, low education, incarceration, physical and mental health, domestic violence, LGBTQ status, unemployment, addiction, limited social support, etc.

- 97% of homeless veterans are male, and most are single
- Nearly one-half of homeless veterans suffer from mental illness
- Greater than 2/3 of homeless veterans have alcohol or drug abuse problems
- More than 1/3 have both psychiatric and substance abuse disorders

# Veteran homelessness: a complex social problem with multifactorial causes

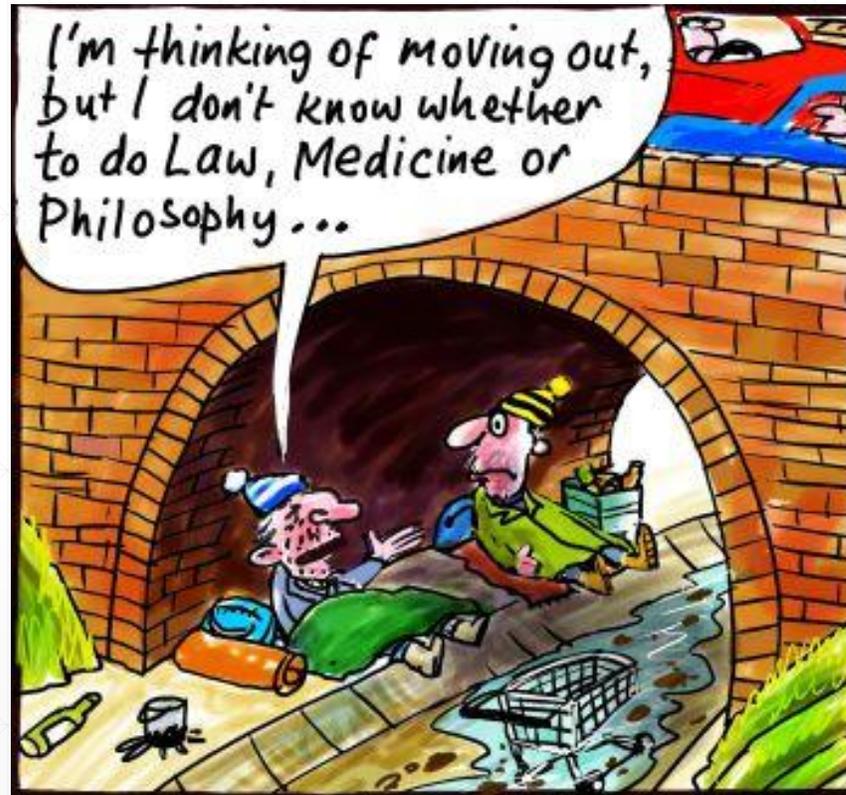


Photo credit: Peter Nicholson

# Theoretical frameworks informing clinical intervention with homeless veterans



# Theoretical Applications to Homelessness

- Housing first
  - Harm reduction
  - Trauma informed care
  - Stages of change
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# Housing First

The Housing First approach does not question readiness to live in housing. It assumes that the veteran has a right to housing, which creates an environment in which other issues can be addressed. There is low or no thresholds for acceptance.

The Department of Veterans Affairs has adopted Housing First as a core strategy to ending veteran homelessness.

Housing First is NOT housing *only*. There is a strong and essential clinical component to the model.

Sources: Pathways to Housing: supported housing for street-dwelling homeless individuals with psychiatric disabilities & HUD-VASH Resource Guide

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# Housing First

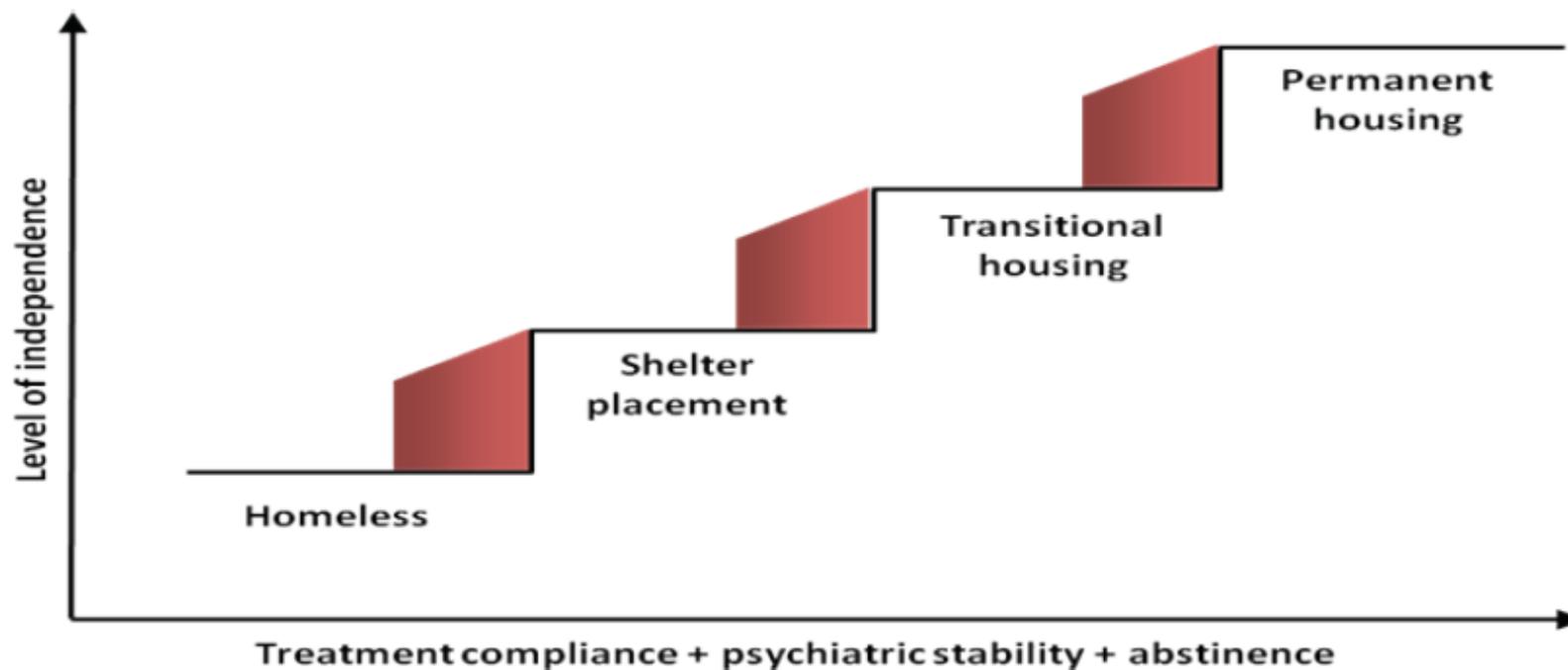
Key elements of the Housing First model include:

- Consumer choice with the veteran at the center of decision-making;
- Separation of housing and treatment to where tenancy is not contingent on compliance w/ services;
- Availability of staff to help individuals pursue personal goals related to health, family and community integration, and meaningful activities.

Sources: Pathways to Housing: supported housing for street-dwelling homeless individuals with psychiatric disabilities & HUD-VASH Resource Guide

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# Traditional Approach to Increasing Housing Stability



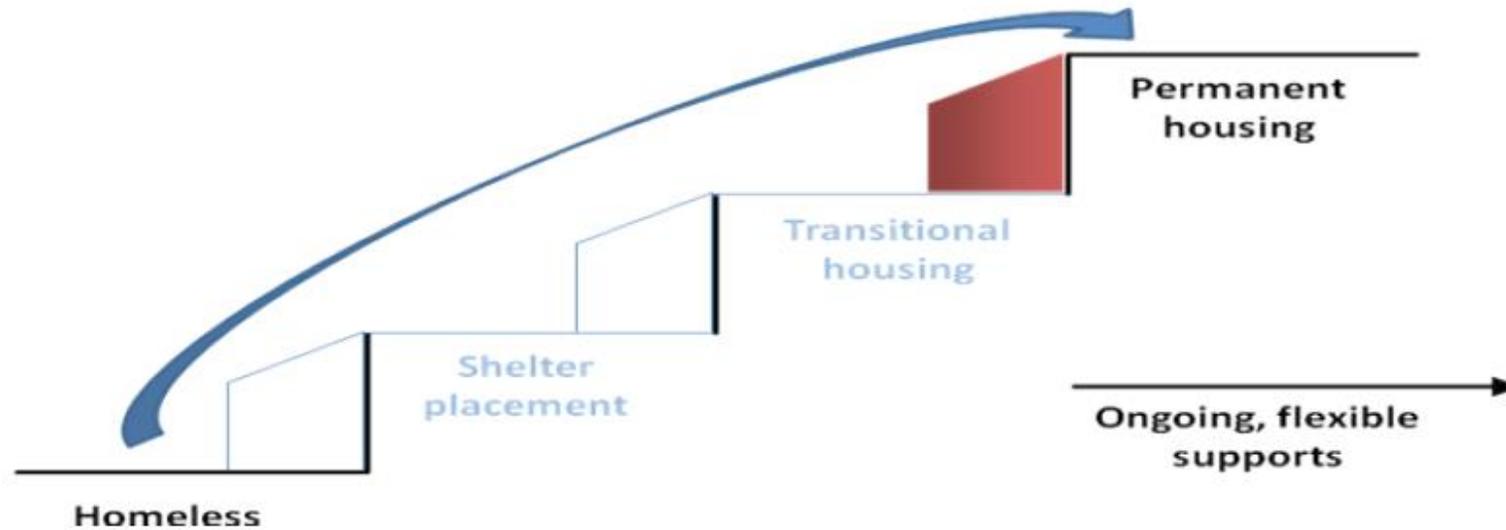
Source: HUD-VASH Resource Guide

**“When a veteran comes home kissing the ground, it is unacceptable that he should ever have to sleep on it.”**

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Michelle Robinson Obama, Former First Lady of the United States

# Housing First model offering rapid access as an alternative to the staircase model w/ CoC



Source: HUD-VASH Resource Guide

# Harm Reduction

- The term “harm reduction” (HR) was coined in Europe in the 1980s to describe public health approaches to working w/ active injection drug users (IDUs) where the focus was on engagement & promoting safety
- Premise of HR is that by welcoming people as they are, and by offering help that meet’s people’s basic needs, we can increase engagement and lower reluctance to change

Sources: Starting Where the Client Is: Harm Reduction Guidelines for Clinical Social Work Practice & PSH Resource Guide

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# Harm Reduction

- HR has widened now since it's emergence to be applied to a variety of risky behaviors including non-payment of rent by unstably housed veterans
- Housing First is grounded in harm reduction principles

Sources: Starting Where the Client Is: Harm Reduction Guidelines for Clinical Social Work Practice & PSH Resource Guide

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## **As Gabor Mate puts it:**

*“The question is: is it better for people to inject drugs with puddle water or sterile water? Is it better to use clean needles or share so that you pass on HIV and hepatitis C? This is what harm reduction is. It doesn’t treat addiction, it just reduces harm. In medicine, we do this all the time. People smoke but we still give them inhalers to open airways, so what’s different? You’re not enabling anything they’re not already using.”*

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Gabor Mate on “harm reduction” as cited in Szalavits, 2012

# Harm Reduction Plan for Housing Stabilization

Housing Risk	Options	Factors in favor	Factors against	Non-negotiable
<p><u>Eviction:</u></p> <p>The Veteran is drinking a lot. His friends are visiting and may be living there. The apartment is a mess. The landlord is moving to evict.</p>	See friends another way.	<ul style="list-style-type: none"> <li>Landlord satisfied, apartment not a mess.</li> </ul>	<ul style="list-style-type: none"> <li>Friends bring the liquor, lonely, doesn't like to clean</li> </ul>	<ul style="list-style-type: none"> <li>Must meet apt. standards</li> <li>No one not on lease can live there</li> </ul>
	Put friend on lease	<ul style="list-style-type: none"> <li>Meets lease</li> <li>Not lonely</li> </ul>	<ul style="list-style-type: none"> <li>No privacy</li> <li>Has a lot of friends</li> <li>Who will clean?</li> <li>More cost for apartment</li> </ul>	
	Move to another apartment	<ul style="list-style-type: none"> <li>May be closer to friends</li> <li>Landlord not angry</li> </ul>	<ul style="list-style-type: none"> <li>Likes apt.</li> <li>May not like new place</li> <li>Rules about drinking</li> </ul>	

Source: ERPi

# Trauma-Informed Care (TIC)

- TIC is a perspective that acknowledges the pervasive influence and impact of trauma on an individual, their provider, and the organization
- Exposure to traumatic events is a highly prevalent aspect in the lives of homeless veterans

Source: Trauma-Informed Care: A Paradigm Shift Needed for Services With Homeless Veterans

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# Trauma-Informed Care (TIC)

- Failing to recognize this association may lead to further victimization, exacerbate MH symptomatology, and hinder a provider's ability to effectively intervene on behalf of homeless veterans
- The impact of trauma is similar to a rock hitting the water's surface w/ a wave followed by ever-expanding, but less intense ripples (TIP 57 – TIC in BH Services)

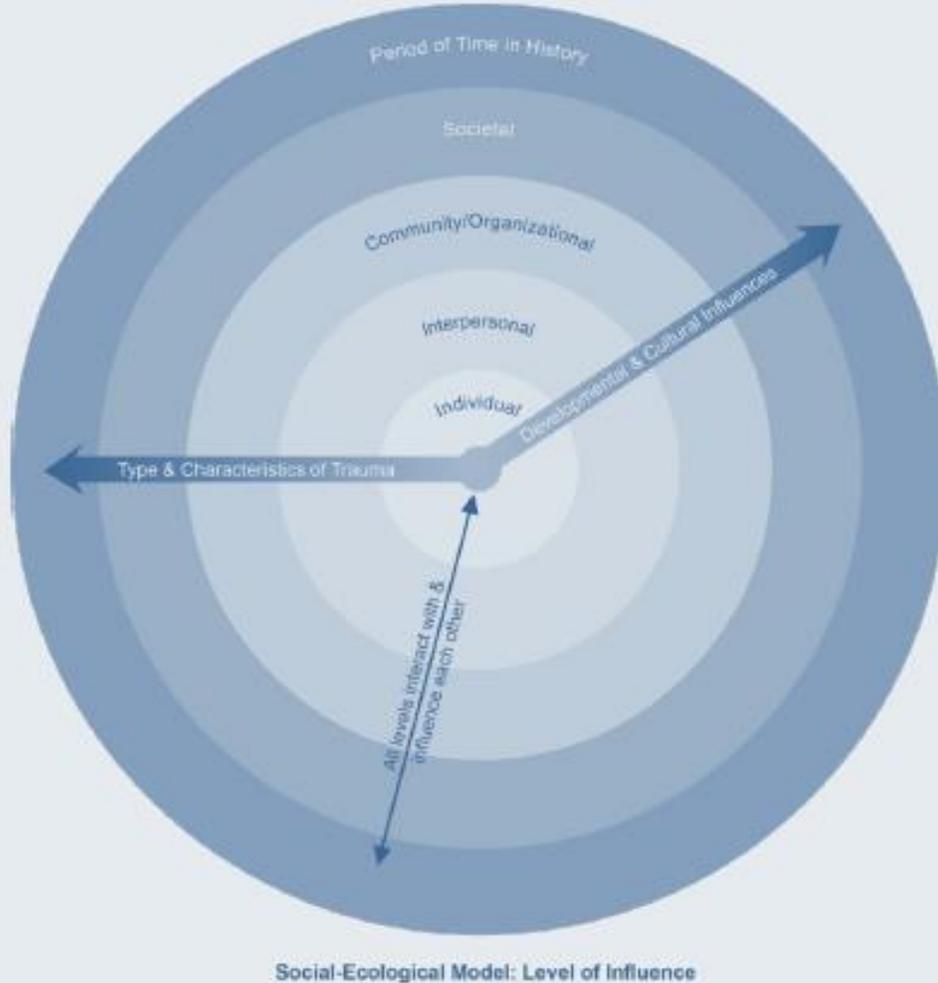


Source: Trauma-Informed Care: A Paradigm Shift Needed for Services With Homeless Veterans

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# Social-Ecological Model for Understanding Trauma and Its Effects

Exhibit 1.1-2: A Social-Ecological Model for Understanding Trauma and Its Effects



**“Trauma-informed programs and services are based on an understanding of the vulnerabilities or triggers a trauma survivor may experience”**

VA National Center on Homelessness Among Veterans & US Department of Veterans Affairs

FACT SHEET: Trauma-Informed Care For Working With Homeless Veterans

Source: TIP 57 TIC in BH Services (SAMHSA)

# Stages of Change (SOC)

- This transtheoretical model (Prochaska, DiClemente & Norcross, 1992) describes the process of behavioral change, beginning with precontemplation and continuing through maintenance that most people cycle through more than once.
- Concurrent w/ the development of SOC model was Miller and Rollnick's creation of motivational interviewing.

# Stages of Change (SOC)

- Helpful when working with veterans who are homeless or having trouble with their housing situation, but are not ready to make a change.
- In addressing obstacles to housing stability, the SOC paradigm provides a useful framework for thinking about how to motivate the veteran for change (motivational interviewing).

Sources: TIP 55 BH Services for People Who Are Homeless, HUD-VASH Resource Guide & PSH Resource Guide

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## The Stage of Change Model

THE STAGES OF CHANGE	
STAGE	VIEWPOINT/CHARACTERISTIC
PRE-CONTEMPLATION	"No problem exists"
CONTEMPLATION	"A problem may exist"
PREPARATION	"A problem exists; I might consider doing something about it"
ACTION	Choosing alternate behaviors
MAINTENANCE	After the first six months of choosing alternate behaviors in the action phase, behavior becomes more habitual, and maintenance phase begins
RELAPSE	Presented as a normal part of the process and an opportunity to learn. After relapse, Veteran motivation to change may be at any of the first three phases.

Source: HUD-VASH Resource Guide

**“Case management is most effective when interventions match the veteran’s stage of readiness.”**

Source: HUD-VASH Resource Guide

# Overview of Clinical Approaches to Treatment of Homeless Veterans

- Motivational interviewing
  - Distress tolerance skills
  - Mindfulness training
  - Critical Time Intervention
  - Peer support as an adjunct to clinical practice
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# Motivational Interviewing (MI)

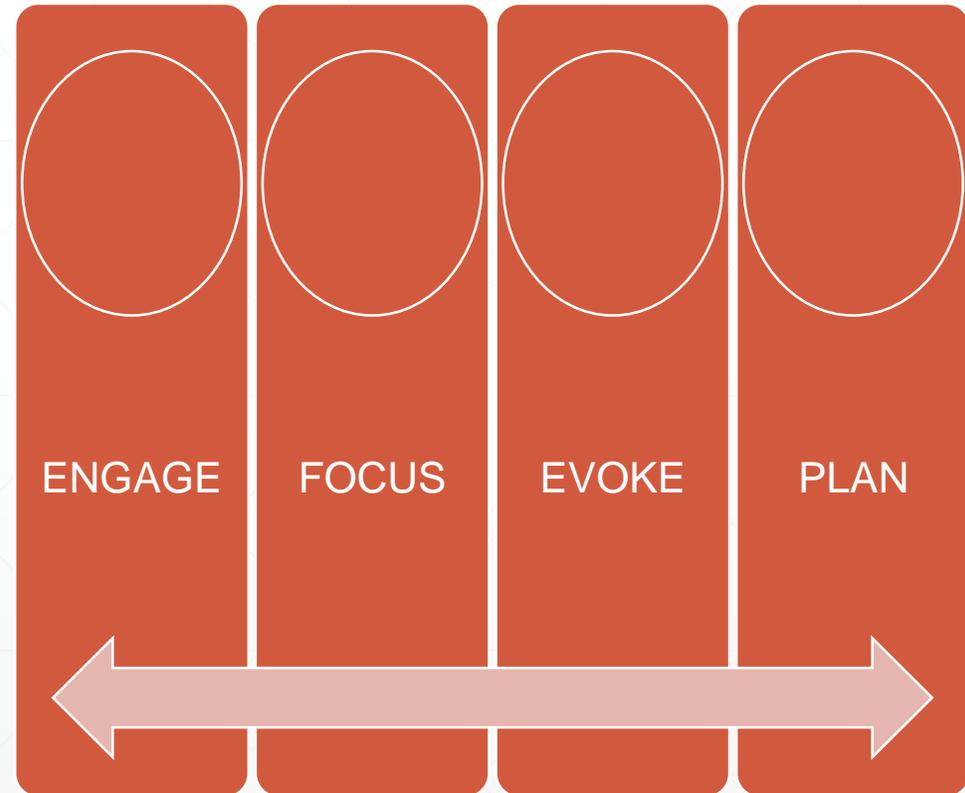
- MI has been defined as “a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.” (Miller & Rollnick, 2002, p.25).
- For example, if something such as substance abuse is threatening housing retention, then that opens up the discussion about the conflict between veteran’s goal of housing and decision to drink/use. Thus, MI techniques are often used in conjunction w/ harm reduction & stages of change model.

# Motivational Interviewing (MI)

- MI is founded on 3 aspects that constitute the “spirit” of MI:
  1. Collaboration
  2. Evocation
  3. Autonomy support

# The Principles & Processes of Motivational Interviewing

1. Express empathy
2. Develop discrepancy
3. Roll with resistance
4. Support self-efficacy



# 10 Strategies for Evoking Change Talk

## Motivational Interviewing

### Ten Strategies for Evoking Change Talk

1. **Ask Evocative Questions:** Ask open question, the answer to which is change talk.
2. **Explore Decisional Balance:** Ask first for the good things about status quo, then ask for the not-so-good things.
3. **Ask for Elaboration:** When a change talk theme emerges, ask for more details. In what ways? Tell me more...? What does that look like?
4. **Ask for Examples:** When a change talk theme emerges, ask for specific examples. When was the last time that happened? Give me an example. What else?
5. **Look Back:** Ask about a time before the current concern emerged. How were things better, different?
6. **Look Forward:** Ask what may happen if things continue as they are (status quo). Try the miracle question: If you were 100% successful in making the changes you want, what would be different? How would you like your life to be five years from now?
7. **Query Extremes:** What are the worst things that might happen if you don't make this change? What are the best things that might happen if you do make this change?
8. **Use Change Rulers:** Ask: "On a scale from zero to ten, how important is it to you to [target change] - where zero is not at all important, and ten is extremely important? Follow up: And why are you at \_\_\_ and not \_\_\_ [lower number than they stated]? What might happen that could move you from \_\_\_ to [higher number]? Instead of "how important" (need), you could also ask how much you want (desire), or how confident you are that you could (ability), or how committed are you to (commitment). Asking "how ready are you?" tends to be confusing because it combines competing components of desire, ability, reasons and need.
9. **Explore Goals and Values:** Ask what the person's guiding values are. What do they want in life? Using a values card sort can be helpful here. If there is a "problem" behavior, ask how that behavior fits in with the person's goals or values. Does it help realize a goal or value, interfere with it, or is it irrelevant?
10. **Come Alongside:** Explicitly side with the negative (status quo) side of ambivalence. Perhaps \_\_\_ is so important to you that you won't give it up, no matter what the cost.

[www.motivationalinterviewing.org](http://www.motivationalinterviewing.org)

# Case Illustration

Robert is a 38-year-old Hispanic single male with a long history of psychotic symptoms and hospitalizations. Currently homeless, he was living in a board and care facility in the downtown area of a large city until 3 months ago and had recently begun a volunteer position as a clerk at a large garden store. An angry verbal dispute with his roommate resulted in Robert leaving the board and care, living on the streets, and not using any psychiatric medications.

Source: Motivational Interviewing in Social Work Practice

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# Clinical Example of MI Adherent Dialogue

**SOCIAL WORKER:** Hey Robert, my name is Susie Maxwell and I am a social worker here at Horizon House. I understand that you met with some people here and learned a little bit about our services [GI].

**CLIENT:** The shower, I used the shower.

**SOCIAL WORKER:** You were able to use the shower [SR].

**CLIENT:** Yeah, that was good.

**SOCIAL WORKER:** You were happy with that [SR].

**CLIENT:** The people here were pretty nice. I don't know how much I want to go to all that group stuff. I've done that. I just wanna have my own space. I've had roommates, I know it's a lot of my fault, I mean I don't like living with other people. I just stay away.

# Clinical Example of MI Adherent Dialogue

**SOCIAL WORKER:** Some of the things that you found here were that you liked the shower facilities and the staff was pretty nice. You're concerned with what else might be involved with being here [CR].

**CLIENT:** I'm thinking that you all might start pushing me—what about meds, what about drinking, what about drug use—and I have done this. I have been in this for a long time. So, I just don't want you to push me. I know what I need.

**SOCIAL WORKER:** Well, my job is not to push you but to get to know you [GI]. But this is your time [MIA—emphasizing personal control] and I am curious as to how you might like to use it. Typically we use it to find out more about you as a person, things you're good at, things you like to do, and also some things that you are concerned about, where we might be able to help you [GI]. So I am curious as to how you would like to use this time together [OQ]?

- Work with one other person
- One will be the speaker and the other will be the listener

If time permits, you can reverse roles

Source: Advanced Workshop in Motivational Interviewing  
(Miller & Moyers), November 14-15, 2016  
Albuquerque, New Mexico

# ACTIVITY:

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A Taste of  
Motivational  
Interviewing

# Activity: A Taste of MI

## The Speaker

**TOPIC:** Something about yourself that you

- Would like to change
- Need to change
- Should or ought to change
- Have been thinking about changing...

## The Listener

- Listen carefully with a goal of understanding the dilemma; give no advice
- Ask these 4 open-ended questions:
  1. What part of you wants to make this change?
  2. What are the 3 best reasons to do it?
  3. How might you go about it, in order to succeed?
  4. On a scale of 0-10, how important would you say that it is for you to make this change?

# Activity: A Taste of MI

## The Speaker

but you haven't changed yet...

i.e. something you're ambivalent about  
– it can be an opportunity

## The Listener

Follow-up: *And why are you at \_ and not a zero?*

- Offer a short summary of speaker's motivations for change
- Then ask: "So what do you think you'll do?"

# Mindfulness Training

- Mindfulness has been defined as: “The awareness that emerges through paying attention; on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment.” (Kabat-Zinn 2003, pg. 145).
- Higher levels of emotional reactivity and impulsivity have been identified as key factors in problematic behavior, which leads to people becoming homeless.
- Mindfulness skills are central to DBT and they underpin and support many other DBT skills. They require practice, practice, practice.

Sources: DBT Skills Training Manual, Second Edition & Mindfulness Training as a Clinical Intervention with Homeless Adults

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**Life is not lost by dying  
Life is lost minute by  
minute  
Day by dragging day  
In all the small and  
uncaring ways**

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-- STEPHEN VINCENT BENET

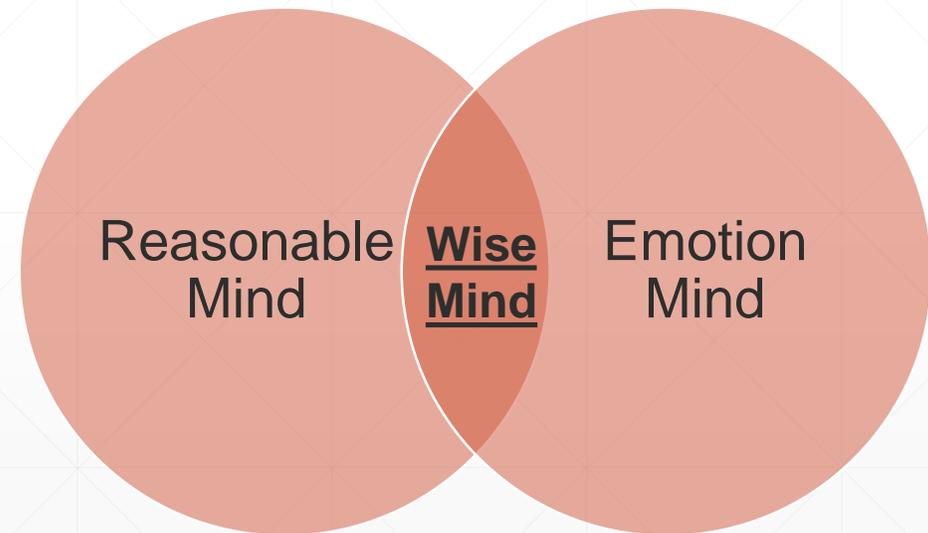
# Mindfulness Skills

## Integration of Mindfulness Practice into Daily Life

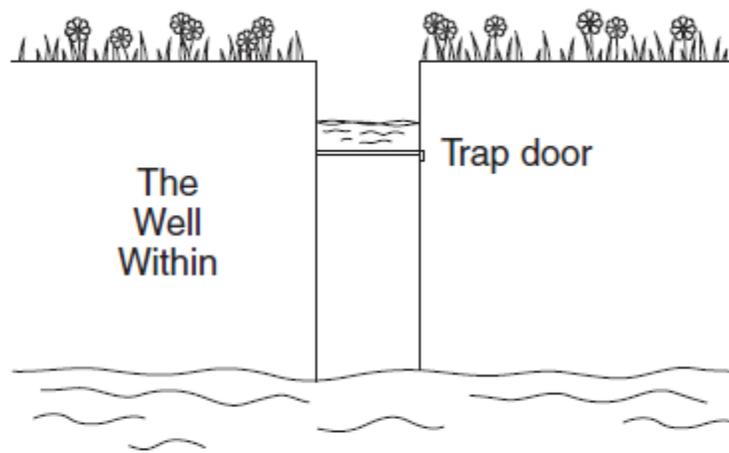
Although living conditions of homeless veterans may present additional barriers to daily practice, many are able to work within the bounds of their situations and find creative ways to apply skills to everyday life, for example:

- Practicing while on long bus rides
- Retreating to public libraries, outdoors by the river, or even their parked cars
- Attending mindfulness-based group in the day room of the emergency shelter

## Wise Mind: States of Mind



# Wise Mind is like a deep well in the ground



**FIGURE 7.1.** The well within: An illustration of wise mind.

# Mindfulness Activity

- Finding Your Lemon
- Mindfully Eating a Raisin
- What's Different About Me?

Source: DBT Skills Training Manual, Second Edition

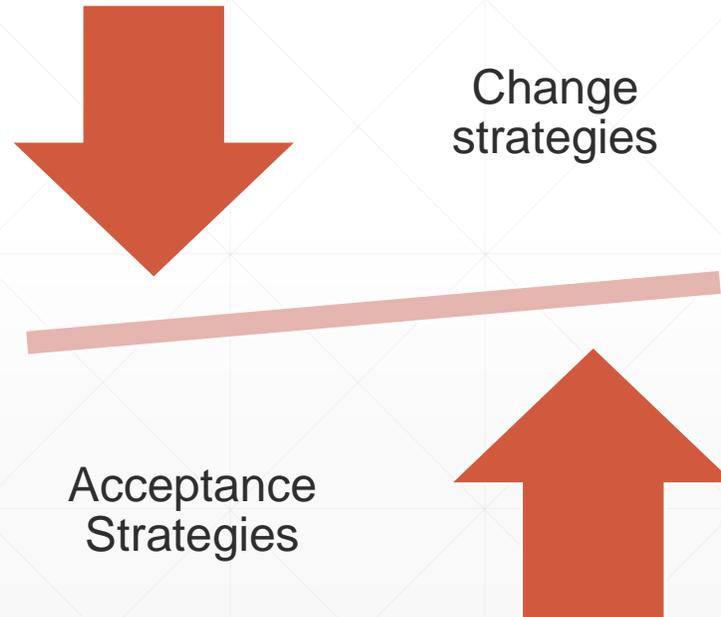
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# Distress Tolerance Skills (DBT Intervention)

## Goals of Distress Tolerance

- Survive crisis situations without making them worse
- Accept reality as it is in the moment
- Become free

## Dialectics



Source: DBT Skills Training Manual, Second Edition

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## Why Distress Tolerance Skills Are Necessary

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Source: Marsha Linehan, Ph.D.

[Borderliner Notes](#)

# Group Exercise: How the TIP Skills Work

- TIP is a mnemonic for Temperature, Intense exercise, Paced breathing, and Paired muscle relaxation (*Note that although there are two P skills, the mnemonic remains the word TIP*)
- The TIP skills can be used to change body chemistry quickly, so as to counteract disabling emotional arousal
- Practice exercise tipping facial temperature

Source: DBT Skills Training Manual, Second Edition

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# Critical Time Intervention

- Critical Time Intervention (CTI) is a time-limited evidence-based practice that mobilizes support for society's most vulnerable individuals during periods of transition.
- It facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical periods.
- CTI has been applied with veterans, people with mental illness, people who have been homeless or in prison, and many other groups.

Source: Center for the Advancement of Critical Time Intervention

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# Critical Time Intervention



Source: [www.criticaltime.org](http://www.criticaltime.org)

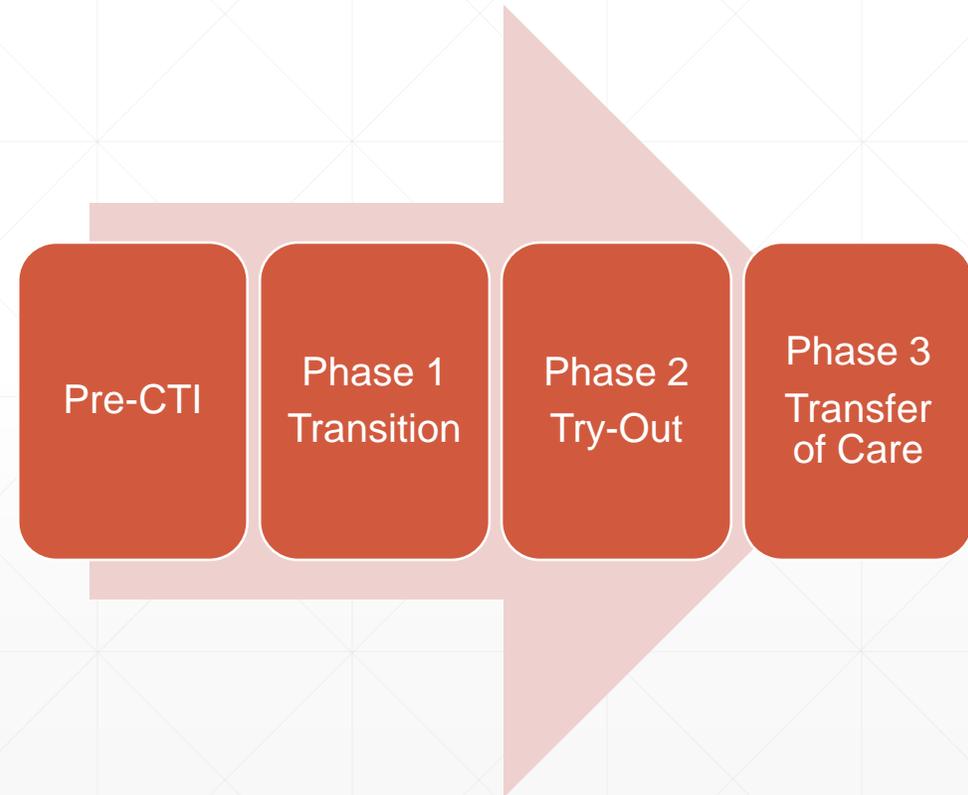
**“Critical Time Intervention helps vulnerable people during times of transition in their lives by strengthening their network of support in the community.”**

Source: Center for the Advancement of Critical Time Intervention, Silberman School of Social Work, Hunter College, NYC

# Critical Time Intervention

## Core Components

- Addresses a period of transition
- Time-limited
- Phased approach
- Focused
- Decreasing intensity over time
- Community-based
- No early discharge
- Small caseloads
- *Harm reduction approach*



# CTI: Phase 1 Case Manger Role and Tasks

- Continue engagement
- Assist with setting up home and getting settled in community
- Begin intensive, assertive outreach to develop linkages to community resources
- With veteran consent, establish working relationship with landlord
- Evaluate veteran's living skills and begin steps to improve areas of limited experience/knowledge
- Support the "settling in" process. Make sure the veteran knows how to deal with repairs, complaints and other problems in the unit
- Provide education about tenancy rights, responsibilities, and expectations
- Model negotiation skills
- Monitor safety in the household
- Meet at least weekly

# CTI Informed HCHV Case Management



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Source: Health Care for Homeless Veterans Case Management Models

# Collaboration with Peer Support

- Peers have shared, lived experiences of phenomena that veterans who are earlier in their recovery present with at the VA, such as veteran status, homelessness, mental illness, and addiction
- The peer approach to service delivery assumes that people that have similar experiences can better relate and offer more empathy and validation than professionals alone

Sources: Which Homeless Veterans Benefit From a Peer Mentor and How?; Expert Viewpoints of Peer Support for People Experiencing Homelessness & HUD-VASH Resource Guide

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# Collaboration with Peer Support

- Within the VA, peers have been shown to inculcate hope, engage veterans in treatment, and help veterans access supports
- For example, potential peer support responsibilities could include: accompanying veterans to 12-step meetings, assertively bringing them to appointments, advocating for veterans, sharing wellness & RP strategies, and providing practical supports to improve socialization & community life skills.

Sources: Which Homeless Veterans Benefit From a Peer Mentor and How?; Expert Viewpoints of Peer Support for People Experiencing Homelessness & HUD-VASH Resource Guide

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# Mr. Eric Boone – Peer Support Specialist



## OVERVIEW OF THE PEER SUPPORT SPECIALIST'S RESPONSIBILITIES, BY CTI PHASE

In the <i>Transition to Community</i> Phase, the PSS:	In the <i>Try-Out</i> Phase, the PSS:	In the <i>Transfer of Care</i> Phase, the PSS:
<ul style="list-style-type: none"> <li>• Meets with the Veteran periodically to establish rapport and encourage the Veteran in the changes he or she is making</li> <li>• Provides input on the HUD-VASH Housing Stabilization plan</li> <li>• Conducts group or individual peer support sessions on topics related to the transition to healthy living in a community setting</li> <li>• Works with the HUD-VASH CM to identify community resources essential for successful community integration</li> <li>• If a Veteran is being discharged with the case management portion of HUD-VASH, PSSs can assist with executing a discharge plan and help the Veteran overcome barriers that arise in using key community supports, including accompanying the Veteran to appointments and meetings when helpful</li> </ul>	<ul style="list-style-type: none"> <li>• Continues to facilitate linkages that have already been established, helping the Veteran think through and resolve obstacles and challenges</li> <li>• Identifies any gaps in support system, barriers in accessing services, or areas where the Veteran needs more support, and works with the CM and other providers to address these gaps</li> </ul>	<ul style="list-style-type: none"> <li>• Celebrates the Veteran's ability to maintain goals in healthy living and puts relapses or slips in perspective</li> <li>• Reflects (with the Veteran) on work that has been accomplished thus far and acknowledges the reduction or end of participation in case management portion of the HUD-VASH program</li> <li>• Reminds Veteran of supports that have been established, says goodbye, and wishes the Veteran the best of luck in continued recovery</li> </ul>

## Peer Support Within the Context of CTI

Source: HUD VASH Resource Guide

**“There’s nothing preventing us from ending homelessness. It’s not a disease like cancer where we still need to find a cure. We know the cure.”**

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Sam Tsemberis, PhD  
Founder & CEO of Pathways to Housing

**“It’s affordable housing for everyone and support services for some small number. As a society, the only thing in our way is our inertia.”**

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Sam Tsemberis, PhD  
Founder & CEO of Pathways to Housing



**Help for Homeless Veterans:  
1-877-4AID-VET (424-3838)  
*va.gov/homeless*  
or make a referral to your  
local VA medical center**

- Ask the question, and make a difference in the care of a veteran:  
“Are you military and receiving VA benefits?”

**Change is possible...**



Photo credit: Beau Rogers



Photo credit: Dave Griffiths

# Questions

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**Thank you for  
participating!**

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Photo credit: Dave Schmidt

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