Self Management Support

HELPING CLIENTS SET GOALS TO IMPROVE THEIR HEALTH

by

Sharon Morrison, RN, MAT

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NETWORK HCH CLINICIANS' NETWORK

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Acknowledgments

This project could not have been completed without the contributions of many people. With heartfelt gratitude I recount the following incomplete list:

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Thank you,

Sharon Morrison

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Introduction

People experiencing homelessness bear a higher burden of illness such as diabetes, asthma or heart disease. Managing one of these chronic conditions while living in a shelter or on the streets can leave clients feeling helpless and overwhelmed. While health care providers play an important role in helping clients to understand and take care of their health, it is the clients themselves who must balance the realities of homelessness while managing their health.

Self management goal setting allows clients to actively participate in their own health care. Health care providers are trained to educate clients on the treatment of their health issues and to use evidence based interventions that have been demonstrated to improve health outcomes. Standard treatment plans focus on areas such as exercise, rest, careful bathing, skin care and proper nutrition. But goals based on standard treatment plans often require resources that are not available to homeless persons, who live in environments in which supportive foot wear, restroom facilities and food options are limited. Likewise, trauma is prevalent throughout the world of homelessness. It complicates care, often compromises the client's perception of safety and must be understood and addressed before diagnosis, treatment or change can occur.

This guide is designed to introduce the health care provider to the basics of self management support within the context of homelessness. It is an introduction to the fundamentals of behavioral change strategies aimed at supporting clients as they take steps to improve their health care. And it will assist health care providers in helping patients identify self management goals that consider the realities of homelessness while designing plans that can promote their independence.

Sharon Morrison
HCH Clinician's Network
National HCH Council

National Health Care for the Homeless Council

The National Health Care for the Homeless Council began as an element of the 19-project HCH demonstration program of the Robert Wood Johnson Foundation and the Pew Memorial Trust. We are now over 94 Organizational Members and over 600 individuals who provide care for homeless people throughout the country. Our Organizational members include grantees and subcontractors in the federal Health Care for the Homeless funding stream, members of the Respite Care Providers' Network, and others. Homeless and formerly homeless people who formally advise local HCH projects comprise the National Consumer Advisory Board and participate in the governance of the National Council.

Statement of Principles

We recognize and believe that:

- homelessness is unacceptable
- every person has the right to adequate food, housing, clothing and health care
- all people have the right to participate in the decisions affecting their lives
- contemporary homelessness is the product of conscious social and economic policy decisions that have retreated from a commitment to insuring basic life necessities for all people
- the struggle to end homelessness and alleviate its consequences takes many forms including efforts to insure adequate housing, health care, and access to meaningful work

Mission Statement

The mission of the National Council is to help bring about reform of the health care system to best serve the needs of people who are homeless, to work in alliance with others whose broader purpose is to eliminate homelessness, and to provide support to Council members.

Consistent with our Mission Statement, we:

- advocate for universal health care and for the improvement of current systems intended to serve people who are poor and homeless
- research critical issues
- train and organize health care providers, service agencies, and homeless people themselves to improve care
- publish newsletters, monographs, action alerts, policy statements, training videos and books
- collaborate with a broad range of public and private entities interested in the problems of health care and homelessness.

For more information, visit the National HCH Council website at www.nhchc.org

Homelessness and Health

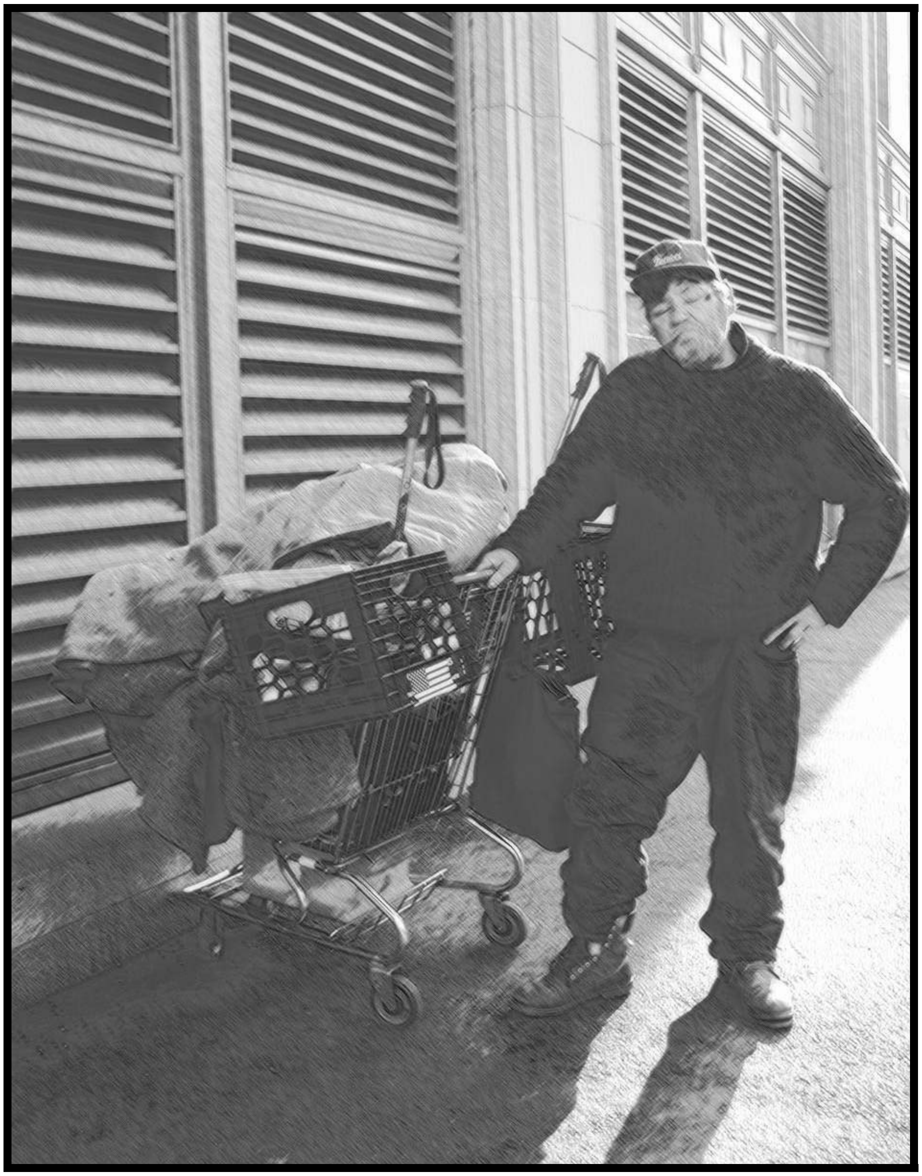

Photo by Sharon Morrison © 2007

The Causes and Conditions of Homelessness

Serious personal health problems and flaws in mainstream health care systems are major contributors to contemporary homelessness. Some health problems – addictions, schizophrenia, major depression, physical disabilities – are distressingly obvious, particularly in persons living in public spaces, while others are less visible but equally insidious, undermining the capacity to maintain stable housing and function independently. In far too many cases, a fragmented health care system has not responded adequately to the multiple needs of homeless persons, who are indigent and typically uninsured.

The Extent of Homelessness

Number of Homeless Persons Annually:
3.5 million

Number of Homeless Persons Nightly:
842,000

Number of Americans Who Have Experienced Homelessness: **12 million**

Urban Institute. What Will It Take to End Homelessness? *2001.*

Homelessness and Poor Health

In 1988, the Institute of Medicine of the National Academy of Sciences found that homelessness and poor health were strongly correlated in three ways:

- **Health Problems Cause Homelessness.** Half of all personal bankruptcies in the United States result from health problems, and it is a short downhill slide from bankruptcy to eviction to homelessness. Moreover, some health problems that are more prevalent among homeless people than in the general population – such as addictions, mental illnesses, and HIV/AIDS – are known to undermine the family and social supports that provide a bulwark against homelessness for many vulnerable people.

- **Homelessness Causes Health Problems.** People without homes are mercilessly exposed to the elements, to violence, to communicable diseases, and to parasitic infestations. Circulatory, dermatological, and musculoskeletal problems are common results of excessive walking, standing, and sleeping sitting up. Homelessness and malnutrition go hand-in-hand, increasing vulnerability to acute and chronic illnesses. Stresses associated with homelessness also reduce resistance to disease, account for the emergence of some mental illnesses, and enhance the false promises of relief offered by alcohol and drugs. Homeless people experience illnesses at three to six times the rates experienced by housed people.

- **Homelessness Complicates Efforts to Treat Health Problems.** The health care delivery system is not well attuned to the realities of living without stable housing. Health care facilities often are located far from where homeless people stay, public transportation systems are insufficient or nonexistent in many places, and most homeless people don't have cars. Clinic appointment systems are not easily negotiated by people without telephones, for whom other survival needs (finding food and shelter) may take priority. Standard treatment plans often require resources not available to homeless persons, such as places to obtain bed rest, refrigeration for medications, proper nutrition, or clean bandages.

These three correlations, noted by the Institute of Medicine nearly two decades ago, still pertain today. The mainstream health care system often is not prepared to contend with multiple co-morbidities commonly seen in homeless people, and is unwelcoming toward those with behavioral health issues who may appear unclean or threatening, cannot pay for services, and typically lack health insurance. Consequently, many individuals who are homeless have had bad prior experiences with the health care delivery system and avoid mainstream providers.

John Lozier

Homelessness & Health Care: Fundamental Issues

Health problems cause homelessness. Homelessness causes health problems. And homelessness complicates efforts to treat health problems. Some of the multiple facets of this intersection between homelessness and health are noted below:

Unstable housing

- Increases risk for serious health problems
- Complicates treatment adherence and recovery

Limited access to nutritious food & water

- Irregular meals with little dietary choice
- Higher risk for dehydration

Higher rates of communicable disease

- Respiratory/sexually transmitted infections including tuberculosis and HIV
- Skin diseases and infestations

Serious & complex medical conditions

- Increased risk for acute/chronic diseases with multiple co-morbidities
- More acute, life-threatening conditions due to delayed care

Lack of health insurance/resources

- Limits access to specialty care and prescription drugs
- Over half of homeless people nationwide are uninsured

Lack of transportation

- Limits access to health care
- Presents obstacle to employment, especially in rural areas

Discontinuous/inaccessible health care

- Due to lack of health insurance, high mobility, and fragmented health services that are ill prepared to deal with complex psychosocial problems

Chronic stress

- Anxiety associated with homelessness, struggle to meet basic needs
- Has negative effects on health, development, and learning

Developmental discrepancies

- Developmental regression/neuropsychological dysfunction common regardless of age, gender, diagnosis, or medical/psychiatric history

Higher rates of abuse

- Over 80% of homeless women are victims of severe physical/sexual assault
- Homeless children are 2–3 times more likely than other children to be abused

Behavioral health problems

- Higher incidence of mental illness, substance use disorders
- Increase risk for disease; can interfere with treatment adherence

Physical/cognitive impairments

- Secondary to trauma, mental illness, chronic substance use, infection, stroke, tumor, poisoning, developmental disabilities

Barriers to disability assistance

- Insufficient documentation of impairments for SSI/SSI claims
- Restrict access to housing and health care, especially for mentally ill

Cultural/linguistic barriers

- Minorities over-represented; health disparities apparent
- Limited English proficiency, cultural insensitivity of providers – obstacles to care

Limited education/literacy

- Less likely to have completed education beyond high school
- Many do not read English well or are unable to read at all

Lack of social supports

- Far from place of origin, seeking jobs, services or respite from abuse
- Alienated from family and friends, stigmatized, isolated

Criminalization of homelessness

- Arrests for activities that are permissible within the privacy of a home
- Medications often confiscated during arrest, not returned
- Criminal record an obstacle to employment, housing, services

From Adapting Your Practice: General Recommendations for the Care of Homeless Patients *Health Care for the Homeless Clinicians' Network. Available at http://www.nhchc.org/Publications/6.1.04GenHomelessRecsFINAL.pdf*

Addressing the Connections Between Poor Health and Homelessness

In communities nationwide, projects providing primary care to homeless people seek to disrupt the terrible nexus between poor health and homelessness. As of April 2007, 185 HCH grantees of the Health Resources and Services Administration (HRSA) were providing health and social services to more than 640,000 clients per year. These projects typically operate as part of Community and Migrant Health Centers, hospitals, Departments of Public Health, or as freestanding agencies. Most combine HRSA funding with other revenue and grants to provide a broad range of services.

At a minimum, each project provides a prescribed set of required services, including primary health care and substance abuse services, emergency care and referrals, outreach and assistance in qualifying for entitlement programs and housing. Many HCH projects go well beyond these basic services, offering dental care, mental health treatment, sub-acute recuperative care, supportive housing, and other services needed to resolve their clients' homelessness.

To engage homeless persons and to provide effective care, HCH projects utilize a number of approaches that accommodate the realities of homelessness. These include:

- **Outreach.** HCH physicians, nurses, social workers and others skilled at making connections with homeless people (often including persons who have experienced homelessness themselves) seek out and bring care to homeless people wherever they are—in encampments, under bridges, on the streets, in jails, at soup kitchens and other service sites.
- **Service locations.** HCH clinics are located in or near shelters and other places where homeless people congregate.
- **Service hours.** Many HCH projects operate during extended hours to accommodate the schedules of clients who work or must be elsewhere at certain times to secure food or shelter.

The Housing Shortage

The US Department of Housing and Urban Development reports 5 million extremely poor households paying >50% of income for housing or living in severely substandard housing.

In no US jurisdiction can a full-time worker earning minimum wage afford an apartment at fair market rates.

National Low Income Housing Coalition

- **Transportation.** HCH projects frequently provide transportation to and from clinics, specialty providers, Social Security or Food Stamp offices, and shelters.

- **Elimination of financial barriers.** HCH projects assure that inability to pay even a small fee does not become a barrier to receiving health services.
- **Sensitivity.** HCH staff endeavor to understand the unique circumstances and stresses associated with homelessness. They understand that the process of engaging individuals who are homeless often involves overcoming significant fear and suspicion, and that a patient, nonjudgmental, persistent approach is often required.
- **Comprehensive services.** HCH providers understand that health care and other basic needs are interrelated, and strive to address each client's needs holistically through the use of multidisciplinary clinical teams. Integration of primary care with the treatment of mental health and substance use disorders is a hallmark of HCH practice, and efforts to secure housing, entitlements, and jobs are intrinsic to this approach.
- **Case management.** Coordination of a wide range of onsite and referral resources receives particular attention in the HCH approach to care.
- **Clinical adaptations**. To promote favorable clinical outcomes, HCH providers have developed techniques such as prescribing simple medical regimens with few side effects, or screening for common problems during the first encounter with a client.
- **Advocacy.** HCH staff engage in advocacy to secure client services, to protect clients' rights, to affect the local service-delivery systems so that they better meet the needs of their clients, and to change policies that cause, exacerbate, or create obstacles to resolving homelessness.
- **Client involvement.** HCH projects are careful to involve their patients in developing realistic treatment plans, in the governance of their agencies, in evaluating the efficacy of homeless services, and in advocating for service improvements and policy change.

The Health Care for the Homeless Program employs a model of care that is appropriate for everyone, but is particularly well adapted to the circumstances of those most in need. By creating numerous new service-delivery sites and modalities, the HCH Program has contributed importantly to the development of the health care infrastructure in the United States. In that respect, HCH is far more than a safety net.

Yet for those whose personal circumstances have reduced them to homelessness and for whom all other systems have failed, HCH remains the final safety net. The quality of care available through

Health Care for the Homeless improves the health and well-being of displaced people and models for all service providers a high standard of care.

Life expectancy

US Population:	77 years
Homeless in Boston:	47 years
Homeless in Atlanta:	44 years
Homeless in San Francisco:	41 years

O'Connell JJ. Premature Mortality in Homeless Populations: A Review of the Literature*, Nashville: National Health Care for the Homeless Council, Inc., 2005*

The HCH approach to care described above is one that can be adopted or modified by a variety of community service providers – disaster shelters, long-term homeless shelters, public health departments – to meet the health needs of displaced persons.

John Lozier

Human Rights, Shelter, and Health Care

The Universal Declaration of Human Rights, adopted by the United Nations in 1948, proclaimed that "everyone has the right to a standard of living adequate for the health and well-being of oneself and one's family, including food, clothing, housing, and medical care."

The Universal Declaration was adopted at the urging of the United States, and extends to the world the promises of our nation's founding documents. Yet our nation still struggles to implement basic human rights, as evidenced by widespread homelessness and the lack of health care for millions of Americans. Indeed, the United States is one of only seven United Nations member States that have not ratified the International Covenant on Economic, Cultural and Social Rights, a legally enforceable treaty that protects the rights to living wages, food, clothing, housing, and "the highest attainable standard of physical and mental health." Emergency shelters do not satisfy these rights – indeed, they are shocking evidence of their violation.

Given the current necessity of emergency shelters, however, it is important to recognize the rights of shelter residents. At the most basic level, shelter residents have the right to be treated with respect, whether their homelessness results from a sudden disaster or from long-term social, economic and personal problems. The opportunity to be heard is an essential component of respectful treatment; shelter operators should establish procedures for redressing grievances and appealing decisions that affect the residents, and should make the procedures known to residents.

Likewise in health care, patients have rights that must be respected by providers of care. Chief among these are the rights to be informed about one's health status, to participate in decisions regarding treatment, and the protection of one's privacy and the confidentiality of treatment relationships. These rights are not abridged by one's economic or housing status.

Care providers, including volunteers and paid staff, also have rights that must be recognized and protected by shelter operators and by shelter residents. Among these rights is the right to be treated with respect, to work in a safe and healthy environment, to have the tools and resources necessary to accomplish their jobs, to earn a living wage, to appeal adverse decisions and to form labor unions.

It is incumbent upon all involved in our work to help assure human rights. Unlike the Economic, Cultural and Social Rights discussed above, Civil Rights to free expression and participation in the political process are well-established in the United States, and their exercise in the struggle for everyone's full human rights is their greatest fulfillment.

John Lozier

The Health Disparities Collaboratives

Photo by Sharon Morrison © 2007

Closing the Gap between What We Know and What We Do

Health Disparities is a term used to describe an increase in:

- the severity of an illness
- the death rate from an illness

by special populations in the United States when these rates are compared to the general population. Persons experiencing homelessness make up one of these special populations.

Areas of disparities include asthma, cancer, cardiovascular disease, depression, diabetes, HIV, immunization status and infant mortality rates. Reasons for these disparities are many and include inadequate access to care, an inability to follow care plans, and systems that fail to understand and address the cultural needs of patients.

The Health Resources and Services Administration (**HRSA**) is the main Federal agency responsible for improving access to health care services for people who are uninsured, isolated or medically vulnerable. HRSA is a part of the U.S. Department of Health and Human Services.

In 1998 the Bureau of Primary Health Care designed a process referred to as the Health Disparities Collaborative as a tool for health centers to look at their practices and to design and implement processes and procedures to eliminate disparities. Through the Collaborative, health centers review the way their care is delivered (process) as well as provide care using guidelines evidenced to improve the health of their patients. In this way they work to close the gap between homeless patients and the general population as well as between what they know and what they do.

Today over 150 Health Care for the Homeless programs participate in HRSA's Health Disparities Collaboratives. The National Health Care for the Homeless Council's Clinicians' Network works closely with the Bureau of Primary Health Care assisting all health centers to understand the complexities of caring for patients who are homeless while working to improve their health and the quality of their lives.

The Care Model

Knowing what you should do and being able to consistently do it has proven to be a challenge to health centers as well as the patients they serve. Health centers that participate in the Bureau of Primary Health Care's Health Disparities Collaboratives are assisted by a model for change called the Care Model. The model summarizes elements for improving care in health systems at the community, organization, practice and patient levels. The components of the Care Model include:

- Organization of healthcare
- Community Resources and policies
- Self management support
- Decision support
- Delivery system design
- Clinical information systems

The individual components interact with each other to create a catalyst for complete change in the way health care is delivered. Self management support focuses on the patient level of care.

The Health Care for the Homeless Clinician's Network has adapted the Care Model to address the needs of persons who are experiencing homelessness as well as the programs that provide services for them.

Below is a diagram that depicts the six components of the Care Model as adapted for Health Care for the Homeless Programs.

Organization of Health Care	**Community Resources**	**Self Management Support**	**Decision Support**	**Delivery System Design**	**Clinical Information systems**
Educate Staff about causes of homelessness and barriers to care	Increase public awareness and understanding of homelessness	Recognize patient priorities are meeting basic needs of food and shelter	Teach providers how to ask about housing status	Gather contact data from patient at each encounter	Use registry for identifying and tracking homeless patients
Furnish personal care items, snacks and socks	Recruit volunteer specialists in podiatry, nutrition, ophthalmology, nephrology, etc.	Recognize trauma as factor that interferes with ability to self care	Educate providers about barriers to care for homeless patients	Use case managers to link patients to entitlement benefits	Enter contact data gathered at each encounter
Train staff in methods to engage patients into care	Collaborate with homeless service providers, emergency dept. staff, criminal justice system and social service agencies	Set and document goals with patients collaboratively to support their independence	Adapt guidelines and treatment protocols	Provide walk in services and or same day appointments	

Organization of Health Care	Community Resources	Self Management Support	Decision Support	Delivery System Design	Clinical Information systems
Recruit providers who embrace change and choose flexibility in the work environment	Collaborate with faith based agencies to provide services		Create interdisciplinary teams	Attempt to provide all services during a single visit	
	Collaborate with homeless coalitions and advocacy groups		Cross train behavioral health and primary care providers	Establish procedures to waive fees for homeless people who are unable to pay for services	
	Solicit donations to help meet care needs for test strips, footwear, glasses, healthy food, etc.		Educate interdisciplinary team members about individual roles	Provide transportation: cab vouchers, bus tokens, van service	
	Educate local businesses about homelessness			Determine outreach staff and services based on a needs assessment	
				Conduct outreach where homeless people congregate	

A Framework for Providing Care

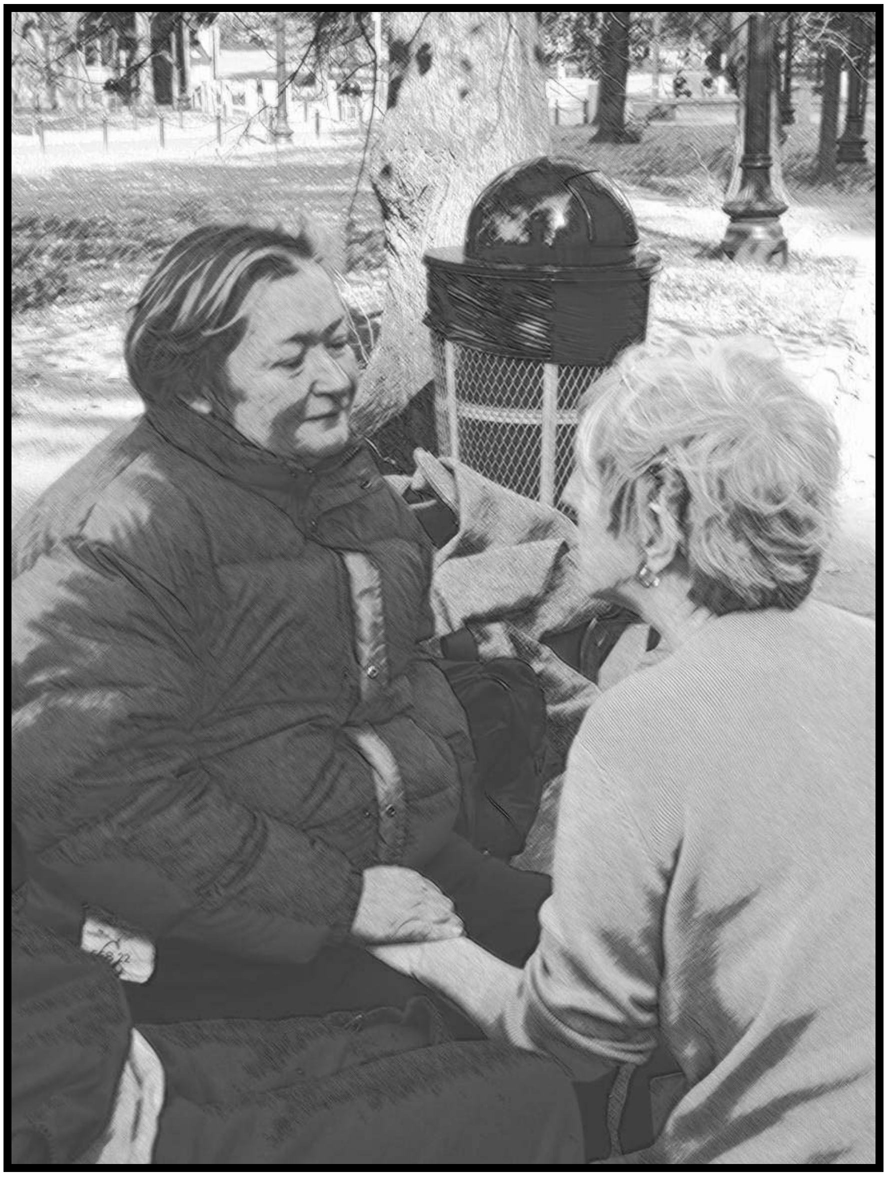

Photo by Sharon Morrison © 2007

Person-Centered
Trauma-Informed
Recovery-Oriented

Person-Centered Care

What is person-centered care? What does it look and feel like? When you eat at a restaurant, check into a hotel, or get a haircut, how do you know if you're receiving person-centered care? When others seek services from you, what lets them know you have a person-centered focus? Often described as "meeting people where they're at" or "starting where the client is," this approach, also known as patient-centered or client-centered, is fundamentally important in reaching out to people who may be reluctant to engage in care.

Person-centered care represents a major shift away from traditional paternalistic models in which the care provider "knows best." It does not make assumptions about who people are, what they need or should value, or what motivates them.

Person-centered care represents a major shift away from traditional paternalistic models in which the care provider "knows best."

Person-centered care is collaborative. It begins with the recognition that the individual already possesses certain strengths, knowledge, skills, hopes, and inner resources. The provider seeks to understand and build upon these attributes.

A person-centered approach is relational *and* goal-oriented. Relational because the provider's style and attitude is characterized by openness, genuine respect, and interest in the well-being of the other. People are more likely to change within the context of a safe, trustworthy relationship in which they can consider their situation and explore possible change steps. Hence, the provider's role is to encourage the person to talk, examine options and resources with them, ask what might get in the way of taking a particular action, help to explore ambivalence, provide useful information and assistance, and support them along the way.

The foremost goals of the provider are focused on the care-recipient's goals, which optimally are collaboratively defined, as well as on the quality of the process of providing care to help meet those goals. The two are interdependent. An effective process of helping, based on using evidence-based practices, enhances the likelihood of favorable outcomes. Conversely, disregard for developing trust and communicating effectively rarely yields positive outcomes, particularly when the person receiving care must be an active participant.

People are most likely to heed advice, adhere to treatment recommendations, and make positive changes when treated with respect and when various options can be considered. The importance of choice cannot be underestimated. The provider consults, but does not coerce. There is a fundamental recognition that individuals rightfully have the authority and responsibility to make decisions about their own lives, except in cases when a person's capacities are severely compromised.

Person-Centered Approach To Care

Genuine, accepting, empathic

Sensitive to individual's worldview

Individualized, holistic

Emphasizes full participation by the individual

Draws on consumer's strengths and inner resources

Emphasizes partnership between individual and provider of care

Individual receiving care determines focus and pace

Promotes consumer choice and self-determination

Person defines outcomes based on own strengths and available supports

Goal-oriented

Decision-making control belongs to the individual

Interventions are consistent with the person's readiness to change

Care is culturally competent

Trauma-Informed Care

Everything about the experience of homelessness is traumatic – the lack of safety, extreme poverty, uncertainties of meeting basic needs, exposure to the elements, lack of access to services, and the loss of meaning and hope. For many homeless people, the trauma is compounded by serious medical conditions, mental health problems, addictions, and/or childhood histories of abuse and neglect.

Constant exposure to multi layered causes of traumatic stress – poverty, illness, violence, and disenfranchisement – has a profound, potentially damaging effect on all aspects of one's being, yet recovery remains possible due to the remarkable resiliency of the human spirit.

Trauma-informed care is an integral aspect of person-centered care. Care providers who have a trauma-informed perspective are likely to be more effective in their practice. They are willing to hear the stories and grieve with others in their suffering, and at the same time be bearers of hope as they help others move in the direction of recovery and healing.

Trauma-informed care providers seek to understand the causes and impact of trauma. They are willing to "look beneath the surface" of a person's life to try to understand why someone may be reluctant to be touched, has difficulty trusting, is fearful or angry, is emotionally detached, has unstable relationships, carries unwarranted shame, or is otherwise affected by traumas that have occurred. Moreover, trauma-informed providers of care also possess the knowledge, skills, and hope of a recovery-orientation.

This guide seeks to encourage all providers, no matter what their role or discipline, to adopt a "universal precautions" approach to trauma. . It is an expectation that trauma plays a prominent role in the lives of people experiencing homelessness; therefore, it is incumbent upon workers to be well-prepared in this regard. A primer on trauma is provided that briefly describes what trauma is, the potential effects it has on an individual, the need for a trauma-informed approach, and what care providers can do.

Understanding the Effects of Trauma

The unexpected loss of a loved one, a car accident, or exposure to a violent experience is familiar to many of us. Everyone reacts to such events, but the responses vary widely, ranging from numbness and withdrawal to crying, nervousness, and agitation.

There is no "right" way to respond to or recover from a traumatic event. Over time, some people are able to integrate these experiences and begin to heal. For others, this is considerably more difficult. Some responses to trauma are prolonged and intense, and interfere with a person's ability to function.

Because traumatic events are prevalent, cause profound suffering, and may lead to life-altering responses, it is imperative that caregivers have the knowledge and understanding to respond skillfully and compassionately to people who have been exposed to traumatic stress.

What is trauma?

A traumatic event is sudden and unexpected, and perceived as dangerous. It may involve a threat of physical harm or actual physical harm, leading to intense fear. It overwhelms our immediate ability to cope.

Traumatic experiences have several key components:

- Intense feelings of helplessness, terror, and lack of control
- Threat to one's physical or mental well-being through violence or threat of violence
- Catastrophic responses

Traumatic experiences come in many forms and can leave survivors with overwhelming feelings of loss, danger, and helplessness. They include:

- Unexpected loss of a loved one
- Loss of job or home
- Accidents
- Community or school violence
- Domestic violence
- Neglect
- Physical and sexual abuse
- Man-made and natural disasters
- Terrorism

Trauma generally falls into two categories:

- **Acute traumatic stress** typically involves a one-time experience (e.g., natural disaster or car accident).

- **Complex trauma** involves prolonged or multiple traumatic events that typically occur within a care-giving relationship (e.g. neglect, physical abuse or sexual abuse).

Effects of trauma

Traumatic experiences are often shattering and life-altering for children and adults. These experiences may affect all levels of functioning and result in an array of distressing symptoms:

- **Physical:** Increase in physical complaints such as headaches, stomach aches, nausea, nervousness, fatigue, palpitations, pain, difficulty sleeping, nightmares, and worsening of existing medical problems. Longer term physical issues include ulcers, asthma, and heart disease.
- **Emotional:** Fear, anxiety, panic, irritability, anger, withdrawal, numbness, depression, confusion, hopelessness, helplessness, difficulty managing, understanding, and regulating feelings.
- **Cognitive:** Difficulty focusing, concentrating, thinking, planning, problem-solving. This "thinking" part of the brain is constantly being shut off in the face of triggers that sound the alarm system. This can lead to problems concentrating, difficulty learning, and struggles at school or work.
- **Relational:** Difficulty maintaining relationships, trusting others, maintaining a sense of self in relationship to others. Perceive the world and others as unsafe. This includes emotional barriers between parents and children, distrust and feelings of betrayal and relationship difficulties (i.e. attachment problems) between parents and children.
- **Developmental:** We all move through various stages of development and learn specific tasks at each stage. For children and some adults, behaviors may "regress" to more immature, younger behaviors.

Nearly all trauma survivors have acute symptoms following a traumatic event, but these generally decrease over time. Various factors can make recovery more difficult:

- **Previous exposure to trauma:** This may include neglect, physical abuse, sexual abuse, or abrupt separation from a caregiver or partner.
- **Duration of exposure to trauma:** A one-time exposure, such as a car accident, results in very different responses than exposure over several years, such as domestic violence. The longer the exposure, the more difficult the healing process.
- **Severity of exposure:** An incident that happens directly to someone or in a person's presence will have a different impact than an incident that happened to someone else or a person learned about later. The more severe the exposure, the more difficult it will be to heal.
- **Prior emotional and behavioral problems:** Pre-existing behavioral problems or a prior history of depression or anxiety may complicate a person's response to a traumatic event.
- **Care provider's response after the exposure:** It matters whether a care provider validates someone's experience or blames the person, or if the worker is able to provide comfort and

reassurance instead of having difficulty responding to the person. When a provider of care experiences a high level of distress, the other person often responds similarly. The care provider's support is one of the most important factors in someone's recovery from trauma.

The need for trauma-informed services

The effects of repeated exposure to traumatic experiences can be long-term and pervasive. All areas of a person's life can be impacted, including biological, cognitive, and emotional functioning; social interactions and relationships; and identity formation. Simply stated, people who have experienced multiple traumas tend to relate differently to the world than those without significant trauma histories.

Many people have endured multiple traumas prior to being homeless and while experiencing homelessness. Their understanding and perception of themselves, their environment, and the people around them is significantly impacted by these experiences. Consequently, these individuals require specific types of services that are sensitive to their status as trauma survivors.

What homeless services providers can do to help

- Adopt a "trauma-informed" approach to service provision and care. This means viewing the lives of people through a "trauma lens" and provides a way to understand their behaviors, responses, attitudes, and emotions as a collection of survival skills developed in response to traumatic experiences. Otherwise, the impact of trauma gets lost amid other mental health, substance use, health, employment, and housing issues in the lives of homeless persons.

- Within shelters, all aspects of programming need to be examined to ensure sensitivity to the needs of those who have been traumatized, including: atmosphere and environment; policies and procedures; assessment and service planning; and staff development and training.

- Shelters and service delivery sites should be trauma-informed spaces for individuals. This requires meeting basic needs and creating a safe environment in which routines and responses are consistent and predictable. Along with the creation of a safe service setting is the need to create an emotional environment that enhances the consumer's sense of safety. This includes a demonstrated tolerance for a range of emotions that may be expressed by the consumer. Tolerance for emotional expression enhances the survivor's internal sense of security and ability to regain self-control.

- Regardless of the response that a trauma survivor exhibits under stress, the provider must understand the individual's reactions in order to provide support. Providers working with trauma survivors should have an understanding of how traumatic experiences affect the brain and the body and how trauma survivors exhibit different reactions in the present due to their past experiences.

- Providers need to be able to recognize how extreme responses of dissociation or overreaction are in fact coping strategies utilized often unknowingly by trauma survivors, to manage their traumatic experiences. Although these strategies work to protect the individual, they may be ineffective and unhealthy in the present. This requires ongoing training and trauma education for providers that allows them to identify what is happening with someone and why the person may be responding in particular ways.

- When providers understand trauma responses, they can help survivors better understand their experiences, provide opportunities for them to practice regaining self-control, and utilize techniques to de-escalate difficult situations. Important components of support for trauma survivors involve helping them:
    - identify specific triggers
    - understand what is happening in their brains and bodies
    - ground themselves in the reality of the present situation
    - develop self-soothing techniques and coping skills to manage feelings associated with past traumatic experiences

- By keeping in mind the potential triggers for trauma survivors, providers can examine their agencies and programs to identify and eliminate daily practices, policies, or ways of responding to people that might result in loss of control or power and feeling re-traumatized.

Points to remember:

- All people respond to traumatic events.
- Responses range from numbness and withdrawal to crying, nervousness, and agitation.
- There is no "right" way to react to or recover from a traumatic event.
- Over time and with support, most people heal.

Adapted from The National Center on Family Homelessness,
Understanding Traumatic Stress in Children, *February 2006*

Recovery-Oriented Care

Care providers use the term *recovery* in various ways.

- From a medical perspective, recovery commonly refers to getting "all better" after being sick or having surgery.
- In the addictions field, recovery has to do with the process of maintaining sobriety or abstinence from using substances.
- For people diagnosed with a major mental illness, recovery has come to be seen as restoration to some optimal level of functioning within one's impairment or disability.
- Recovery from trauma is regarded as regaining a sense of safety, control, connection, and meaning that has been disrupted.
- Recovery from homelessness involves the process of becoming "at home" within one's own being, in one's housing, and in the larger community.

There are as many different definitions of recovery as there are individuals who recover. Moreover, people with multiple and complex problems will define recovery differently for each problem.

Whatever one's perspective on recovery, the good news is that people with serious mental illnesses and/or co-occurring substance use disorders can and do recover. Understanding the concept and practice of recovery is fundamental to the development of effective services for people with serious mental illnesses and/or co-occurring disorders who are homeless.

A Definition of Recovery

The Connecticut Department of Mental Health and Addiction Services has endorsed a broad vision of recovery as:

> **"a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding a life despite or within the limitations imposed by that condition"**

For many, if not most, homeless people who suffer from mental illness, substance use disorders, and trauma, recovery will involve some type of professional intervention, including the use of medication, where appropriate. The following discussion examines other critical facets of the recovery process.

Recovery from Substance Use Disorders

The term "recovery" has been used extensively in the field of substance use where it refers to a return to sobriety. For many individuals, spirituality and peer support are critical to their recovery from addictions.

Recovery from Mental Illness

Use of the term "recovery" only recently has been applied to people with mental illnesses, in part because of the mistaken belief that having a serious mental illness is a lifelong condition. Researchers have found that illness self-management skills – including greater knowledge of mental illnesses, coping skills, and relapse prevention strategies – play a critical role in people's recovery from mental illnesses. However, much of what is known about mental health recovery comes from the writings of mental health consumers themselves. Ultimately, recovery from a serious mental illness is a very personal process that involves the recovery of hope, of meaningful activities and relationships, and of self-esteem and self-worth.

Recovery from Homelessness

Recovery from homelessness also is a process that some researchers have defined as being sober, employed, and housed. Six themes were found to support this process of recovering from homelessness: spirituality, self-insight, security, self-awareness, support, and suppression of poor self-concepts and negative attitudes.

Excerpted from Substance Abuse and Mental Health Services Administration (SAMHSA), Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Use Disorders, *2003*

Three Homes

Home*: one's place of residence, domicile, house, the social unit formed by a family living together, a familiar or usual setting, congenial environment, the focus of one's domestic attention (home is where the heart is), habitat, a place of origin (salmon returning to their home to spawn), headquarters, an establishment providing residence and care for people with special needs, the objective in various games, out of jeopardy, in a comfortable position with respect to some objective, to a vital sensitive core (the truth struck home)*

At home*: relaxed and comfortable, at ease (felt completely at home on the stage), in harmony with the surroundings, knowledgeable (teachers at home in their subject fields), on familiar ground*

Each of us "resides" in three homes.

The **first home** is our very own being – physically, emotionally, intellectually, socially, and spiritually. It is the home of our identity. Early on, others play a primary role in caring for us. Gradually we come to claim more of this responsibility for ourselves.

This home must be kept warm, dry, safe and in good working order. It needs exercise, rest, nutrition and proper maintenance. It also needs to be nurtured and maintained through intellectual stimulation, emotional support, behavioral regulation, time for reflection and development of a sense of purpose and meaning in connection to the outer world.

Although we are wonderfully and complexly made with the ability to do great things, we are also created with considerable fragility and vulnerability. Even the strongest among us experience great frailty at times. Each of us requires the sustaining efforts of others in order to thrive. Despite our best self-care efforts, we still need the knowledgeable care, love and support that others can provide.

Our **second home** is that with which we are most familiar – the place where we live, our housing, where we "nest." It refers not only to the physical structure in which we live but also to the kind of living environment we create within it.

Like the first home, this home possesses important physical, mental, emotional, social and spiritual characteristics. It offers safety and protection from the elements and the outside world. It provides an adequate, private space in which to properly attend to hygiene, rest, and nutrition needs.

This home serves as a base of operations and a place to keep and use one's possessions. It offers a place of welcome, familiarity, and stability. In this home we can welcome guests, share in celebration and suffering, be creative and silly, be still and mindful, be intimate with loved ones, and find renewal of energy and purpose.

The very structure and design of typical housing in our cultural context points to these functions. For example, we construct a foundation (stability, grounding), walls (protection, privacy), a roof (shelter, protection from the elements), doors (welcoming, shutting out), and windows (light, connection with the outside world).

Space is divided into a living room (relaxation, socialization, play), kitchen (hospitality, nutrition), bedroom (rest, intimacy), bathroom (hygiene), study (intellectual stimulation, meditation), closets (secrets), and a yard/garden (play, relaxation). This second home provides the necessary context for meeting the needs of the first home and an important foundation and link to the third home.

The **third home** in which we reside is the larger community, or more accurately, the multiple communities, from the local to the global, in which we are located. Here our interdependence with other people and organizations is fully evident. It is in the context of these various communities that we fulfill various roles and participate in the life around us. We give and receive, produce and consume, lead and follow, serve and are served.

There are numerous opportunities for participation and resources in this third home that permit us to meet the needs of our first and second homes. For example, it is in the context of the larger community that we are connected to health care, education, work, food procurement, transportation, socialization, purchasing goods, entertainment, the arts, politics, recreation and community service. This third home provides the social, economic, service and cultural context for our lives.

What implications does this notion of "three homes" have for care providers? People on the streets often do not feel "at home" in their own bodies, minds, and souls, have no housing to call home, and are disaffiliated from a meaningful role and purpose in the larger community.

It seems clear that if we are to help people resolve their home-less-ness, we are compelled to direct our efforts even beyond addressing basic survival, health, and housing needs. As the saying goes, a house is not a home. We must assist them in making their housing into a home. In addition, we must also help them be more attuned to their own personal conditions, needs and care. And we must help them find their "place" in the larger community.

Helping others move towards a greater sense of being "at home" in their lives begins with the very first outreach encounter. For example, by offering a hospitable presence – "creating a free and friendly space for the stranger" (Henri Nouwen) – one makes it possible for the other person to experience a taste of being "at home." The seeds planted in such a relationship can go a long way to help someone take the necessary steps towards greater stability in all three homes of their lives.

Ken Kraybill

Motivational Interviewing

Photo by Sharon Morrison © 2007

Helping people talk themselves into change

Motivational Interviewing

Motivational Interviewing (MI) is an empathic, person-centered, counseling approach that prepares people for change by helping them resolve ambivalence, enhance intrinsic motivation, and build confidence to change. Or put more simply, helping people talk *themselves* into changing.

The principles and methods of motivational interviewing evolved from the experience of clinical psychologists William R. Miller and Stephen Rollnick in the treatment of problem drinkers. Motivational interviewing has since been found to be effective in a variety of health and social service settings, across many population groups, and with multiple problem areas.[1]

When practiced effectively, MI tends to increase people's willingness to accept care, adhere to treatment, and continue to receive care. The following pages provide a brief introduction to the spirit, principles, and basic skills of motivational interviewing.

Seven Human Needs

To be treated as an individual

To express feelings

To receive empathic responses

To be recognized as a person of worth

To not be judged

To make one's own choices and decisions

To keep secrets about oneself

Adapted from Biestek, F.P. The Casework Relationship, 1957

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[1] Miller and Rollnick, *Motivational Interviewing: Preparing People for Change,* 2nd edition, 2002.

The Spirit of Motivational Interviewing

Motivational interviewing is not a series of techniques for doing therapy but instead is a way of being with patients. - *William Miller, Ph.D.*

The spirit, or style, of motivational interviewing is communicated through the "way we are" with clients. It refers to the attitude and manner that is conveyed – the part of communication that "speaks louder than words." It is well documented that a counselor's spirit, or style, has a more significant impact on the therapeutic relationship than the techniques used.

Below are three frameworks – hospitality, story, and care – each of which speaks in unique way to the spirit of motivational interviewing.

Hospitality – Creating Space for the Stranger

Estrangement, not belonging, is common to the experience of homelessness. One becomes separated from ordinary activities, relationships, and a sense of place and purpose in the world. Literally, one becomes a stranger. The longer homelessness persists, the more deeply ingrained this experience of disaffiliation becomes.

"Offering the gift of hospitality" is an antidote to estrangement. In his book, Reaching Out, Henri Nouwen defines hospitality as "creating free and friendly space for the stranger." As such, it is an invitation to relationship. A hospitable relationship provides a welcoming face and presence, and creates an interpersonal refuge from an often impersonal, hostile world. Thus, a person in the midst of homelessness can experience a bit of being "at home" in the context of a safe, friendly relationship.

Hospitality comes with no strings attached. It does not pass judgment or make demands. Instead, it provides space in which the other can freely explore personal needs, concerns, capabilities and hopes. It allows for self-reflection and restoration. It instills and renews hope. Such a relationship provides both a "resting place" and a "guiding light." The power of hospitality lies not in coercion but in listening reflectively, sharing information and ideas, and in the art of gentle persuasion. It is founded upon the trustworthiness, competency and integrity of the provider.

When we think of our own experiences of being graced with the hospitable presence of another, we remember it as calming, orienting and renewing. It allows us to remember who we are – returning to our true home – so that we can move ahead more confidently in our lives. The absence of such a presence often leads to isolation, disorientation, confusion and despair.

Hospitality can be offered in many ways – sometimes by a simple gesture of acknowledgement, a warm smile, a cup of coffee, listening patiently without interrupting, offering information, a word of encouragement, or simply by being present with the other person in silence. Hospitality cannot be rushed. It requires time, patience and kindly persistence. It sees the "bigger picture" rather than seeks the "quick fix."

As trust within the relationship builds, a sense of companionship develops. Time is spent together on a more predictable basis. Basic needs are addressed. The homeless individual shares more and more of his or her story. Small tasks are shared. Inquiries are made about other resources. In time, hospitality leads to increasing the "circle of care" to help the individual access needed resources and services. In this manner, health care, housing, financial and other treatment and social service needs are met.

Over time, as the individual progresses towards greater stability, the relationship reflects a growing sense of mutuality. It is not just one-sided. Once a stranger, this person becomes known as neighbor and friend. We discover that our stories are interwoven and that we are bonded by our common humanity. In this mutuality, each person is recognized for the strengths and gifts that they bring to the relationship as well as to the larger community. In the end, hospitality that is given becomes hospitality received.

Ken Kraybill

Story

Everyone has a story. Sharing our stories creates a common ground on which we can meet each other as human beings. Our stories are neither "right nor wrong." They are simply our stories. Some of us can tell our stories with an unclouded memory for our past, clarity about our present situation, and a realistic understanding of where our journey is heading in life.
Some of us find telling our story extremely difficult. Our past may be painful and deeply hidden from memory. We may never have had much support in putting together any real, coherent sense of ourselves in relationship to others. Current stresses in our life may be upsetting or confusing the sense of who I am, where I have been, and where I am going.

Mental illness, intoxication, neurological disorders, developmental disorders, and brain injuries can deprive a person of the capacity to tell their story and locate themselves with others and the world. In the midst of illness a person's story may take on disjointed or bizarre dimensions. Difficulty in sharing a coherent story may be an indication of disability, and a need for a patient, especially careful approach to working together.

Inviting another to share their story can be a non-threatening way to gain mutual trust, and develop a picture of a person's situation and needs. A willingness to share a little of our own story in the conversation helps build the common ground. We end, in a sense where we began. As we share our stories over time, hopefully we are both enriched. At best, I have been able to add a little something to another's story, some hope, some concrete help, some encouragement, and they have added something of their courage, their humanness, and their experience to my story.

Craig Rennebohm

Care

The word "care" finds its roots in the Gothic "Kara" which means lament. The basic meaning of care is: to grieve, to experience sorrow, to cry out with. I am very much struck by this background of the word care because we tend to look at caring as an attitude of the strong toward the weak, of the powerful toward the powerless, of the haves toward the have-nots. And, in fact we feel quite uncomfortable with an invitation to enter into someone's pain before doing something about it.

Still, when we honestly ask ourselves which persons in our lives mean the most to us, we often find that it is those who, instead of giving much advice, solutions, or cures, have chosen rather to share our pain and touch our wounds with a gentle and tender hand. The friend who can be silent with us in a moment of despair or confusion, who can stay with us in an hour of grief and bereavement, who can tolerate not-knowing, not-curing, not-healing and face with us the reality of our powerlessness, that is the friend who cares.

To care means first of all to be present to each other. From experience you know that those who care for you become present to you. When they listen, they listen to you. When they speak, you know they speak to you. And when they ask questions, you know it is for your sake and not for their own. Their presence is a healing presence because they accept you on your terms, and they encourage you to take your own life seriously and to trust your own vocation.

Our tendency is to run away from the painful realities or to try to change them as soon as possible. But cure without care makes us into rulers, controllers, manipulators, and prevents a real community from taking shape. Cure without care makes us preoccupied with quick changes, impatient and unwilling to share each other's burden. And so cure can often become offending instead of liberating.

Henri Nouwen, excerpted from Out of Solitude

Four Principles of Motivational Interviewing

Motivational Interviewing – a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence

Miller & Rollnick, Motivational Interviewing, 2nd edition, 2002

Express Empathy

- Create atmosphere in which client can safely explore conflicts and face difficult realities
- Acceptance facilitates change, pressure to change tends to immobilize it
- Accurate, skillful reflective listening is fundamental – seeks to understand the client's feelings and perspectives without judging, criticizing, or blaming
- Ambivalence is normal, not pathological

Develop Discrepancy

- When one's own behavior is seen as conflicting with important personal goals such as health status, living situation, self-image, change is more likely to occur
- Counselor uses and amplifies discrepancy within the person to explore importance of change for him or her
- Goal is to have client, not the counselor, present reasons for change – consistent with self-perception theory – essentially that we come to know what we believe by hearing ourselves say it
- Motivational interviewing is designed to elicit and reinforce change statements. These statements include recognition of the problem, expression of concern, intention to change, and optimism for this change

Roll with Resistance

- Avoid arguing for change
- Resistance is not to be directly opposed – opposing resistance generally strengthens it
- Resistance is a signal to respond differently
- Offer new perspectives but don't impose them
- The client is a primary resource in finding answers and solutions
- Client resistance is significantly influenced by the counselor's behavior

Support Self-Efficacy

- Goal is to enhance the client's confidence in his or her capability to cope with obstacles and to succeed in change
- Assumes the client, not the counselor, is responsible for choosing and carrying out change
- Self-efficacy is a key element for motivating change and a reasonably good predictor of the treatment outcome
- The counselor's own belief in the person's ability to change can have a powerful effect on the outcome – often becomes a self-fulfilling prophecy

Adapted from Miller & Rollnick, Motivational Interviewing*, 2nd edition, 2002*

Self Management Goal Setting

Photo by Sharon Morrison © 2007

Introduction

Self management support involves helping clients to understand actions that affect their health and collaborating with them to develop strategies to live as fully and productively as possible. Self management tasks include a person's ability to:

- Manage the illness
- Carry out normal activities of daily living, and
- Identify and regulate emotional changes.

Self management support consists of helping patients to:

- Understand their disease;
- Decide and choose their treatment;
- Adopt, change, and maintain behavior to contribute to their health;
- Develop skills and use resources available to support changes;
- Cope with their health issues;
- Overcome barriers to better health.

Studies have shown that education based on knowledge alone is not sufficient to sustain behavior change.[2] Interventions that couple knowledge and technique skills along with those that address emotional and behavioral issues are more effective. For this reason, motivational interviewing is an ideal strategy for understanding the strengths and barriers to change from the client perspective. It allows the health care provider to work collaboratively with the client to develop goals that the client identifies as important and achievable. By building on these goals, the person is encouraged to participate in the management of their own health care.

When working with clients to establish self management goals, the provider assists the person to develop a **Personal Action Plan**. The plan will:

- Identify something the client wants to do (i.e. stop smoking);
- Describe what, when, where, and how often the identified change will occur;
- Identify and list barriers to the behavior change;
- Identify and list strategies to overcome the barriers;
- Assess the client's confidence in his/her ability to accomplish the change; and
- Document a follow up plan.

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[2] Bodenheimer, 2002; Funnell and Anderson, 2003; Norris et al, 2002; Piette, 2001; Wolf et al, Cochrane Review; Valk et al,Cochran Review

The Care Model utilizes a simple method to remember the areas to be addressed during the self management support session: The 5As of self management support [3]

- **Assess:** Determine beliefs, behavior and knowledge, conviction and confidence.
- **Advise:** Provide specific information about health risks and benefit of change.
- **Agree:** Collaboratively set goals based on patient's priorities, conviction and confidence in his/her ability to change or self manage.
- **Assist:** Identify personal barriers, strategies, problem solving techniques, and social and environmental supports.
- **Arrange:** Specify a plan for follow up, such as visits, phone calls, or mailed reminders.

Assess

Providers should employ motivational interviewing to assess the client's readiness for change. The four basic tools that are used in motivational interviewing are open questions, affirmations, reflective listening and summarization. Open questions are used to invite the person to tell their story. They encourage the person to talk about what is important to them. By using open questions, the provider can gather information, strengthen his/her understanding of the client's priorities, and establish rapport. Some examples of open questions that might be useful when first meeting with a person to explore self management might be:

- What concerns you most about _____?
- What have you noticed about your _____?
- How can I help you with _____?
- How would you like things to be different?

Open questions are better expressed by "what" and "how" instead of "why", which can lead the client to feel defensive. In the beginning of a session, the provider strives to understand meaning or significance rather than just facts. To contrast open vs. closed questions, consider the following examples. Note how the topic is the same in both questions, but the likely responses will be very different.

- Did you have a good relationship with your parents?
- What can you tell me about your relationship with your parents?

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[3] Whitlock et al, 2002 American J. Prev Med 22:267 – 284

Open questions are also used when trying to asses the client's conviction to change, as well as his/her confidence in their ability to change. A provider might ask:

- What are the good things about ___?
- What are the things about____that cause you concern?
- What do you think you will lose if you give up ___?
- What have you tried before to make a change?
- What do you want to do next?

By using open questions often and throughout the support session, the provider is able to understand what the client views as important.

Advise

The provider can be an important resource in helping the client to understand his/her health issues. In the spirit of motivational interviewing, this information is given to help the client evaluate options and not to convince the client of the folly of his/her ways. To be certain that he/she is not giving unsolicited advice, the provider can ask:

- "How can I help you better understand your ___?"

Education sessions should be tailored from this point to assure that the client is receiving information that is relevant to his/her needs. Resist the desire to give the client everything he/she needs to know about the particular health issue in one session. Building the education around the client's questions will better ensure his/her ability to retain the information.

The provider can review the risks and benefits of behavior change in relation to health issues by using a motivational skill called reflective listening. In reflective listening the provider continually "checks in" with the client to assure they understand correctly what the person is saying. It opens the pathway for engaging the client in relationship, building trust, and fostering motivation to change. Reflective listening appears to be deceptively easy, but it takes hard work and skill to do well. Unfortunately, the "skills" we use in working with clients often do not exemplify reflective listening, but instead serve as roadblocks to effective communication. Examples include misinterpreting what is said or assuming what a person needs.

It is vital to learn not just to listen reflectively, but to ***think*** reflectively. This practice depends upon interest in what the client has to say and respect for his/her inner wisdom. It demands that you test your hypothesis and assumptions, recognizing that what you think the person means may not reflect what they really mean.

A breakdown in the communication process occurs in any of three places:

- The speaker does not say what is meant;
- The listener does not hear correctly; or
- The listener gives a different interpretation to what the words mean.

Reflective listening is meant to close the loop in communication to guard against breakdowns. The listener's voice turns down at the end of a reflective listening statement. Some people find it helpful to use some standard phrases:

- "So you feel..."
- "It sounds like you..."
- "You're wondering if..."

This may feel presumptuous, yet it leads to clarification and greater exploration, whereas questions tend to interrupt the client's flow.

There are three basic levels of reflective listening that may deepen or increase the intimacy and thereby change the affective tone of an interaction.

- **Repeating or rephrasing** is when a listener repeats or substitutes synonyms or phrases, staying close to what the speaker has said.
- **Paraphrasing** is when a listener makes a major restatement in which the speaker's meaning is interpreted and summarized.
- **Reflection of feeling** is when a listener emphasizes emotional aspects of communication through feeling statements. This level is the deepest form of listening.

Varying the levels of reflection is effective in listening. In general, the depth should match the situation. At times there are benefits to over-stating or under-stating a reflection. An overstatement (i.e. an amplified reflection) such as "You really have no intention of changing your diet" may cause a person to back away from a position, while an understatement such as "You say it's time to make some major changes in your diet. Doing something about it is kind of important to you." may lead to the feeling and intensity continuing and deepening.

Agree

Once the client and provider have shared information on the medical aspects of the health issues and the client has identified areas of change that he/she views as important, the two can collaboratively set goals based on these priorities. Commitment to change comes from two interacting elements: ***conviction*** in the importance of change and ***confidence*** in the capacity to promote as well as maintain change.[4] Using a 0 – 10 scale reference, the provider can assess for both conviction and confidence. When assessing for conviction, the provider can ask:

- On a scale of 0 to 10, if 0 represents that you are not convinced at all and 10 represents that you are totally convinced, how convinced are you that it is important to __________?

0	1	2	3	4	5	6	7	8	9	10

Not convinced at all Totally convinced

The provider can enhance conviction by using open questions.

- What makes you say 3 and not 0? (this second number should always be lower)
- What would influence you to rate this a 4 or a 5? (a number higher than the one they have chosen)

The provider can then assess confidence by using the same method.

- On a scale of 0 to 10, if 0 represents that you are not confident at all and 10 represents that you are totally confident, how confident are you that you will be able to make this change?

0	1	2	3	4	5	6	7	8	9	10

Not confident at all Totally confident

The provider can enhance confidence by using open questions.

- What makes you say 5?
- What has helped you to be confident in the past?
- What might help you get to a 6 or 7?
- What can I do to help you feel more confident?

[4] Keller and White, 1997; Rollnick and Butler, 1999

Ambivalence

Ambivalence is a natural phase in the process of change and an important issue to resolve in order for change to occur. Clients can “get stuck” in ambivalence if they are unable to see a clear path forward. If open questions, affirmations, reflective listening, and summarizing were the only skills used by the provider, it would be quite possible for the client to remain stuck in ambivalence. The provider can be instrumental at these times by utilizing a conscious, directive strategy to resolve ambivalence. Instead of the counselor advocating for change, which often puts the client in the position of defending against it, motivational interviewing takes a different tact. The idea is to have the counselor facilitate the client’s expression of change talk - that is, for the client to present the arguments for change and for the counselor to refrain from imparting any bias.

Four Categories of Change Talk

- **Recognizing disadvantages of the status quo** – “This is more serious than I thought.”
- **Recognizing advantages of change** – “I’d probably feel a lot better.”
- **Expressing optimism about change** – “I think I could do that if I decided to.”
- **Expressing intention to change** – “I’ve got to do something.”

Methods for Evoking Change Talk

- Asking evocative questions – “What worries you about your current situation?”
- Exploring the decisional balance – “What do you like about your present pattern?” “What concerns you about it?”
- Elaborating – “What else?”
- Querying extremes – “What concerns you most about ___? What are the best results you could imagine if you made a change?”
- Looking back – “What were things like before you ___? What has changed?”
- Looking forward – “How would you like things to be different a year from now?”
- Exploring goals and values – “What things are most important to you?”

Below is a tool that can be used to explore the ambivalence of change.

Benefits of Status Quo	**Benefits of Changing**
1.	**4.**
2.	**3.**
Costs of Status Quo	**Costs of Changing**

Here is an example using drinking as a health issue:

Benefits of Status Quo	**Benefits of Changing**
1. **Helps me relax** **Enjoy drinking with friends** **Eases boredom**	**4.** **Feel better physically** **Have more money** **Less conflict with family**
2. **Hard on my health** **Spending too much money** **Might lose my job**	**3.** **I'd miss getting drunk** **I would lose friends** **What to do with stress**
Costs of Status Quo	**Costs of Changing**

It is not necessary to conclude with an absolute commitment to change. Instead, the provider should offer an opportunity for the client to explore the possibility for change and to express his/her concerns.

Assist

Providers can offer encouragement by helping the client identify barriers to change and problem solving ways to overcome the barriers. The provider can ask:

- What will get in the way?
- Anything else?
- What could help you to overcome that barrier?
- What has helped in the past?

And by offering:

- Here are some things that others have done…

To help the client envision his/her strengths, the provider can use affirmative statements or gestures to recognize and acknowledge behaviors that lead in the direction of positive change, no matter how big or small. Affirmations build confidence in one's ability to change. To be effective, affirmations must be genuine and congruent. Some examples of affirming responses include:

- I appreciate that you are willing to meet with me today.
- You are clearly a very resourceful person.
- You handled yourself really well in that situation.
- That's a good suggestion.
- If I were in your shoes, I don't know I could have managed nearly so well.
- I've enjoyed talking with you today.

The provider can build confidence further by reviewing past successes the client may have had and defining small steps that can lead to his/her continued success. The provider can teach skills necessary to assist the client, and they can provide statements of hope.

Follow up

Behavior change is difficult, and the gap between what we know and what we are able to do is continually tested by the challenges of our lives. For persons who are experiencing homelessness, these challenges can range from the daily struggle to find food and shelter, to finding the strength to survive despite the overwhelming weight of adversity. Providers need to be vigilant in their efforts to offer support and guidance to clients who live their lives in this balance.

Arranging follow up plans is vital to sustaining self management goals. It reminds the client that they can find continued support, and it offers the provider an opportunity to summarize the process and formalize an action plan. Summary statements can be used throughout a conversation but are particularly helpful at transition points, such as after the person has spoken about a particular topic, or a personal experience or when the encounter is nearing an end.

Summarizing helps to ensure that there is clear communication between the speaker and listener. Also, it can provide a stepping stone towards change.

Structure of Summaries

1) Begin with a statement indicating you are making a summary. For example:

    - Let me see if I understand so far …
    - Here is what I've heard. Tell me if I've missed anything.

2) Give special attention to Change Statements. These are statements made by the client that point towards a willingness to change. Miller and Rollnick have identified four types of change statements, all of which overlap significantly:

    - **Problem recognition** - "My use has gotten a little out of hand at times."
    - **Concern** - "If I don't stop, something bad is going to happen."
    - **Intent to change** - "I'm going to do something; I'm just not sure what it is yet."
    - **Optimism** - "I know I can get a handle on this problem."

3) If the person expresses ambivalence, it is useful to include both sides in the summary statement. For example: "On the one hand …, on the other hand …"

4) It can be useful to include information in summary statements from other sources (e.g. your own clinical knowledge, research, courts, and family).

5) Be concise.

6) End with an invitation. For example:
    - Did I miss anything?
    - If that's accurate, what other points are there to consider?
    - Anything you want to add or correct?

Depending on the response of the client to your summary statement, it may lead naturally to planning for or taking concrete steps towards the change goal.

~Sharon Morrison

Adapted from handouts created by David B. Rosengren, PhD and from Motivational Interviewing *by Miller and Rollnick,* 2002

Tools and Resources

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Health Literacy

Health literacy is the "ability to read, understand, and act on health care information" (Center for Health Care Strategies 2005). In the context of health promotion, an individual's health literacy is critical to his or her buy-in and maintenance of healthy behaviors. It is important to understand that not all of your clients will have the same degree of health literacy.

Functional health literacy is defined as the "ability to read and comprehend prescription bottles, appointment slips, and the other essential health-related materials required to successfully function as a patient" (AMA Council of Scientific Affairs 2007).

- **Patients with poor health literacy skills have a hard time understanding basic medical forms and instructions, such as:**
  - ❖ intake forms
  - ❖ informed consent forms
  - ❖ insurance enrollment forms
  - ❖ prescription labels
  - ❖ self-care instructions

- **Most informed consent and insurance forms are written at a high school level or higher.**

- **People with low functional health literacy are less likely to:**
  - ❖ Understand written and oral information given by physicians, nurses, pharmacists, and insurers.
  - ❖ Act upon necessary procedures and directions such as medication and appointment
  - ❖ Be able to navigate the health system to obtain needed services.

- **Those with poor health literacy are more likely to have a chronic disease and less likely to get the health care they need.**

A study of public low-income hospital patients found that:

26% were incorrect about when their next appointment was scheduled

65% were incorrect about taking medication on an empty stomach

75% were incorrect about how to determine if they were eligible for financial aid.

Williams et al. 1995

Adapted from Center for Health Care Strategies, Inc. Health Literacy Fact Sheets 1, 2 and 4
http://www.chcs.org/usr_doc/Health_Literacy_Fact_Sheets.pdf

Strategies to Assist People with Low Health Literacy

Create an environment that is "shame-free." Here, individuals can feel comfortable asking for help.

Here are some suggestions:

- Provide surrogate readers.
- Prior to an appointment, talk with the individual about what information will be needed.
- Tailor medication schedules to fit a person's daily routine and/or use daily events as reminders to ensure compliance. You may also want to consider color coding medicines, or asking the person what other measures would be helpful.
- Providers might ask patients to "teach back" a medical concept in his or her own words to ensure thorough understanding.

Verbal communication is a critical component of the patient-provider relationship. Individuals with poor health literacy tend to be more responsive to information designed to promote action, motivation, and self-empowerment than detailed facts.

Here are some suggestions:

- If you think the person is having difficulty understanding written or spoken directions, you might want to say, "A lot of people have trouble reading and remembering these materials. How can I help you?"
- Use commonly understood words. For instance, use "keeps bones strong" instead of "prevents osteoporosis."
- Slow down and take time to listen. Build an atmosphere of trust and respect.
- Limit the information given during each visit.

Oral and visual tools help patients to absorb new information.

Here are some suggestions:

- Diagrams or pictures can help someone to understand a recommended action. Consider making a clear and accessible diagram or picture that individuals can take with them.
- Audiotape instructions can be effective if limited to one to five minutes in length. The focus of the instructions should be on behavior rather than facts.
- Videotapes are a useful instructional tool if interactive or instructional, and eight minutes or less in length.
- Interactive computer programs that are user-friendly and geared toward a low reading level can be effective. These programs could also utilize touch-screen interaction and graphics to illustrate the intended behavior.

Create patient education materials that are simple and attractive.

- Brochures will not change behavior, but provide important and accurate information that is easy to digest.
- Written materials used in conjunction with graphics and videos can help patients absorb new information.
- Emphasize the intended behavior, rather than the medical facts.
- Less is more. Only include one or two educational objectives at one time.
- Use clear headings, bullets instead of paragraphs, and ample white space.
- Use short sentences, active voice, and conversational language.
- Use examples and pictures to illustrate important points.

Patients are your best source of information.

- Consider pulling together a focus group to discuss how messages can be made more attractive, relevant and understandable to your target audience. Patient education materials should be field tested, revised and retested to ensure effectiveness.

One study showed that elderly patients given a leaflet with **graphics** were more likely to follow the health-related behavioral suggestions than those who received a text-only brochure.

Jacobson et al., 1999

Adapted from Center for Health Care Strategies, Inc. Health Literacy Fact Sheets 1, 2 and 4
http://www.chcs.org/usr_doc/Health_Literacy_Fact_Sheets.pdf

Understanding Self-Care

In order to effectively serve others, it is important
to find ways to take care of ourselves.

How do we understand self-care?

“Self-care” can be understood in many different ways. In its simplest form, the term refers to our ability as human beings to function effectively in the world while meeting the multiple challenges of daily life with a sense of energy, vitality, and confidence. It also implies that we are active participants in that process. ***Self-care is not “other-care.”*** Rather, it is care that is initiated and maintained by us as individuals. It requires our active engagement.

The term “self-care” spans a full range of issues from the physical, the emotional, the intellectual, and the spiritual. Some conceptualize this construct by considering the dimensions of mind, body, and spirit, or in terms of thinking, feeling, and behaving. It is referred to as “wellness”, a “healthy balance”, “resilience” and simply, mental health. It is important to note, though, that no matter how one breaks down the dimensions of self-care, in the end, all of these different aspects are interconnected. ***Failure to take care of oneself in one realm can lead to consequences in another.***

Personal Stress and its Causes

At the personal level, there is no way to provide a comprehensive list of the different stressors that people experience. Some examples are personal issues like divorce, the death of a loved one, parenting stress, and natural catastrophes. Other stressors might include increased family responsibilities or personal commitments outside of work. What is stressful for one person, however, may have little or no effect on another. This fact calls attention to the importance of self-awareness. By finding the time to monitor our own stress, we can better deal with things as they arise.

Professional Stress and its Causes

Homeless service providers work in highly stressful environments. If allowed to escalate, stress can lead to many negative job-related outcomes. How we choose to negotiate these environments has a lot to do with whether or not our stress is alleviated. As is the case with personal stress, the causes of occupational stress are also many. Some identified factors are listed here:

- Caseload
- Clientele
- Job Expectations
- Organizational Issues

Adapted from Self-Care: Essential Information, Syracuse University
http://suedweb.syr.edu/chs/new_CHS_website/OnlineField/selfcare/home.html.htm

Finding Resiliency and Renewal in Our Work

"In the event that oxygen masks may be needed, place the mask over your own face before assisting others."

Providing care to people experiencing homelessness involves working under demanding circumstances, bearing witness to tremendous human suffering, and wrestling with a multitude of agonizing and thorny issues on a daily basis. At the same time, we have the privilege of becoming partners in extraordinary relationships, marveling at the resiliency of the human spirit, and laying claim to small but significant victories. Such is the nature of this work that it can drain and inspire us all at once.

Despite the rewards inherent in the work, it inevitably exacts a personal toll. By listening to others' stories and providing a sense of deep caring, we walk a difficult path. Yet we do so willingly, knowing that first we must "enter into" another's suffering before we can offer hope and healing. It is interesting to note that the word *care* finds its roots in the Gothic "kara" which means "lament, mourning, to express sorrow."

Caring can become burdensome causing us to experience signs and symptoms of what the literature variously calls compassion fatigue, secondary traumatic stress, or vicarious traumatization. The impact is compounded by the frustrations of trying to provide help in the face of multiple barriers to care, including inadequate resources and structural supports for homeless people such as housing, health care, and incomes. To feel weighed down by these circumstances is not unusual or pathological. It is, in fact, a quite normal response.

The "treatment of choice" for diminishing the negative effects of this stress is to seek resiliency and renewal through the practice of healthy self-care. Self-care is most effective when approached with forethought, not as afterthought. In the same manner that we provide care for others, we must care for ourselves by first acknowledging and assessing the realities of our condition, creating a realistic plan of care, and acting upon it. Though many providers practice self-care in creative and effective ways, we all sometimes lose our sense of balance, and fail to provide the necessary care for ourselves with the same resoluteness that we offer care to others.

To better understand what self-care is, here are three things it is *not:*

1) Self-care is *not* an "emergency response plan" to be activated when stress becomes overwhelming. Instead, healthy self-care is an intentional way of living by which our values, attitudes, and actions are integrated into our day-to-day routines. The need for "emergency care" should be an exception to usual practice.

2) Self-care is *not* about acting selfishly. Instead, healthy self-care is about being a worthy steward of the self – body, mind and spirit – with which we've been entrusted. It is foolhardy to think we can be providers of care to others without being the recipients of proper nurture and sustenance ourselves.

3) Self-care is not about doing more, or adding more tasks to an already overflowing "to do" list. Instead, healthy self-care is as much about "letting go" as it is about taking action. It has to do with taking time to be a human being as well as a human doing. It is about letting go of frenzied schedules, meaningless activities, unhealthy behaviors, and detrimental attitudes such as worry, guilt, being judgmental or unforgiving.

The following A, B, C's of self-care can provide a useful guide in reflecting upon the status of your own practices and attitudes.

AWARENESS Self-care begins in stillness. By quieting our busy lives and entering into a space of solitude, we can develop an awareness of our own true needs, and then act accordingly. This is the contemplative way of the desert, rather than the constant activity of the city. Thomas Merton suggests that the busyness of our lives can be a form of "violence" that robs us of inner wisdom. Too often we act first without true understanding and then wonder why we feel more burdened, and not relieved. Parker Palmer in Let Your Life Speak suggests reflecting on the following question: "Is the life I am living the same as the life that wants to live in me?"

BALANCE Self-care is a balancing act. It includes balancing action and mindfulness. Balance guides decisions about embracing or relinquishing certain activities, behaviors, or attitudes. It also informs the degree to which we give attention to the physical, emotional, psychological, spiritual, and social aspects of our being or, in other words, how much time we spend working, playing, and resting. I once heard it suggested that a helpful prescription for balanced daily living includes eight hours of work, eight hours of play, and eight hours of rest!

CONNECTION Healthy self-care cannot take place solely within oneself. It involves being connected in meaningful ways with others and to something larger. We are decidedly interdependent and social beings. We grow and thrive through our connections that occur in friendships, family, social groups, nature, recreational activities, spiritual practices, therapy, and myriad other ways. Often times, our most renewing connections can be found right in our midst in the workplace, with co-workers and with the individuals to whom we provide care.

There is no formula of course for self-care. Each of our "self-care plans" will be unique and change over time. We must listen well to our own bodies, hearts and minds, as well as to the counsel of trusted friends, as we seek resiliency and renewal in our lives and work.

Fasten your seatbelts and enjoy the ride!

Ken Kraybill

Resources

The National Health Care for the Homeless Council
PO Box 60427 Nashville TN 37206-0427
(615) 226-2292
www.nhchc.org/

The Health Care for the Homeless Information Resource Center
Policy Research Associates, Inc.
345 Delaware Ave. Delmar NY 12054
(518) 439–7415
http://bphc.hrsa.gov/hchirc/

Federal Agencies

Health Resources and Services Administration, Bureau of Primary Health Care
U.S. Department of Health and Human Services
Parklawn Building, 5600 Fishers Lane Rockville, Maryland 20857
Telephone: (301) 594-4303
www.hrsa.gov/

Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Washington, D.C. 20201
Telephone: 202-619-0257 Toll Free: 1-877-696-6775
www.samhsa.gov

Centers for Disease Control and Prevention
Telephone: 800-CDC-INFO□
www.cdc.gov/

Interagency Council on Homelessness
The United States Interagency Council on Homelessness
409 Third Street SW Suite 310 Washington, D.C. 20024
Telephone (202) 708-4663
www.ich.gov/

Other Organizations Focusing on Homelessness

Homelessness Resource Center
189 Wells Ave
Newton Centre, MA 02459
(617) 467-6014
homeless.samhsa.gov

National Coalition for the Homeless
2201 P St NW
Washington, DC 20037
Phone: (202) 462-4822
www.nationalhomeless.org

National Law Center on Homelessness and Poverty
1411 K Street NW, Suite 1400
Washington DC 20005
Phone: (202) 638-2535
www.nlchp.org

National Alliance to End Homelessness
1518 K Street NW, Suite 410
Washington, DC 20005
(202) 638-1526
www.endhomelessness.org

National Center on Family Homelessness
181 Wells Avenue
Newton Centre, MA, 02459
(617)964-3834
www.familyhomelessness.org

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