

HEALING HANDS



Clients access safe, clean injection supplies at the Center for Harm Reduction in Los Angeles, California.

Partnering with People for Life-Saving Change

Harm reduction—or harm minimization—is an approach to managing alcohol use, drug use, and other risky behaviors. It is nonjudgmental and neither condones nor condemns any behavior. Harm reduction practitioners negotiate with clients around what they are most interested in changing and likely to achieve with a focus on reducing the negative consequences of risky behavior. These approaches lead to safer use, improved quality of life, and reduced harm to the individual, the community, and society as a whole (Midwest Harm Reduction Institute [MHRI], 2009; MHRI, 2014).

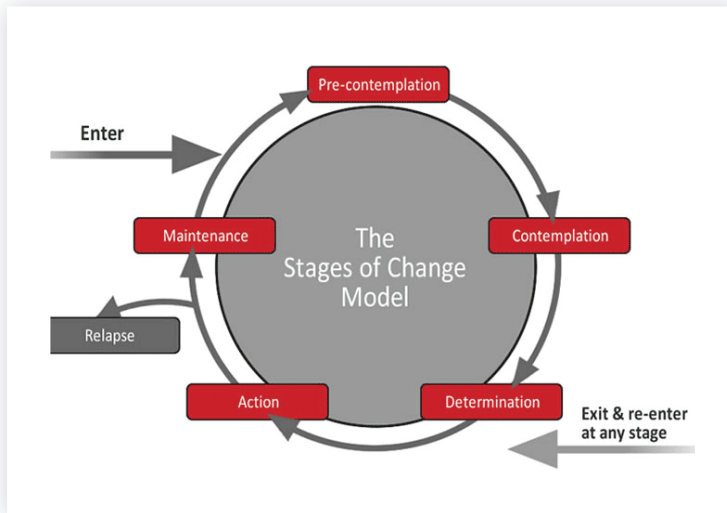
Harm reduction is also a social justice movement committed to universal human rights. A belief in—and respect for—the rights of people who use substances or engage in other unhealthy behaviors are the philosophy's foundation. The practice of harm reduction promotes these rights: to be treated with dignity, to exercise self-determination related to use, and to expect and receive collaboration in therapeutic relationships. Given that this is a person-centered approach, there is no universal formula

for implementing harm reduction strategies (Harm Reduction Coalition [HRC], n.d.; MHRI, 2014).

The Client is the Change Agent

A unifying principle of harm reduction is that substance users do not necessarily have to quit to lessen harm or to resolve problems. While abstinence is a worthy treatment goal, it is not the only one and it is only legitimate if it is proposed by the client. Harm reduction therapy facilitates client-driven behavior change using several techniques: motivational interviewing, psychoeducation, substance use management, and relational psychotherapy. Clinicians use these methods to discuss the risks of combining drugs, overdose, physical harm, and the prevention of victimization (Little & Franskoviak, 2010; Russell, 2010).

Behavioral health clinicians see change as an incremental process in which people engage in self-discovery and transition through



Source: Johnny Holland, 2011

stages of change. Based on studies of how people modify a problem behavior or adopt a positive behavior, these stages include precontemplation, contemplation, preparation, action, and maintenance. The model focuses on the decision making of the individual. Change is not something that most people are ready to do right away. It is something they work up to, and not everyone goes at the same pace. Furthermore, when people are not ready, they can resist pressure to take action. The stages-of-change model breaks the change process into distinct stages of readiness, which provide approaches to help people move forward. Understanding their readiness stage can help clients choose action steps that are right for them while helping them find and maintain the motivation to change (American Psychological Association [APA], 2003; Gold, 2006; Pro-Change Behavior Systems, 2013).

One Size Doesn't Fit All

Traditional treatment for substance-related disorders is rooted in an abstinence-only orientation (MacMaster, 2004), meaning

Principles of Harm Reduction Practice

- » Individuals have a voice
- » The individual is treated with dignity and respect
- » The focus is on reducing harm, not necessarily consumption
- » The individual's decision to engage in risky behaviors is accepted
- » The individual is expected to take responsibility for his or her behavior and resultant natural consequences
- » The practitioner should avoid having predefined outcomes

Source: MHRI, 2009

there is a requirement of sobriety. The 12-step recovery program is one of the best-known and widely available abstinence-based programs, although there is little research regarding the effectiveness of an abstinence-only approach with homeless substance users (Zerger, 2002).

The success rate of the abstinence-only approach drops significantly over time, with only 5 to 7 percent of participants sustaining long-term abstinence (Thompson, n.d.). "Abstinence is black or white: you use or you don't use. Harm reduction falls into the gray area in-between," says **Martin Walker**, harm reduction outreach program coordinator for Albuquerque Health Care for the Homeless (AHCH) in New Mexico.

Abstinence-based programs often have rigid, limited views of success that may translate into unattainable goals for those experiencing homelessness and struggling with mental disorders. Terminating services and other harsh consequences are counterproductive to easing addiction and improving functioning. Agencies that require sobriety often respond

Before I start asking questions, I explain our culture. We don't mandate abstinence from drug use or other risky behaviors.

Colt Coffin, Medical Case Manager, Heartland Health Outreach's Early Intervention Program, Chicago

ineffectively to people who lapse or continue using, interpreting these behaviors as failure instead of being a natural part of recovery (Russell, 2010).

Abstinence may not be realistic or safe for some, so the harm reduction model accepts substance use and other risky behaviors as fact. For many, substance use is not necessarily harmful, while for others, addictions are debilitating. Different people need different solutions. Embracing people as they are and offering a menu of choices and options are fundamental to the harm reduction approach (Gaetz, 2012; MacMaster, 2004).

Substance Use and Harm Reduction

The harm reduction model originated in drug-user communities in reaction to the unresponsiveness of health care and helper professions and the decimation of their communities by viral hepatitis and HIV, says **Valery M. Shuman, ATR-BC, LCPC**, associate director of the Midwest Harm Reduction Institute in Chicago. "Developed by and for drug users, harm reduction involves peer-to-peer interventions," she says. Although public health interventions employ similar strategies, they may not always involve drug users, former drug users, and community stakeholders in active, meaningful ways.

When adapted by public and behavioral health professionals, a harm reduction intervention includes a spectrum of strategies

on a continuum from safer use, to moderation, or to abstinence, depending on the client's desires and needs. These strategies address the conditions of use along with the use itself. Basic assumptions of the approach are that clients want to make positive changes, change is difficult, and failure is discouraging. While it may be difficult or impossible to stop risky behavior, any steps toward decreased risk are steps in the right direction (HRC, n.d.; MHRI, 2009; MHRI, 2014).

An estimated 20 to 35 percent of individuals experiencing homelessness have substance use disorders, which research indicates as being both a result of and a precipitating factor in the continuance of homelessness. Approximately 10 to 20 percent of those with substance use disorders also suffer from moderate to severe mental illness (United States Interagency Council on Homelessness [USICH], 2013; Zerger, 2002). Many of these individuals self-medicate by using alcohol or other drugs to alleviate their symptoms or as a way of coping with their living situation (Russell, 2010).

Typically, those who use substances encounter contemptuous attitudes and dismissive treatment from health care professionals and other service providers (Gunn, White & Srinivasan, 1998). In contrast, harm reduction programs create a welcoming, respectful atmosphere in which clients can connect to the program as a whole. This connection helps address two consistent problems of traditional substance use treatment: engagement and client retention (Russell, 2010; Zerger, 2002).

"Before I start asking questions, I explain our culture," says **Colt Coffin**, a medical case manager for Heartland Health Outreach's (HHO's) Early Intervention Prevention Program in Chicago. "We don't mandate abstinence from drug use or other risky behaviors."

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At HHO, clients build relationships with a team—case managers, a medical provider, nurse practitioners—and this rapport nurtures open, honest conversation. "We do a good job engaging and holding onto the population that we serve," Coffin says. "The key is not to push people to move too fast, which can potentially damage the therapeutic relationship."

Harm Reduction in Practice

Clinicians can use risk-reduction practices with people who engage in any kind of behavior that causes harm or risk of harm. "Think of harm reduction as being health promotion," says Shuman. Harm reduction interventions have been applied to dozens of health promotion campaigns, ranging from seatbelt use to increasing exercise to adopting a low-fat diet (APA, 2003).

Decision Making & Art Therapy

An art therapist, Shuman previously worked at Heartland's Pathways Home, a residential facility for formerly homeless adults who are living with co-occurring mental health and substance use disorders. "Most program participants are actively using," she says, "and while substance use isn't permitted on site, participants may return to the program intoxicated as long as their behavior remains within appropriate limits."

Therapists conceptualize decision making as being a 'balance sheet' of comparative potential gains and losses (Cancer



Homeless Health Care Los Angeles offers additional holistic services like tai chi and mindful meditation alongside harm reduction strategies.

Prevention Research Center, 2000). "Assessing the person's readiness to change and exploring ambivalence is essential before you move into problem solving," explains Shuman. The decisional balance sheet is a motivational interviewing tool that therapists can use with any change process. Mixed feelings often occur when making decisions, "and this exercise helps the client look at the good and not so good things about changing," she says. It is also a way of communicating a therapist's willingness to honor the client's reasons for and benefits of the risky behavior. If one is to change, the scale needs to tip so that the costs of continuing the behavior outweigh the benefits (Sobell & Sobell, 2011).

The therapist can conduct this assessment verbally or graphically, but Shuman finds that art yields the richest picture and is more engaging and less threatening to the client. She has the client create a visual decisional balance by constructing a collage of words and images cut from magazines. "I ask the client to think about the positives and negatives of changing or not changing the risky behavior, and to grab any words and images that seem related." The client selects images they are attracted to, perhaps without consciously knowing why.

"When making art, clients aren't as censoring of themselves and they're often surprised at their insights," observes Shuman. The

client and therapist discuss the collage, the creation process, what prompted the selection of certain items, and what the images and words may mean. This communication can set a tone of openness and honesty, strengthening the therapist/client relationship. "Saying something aloud can create greater clarity in the mind so that ideas aren't so jumbled," she says. "Examining negative aspects of change helps identify barriers that clients must address in order to resolve their ambivalence and move through the change process."

Syringe Exchange & Safer Injection Drug Use

Harm reduction programs have been shown to lower HIV risk and hepatitis transmission, prevent overdose, and provide a gateway to drug treatment programs for drug users by providing health education and services while respecting individual autonomy. Evidence-based, feasible, and cost-effective ways of mitigating health risks associated with drug use and other high-risk behaviors include condom distribution, access to sterile syringes, medications for opioid dependence (i.e., methadone and buprenorphine), and overdose prevention (North Carolina Harm Reduction Coalition, 2014).

New Mexico has the highest rate of heroin and prescription drug overdose deaths in the nation, and teen heroin use in New



Decisional balance sheet represented by collage. Image courtesy of Valery Shuman, ATR-BC, LCPC, and used with permission of the artist.



Needle disposal unit at the Center for Harm Reduction in Los Angeles.

We keep our clients safe by distributing clean injection supplies, providing disease management, and offering education that focuses on overdose prevention/reversal with naloxone and safer injecting techniques.

Mark Casanova, Executive Director,
Homeless Health Care Los Angeles

Mexico is double the national average (Krueger, 2014; New Mexico Department of Health, 2013). In 2001, New Mexico was the first state to pass harm reduction laws to increase the availability of life-saving naloxone (also known by the brand name Narcan), an overdose antidote administered by injection or nasal spray. There is a 911 Good Samaritan provision in the law to mitigate bystanders' and overdose victims' fear of criminal repercussions for reporting overdoses. The intent of these laws is to fight the scourge of drug overdoses (Miller, 2014).

While using drugs can undoubtedly be harmful—heroin can cause respiratory collapse, alcohol can cause cirrhosis, and methamphetamines can cause psychosis—no known drugs cause hepatitis C, HIV infection, abscesses, cellulitis, or endocarditis. Because of limited access to new injecting equipment and lack of safer injection education, these infections spread among injection drug users resulting in considerable morbidity and mortality. Furthermore, through perinatal transmission and high-risk behaviors (e.g., exchanging sex for money or drugs, having multiple sexual partners), people who inject drugs can become a vector for infectious disease transmission into noninfected, non-drug-using populations (Gunn, White & Srinivasan, 1998).

Based on the harm reduction philosophy, needle exchange programs provide injection drug users with syringes and

associated equipment at little or no cost, although programs may require participants to return used syringes to receive new ones. AHCH collaborates with the New Mexico Department of Health to provide syringe exchange and related harm reduction services. "We get back 99 percent of the needles that we give away," says Walker. AHCH uses a van to go to five needle exchange sites, and plans are underway for a sixth location at the Transgender Resource Center of New Mexico.

The AHCH Harm Reduction Outreach Program serves a client base of nearly 1,600. During a recent Thursday morning on a street in northwest Albuquerque, the team interviewed clients, collected dirty needles, and provided fresh ones. "You guys provide a great service," a client tells Walker on the outreach van. "When I was a kid, you'd have up to 25 people sharing one needle," he says. "The pharmacy wouldn't sell you needles; once I had a needle break in my arm. This is a very good program; it helps a lot of people." Another client tells us that the clean needles are critical to protecting his health and keeping him safe.

The program is welcoming and efficient with each visit lasting only a couple of minutes. More than just a needle swap, the program is a one-stop shop for injection drug users, offering testing for HIV and hepatitis, counseling, support groups, case management, and *acudetox*, ear acupuncture to help manage drug cravings and reduce stress and anxiety associated with homelessness. The outreach team invites clients to take whatever they need from an array of injecting equipment, condoms, health education materials, and granola snack bars.

"We fought hard to for this, and I'm happy that New Mexico is a state where needle exchange is available to those who need it," says another client. She tells us that years ago she accompanied AHCH staff to the Roundhouse [the State Capitol] in Santa Fe to advocate for needle exchange. When Walker asks if she knows about Narcan, the client says that she recently saved a friend who had overdosed, and that it took two doses of naloxone to wake him. Free naloxone is available to clients who complete a brief training in overdose prevention.

Adapted Clinical Guidelines: Opioid Use Disorders

Prompted by an increase in deaths nationwide from opioid overdose—particularly among homeless people—the HCH Clinicians' Network developed *Adapting Your Practice: Recommendations for the Care of Homeless Patients with Opioid Use Disorders*. The comprehensive guidelines address standards of care, outreach and engagement, and service delivery design as well as testing and assessment, care plans, treatment management, complications, and follow-up. The document is available on the National Health Care for the Homeless Council website at www.nhchc.org.

Heroin is the 'substance of choice' for 76 percent of program participants. The team uses tablet computers to gather client data and to track the needles. Client names are never used. Instead, a unique code number serves as identification. Clients receive special ID cards allowing them to legally carry syringes; otherwise, they could face a drug paraphernalia charge if police stop them. The outreach team reminds clients to rinse the syringe with water to avoid being charged with possession of illegal substances should blood and drug traces be found in the used syringes.

Community safety is another consideration. The syringe exchange program helps keep used needles out of public places and city landfills, preventing needle stick accidents and possible exposure to infectious disease. The needle exchange program supplies biohazard containers for dirty needles and encourages proper disposal of used equipment, increasing safety for first responders, medical personnel, and neighborhood residents. In 2013, the program disbursed more than 682,000 needles and "our goal for 2014 is one million," says Walker.



Keeping Clients Safe in Los Angeles

Located in Los Angeles's Downtown Skid Row, the Center for Harm Reduction offers a Syringe Exchange program that provides treatment, prevention, and disease management for any user of injection drugs. Every day, injection drug users from all over Los Angeles County come into the exchange to pick up new syringes and drop off used ones to be disposed of safely. "Harm Reduction is all about safety, and at our Center for Harm Reduction we keep our clients safe," says Mark Casanova, Executive Director, Homeless Health Care Los Angeles. "We accomplish this by distributing clean injection supplies, providing disease management, and offering education that focuses on overdose prevention/reversal with naloxone and safer injecting techniques."

The Center for Harm Reduction is not just about managing drug use, however. The building also houses the Healing, Arts, and Wellness program where people live in supportive housing and may participate in holistic services including acupuncture, tai chi, yoga, massage, and meditation. There is also a computer lab along with art therapy and jewelry making programs. The program gives people an alternative place to spend time, allowing them to experience a safer environment that can lead to an improved quality of life. The program is a constructive place to socialize and gain information and life skills where participants are encouraged to make positive choices.

"It's a big decision to quit using drugs," Walker says, "and navigating the substance use treatment system can be overwhelming. We learned that 20 percent of our clients had tried to get treatment, but couldn't for three main reasons: lack of insurance, long waiting lists, and program admission criteria, such as sobriety." In response, AHCH created a specialist position that focuses on getting clients linked to the services they want. In six months, the program saw a 25 percent increase in participants who received a referral and follow-up to substance use treatment.

"We already see clients gaining treatment access as a result of the Affordable Care Act," Walker says. "We went from 15 to 80 percent of our clients being Medicaid-eligible or enrolled, so now most of our treatment referrals will be covered by insurance."

Healthy Eating & Wellness

"Dietitians take a harm reduction approach, although we may not call it that," says **Laura Ritland MS, RD, LDN**, food and nutrition program manager for the Vital Bridges Center on Chronic Care in Chicago. Vital Bridges serves those with HIV/AIDS by providing nutritious food; safe, stable housing; counseling and support; case management; and education and vocational training. The majority of Vital Bridges clients are formerly homeless or living in unstable housing situations.

Many HIV-positive individuals are also dealing with chronic conditions, such as diabetes, liver disease, or renal disease. Diabetes can be challenging to manage for anyone, but especially for someone with an unstable living situation, Ritland says. "Diabetes is easier for the client to manage if changes are broken into small steps. The key is finding where the client is ready to make change," she explains. "We ask, 'What can you do now to manage your diabetes better?' Maybe the client is unaware of how eating better or exercising more may improve the way they feel, so we discuss how these changes could help them de-stress."

People who have diabetes should regularly monitor their blood glucose level to manage their condition and prevent diabetes complications. "The recommendation is to test their blood sugar before and after every meal. For clients who cannot always afford monitors and needles, however, we suggest that they test and record their levels daily—or every other day—upon awakening," says Ritland. This practical approach yields good results, and the blood glucose record helps the clinician understand how well the client's diabetes management plan is working.

To help clients pinpoint where they can make changes to help lose weight, Ritland asks them to do a 24-hour food recall. "If they typically drink a liter of soda, we ask if they are willing and able to move to 16-ounces, and from there, to a 12-ounce serving." Ritland sees the biggest improvement and progress towards clients' goals when they work toward achievable steps.

"Poor people have different struggles," Ritland continues. "If they have food stamps, we show them how to eat healthier within their budget. Instead of buying a small bag of chips at the convenience store, we show them that with the same amount of

money they could buy three apples.” Vital Bridges hosts cooking demonstrations and teaches clients how to compare food’s nutritional value and cost so they can make healthy, budget-friendly choices.

Harm Reduction Housing

Housing is the greatest harm reduction approach that we can take to decrease the risks of mortality and morbidity. Those with substance use problems, however, face barriers to accessing and maintaining housing. Many shelters require sobriety and the abstinence-only policies of public housing may screen out these individuals. Being without stable housing only increases the likelihood that any substance use treatment will fail (USICH, 2013).

Both harm reduction and Housing First models lessen the negative consequences of addiction while also working to alleviate homelessness. Compared to traditional treatment, combining harm reduction with Housing First is a more effective form of treatment in lessening homelessness and alleviating negative effects of substance use. The model recognizes the importance of providing quick, permanent, and independent housing to homeless individuals before offering case management and other voluntary supportive wraparound services, such as counseling or help with addiction (Russell, 2010).

This relatively recent approach focuses on housing retention and the individual’s increased functioning. Harm reduction strategies are an essential element of Housing First programs, as sobriety is not a requirement to obtaining and maintaining housing. A 2007 study by the Substance Abuse and Mental Health Services Administration found that 80 percent of Housing First program participants remained housed compared to 30 percent of participants in the traditional abstinence-based housing program (Russell, 2010).

Harm reduction is the lowest threshold, most comprehensive treatment for working with complex individuals, particularly those who are homeless, poor, and otherwise marginalized by society (Little & Franskoviak, 2010). “The harm reduction model offers culturally appropriate and trauma-informed care for those who are experiencing homelessness. It’s consistent with the health care for the homeless approach, and can be incorporated across the services we provide,” Walker says. Meeting people where they are, in a nonjudgmental way that engages them in services, can help accomplish the goal of ending homelessness.

References

American Psychological Association. (2003). *Understanding how people change is first step in changing unhealthy behavior*. Retrieved from <http://www.apa.org/research/action/understand.aspx>

Cancer Prevention Research Center. (2000). *Transtheoretical model: Decisional balance*. Retrieved from <http://www.uri.edu/research/cprc/TTM/DecisionalBalance.htm>

Gaetz, S. (2012). *Substance use and addiction: Harm reduction*. Retrieved from <http://homeless.samhsa.gov/channel/harm-reduction-273.aspx>

Gold, M. S. (2006). Stages of change. *PsychCentral*. Retrieved from <http://psychcentral.com/lib/stages-of-change/000265>

Gunn, N., White, C., & Srinivasan, R. (1998). Primary care as harm reduction for injection drug users [Essay]. *Journal of the American Medical Association*, 280(13), 1191 – 1195.

Harm Reduction Coalition. (n.d.). *Principles of harm reduction*. Retrieved from <http://harmreduction.org/about-us/principles-of-harm-reduction>

Krueger, J. G. (2014, February 15). Heroin scourge cuts across cultural and economic barriers. *Albuquerque Journal*. Retrieved from <http://www.abqjournal.com/353525/news/heroin-use-is-up-nearly-80-percent.html>

Little, J., & Franskoviak, P. (2010). So glad you came! Harm reduction therapy in community settings. *Journal of Clinical Psychology*, 66(12), 175 – 188.

MacMaster, S. A. (2004). Harm reduction: A new perspective on substance abuse services. *Social Work*, 49(3), 356 – 363.

Midwest Harm Reduction Institute. (2009). *Harm reduction: Preparing people for change*. Retrieved from <http://www.heartlandalliance.org/mhri/about-us/harm-reduction-defined.pdf>.

———. (2014). *Midwest Harm Reduction Institute*. Retrieved from <http://www.heartlandalliance.org/mhri>

Miller, D. (2014). States adopting harm reduction laws to prevent overdose deaths. *Capitol facts & figures*. Retrieved from <http://knowledgecenter.csg.org/kc/content/states-adopting-harm-reduction-laws-prevent-overdose-deaths>

New Mexico Department of Health. (2013). *New Mexico substance abuse epidemiology profile*. Retrieved from <http://www.health.state.nm.us/ERD/SubstanceAbuse/NMDOH-ERD-SubstanceAbuse-SEOW-2013-EN.pdf>

North Carolina Harm Reduction Coalition. (2014). *What is harm reduction?* Retrieved from <http://www.nchrc.org/harm-reduction/what-is-harm-reduction>

Petersen, S. R. (2008). *Harm reduction: Expanding the dialogue of recovery* [PowerPoint presentation]. Presentation for the Gateway Foundation Alcohol and Drug Treatment.

Pro-Change Behavior Systems. (2013). *The transtheoretical model: Evidence-based behavior change*. Retrieved from <http://www.prochange.com/transtheoretical-model-of-behavior-change>

Russell, A. (2010). Housing First and harm reduction: Effective models for substance abuse treatment with individuals who are homeless. *Praxis*, 10, 63 – 69.

Sobell, L. C., & Sobell, M. B. (2011). Decisional balance exercise [Client handout 3.1]. In *Group therapy for substance use disorders: A motivational cognitive-behavioral approach* (pp. 61 – 63). New York, NY: Guilford Press.

Thompson, G. (n.d.). *Abstinence approaches to addiction treatment*. Retrieved from <http://canadianharmreduction.com/node/281>

United States Interagency Council on Homelessness. (2013). *Substance abuse*. Retrieved from http://usich.gov/issue/substance_abuse

Zerger, S. (2002). *Substance abuse treatment: What works for homeless people? A review of the literature*. Nashville, TN: National Health Care for the Homeless Council.

Websites accessed March 2014.



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