Going Deeper: expanding your toolkit to collaborate with tricky clients

Vermont Health Care Innovation Project

Advanced Care Coordination Training

Presented by Julie Barnes, LMHC & PCDC

September 20-21st, 2016

Arriving…

- Stretch & poem
- Introductions:
  - Stand Up/Sit Down
  - At tables
- Group agreements

Group agreements

- *Confidentiality
- Tech etiquette
- Step up/step back
- 1 Diva 1 Mic
- Respectful listening/agree to disagree
- “Don’t yuck my yum”
- Positive risk
- Get your needs met
- Have fun!

2 Day Agenda

- Day 1:
  - AM: Recap & overview, mental health principles & practice
  - PM: Harm reduction & substance use

- Day 2:
  - AM: Team -based care: good, bad, ugly; peer consultations circles
  - PM: Managing homelessness, integrative practice

*1 hour lunch, 15 minute break am & pm at flexible times

Learning goals

- Strengthen existing skills & knowledge for coordinating care for high-risk clients facing multiple barriers to health.
- Deepen understanding of & confidence in using Motivational Interviewing and Harm Reduction approaches to engage and retain clients in care.
- Learn how to use the “Healthy Conversations” curriculum: plan & troubleshoot practical ways to use these tools with the people you accompany.
- Develop a more nuanced, flexible, and collaborative stance towards challenging clients and their challenging behaviors.
- Improve ability to be self-reflective & integrate best practices for “managing one’s own stuff” into work with clients.
- Be able to acknowledge and work with personal & structural barriers our clients face by holding a holistic & systems perspective.
- Recognize the myriad of challenges we face as providers and work together to tackle them mindfully & skillfully by learning from each other.

Our intentions are to offer space for

- Peer learning
- Sharing practical tools
- Building on your existing knowledge
- Reflecting on own work, both joys & stressors
- Conversations that draw from & relate back to real patients & challenges
- Lively collaboration

<u>Advanced training=</u>

We recognize the expertise & wisdom in the room and draw on that a central resource.

We aim to challenge you to stretch and grow as a professional in a safe, relaxed, collegial environment.

Teachback

- What are the most meaningful things you took from the initial training?
- What lingering questions do you have?
- What would you say are some of the best practice for coordinating care in a client-centered way? What are some challenges?

Motivational interviewing recap

- What do you remember about Motivational Interviewing? How do you use it now in your work?
- OARS
- Active listening to build trust, assess and build on intrinsic motivation, and set small, realistic goals based on where client is at now!

We review because we expect you will practice these skills throughout our 2 days together!

Self-assessment & partner sharing

- On your own, reflect & answer the questions in the handout. Focus on those that draw your attention, as you don't need to answer them all.

- When you're done, find a partner that you don't know to share your insights to the degree you feel comfortable.

1. Useful mental health concepts

Breath practice: breath of joy

- Energizing
- Free, safe, easy
- Great first thing in the morning or anytime you feel sleepy & likely to reach for coffee/sweets

“But some of us are not therapists!….”

- True!…and MH concepts are **useful lenses** to help us understand ourselves & our clients better.
- You don’t have to totally believe the concepts for them to be a **resource** for working through stuck places, challenging clients & uncomfortable feelings we have in our jobs.
- **Invitation** to try it on: see what resonates with you, ask questions, & challenge the framework as we explore it together.

7 key concepts

- Ambivalence
- Defenses
- Projection
- Unfinished business
  - Un-grieved losses
  - Repetition compulsion
- Transference
- Countertransference

Ambivalence

- From “ambi” meaning both, “valence” meaning directions.
- Wanting two contradictory things at once, being deeply pulled in two directions.
- **Normal** part of being human, especially in the face of trying to change health behaviors & habits.
- *Example: Wanting to quit drinking because it’s hurting your relationships with your kids but being afraid of losing friendships if you do quit because you whole network drinks.*

Defenses:

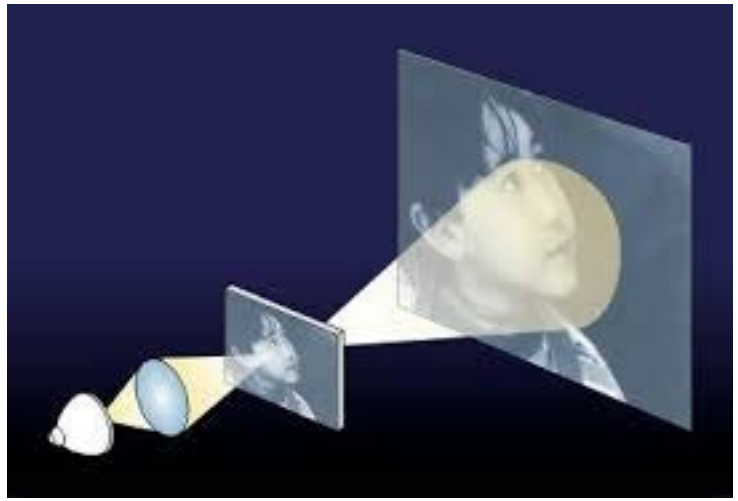
Protective, learned behaviors from childhood to deal with uncomfortable, scary, or threatening situations or feelings that work less well in adulthood

- Common unskillful defenses:
  - Rationalization/ intellectualization
  - Denial/repression
  - Acting out
  - Compartmentalization
  - Disassociation
  - Reaction formation
- "Mature defenses"
  - Sublimation
  - Compensation
  - Assertion

http://psychcentral.com/lib/15-common-defense-mechanisms/2/

Projection

- WHAT: Avoiding uncomfortable feelings by attributing them to another person.
- WHY: Often the feelings challenge the person's idea of who they are or make them feel very ashamed so it's hard to admit or face them directly.
- WHO: All of us, from clients to clinicians, do this unconsciously sometimes as a way to protect ourselves.



WHAT CAN WE DO: Develop self awareness, aim not to judge ourselves or each others, take responsibility for healing & making peace with our past so we can live with more clarity & freedom!

Our baggage= unfinished business

1. Un-grieved losses: Death/loss from the past that has not been fully felt, worked though, and integrated. Grieving is hard work!

*May be personal, familial, or communal and handed down

2. "Repetition Compulsion": We unconsciously seek our people & situations that are similar to the painful parts of our growing up in hopes of healing/a different ending.

What feels like "love"/"home"= shaped by childhood & very hard to let go of. We are seeking what we didn't get!

One perspective on transference & countertransference

“Countertransference” examples:

- A SASH coordinator works with a sick **elderly patient, who reminds her of her deceased grandmother** who raised her, and goes by the apartment every day (even though she’s supposed to visit weekly).
- A social worker who once lived in a **domestic violence shelter** with her children gets frantic when her clients’ housing is at risk or when she sees signs of DV in the home and gets pushy with her clients about their **safety.**
- A patient navigator in long-time **recovery** from heroin addiction who quietly thinks his actively using clients have to **“hit bottom”** before they will get better, so doesn’t make much effort to re-schedule home visits if these clients miss one.
- An outreach worker who identifies as **queer** who avoids meeting with a new client who appears very **religious** and reports attending a fundamentalist church.

Mental checklist for “countertransference”:

- 1) **Is this feeling characteristic?** (i.e., does the worker have it a lot?)
- 2) **Is the feeling triggered by something unrelated to the patient**?
- 3) **Is the feeling obviously related to the patient**?
- *4) **Is the feeling uncharacteristic of the worker, a reaction to a particular patient, and yet the exact trigger is not obvious?**
- *Questions adapted from Steven Reidbord M.D., Sacramento Street Psychiatry,* https://www.psychologytoday.com/blog/sacramento-street-psychiatry/201003/countertransference-overview

Take away points

- Pay attention to your own:
  - History
  - Development & evolution
  - Players in your life
  - Relationship to authority (+ & -)

Be on the lookout for **"the double whammy of secondhand shock"**

= your empathy for the client + body memories of your own similar difficulties

Notice without judging

- The goal with these ideas is not to make us or our clients "bad/wrong"
- All of these feelings/approaches are normal & not a sign of mental health issues
- When we understand a little but about basic psychology, we can work with these built-in challenges more skillfully in a way that:
  - Protects client from harm due to unprofessional behavior
  - Protects us from burnout from doing too much, loose boundaries, or taking problems home

Activity: trios conversation

- Think of a client that you have strong feelings about (caring/connection or frustration/annoyance).
- Journal about what it is about the client or their behaviors that pushes your buttons & how that may connect with your history.
- Share as much as you'd like with 2 colleagues.
- Together, come up with 1-2 strategies together to shift the way you think about/relate to this client.

Risks of not dealing with our “stuff”

- Unequal time/attention across the caseload
- Boundary crossing
- Rescuing
- Overwork/bringing work home
- Confusion
- Increased emotional distress/suffering by staff
- Risk of neglect or lower quality care to some patients
- Burn-out
- Ethical violations
- Job loss

Best practices

- Clinical supervision
- Outside therapy (as needed)
- Peer consultation
- Taking time away to reflect/recharge
- Revisiting your boundaries regularly (pro/cons)

*Goal= awareness of self without judgment and moving to skillful action not reacting from old baggage

Breath into break

- Alternate nostril breath for balance

Mental health: holistic perspectives & practical tools

Intersectional framework

- **Holistic view** of person, person is NOT their diagnosis or history
- Looks at family, community, cultural, **systemic, & structural factors** that shape a person's health, quality of life, and behaviors
- **Recognizes oppression** & inequality are root causes of addiction, chronic disease, and many mental health symptoms
- Emphasizes the common challenges & **less than perfect coping skills** we share with clients as human beings
- **Avoids trying to fix people**, blame people for their problems, or take responsibility for "saving people" from themselves
- Increases empathy, flexibility, & our ability to**see complexity & sit with discomfort**
- **Believes change is possible** with individualized support and effort over time, with respect & collaboration as core practices <3

What are you seeing?

- What kinds of mental health issues are most common with our population?
- Which strategies of working with these clients have you found most helpful?
- What are the biggest unmet needs you see for this population?
- What makes you proud of your work with this population?
- What are the biggest challenges for you in successfully accompanying folks with MH issues?

Challenges

- Stigma (pathology framework)
- Healing is a long-term process!
- Broken or inaccessible systems of care
- Multiple issues: dual diagnosis, chronic diseases, poverty, etc.
- Agencies under stress: staff turnover, unreliable funding, burdensome documentation, unclear roles, limited support
- Clients with MH issues may particularly trigger us into defensive behaviors that lead to burnout
- Larger context: income inequality, sexism, structural racism, war on drugs etc.

"Healthy Conversations"

- Blue Cross Foundation grant to PACT Project in 2013 for reducing health disparities
- Developed by a *multi-cultural team* of CHWs, social workers, MPHs, primary care doctors, and psychiatrists in Boston
- Rooted in harm reduction, motivational interviewing, **person-directed** care, holistic health, & a strengths perspective
- Currently used by CHW teams with HIV+ people in NYC & Boston and folks with chronic diseases in LA & rural AR.

- **Goal:** build behavioral health knowledge & skills among care teams, educate & empower participants around their MH/SU issues, build readiness for care, decrease stigma, and share holistic coping tools for these difficult problems.

Nuts & Bolts

- 3 tracks: Mental health, substance use, dual diagnosis
- Order: intentional but flexible
- Topics broken into conversations, each with teaching content & activities, designed to take about 20 minutes
- Priority v. optional topics
- Guide not a script
- Meant to facilitate conversation, uncover barriers, hone in on motivation, and focus reflection & action using an array of tools & resources
- Resources: images/metaphors on key concepts, digestible bits of psychoeducation, wellness activities, expressive arts, planning worksheets, and more

Our plan for using this curriculum

- Give you sample of the variety of tools & resources in the curriculum
- Integrate these tools into practice time so you can get comfortable using them
- Ask you to use tools in role plays with diverse clients to gain confidence adapting the material to different people's needs

MH pairs role play

- Role play an 8 min visit using MI, goal= build relationship & use curriculum in a person-centered way
- Person with longer hair will play the client first
- When bell rings, switch roles (new client & new piece of curriculum)
- Group Debrief: what went well, challenges, aha moments

Lingering questions?

- What stands out for you from our conversations & activities this morning?
- What questions are on your mind?
- How will you apply any of this to your work?

1 hour & 15 mins, Enjoy!

2. Collaboration through harm reduction

Effective approaches to working with substance users & folks in recovery

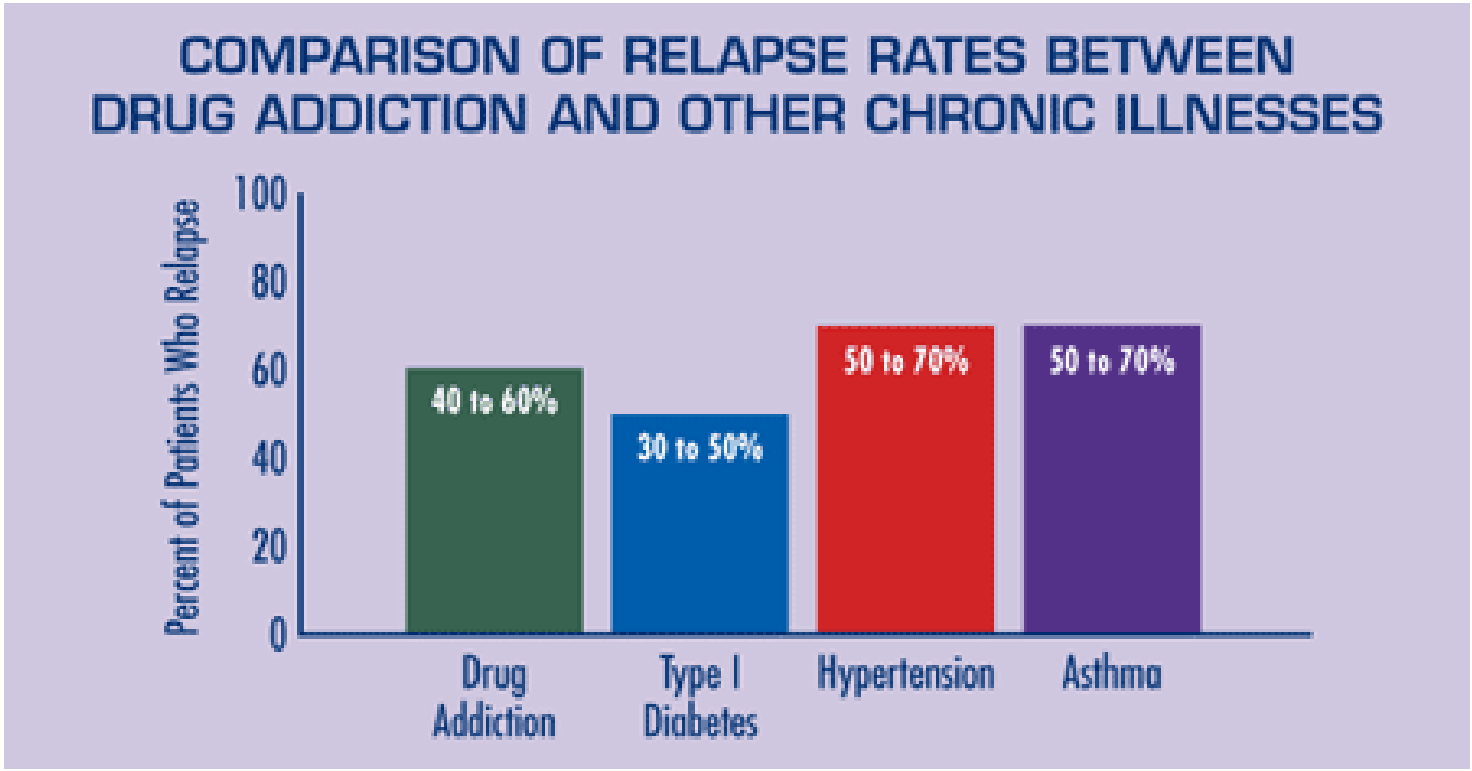
What are you seeing?

- What drugs do you see used/abused most commonly?
- How comfortable are you assessing and exploring drug use with clients?
- What kinds of issues are most common among the users you work with?
- Which strategies of working with these clients have you found most helpful?
- What are the biggest unmet needs you see for this population?
- What makes you proud of your work with this population?
- What are the biggest challenges for you in successfully accompanying folks who use drugs?

Challenges managing SU & chronic disease together

- Stigma/shame (barrier to honest conversation & seeking help)
- Legal complications
- Substance use may impact adherence to meds, appointments, & self care
- Substances may speed up disease progression (crack & HIV, drinking & liver disease)
- Substance use may create instability (financial, housing, employment) that undermines overall health & intensifies stress
- Substance use is often connected to trauma which unhealed can be a barrier to feeling deserving/accessing support (in life and health care)
- Current & former users may not get needed medication (ie: meds for pain or anxiety) due to being seen as “med seeking”
- Some needed medical treatment can be a trigger for folks in recovery (ie: injecting insulin)

Relapse is pretty universal…

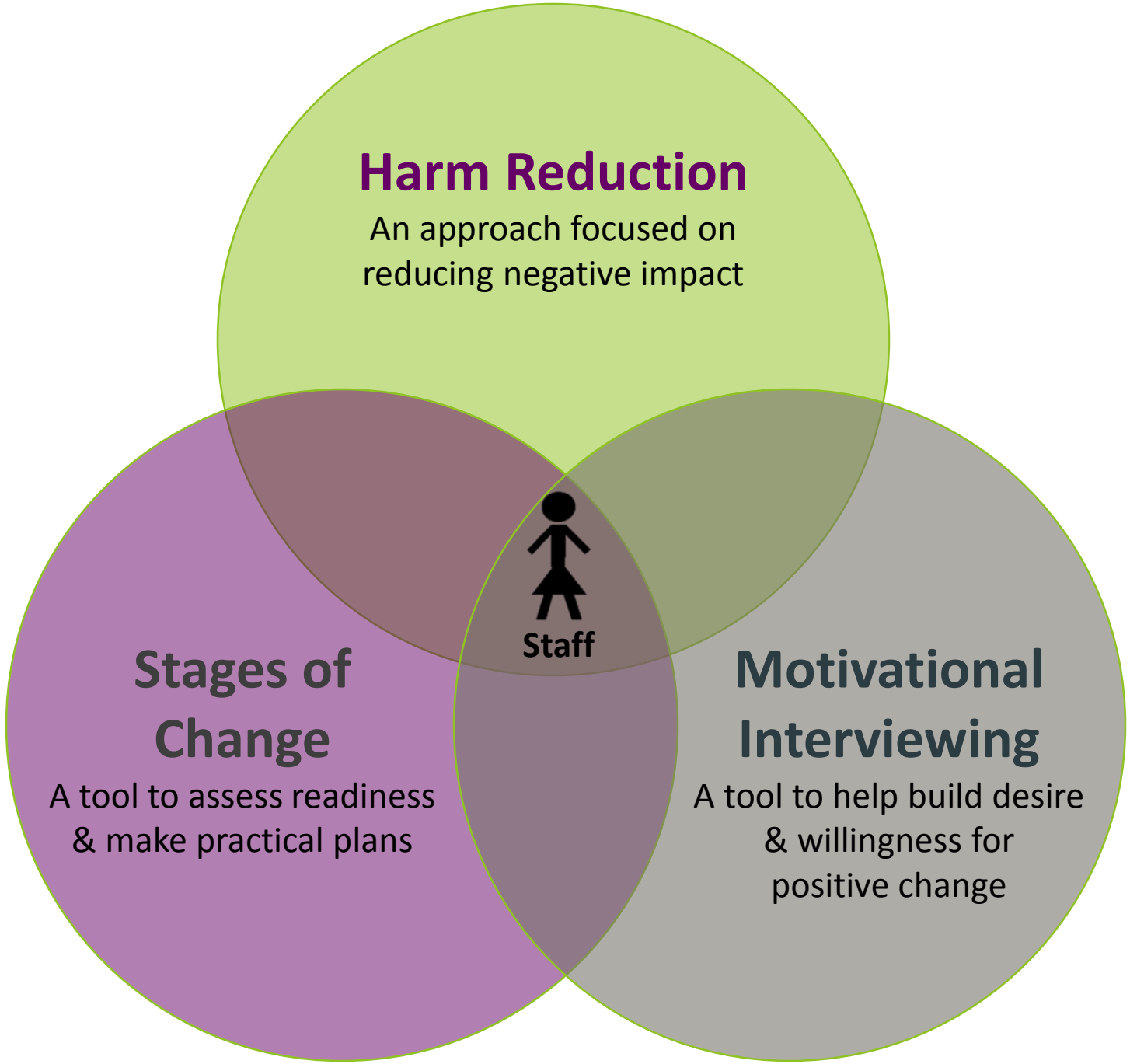


Source: JAMA, 284:1689-1695, 2000

..access to services for users should be too!

What is harm reduction?

- Have you heard the term before?
- What does it mean to you?
- What comes to mind when you think of harm reduction?


Harm Reduction
An approach focused on reducing negative impact
Staff
Stages of Change
A tool to assess readiness & make practical plans
Motivational Interviewing
A tool to help build desire & willingness for positive change

Harm reduction is:

- Reducing the harm caused by a behavior without stopping completely
- Realizing that there can be many personal, social and economic barriers to change
- Believing that changes can be made despite these barriers
- Even small changes are valuable

Harm reduction philosophy

- Based on the idea that we **ALL** do things that are not good for us
- So we support our clients in making the changes that they are ready to make
- Examples:
  - Seat belts
  - Designated drivers
  - Needle exchange

Harm reduction vs. abstinence only

- Working towards the goals that the client is ready for right **now**.
- Drinking less alcohol
- Having pizza without pepperoni and limiting to two slices

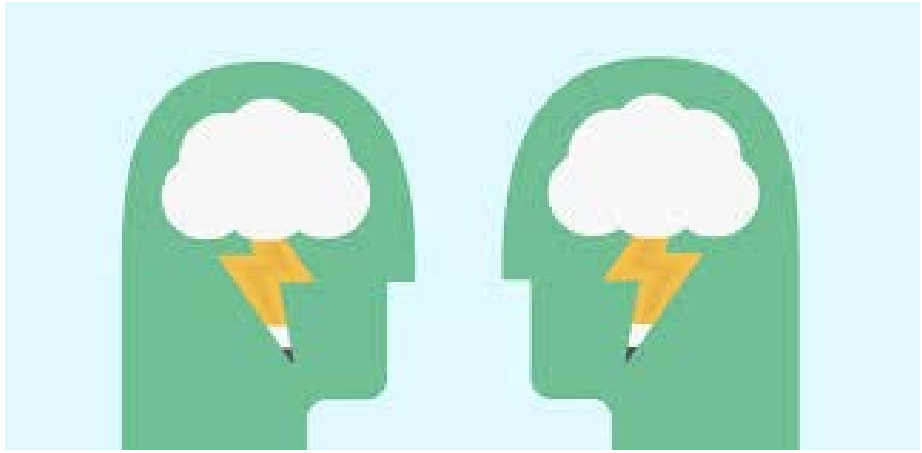
- The only goal is **stopping** the harmful behavior completely.
- Stop drinking
- No pizza!!!

Three brainstorms

- Harm reduction for:
  - 40 year old refugee client with uncontrolled diabetes drinking 12 beers daily living in a shelter.
  - 70 year old depressed client with asthma who smokes 1-2 packs of cigarettes each day.
  - 19 year old sexual abuse survivor with PTSD & chronic pain using weed to manage anxiety & painkillers for sleep.
- Each small group is assigned one topic & chooses a scribe to take notes & report back.

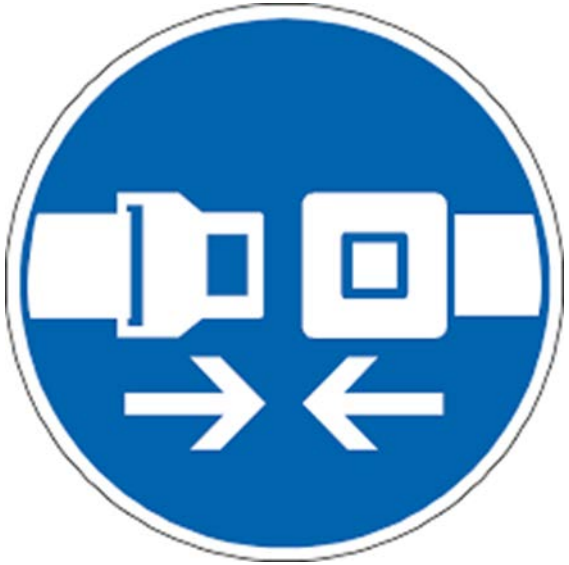
Brainstorm questions

- What makes these habits hard to change? *Identify individual & **systemic** barriers.*
- What are specific, small changes that our clients can make to reduce harm to be healthier? *Come up with as many creative ideas as you can.*



Take-away points

- Harm reduction is about:
  - Understanding the client's barriers
  - Setting goals that are right for the client at this time
  - Appreciating small changes
  - Practicing non-judgement
- Harm reduction applies to any unhealthy behavior



Working with our counter-transference

- What if we support clients in making the small changes they are ready for, but that's not enough to avoid serious consequences?
- How might we feel & how can we sit with it?

Partner reflection with OARS

- Share one example of practicing harm reduction with yourself or someone in your life *(ie: going for a walk with diabetic husband instead of nagging him, switching to decaf).*
- Explore: how did it work to make a small change, how did you get ready to do it, what were your barriers, how did it feel, how were you able to maintain it, what supported you?

Substance use framework

Continuum of use, commonly used drugs , & more

Let’s talk about drug use

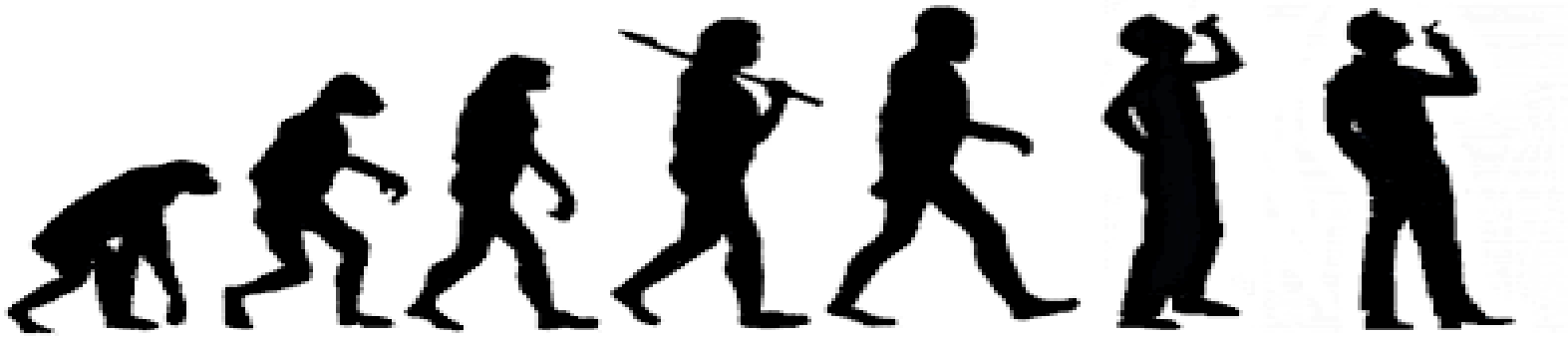
- What counts as a “drug”?
- What’s the difference between use & abuse?

Assessment questions with clients

- What are pros and cons of their drug use?
- What problems does it help with?
- What problems does it create? How much is that impacting the person's life?
- How in control of the person of their use?
- Do they ever want to stop & if yes what gets in the way?
- What fears do they have about their use?
- If stress & addiction were no issue, how much would they want to use and why?

Continuum of use

1. Abstinence (none)
2. Experimenting (“what’s this like?”)
3. Regular Use (becomes habit)
4. Problem Use (creates trouble)
5. Abuse (big problems!)
6. Addiction (can’t function without it)



Dr Carl Hart: neuroscience researcher, former user/dealer, drug tx warrior

- 80-90% of people who use drugs don't have drug problems
- "Attractive alternatives dramatically decrease drug use" (ie: meaningful employment)
- "Drug addiction doesn't cause crime—it's other factors."
- Advocates drug decriminalization (like traffic violation, like Czech & Portugal, reduce ODs & incarceration)
- 1.5 million people arrested for drug law violation, 80% are simple possession
- Decrease marginalization, stigma, & racial disparities
- Biased drug law enforcement: 1/3 black men will do time vs. 1/20 white men
- Flawed science driving drug policy & education
- Honesty: public health education re: safe use
- Assume drug are part of human life & take on harm redux: keep recreational users safe
- *Drugs are not the problem; problem is poverty, unemployment, ignorance re drugs, racial disparity in drug law enforcement.

Risk factors for drug problems

- Biology
- Growing-up & current environment
- Other life stressors (trauma, poverty, MH issues)
- Experiences of violence/oppression (racism, sexism, homophobia, etc)
- Role models
- Lack of other coping options
- Individual psych/spiritual issues

Real stories– trios discuss

- Think of people you know or your own journey into addiction.

  How did you get started?

  How did it progress?

  How did it get better?

Self-medication?

- Theory that people use particular drugs to deal with/avoid particular feelings
- Assumes that there is understandable reason for people's use that deserves our respect and curiosity
- Helps client and worker deal with stigma better vs. "character" or "disease model" which can both be disempowering!

Types of drugs

- “Downers” aka depressants
- “Uppers” aka stimulants
- Narcotics aka pain killers
- Hallucinogens aka psychedelics
- Marijuana
- Club drugs

Uppers

- Examples: coffee, speed, meth, crack, nicotine, cocaine, ADHD meds
- What they do: speed up central nervous system, give energy, reduce inhibitions, increase libido
- Signs of trouble: rapid speech, weight loss, nose bleeds, anxiety, mood swings, aggressive/ risky behavior, dilated pupils.

Downers

- Examples: alcohol, sedatives, benzos (Klonopin, Xanax, Valium), tranquilizers
- What they do: slow central nervous system, relieve tension, bring calm, promote sleeps.
- Signs of trouble: depression, drowsiness, slurred speech, disorientation, poor coordination.

Pain Killers

- Examples: heroin, morphine (from poppy) methadone, Vicodin, Oxycontin (synthetic)
- What they do: numb pain (physical & emotional), slow body down.
- Signs of trouble: low motivation, nodding out, pinned pupils, track marks, slowed breathing

Psychedelics

- Examples: LSD, mushrooms, peyote
- What they do: alter the mind & senses, distort space & time
- Signs of trouble: mood swings, hallucinations, paranoid behavior, odd/risky behavior

Marijuana

- MJ= dried leaves/buds of cannabis plant
- Most used drug in US
- What it does: increases appetite, decreases nausea, giggling, short term issue with memory/concentration
- Signs: distinct smell, bloodshot eyes

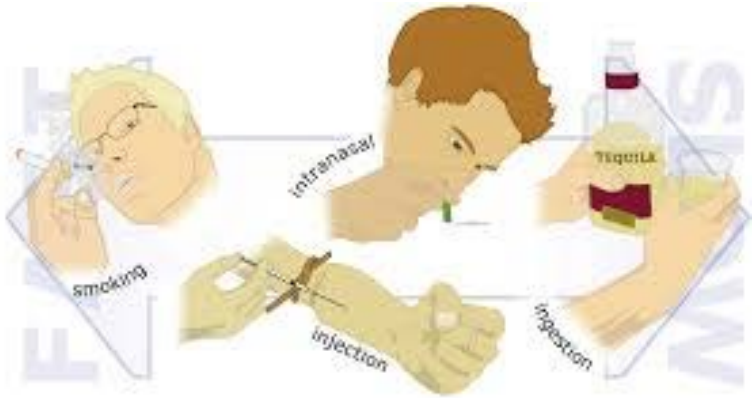
Club drugs /designer drugs

- Examples: Ecstasy (MDMA), "GBH (liquid X), Roofies (rohypnol), Special K (ketamine, tranquilizer
- What they do: give happy feelings, up libido, often combo of other drugs
- Signs of Trouble: delirium, memory loss, psychosis, aggressive/risky behavior, poor coordination,

Methods of Use

- Drink (alcohol, methadone)
- Swallow pill/tab (LSD, oxy)
- Smoke (MJ, nicotine, crack)
- Snort (cocaine, heroin)
- Inject (heroin, meth)

- What‘s riskier and safer & why?



Biggest risks

- Injecting drugs risk for Hepatitis C & HIV
- Mixing drugs (ie: speedball as heart attack risk)
- Opiates + downers= risk of overdose death (CNS shuts down)
- Behavioral risk (sex, crime, violence): uppers may be worse.
- Disease progression: for folks with chronic illness, particular drugs can be problematic (alcohol for folks with liver disease, cocaine for people with heart problems, etc.)

Our Role

- Nonjudgmental ally
- Understand client's use through their eyes
- Help client reflect on and better understand the benefits and risks of their use
- Help client think about realistic options to increase safety & health
- Discuss treatment options only when client is ready

Bring it up?

- Once there's rapport, it's important to ask about client's use in a neutral way.
- Explain your role is to listen and support not judge or push treatment.
- If client denies use, don't challenge her. Let her know you're open to talking about in the future if she wants to.

Watch out for…

- Our personal beliefs re: drug use
- Our history of use/recovery
- Family issues with addiction
- Internalized social stigma re: use
- Countertransference!

- **Check yourself & respect your client to earn trust.**

Afternoon break

Snack, sunshine, or a quick walk may help you pep up!

Counseling work with active users

https://www.youtube.com/watch?v=h0I0uV-XqpI

SU practice: trios role play

- Trios with observers: Luis & Jenna
- Role play an 8 min visit using MI, goal= build relationship & use curriculum skillfully
- Once complete, observer will give feedback using feedback form for 3-4 minutes
- When bell rings, switch roles & scenario. Each person will play a different role!
- Group debrief: what went well, challenges, aha moments

Breath practice: ocean breath

Ocean-sounding breath (ujjayi)

- Calming or energizing
- Starts relaxation response ☺
- Free, easy, can do anytime

Wrap-Up

- Round robin: take-aways & any suggestions for tomorrow
- Review tomorrow's agenda briefly
- Evaluations…
- Farewell!

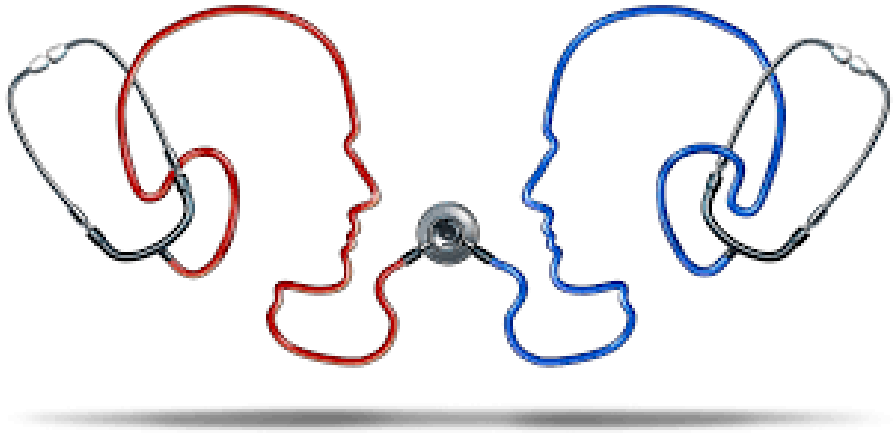
DAY TWO ;-) Welcome back, friends…

***Please sit at a different table!**

- Stretch & coherence breath
- Icebreaker: 3 questions
- Review agenda & ground rules

Team-based care: good, bad, ugly?

- Why does care coordination matter to you & your clients?
- How's it going now on your team? With other agencies?
- What are the major successes you've had?
- What are the biggest challenges?
- What are your hopes for the impact if we could do this well?



Challenges

- Duplication of services
- Unclear roles
- Not knowing about available resources in other care systems
- Client running around in complex & stressful systems
- Splitting!
- Our countertransference
- Territory/turf battles (often unconscious)
- Poor communication
- Power dynamic/rank issues between providers
- Lack of trust
- Programs competing for limited resources
- Staff capacity & time
- Takes effort to build inter-agency partnerships that work!
- Accountability?

Who's on the team?

Varies by client– cast a wide net!

- Housing providers (landlord, case manager, eviction prevention specialist)
- Mental health (therapist, psychiatrist, outreach worker)
- Substance use (counselor, sponsor, case manager)
- Medical: Primary care, specialists, holistic health providers
- Employment & training
- Educational needs
- Food & nutrition
- Social Support (family, friends, & peers)
- Parenting (DCF, school counselor)
- Elder care (home care, PCA, COA, etc)
- Legal issues (lawyer, PO, advocate)
- Refugee services & more…

Best practices

- Create an expansive provider contact sheet for all clients & update regularly
- Formal case conferences
- Email updates (cc all) or check-in calls
- Monthly or quarterly provider networking meetings (with food)
- Clear division of roles (clear to all providers and to client)
- Signed releases at intake
- Actively build collegial relationships (ie: James A)
- Accompaniment as opportunity to learn about services & network
- Pro-active, positive communication
- Assume good intentions!

CC Mini-cases for discussion

1. **Jane:** a frail senior with COPD lives at home with a controlling husband, a long-time PCA who works too many hours, a care manager at the clinic who has a panel of 200 patients, a young PCP who is very worried her patients may die, and a guilty son living out of state who's an NP and calls the clinic to intervene.
2. **Kevin:** a depressed, white, homeless 17 year old who has an NA sponsor, a counselor at his alternative high school who's disappointed in him, a suboxone counselor at the clinic, a pediatrician who's taken care of him & his sisters for 10 years, and a housing search worker at the shelter who's passionate about getting him housed before winter.
3. **Munira:** a diabetic, grieving Somali widow, refugee, & mother of 2 who English is limited, has a 12 year old daughter who interprets for her at appointments, a competent but slightly zenophobic nurse, a settlement worker who's also Somali and personally invested in this family (they go to mosque together), a therapist who's new to working with refugees, and an Imam who offers spiritual counseling.

Questions to discuss

1. What are the key barriers to teamwork here? What might be some root causes of these barriers?
2. What are some practical or creative ways to intervene to strengthen care coordination? What might go wrong and how could you pro-actively prevent that?
3. How do you ensure your approach stays person-centered with the client leading?

Action Planning in teams

- Get folks in teams across agencies to share their role, focus, and best ways to collaborate. Let each team come up with 3 action steps they can implement for better collaboration between agencies.

- Get folks in their work teams and talk about what's working well & not in collaboration. Let each team come up with 3 action steps they can implement for better teamwork in house.

Morning break

- Go play– be back in 15!

Group work: peer consultation

- Brainstorm relevant topics
  - Client cases
  - Team challenges
  - Mental health & substance use issues

- Break into 4 simultaneous working groups: blend of folks who have expertise & learners on this topic

- A scribe takes notes & reports back to larger group

Topics for your team discussion

1. Key questions/specifics of current challenge
2. Lessons learned (what may not work & why)
3. Best practices (source from group wisdom & creativity)

1 hour & 15 minutes…

Thought experiment

- Imagine you were **suddenly homeless** tomorrow. What are at least 5 aspects of your life that would change & how?

- List as many of the ways you might be feeling as you can.

- How do you think people in your family/community would see you or treat you differently?

Homelessness in USA

- Numbers: 2.5-3.5 million homeless people per year in US, about 600,000 any given night (1/2 in shelters), 80,000 chronically homeless.
- Cause: "interplay of individual & structural factors & the absence of a safety net"
- Individual factors: **poverty,** mental health issues, substance use, trauma history, less education, limited work history, LGBTQ, incarceration. More vulnerabilities= higher risk!
- Contextual factors: strength of safety net (income support, subsidized services, & treatment), availability of living wage work & affordable housing.
- National crisis: in housing affordability & shrinking resources for help creating more homelessness
- Race: **powerful** structural factor (wealth gap, prison system, & housing/employment discrimination); African-Americans 4x more likely to be homeless.

Homelessness in VT

- 1,500 Vermonters are without housing on any given night. Nearly 1 in 4 is a child.

- Availability crisis: a healthy housing market has 4-6% vacancy. Currently, VT has a 1% vacancy rate for multi-family properties.

- VT Plan to End Family homelessness by 2020:
  - coordinated entry system to help folks access prevention & immediate shelter
  - increase public & private affordable rental housing (new construction & rehab)
  - expand evidence-based services for homeless families
  - help renters move to ownership, better coordinate among providers across sectors.

Source: http://humanservices.vermont.gov/end-family-homelessness

Working with homeless clients

- What is unique in VT context?
- What do you like about this work?
- What have you learned from homeless clients so far?
- What are the biggest challenges for them? For you as their providers?
- If you could recommend one strategy for working well with homeless clients, what would it be?

Homelessness & health care

- Homeless yields: **poor health outcomes, lower quality of life, & dying young**
- Less use of primary care, more ED use
- Factors: no bathroom access, limited social support, unreliable food, no $ for copays, transportation issues, incarceration risk, poor sleep (safety issues outdoors/in shelters), poor diet.
- Adherence barriers: survival needs come first, no safe storage for belongings/meds, depression, hygiene (no showers), stigma/shame, trouble getting mail/messages consistently.
- Health issues exacerbated by: smoking, drug use, poor access to chronic disease mgmt, poor diet, more injuries, get to care later in illness.
- Hospitals: admitted more easily, longer admissions, more readmissions (hard to recover without stable housing)

Assessing homelessness

1. Look for risk factors: high % of income for rent (over 50% is concern), name on lease?, behind in rent/utilities, fear of losing housing, dependence on someone else to pay.

2. Savvy screening: normalize unstable housing, don't ask directly (stigma), ask if person has been without a place in the past month (sleeping in car, outdoors etc).; if doubled up, ask how long they can stay and if they have to couchsurf?

3. Assess at "vulnerable" times: job loss, illness, or death in the household, birth of child, leaving institution (jail, nursing home), divorce/break-up, domestic violence.

- **Why ask?:** builds trust, unravel stigma, make referrals, successful future contact if client moves

Adapted from: "Homelessness: A Primer," presentation by Dr. Margot Kushel, UCSF, 5.20.16

Collaboration tips

- Plan **multiple** avenues of communication (friends/family to call, physical places to look like park/ Dunkin Donuts they frequent)
- Help set-up a reliable way to reach the person: voicemail, PO Box, SafeLink phone.
- Be flexible on when/where to meet
- Get involved in meeting basic needs (food, shelter, housing search, showers, safe storage for belongings)
- Recognize how homelessness makes everything else harder (health care, school, parenting, recovery, maintaining mental health)
- Give clients as much choice & control over the collaboration as possible, as their lives are often chaotic & at the mercy of other people's rules
- Have clear & well-communicated boundaries***
- Patience & empathy help

Group brainstorm: your clients

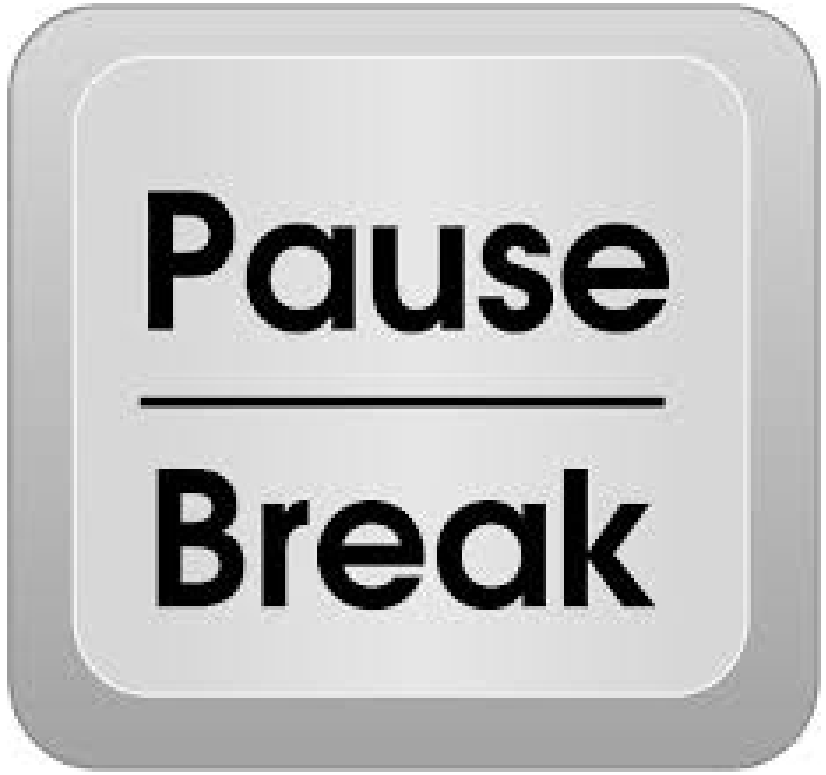
- At your table, chose 1 real case of a homeless client dealing with chronic disease management

- Talk together about priorities and strategies for:
  - Developing trust
  - Coordinating care
  - Stabilizing health & housing
  - Realistic goal-setting

A scribe reports back highlights to the larger group

Afternoon break

- Time for tea?



Integrative practice activities

- 1. Pairs practice with their real client dealing with dual diagnosis and/or homelessness and chronic disease management

*Curriculum: Dual Diagnosis A

- 2. Fishbowl using MI/Harm Redux & Change plan worksheet p.130

Wrap-up

- Closing poem…
- Share @ table: what will stay with you?
- Next steps: future trainings, plans to stay connected?
- Evaluations…
- Farewell!

Keep in touch:

- Julie: sameboatconsulting@gmail.com