The Culture of Generational Poverty
Presented by Lance Parks, LCSW

Introduction

As shown in this course, over the years poverty and homelessness has grown extensively. The contributors of poverty are wide and varied, and the debates about the causes are just as far and ranging. Poverty and homelessness is often generational, and has created its own culture. Additionally, increased mental illness and substance abuse have contributed to worsening the issue in higher numbers.

The course included the trends, the contributors, the politics, and the behavioral interventions surrounding homelessness.

Chapter 1—Trends and Politics

A. Poverty in the United States

The following is retrieved from: https://www.debt.org/faqs/americans-in-debt/poverty-united-states/

Poverty is a pervasive human condition of being unable to obtain or provide a standard level of food, water and/or shelter. It exists in every country in varying degrees, and it is unlikely to disappear anytime soon. The United States is considered the richest country in the world, and yet millions of its residents live in poverty.

Poverty is measured in two ways – absolute poverty and relative poverty. **Absolute poverty looks at the goods and services someone (or a family) cannot obtain.** Relative poverty looks at the context of the need, how one social group compares to others. The official method of calculating America's poverty levels was developed in the 1960s and has not been refined substantially since then, although critics maintain that the government overstates the U.S. poverty level because it counts as impoverished people

who in generations past would be considered as not living in poverty. The highest poverty rate on record was 22 percent (1950s). The lowest was 11.1 percent (1973).

How is Poverty Defined in America?

According to the U.S. Census Bureau's 2011 Current Population Report, 46.2 million Americans are considered impoverished – 15 percent of the country's population. Approximately 16.4 million American children – 22 percent of the population younger than 18 – live in poverty. The rate for people 65 and older is 8.7 percent.

Among the most impoverished are:
• Those living in female-headed households with no husband present (31.2 percent). • Young adults without a high school diploma (31 percent overall; 43 percent for blacks) • Those living in a family whose head is unemployed (32.9 percent). • Minorities (27.6 percent for blacks).

If any good news can be extrapolated from these grim statistics, it would be that after three consecutive years of increases in the level of poverty in the United States, neither the number of people living in poverty nor the poverty rate was statistically different from the 2010 findings. In other words, things didn't get any worse.

Measuring the extent of poverty does nothing to ameliorate the lives of the poor, but compiling and understanding poverty statistics is essential to solving, or at least addressing, the problem.

Governments, policy makers and society at large depend upon precise and timely information about poverty in order to create and deliver the most effective solutions, as they continue to chip away, bit by bit, family by family, and community by community, at the scourge of poverty.

Where Is Poverty Most Common in the U.S.?

The face of poverty for most Americans is pictures of families in rundown housing in large cities where the industry has moved away.

The true face of poverty, however, is found in rural areas of the South and Southwest regions of the U.S. where living conditions are even more run down and industry never really started up.

Seven of the 10 states with the highest poverty rates in the U.S. are in the South. That includes Mississippi (20.8% of population below the poverty line); Louisiana (20%), Kentucky (18.5%), West Virginia (17.9%), Arkansas (17.2%), Alabama (17.1%) and Georgia (16%) lead the way.

The other three are all in the Southwest and include New Mexico (19.8%), Arizona (16.4%) and Oklahoma (16.3%).

These areas have a long history of poverty and there are many factors contributing to it, but the most obvious are that they were agricultural economies first and foremost with light emphasis on education and innovation.

Absolute Poverty

Absolute poverty is a measure of the minimal requirements necessary to afford the minimal standards of life-sustaining essentials — food, clothing, shelter, clean water, sanitation, education and access to healthcare. The standards are consistent over time and are the same in different countries. For example, one absolute measurement is the percentage of a population that consumes enough food daily to sustain the human body. This standard – 2,000 – 2,500 calories per day – is applied worldwide and across all cultures.

The World Bank defines poverty in absolute terms:
• Those living on less than $1.25 per day live in extreme poverty. • Those living on less than $2 per day live in moderate poverty.

For instance, in 2008, one-half of 1 percent of the population of Europe and Central Asia lived in extreme poverty, compared with almost 50 percent of Sub-Saharan Africa.

Relative Poverty

Relative poverty is a measurement of income inequality within a social context. It does not measure hardship or material deprivation, but rather the disparities of wealth among income groups.

For example, in the United States, **a household that has a refrigerator, televisions, air conditioning can be considered impoverished if its income falls below a certain threshold**. In other countries, those households might be thought of as wealthy.

Measuring U.S. Poverty

The federal government's measurement of U.S. poverty was developed in the early 1960s by Mollie Orshansky, an economist and statistician at the Social Security Administration. Orshansky based her original poverty thresholds on the Department of Agriculture's economy food plan, which detailed what it considered the least expensive, yet still nutritionally adequate, diet for American families that were experiencing a temporary shortage of funds.

She then deduced from Department of Agriculture surveys that average families of three or more people spend about one-third of their money on food. By multiplying that amount by a factor of three, to include all other family expenses, and applying various weighted data, Orshansky established a detailed matrix of 124 poverty thresholds for families of different sizes and compositions. (Today, there are 48 thresholds.) Poor families were those whose yearly income was below the threshold for their category.

Over the years, many attempts have been made to improve, update or even replace Orshansky's methodology. In 1992, a National Academy of Science (NAS) panel suggested revisions to the system based on alternative definitions of both income and needs, suggesting that the traditional approach no longer provided an accurate picture of poverty. Legislation based on those findings has been introduced in Congress from time to time but has never been enacted.

The Census Bureau uses several alternative methods to calculate the poverty indices, including the American Community Survey (ACS), which details a substantial increase in the number of Americans in poverty – from 46.2 million in 2010 to 48.5 million in 2011. In 2010, the Census Bureau introduced the Supplemental Poverty Measure (SPM) to reflect long-term changes in government policies that altered disposable income available to families and therefore their poverty status. However, the official rate is still based on data from the Bureau's Current Population Survey Annual Social and Economic Supplement (CPS ASEC).

Overstating Poverty

Critics of the current method of calculating poverty thresholds point out that the CPS ASEC measures only monetary income (e.g., earnings, Social Security income, veterans' payments, workers' compensation, pensions), but does not include other sources of in-kind or non-cash gifts from public or private sources, including:

- Benefits from anti-poverty programs such as food stamps, federal housing subsidies, school lunches and Medicaid.
- Tax advantages such as the Earned Income and Child Tax Credits.

Adding these sources of income would change the poverty numbers considerably.

They also contend that many families reported as living in poverty are not poor in the ordinary sense or as understood by most Americans. Impoverished families often have household appliances and adequate food, and live in an adequate shelter — a higher standard of living than even middle-class families maintained several decades ago.

Therefore, current government methodology of measuring poverty, which calculates income inequality and not actual material deprivation, could be overstating the extent of poverty in the United States.

Historical Changes in Poverty Levels

In the late 1950s, the poverty rate was approximately 22 percent, with just shy of 40 million Americans living in poverty. The rate declined steadily, reaching a low of 11.1 percent in

1973 and rising to a high of nearly 15 percent three times – in 1983, 1993 and 2011. However, the 46.2 million Americans in poverty in 2011 is the most ever recorded.

Since the late 1960s, the poverty rate for people 65 or older has fallen dramatically. This drop could be ascribed to the enactment of the Medicare Program in 1965, which dramatically lowered out-of-pocket health care costs for this age group.

What are the Causes and Effects of Poverty in America?

Impoverished families tend to have less education, more health problems and less access to nutritionally adequate food. They also are more likely to live in high-crime areas.

Poverty and Education

The more advanced one's education, the greater the likelihood of achieving a more secure economic future. High school graduation rates for African-American and Hispanic students are almost 20 percentage points lower than for other ethnic groups, while their poverty rates greatly exceed the average.

Without the knowledge and skills required for well-remunerated work in the modern workplace, each succeeding generation of undereducated adults merely replaces the one before it without achieving any upward mobility or escape from poverty.

Poverty and Health

Health is also strongly related to income. Poor people have higher mortality rates, a higher prevalence of acute or chronic diseases and more emotional and behavioral issues.

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According to a 2011 report issued by the U.S. Senate Subcommittee on Primary Health and Aging:

- People in the highest income group live an average of 6.5 years longer than those in the lowest income group
- The mortality rate for African-American infants is double that of white infants
- Poor adults are twice as likely to have diabetes as affluent adults.
- Poor children are twice as likely to have unhealthy levels of lead in their blood than other children.

Poverty and Food

Food poverty is defined as the inability to obtain healthy and affordable food. Poorer families tend to have low intakes of fruit and vegetables and high intakes of junk food. They also tend to suffer more from cancer, diabetes, obesity and heart disease.

While food insecurity and poverty are not the same, they are related. Food insecurity means that that the availability of nutritionally adequate food or the ability to acquire it is limited or uncertain. In 2011, 14.9 percent of households – or 50.1 million Americans – were food insecure, according to the U.S. Department of Agriculture (USDA). Blacks and Hispanics were two and a half times more likely to face food insecurity than whites.

Poverty and Crime

The relationship between poverty and crime is complex, and many factors are associated with poverty and crime, including unemployment, population density, high school dropout rate and incidence of drug use.

While difficult to quantify, some studies have indicated that as a particular population's poverty rate increases, crime, particularly violent crime, tends to increase, as well.

Government Programs that Lift or Help Keep People Out of Poverty

Government benefits keep millions of Americans out of poverty, mostly women, children and the elderly. Social Security alone keeps approximately 21.4 million people above the poverty line, including 14.5 million senior citizens 65 or older. Expanded unemployment benefits helped an additional 2.3 million people stave off poverty in 2011.

If non-cash government aid programs were counted in the Census Bureau thresholds, food stamps would lift another 3.9 million Americans out of poverty. In addition, the combined Earned Income Tax Credit and Child Tax Credit kept 9.2 million families from falling into poverty in 2010.

Other government programs include:

- Community Services Block Grant
- Head Start
- Low-Income Home Energy Assistance
- Medicaid
- Medicare prescription drug coverage
- Family planning services
- Supplemental Nutrition Assistance Program (SNAP) (formerly known as food stamps)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- National School Lunch and Breakfast Programs
- Legal services
- Jobs Corps

Some state and local governments provide programs for the poor, as do some private companies and charities.

How U.S. Poverty Levels Compare to Countries around the World

According to the Organization for Economic Cooperation and Development (OECD), the United States has the highest poverty rate among the world's developed countries. The United Nations Children's Fund (UNICEF) ranks the United States second behind Romania on a scale of what economists call "relative child poverty" when measured against 35 of the world's richest nations.

These rankings are not absolute measures. Relative child poverty refers to a child living in a household where the income is less than half of the national median; the relative standards in the United States are high.

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Bill “No Pay” Fay has lived a meager financial existence his entire life. He started writing/bragging about it seven years ago, helping birth Debt.org into existence as the site’s original “Frugal Man.” Prior to that, he spent more than 30 years covering college and professional sports, which are the fantasy worlds of finance. His work has been published by the Associated Press, New York Times, Washington Post, Chicago Tribune, Sports Illustrated and Sporting News, among others. His interest in sports has waned some, but his interest in never reaching for his wallet is as passionate as ever.

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New data paint an unpleasant picture of poverty in the US
By Steven Pressman
The Conversation

The Following is sourced from: https://theconversation.com/new-data-paint-an-unpleasant-picture-of-poverty-in-the-us-101069

On Sept. 12, the U.S. Census Bureau released national poverty data for 2017.

The headline was that 39.7 million people were poor in 2017. This works out to 12.3 percent of the population or one in eight Americans. The good news is that the U.S. poverty rate has fallen since 2010, when it hit 15.1 percent, and is now where it was before the Great Recession.

The bad news is that poverty still exceeds the 11.3 percent rate of 2000 and far too many people are poor in a country that is so rich. Another bit of bad news is that things look even worse if we use what many scholars like myself believe is a better poverty measure.

Who is poor?

In 2017, women had higher poverty rates than men and minorities had higher poverty rates than non-Hispanic whites, mainly because women earn less than men and minorities receive lower wages on average than whites. For similar reasons, adults with lower education levels are more likely to be poor.

Knutson, S. (May 13, 2018). *The author had several encounters with homeless people in Seattle. He spoke to men who had hit rock bottom with alcoholism and other addictions*. [digital image].
Retrieved from https://unsplash.com/photos/lQ2BzDNmnHE

What's more, having an additional adult able to earn money gives married-couple families much lower poverty rates than households headed by a single woman.

Poverty also varies by age. For those 65 and over, the poverty rate fell from the 1960s until the 1990s, mainly due to more generous Social Security benefits. Since then, it has remained at around 10 percent. The poverty rate for prime-age adults fell until around 1980. After 1980, it fluctuated around 10 percent, rising during recessions and falling during economic expansions.

Child poverty, however, has been relatively high in the U.S. since the late 1970s; it now stands at 17.5 percent. For children in a female-headed household, the poverty rate is near 50 percent.

Problems with measuring poverty

These data all come from American households, using methodology developed in the early 1960s by Mollie Orshansky of the Social Security Administration.

Taking Agriculture Department data on minimum food requirements, Orshansky calculated the annual cost of a subsistence food budget for families of different sizes and types. Household budget studies from the 1950s showed that families spent one-third of their income on food. So, Orshanksy multiplied the cost of a minimum food budget for

each family type by three to arrive at their poverty threshold. Thresholds rise annually based on inflation over the past year.

Being poor means having insufficient income during the year to purchase bare necessities. The poverty rate is the percentage of the population in this situation.

The Orshansky poverty measure has been subject to substantial criticism. Clearly, poverty thresholds are not very high. A single individual making US$1,060 a month would not be considered poor. Yet, in most areas in the U.S., it's hard to rent a place for less than $500 a month.

Even if that's possible, this leaves only $20 a day for transportation, clothing, phone, food and other expenses. Orshansky's minimal food budget assumed that people shop wisely, never eat out and never give their children treats. She actually preferred a more generous food budget to get multiplied by three; but she was overruled by senior government officials.

Another problem is that the U.S. poverty measure ignores income and payroll taxes. In the early 1960s, the poor paid minimal taxes. Starting in the late 1970s, low-income families faced a more formidable tax burden, leaving them less money to purchase basic necessities. Conversely, in the late 1990s, tax credits began to lower the tax burden on the poor.

Finally, standards concerning what is required to be a respectable member of society vary over time and place. For example, cellphones did not exist until recently. Childcare was not necessary for many in the 1950s or 1960s; but when all adults in a family work, it's essential.

More bad news

To deal with this last problem, many scholars prefer a relative measure of poverty. The Luxembourg Income Study, a research organization that analyzes income distribution, considers households to be poor if their income, adjusted for household size, falls below 50 percent of the median income of their country for the particular year.

Unlike the U.S. Census Bureau, the Luxembourg Income Study subtracts taxes from income when measuring poverty. It also adds government benefits, and makes data as comparable as possible across nations. The result is a poverty rate that is typically two to four percentage points above the official U.S. measure.

From an international perspective, the U.S. clearly does poorly. According to Luxembourg Income Study, the U.S. poverty rate was 17.2 percent in the mid-2010s – much higher than other developed countries, such as Canada and the U.K.

Things are even worse when it comes to child poverty. In the U.S., child poverty rates have surpassed 20 percent for several decades, making it an outlier among developed nations.

My research has identified two important policies responsible for this last result: child allowances and paid parental leave. Child allowances are fixed monthly payments to parents made for each child. Paid leave provides income to parents around the birth or adoption of a new child. Both policies are available in developed nations throughout the world – except the U.S. The more generous these national benefits are, the lower the child poverty rate.

Considerable research shows that growing up poor adversely affects children's health, as well as their intellectual and social development. It lowers earnings in adulthood, and reduces future tax revenues for the government while increasing government social spending.

The annual cost of child poverty comes to around $1 trillion. Meanwhile, every dollar spent reducing child poverty is estimated to yield $7 in the future. This exceeds the return on most private investments.

B. The Politics of Poverty

Few would dispute that poverty and increased homelessness are growing problems. It is commonly in the news, and seems to be a major issue in nearly all societies for millennia. In the political sphere it touches on a variety of issues, not the least of which are economic and social policies. The approaches to helping reduce poverty are wide and varied, even within political parties. If you go solely based on what the political parties say about each other you would believe Democrats want to take away everybody else's money, and take all money from all other government problems, and give it all to those who are not willing to work, without any expectation of other improving their lives. Democrats buy the vote by promising and delivering to the people free money—if you vote for Republicans, they will take away your welfare check, throw your grandmother who needs medical care off the cliff, and make all people homeless. You would believe Republicans do not care

about the poor at all, have no interest in helping them, would take away all social programs and all welfare monies and spend it all no defense, and tax the poor and give to the rich. Republican buy the vote of the rich through "corporate welfare," lowing the taxes of only the rich, and keeping the poor subservient.

While there are most likely individuals in political sphere who believe this way, it is truer that both sides would like to end poverty, want people to be able to have good paying jobs, and medical care—the biggest difference is how the parties approach the problem, and what each think will work.

Ryan, K. (November 30, 2018*). Untitled*. [digital image]. Retrieved from https://unsplash.com/photos/Yp4UKgyDUTo/info

"Approximately 13 percent of Americans live below the poverty line, a fact [Paul] Ryan says is one of the "most persistent, stubborn problems facing the country." That—at least—is something that both Democrats and Republicans can agree on. But when it comes to how to solve this problem, the two parties' ideas differ greatly." (Fernandez Campbell, 2016)

Republicans would argue the War on Poverty began in the late 1960's, the official poverty rate has hardly budged—which is proof such programs do not work. In liberal bastions such as Los Angeles and San Francisco, where Billions has been spent to relieve poverty, the homeless situations continue to grow. (Holland, 2019) "Throwing" money at the problem is certainly not the solution.

The Republic solution: stricter program to make sure those receiving welfare are actively looking for work, require evidence that social program is working, and create policies which move more unemployed into full-time jobs. Also, there needs to be a financial incentive to have people work rather than stay on welfare.

The Democrat solution agrees with many of the Republican idea in principle, but they believe the money need to be given from the bottom up. People cannot wait for the economy to reach them while they are hungry and homeless now. Many go into large amounts of debt just trying to put food on their table.

“Liberals and Democrats believe consumer debt is the result of a flawed economic system that favors individuals who are already rich. They think it’s the government’s job to take action in favor of indebted Americans and help citizens take control of their household finances.” (Pilnick, 2012)

As political parties work to differentiate themselves to voters, and appeal to their base, political solutions are difficult to find. It is doubtful the rhetoric will change anytime soon making compromise and solutions unlikely to be reached.

The following is an article written specifically for this course:

Chapter 2: The Culture of Generational Poverty: Providing Meaningful Help to the Impoverished

Using This Course Book

This course is organized into eight (8) modules. Each module deals with a different aspect of generational poverty, and providing help to those who are in need. The *Empty Pockets* picture will indicate to the reader that an anecdotal story has been inserted to illustrate various learning points. These stories are entitled “The Real Deal” because they are true. The names have been changed to protect the anonymity of the people described.

When you have finished studying the coursework, you will be ready to take the online test, prove your knowledge, and be awarded your CEUs.

Content

At the conclusion of this course learners will…

- Compare the three predominant economic classes in America and examine the attitudes and beliefs held about each of them in mainstream culture.
- Draw conclusions as to how economics impact the acculturation and exploitation of at-risk populations living in poverty

- Distinguish between how the poor, the middle class, and the rich view their history, their present possibilities, and their future potential
- Recognize the common tenets and norms of generational poverty culture
- Inspect the link between poverty and criminal activity.
- Be able to explain the hidden rules of the middle class to their clients and customers who are attempting to escape poverty in order to promote their success.
- Identify various State, Federal, and nonprofit social programs that assist the impoverished to promote effective linking and referral efforts.
- Be able to use knowledge of poverty culture norms to provide meaningful advocacy for adults and children living in poverty culture.

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A. If I were a Rich Man…

"There is no class so pitiably wretched as that which possesses money and nothing else."

Andrew Carnegie

Think back to the 1980's and recall the song by Cindy Lauper called *Money Changes Everything.* Is the song's title accurate in its contention? Recall the old adage "Money rules the world." Is this statement true? Does money alone bring people out of poverty? These and other thought-provoking questions will be discussed as we consider the nature of generational poverty. As if the issue of money is not controversial enough, there is also the cultural aspect of generational poverty. To some, the suggestion that there is a cultural aspect of poverty is quite offensive, and to others it makes perfect sense.

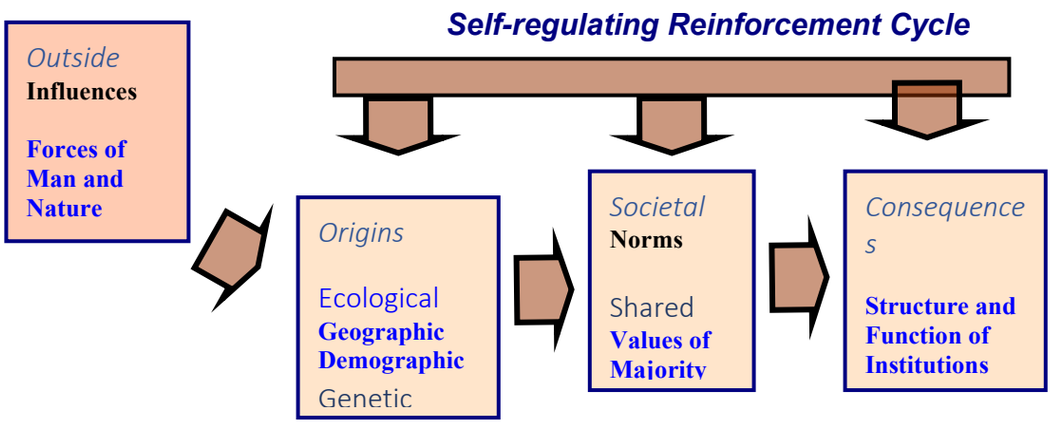
In an effort to keep from offending anyone, the first section of this course book is dedicated to explaining some basic principles of culture.

A Primer on Culture

Culture refers to the total system of values, beliefs, attitudes, traditions, and standards of behavior that regulate life within a particular group of people and are thought necessary to their survival in the context of their environment.

Any culture, be it familial or national, tends to be homeostatic and self-reinforcing in nature. Greet Hofstede is an early culture guru who explains this dynamic in his model entitled *The Stabilizing of Cultural Patterns* depicted in *Figure 1.*

Figure 1: Hofstede's The Stabilizing of Cultural Patterns (1981)



Hofstede defines culture as “the collective programming of the mind which distinguishes the members of one human group from another.” He contends that cultural change is brought about primarily by outside influences consisting of forces of man and nature. When the strength of the outside force is greater than the culture’s self-regulating cycle, cultural adaptation, or change will occur. The self-regulating cycle is rooted in the group’s origins and involves ecological, genetic, and historical factors that shape and define the group. These origins form the basis for a shared values system upon which societal norms are built. Societal norms provide the framework to structure societal institutions such as families, roles, education, religion, and corporate and political structures.

Do people who are living in generational poverty know that they are a part of poverty culture? Probably not. Hofstede compares culture to a fish swimming in water. “The fish does not know it lives in water until it is caught up in the fisherman’s net,” he contends. Likewise, people are generally not aware of their own cultural norms until they travel outside their culture of origin, whether it is travel to a foreign country, or to an area where another economic class is prevalent.

In today’s “politically correct” America it is difficult to discuss the norms of a given culture without someone claiming that stereotyping is occurring. There is a fine line between stereotyping and disseminating culturally relevant information. Every attempt will be made not to cross that line in this course book.

Stereotyping involves making a judgment or assumption about a person or his/her behavior not on the basis of knowing that person, but based upon generalized observations or beliefs about the group to which this person belongs. Stereotypes often contain a “kernel of truth” which has been over-generalized or exaggerated to the point of distortion.

Culturally relevant information describes the tenets, norms, beliefs, behaviors, attitudes and ways of thinking common to a group in the most accurate terms possible. Culturally relevant information is surfaced through observation and interview of similar groups over time and geography. This course offers a plethora of culturally relevant information about those who have lived in poverty over two or more generations in an effort to assist helping professionals in becoming more culturally competent in serving this population.

Cultural competence involves recognizing, understanding, and valuing cultural differences *and* the commonalties that underlie these differences. Cultural competence

prohibits condemnation and seeks to foster understanding between those who view the world through the lenses of their own cultural perceptions.

This course is not about people who were raised in the middle class, and plummeted into poverty for a brief period due to transient circumstances. This course describes the culture of individuals who were born and raised in poverty, as were their parents and grandparents. Virtually every community in the U.S. is inhabited by at least a few families who have “always been poor.”

Is America Classist?

While it is true that America doesn’t have a caste system, it does possess economic layers labeled as poverty class, middle class, and wealth class. The middle class is further divided into lower middle class, middle class, and upper middle class, defining five economic classes in American culture.

Trikosko, M. (August 28th, 1963). *Demonstrators marching in the street holding signs during the March on Washington.* Library of Congress Prints and Photographs Division Washington, D.C. 20540 USA. [digital image]. Retrieved from https://unsplash.com/photos/BBxy12IGzvk

America is known as “the land of opportunity.” The underlying concept behind this idea is that anyone can be successful through perseverance and hard work. Is this an accurate concept? Can one go from rags to riches in America without winning the lottery?

In 2005, The New York Times and The Wall Street Journal each published a series of ground-breaking articles about the changing nature of social class in America. The Wall Street Journal published the first in a series of articles called “Moving Up: The Challenges to the American Dream.” The lead article was a sobering review of data chronicling declining mobility and opportunity in the U.S. As the Journal observed, “As the gap between rich and poor has widened since 1970s, the odds that a child born to poverty will climb to wealth -or that rich children will fall into the middle class -remain stuck.”

An excerpt from an analysis of the two series of articles sums up America's attitude towards classism:

When it comes to talking about class, it's as if we stumble and go speechless when confronted with the most basic of American divides. Of course, class differences exist. And people talk about them, but often in code and euphemism. Our discourse on class is in arrested development compared to our conversations about the other ways we differ from one another. One indicator: put the words "racism," "sexism," "homophobia" and "classism" in your computer spell-checker and see which one is underlined as a misspelled.

The conclusions drawn by investigative reporters after a year of research into the topic of classism in America are as follows:

- In the last three decades, we've become a vastly more unequal society. The rungs of the ladder of opportunity are weakening, threatening our national self-image as a meritocratic opportunity society.
- Inequality matters and too much inequality can lead to worsened opportunity
- Classism wounds everyone, albeit in different ways. For poor and working-class people, class divisions contribute to what sociologist Lillian Rubin described three decades ago as a "world of pain," inflicting real physical and emotional damage to people.
- If a society advertises itself as a meritocracy, but in practice allocates success based on hereditary advantage, many poor and working people are forced to internalize their shame and blame, instead of demanding that the society live up to its promise of opportunity.
- Internalized oppression plays itself out in violence, put-downs, and the ways that families might hold their children back from their potential.

Could You Survive in Any Class?

Below are three short quizzes taken, with permission, from Ruby Payne's book, *A Framework for Understanding Poverty.* These quizzes describe the skills needed to survive in poverty, middle class, and wealth cultures. Please take a moment and check all of the skill sets that you possess. Could you survive in any of the three classes?

Could you survive in poverty?

Put a check by the items you know how to do.

___1. I know which churches and sections of town have the best rummage sales.
___2. I know which rummage sales have “bag sales” and when.
___3. I know which grocery stores’ garbage bins can be accessed for food.
___4. I know how to get someone out of jail without using cash.
___5. I know how to physically fight and defend myself physically.
___6. I know how to get a gun, even if I have a police record.
___7. I know how to keep my clothes from being stolen at the Laundromat.
___8. I know what problems to look for in a used car.
___9. I know how to live without a checking account.
___10. I know how to live without electricity and a phone.
___11. I know how to use a knife as scissors.
___12. I can entertain a group of friends with my personality and my stories.
___13. I know what to do when I don’t have money to pay the bills.
___14. I know how to move in half a day.
___15. I know how to get and use food stamps or an electronic card for benefits.
___16. I know where the free medical clinics are.
___17. I am very good at trading and bartering.
___18. I can get by without a car.
___19. I know how to raise money in two days to cover the cost of a funeral.

Could you survive in middle class?

___1. I know how to enroll my children into Little League, piano lessons, soccer, etc.
___2. I know how to properly set a table.
___3. I know which stores are most likely to carry the clothing brands my family wears.
___4. My children know the best brands in clothing.
___5. I know how to order in a nice restaurant.
___6. I know how to use a credit card, checking account, and savings account—and I understand an annuity. I understand term life insurance, disability insurance, and 20/80 medical insurance policy, as well as house insurance, flood insurance, and replacement insurance.
___7. I talk to my children about going to college.
___8. I know how to get one of the best interest rates on my new car loan.

___9. I understand the difference among the principal, interest, and escrow statements on my house payment.
___10. I know how to help my children with their homework and do not hesitate to call the school if I need additional information.
___11. I know how to decorate the house for the different holidays.
___12. I know how to get a library card.
___13. I know how to use the different tools in the garage.
___14. I repair items in my house almost immediately when they break—or know a repair service and call it.

Could you survive in wealth?

___1. I can read a menu in French, English, and another language.
___2. I have several favorite restaurants in different countries of the world.
___3. During the holidays, I know how to hire a decorator to identify the appropriate themes and items with which to decorate the house.
___4. I know who my preferred financial advisor, legal service, designer, domestic-employment service, and hairdresser are.
___5. I have at least two residences that are staffed and maintained.
___6. I know how to ensure confidentiality and loyalty from my domestic staff.
___7. I have at least two or three “screens” that keep people whom I do not wish to see away from me.
___8. I fly in my own plane, the company plane, or the Concorde.
___9. I know how to enroll my children in the preferred private schools.
___10. I know how to host the parties that “key” people attend.
___11. I am on the boards of at least two charities.
___12. I know the hidden rules of the Junior League.
___13. I support or buy the work of a particular artist.
___14. I know how to read a corporate financial statement and analyze my own financial statements.

Perhaps you are thinking, “I could live in any of these cultures without learning the skills common to the culture if I wanted to.” Of course, you could, but would you be fully accepted into the culture if you refused to participate in the thinking, activities, educational level, possessions, and sensibilities of the culture? Would there be consequences rendered by others in the culture if you opted out of the survival strategies needed to fit in?

If you were able to move up from the class where you currently reside, how would others who support you now react to your good fortune? Would you be welcome in the new culture you are entering, or would those who are established in that culture attempt to undermine you?

Yes, the barriers to transcending class in America today are numerous and insidious, yet we still expect the poor to "pull themselves up by their bootstraps" never noticing that they are too impoverished to afford boots. Much like the middle class who find themselves in a position to move to wealth class, people living in poverty might find they want the benefits of living in the middle class without learning the life style. For those who do wish to fit in, learning how to do so can present quite a challenge.

Skills, Sensibilities, Motivation and Connections

So, what does it take to become "upwardly mobile" in 21st Century America? Certainly, it is necessary to acquire new skill sets, but then the question becomes, "How does one know what they don't know?" It is difficult to seek out new information and build new skills when you don't recognize the gaps that currently exist in your knowledge. Each class has its own "hidden rules" that they don't typically share with those outside their membership. How does one learn rules that are hidden, and whose existence is not known?

Making connections with powerful people is a highly valued success strategy in all three classes. Gaining assistance from important and influential others within one's own class is often easier said than done. Making meaningful connections with those who live in the class above you is nearly impossible. It is primarily through such sponsorship that one is exposed to the hidden rules of a social culture. Even formal mentoring programs seldom address insider information that is common knowledge in the upper classes. These rules remain hidden in order to be a responsible gatekeeper for one's own culture, thereby keeping the riff raff out of the sacred domain.

How does one adopt to the sensibilities needed to transcend class without exposure to these ways of thinking? Sadly, **the primary avenue for exposure to the sensibilities of the upper classes comes to us through television and the Internet.** The lower classes learn what it means to live in the upper classes by watching soap operas, reality shows, talk shows, news shows, sitcoms, and dramas. They read the news bites that stream constantly over the Internet, and participate in blogs that discuss how Paris Hilton

fared during her brief incarceration. They believe the spin, and are misled by the hope that they are integrating true messages from a corrupt media.

Yet and still, Americans remain convinced that if you just try hard enough, you can achieve upward economic and social mobility. The trick is simply to keep your motivation high, apply some elbow grease, and be willing to work from sun up to sun down, and you too can have a piece of the American dream. If you are not willing to do these things, you are condemned as being lazy, inept, or too easily satisfied. Hence, the cycle of internalized oppression is fed.

The Real Deal

Paul could hardly believe the good fortune that had recently befallen him. After struggling for years on a meager salary as a mechanic at a small neighborhood car repair shop, he finally hit the big time. He was hired by a major car dealership to repair and maintain luxury cars. At a salary of $18/hour he could finally afford to purchase a home for his family in a safe neighborhood in the town's best school district.

Shortly after moving into his new home he was working late one night and had just finished repairing a Lexus when he received a call from his wife stating that one of their children had been taken to the emergency room for a head injury incurred while riding her bike. Paul rushed to his own dilapidated car only to find that it wouldn't start. Desperate, Paul "borrowed" a loaner car from the dealership and drove it to the hospital. He returned the loaner car, unblemished and full of gas, early the next morning before the other employees arrived at work.

At about noon Paul was called to his boss's office to view a video tape of him driving off in the loaner car. Although he did his best to explain his actions, his boss insisted that he must have taken the luxury car to impress his friends, and even wondered aloud if he had been driving drunk after a night of heavy partying before returning the vehicle. The police were called and Paul spent three days in jail before Paul's wife was able to show his employer the paperwork from the emergency room to prove his story was accurate. The theft charges were dropped, but Paul was fired for his "poor judgment."

The story of Paul's arrest appeared in the local paper, but there was no retraction printed when the charges were dropped. The day after the story appeared Paul was confronted by his tearful daughter. "Daddy, Kelly isn't allowed to play with me anymore because her Mom says you are a thief," the little one sobbed. Paul was almost relieved several months later when his new home went into foreclosure and he was forced to

move his family back to their old neighborhood. At least the people understood the fact that desperate times call for desperate measures, and they forgive lapses of judgment instead of levying lifelong punishment on your family.

B. Double Jeopardy: Poor and At-Risk

"The rich would have to eat money if the poor did not provide food."

Russian Proverb

The Bible tells us that "the poor will be with us always." Any freshman sociology textbook will be quick to inform the student that "economic balance" is achieved within democracies by maintaining a class system. **The rich employ both the middle class and poverty class, and the middle class also sustains itself on the labor produced by poverty class**. The weight of the entire system rests on the poverty class, so it must be maintained. This is basically the argument that the Bush administration has made for doing little to stem the flow of illegal immigration. America must have a steady supply of workers who will perform low-paying, labor intensive jobs that other Americans refuse to do. In other words, we need more poor people if the rich are to get richer.

Throughout the history of America, the rich have found creative methods for maintaining a poverty class in our society. The American Indians were given disease-bearing blankets to cover themselves with to weaken their physical strength and reduce their numbers. Alcohol was provided to tribal chiefs to muddle their minds and addict their tribesmen.

In Colonial America slaves were divided by selective breeding. Slave owners were directed to rape light-skinned female slaves and impregnate them to produce a breed of slaves that were suitable to live in the main house and care for the family. The slaves were then segregated by skin tone, so as to create house Negroes and field Negroes which were pitted against one another to divide and conquer this strong and rebellious race of people. *The Willie Lynch Letter* suggested that one might make a slave by breaking his spirit, much as one would break a horse for use as a beast of burden.

During the emancipation era slaves were denied the reparations that they were promised by the government, and were disempowered by laws were designed to limit their earning capability when they showed themselves to be gifted entrepreneurs.

Any avid conspiracy theorist is able to offer up proof that the CIA was behind the introduction of crack cocaine into impoverished black communities in the early 1990's to destroy any ambition that might be sprouting there.

Jing, X. (July 16, 2020). *Untitled*. [digital image] Retrieved from https://unsplash.com/photos/Y5oVH2tNN9U

Through the early 20th Century child labor laws were lax, if not non-existent, so that shop owners could exploit the cheap labor provided by children in the U.S. This practice still exists in the countries that currently supply the U.S. with the goods that stock the shelves of our "Big Box" stores.

Currently, it seems that politicians are prepared to look the other way while millions of undocumented immigrants flood our southern boards to live in over-crowded homes and take migratory jobs that feed, clothe, and house middle class Americans.

Unfortunately, both historic and current practices that were put in place to oppress the poor are still reverberating in society today. Alcoholism on American Indian reservations is at an all-time high. Used as a means of escapism, alcohol has robbed over 10 generations of American Indians of their rightful place in today's society. Even more tragic is the intellectual decline of these stoic people caused by multiple generations of Fetal Alcohol Syndrome which causes mental retardation and developmental disabilities.

In the African-American community drug addiction continues to be the scourge that interferes with economic security. Out-of-wedlock births continue to be higher in this population than in any other, and black on black crime is still far more common that black on white crime. Willie Lynch promised that if his system of slave control was set into motion that its impact would continue for 200 years, and it appears that he was correct.

These past practices, along with hunger, a lack of health care, poor educational resources, and lingering oppression of the poor all come together to produce a dependent population with a myriad of social, physical, and psychological impairments that put them at double jeopardy in today's dog eat dog world.

Does Money Solve the Problem of Poverty?

The Welfare Reform Act of 1996 declared that all able-bodied welfare recipients were to find gainful employment and end their dependency on the welfare system. Although millions of dollars were poured into job training programs, occupational training, child care, and resources for the poor (transportation, household appliances, bus tokens, job seeking skills classes, etc.) the impact on poverty in America was minimal. Welfare reform was successful in one regard, it moved the poor from unemployment to under-employment. Although the number of working poor rose, few of these families were successful in moving out of poverty.

For those who like to view hard data, the Census Bureau has compiled a press release that summarizes the face of poverty in America in 2006. These figures appear below.

Poverty Overview

- There were 37 million people in poverty (12.6 percent) in 2005. Both the number and rate were statistically unchanged from 2004 and marked the end of four consecutive years of increases in the poverty rate (2001-2004).
- There were 7.7 million families in poverty in 2005, statistically unchanged from 2004. The poverty rate for families declined from 10.2 percent in 2004 to 9.9 percent in 2005. The poverty rate and the number living in poverty both declined for married-couple families (5.1 percent and 2.9 million in 2005, down from 5.5 percent and 3.2 million in 2004). However, the poverty rate and number in poverty showed no statistical change between 2004 and 2005 for female-householder-with-no-husband-present families (28.7 percent and 4.0 million) and for male-householder-with-no-wife-present families (13.0 percent and 669,000).
- As defined by the Office of Management and Budget and updated for inflation using the Consumer Price Index, the average poverty threshold for a family of four in 2005 was $19,971; for a family of three, $15,577; for a family of two, $12,755; and for unrelated individuals, $9,973.

Race and Hispanic Origin (Race data refer to people reporting a single race only.)

- Poverty rates remained statistically unchanged for blacks (24.9 percent) and Hispanics (21.8 percent). The poverty rate decreased for non-Hispanic whites (8.3 percent in 2005, down from 8.7 percent in 2004) and increased for Asians (11.1 percent in 2005, up from 9.8 percent in 2004).
- The three-year average poverty rate for American Indians and Alaska Natives was 25.3 percent. The three-year average poverty rate for Native Hawaiians and other Pacific Islanders was 12.2 percent. (Because of the relatively small populations of American Indians and Alaska Natives and Native Hawaiians and other Pacific Islanders, the Census Bureau uses 3-year-average medians.)

Age

- The poverty rate in 2005 for children under 18 (17.6 percent) remained higher than that of 18-to-64-year-old (11.1 percent) and that of people 65 and older (10.1 percent). For all three groups, the rate was statistically unchanged from 2004.
- In 2005, the number in poverty remained statistically unchanged from 2004 for people under 18 and people 18 to 64 years old (12.9 million and 20.5 million, respectively).
- The number in poverty increased for seniors 65 and older – 3.6 million in 2005, up from 3.5 million in 2004.

Nativity

- Among the native-born population, 12.1 percent, or 31.1 million, were in poverty in 2005. Both the rate and number were statistically unchanged from 2004.
- Among the foreign-born population, 16.5 percent, or 5.9 million, were in poverty. Both the rate and number were statistically unchanged from 2004.
- Among the foreign-born population, poverty rates in 2005 were 10.4 percent for foreign-born naturalized citizens and 20.4 percent for those who had not become citizens – both statistically unchanged from 2004.

Regions

- In 2005, the poverty rates in the Northeast (11.3 percent) and the Midwest (11.4 percent) were not statistically different from each other. However, they were lower

than the other two regions. Poverty rates for the South and the West were 14.0 percent and 12.6 percent, respectively. Both the poverty rate and the number in poverty remained stable in all regions between 2004 and 2005.

During the '90s, there was a steady decrease in poverty, the first since the 1970s. But, there has been a 10 to 12 percent increase since the late '90s, according to Census Bureau statistics, with no change in the last year.

Obviously giving people money has never helped much to bring them out of poverty. The contention that a person doesn't value what s/he does not earn is likely accurate, but even when the poor earn money it seems to slip through their fingers like water through a sieve. Of course, when you are earning minimum wage and only being given 15-30 hours of work per week, there isn't a lot of money to hold on to.

Does money alone alleviate poverty? No, it doesn't. Poverty today means not one simple thing--lack of money--but many complicated things: low cognitive skills, depression, lack of transportation, and lack of self-esteem. So, if money doesn't help, what does?

Resources Lacking in Poverty Culture

There are a number of resources lacking in poverty culture:

- Financial
- Emotional
- Mental
- Spiritual
- Physical
- Legal
- Support System
- Relationships/Role Models
- Knowledge of Hidden Rules

Along with a dearth of money, those who live in generational poverty often lack the will to keep trying. It is not uncommon to find an impoverished person who has run through a series of minimum wage jobs in a short period of time. Depression sets in, and they simply quit searching for work outside their home. Some become convinced that God has turned his back on them. Others find they cannot tolerate the physical demands of a labor-intensive position. More than a few find they are mired in a legal mess due to past bad

decisions that have left them without a driver's license or with an insurmountable pile of debts.

Support systems in poverty culture are usually composed of other poor people who have no more information about the way out of poverty than those they are supporting. Flesh and blood role models are scarce, and relationships are often in turmoil due to a lack of stability and a dependence on irresponsible others. The generationally impoverished have no real idea about how the other half lives, and how to change their thinking and behavior to gain entrance into mainstream culture. With the hurdles to economic success being so hard to scale, some decide that they want no part of life in the middle class, and simply refuse to jump through the hoops to get there.

Special Needs Means Special Costs

One might argue that all people who live in generational poverty are at risk in today's society because they lack the resources to meet their basic needs, and the contention would-be right-on target. There are, however, special populations that exist within the poverty community whose lives are further complicated by disabilities.

Poor Children with Learning Disabilities

Leeper, N. (November 4, 2019). *Untitled.* [digital image]. Retrieved from https://unsplash.com/photos/GfF9fYvmVTU/info

Children with learning disabilities (LD) are of special concern. Special education is more costly for school systems to offer than mainstream education, and children who come from poverty are often overlooked when deciding who will get a coveted seat in an LD class. Middle class parents are often heard to complain that they must hound their school district to get their child tested for LD and enrolled in a special class. If fierce parental advocacy is a requirement for entry into an LD classroom, poor children already find themselves behind the eight ball. The parents of children living in generational poverty are likely to have educational gaps themselves,

and may not know the how the education system works. They fail to advocate for their children believing that the school system will do right by their offspring without their assistance or interference.

Robert Worth's scathing article entitled *The Scandal of Special Ed* succinctly sums up several concerns regarding the plight of impoverished children:

Anyone who's spent time in an inner-city classroom can tell you that the challenges the average poor kid faces are often hard to distinguish from those you'll find in special ed. This may be the greatest absurdity of the special ed law: It fails to acknowledge "environmental, cultural, or economic disadvantage" as disabling conditions. Why should a child with a broken back be guaranteed round-the clock, state-of-the-art medical care, no matter what the cost, while the millions of kids whose difficulties stem from poverty and neglect are left to hope that their teachers will break the rules so they can get some extra help? Should we really be spending $10 billion (at least) a year on "learning disabilities" when we still don't adequately fund Head Start and Title I, the federal programs that were designed to help poor children catch up with their wealthier peers?

Mr. Worth also points out that impoverished children who do get into special education classes often languish there without regular re-evaluation and do not get mainstreamed when their skill level achieves designated benchmarks, thereby further retarding their progress.

The *No Child Left Behind Act* holds special education students to the same high standards as regular education students, meaning that by the year 2014, learning-disabled children must perform proficiently or above on all state tests. With more than 13% of public-school students receiving services under the

Individual with Disabilities in Education Act, it is imperative that we find better ways to help learning disabled children reach these standards.

Children who need special education but are not receiving it are already failing mandated proficiency tests needed to receive a high school diploma. These youth are forced to enroll in Graduation Equivalency Diploma (GED) classes to validate their education. The problem is that GED classes for the learning disabled are as scarce as hen's teeth.

It is common for an adult who lacks a diploma to undergo testing prior to enrollment in GED classes. The Test of Adult Basic Education (TABE), or a similar test, is used to assess a student's grade level in math, reading, language, and writing. It is not unusual for a student to test at a third or fourth grade level in these basic skill areas although they stayed in school until the eighth or ninth grade. One might suspect that undiagnosed learning disabilities are at play here, yet, without LD GED classes, the student is set up to fail again by being required to participate in a regular GED program where the student will eventually drop out due to overwhelming frustration at their own lack of progress.

On its' face, this situation is dismal enough, but when one considers that any welfare grants the person is receiving will be sanctioned (withheld) if they drop out of a GED program, the problem becomes untenable. Label the student as too "resistant and uncooperative" to help, and cut them loose to depend on their own devices. It is little wonder that these individuals sometimes turn to a life a crime to support themselves and their families.

The Real Deal

Melinda is the mother of four. She has recently been abandoning by her spouse and is a middle school dropout. With an eighth-grade education she is unable to find a living wage job to support her family, and her spouse cannot be located to pay child support. Although she vowed that she would never depend on the State Welfare system, she makes a visit to the local office to apply for Aid for Dependent Children and food stamps. At age 22 she is found to have no marketable job skills, and is placed on a work assignment to earn her meager welfare grant. She is assessed with a TABE which reveals that she has attained only a fourth-grade level in her learning.

Day after day Melinda struggles in a GED class where the other students come and go after a few weeks of education, yet Melinda remains, unable to pass even one of the pre-tests offered in class. Ten hours of class a week, coupled with 30 hours a week cleaning cages at the local dog pound, and studying each evening leaves her little time to spend with her children. The Welfare Department's daycare provider lives across town from her home requiring the family to catch the bus at 6:00 AM each morning, and not return home until 6:00 PM each evening. Melinda suspects that her children are not being well cared for by the daycare provider because they cry in protest each morning as she wrestles them to the front door of the sitter's home.

One morning Melinda can no longer ignore the desperate protests of her children, gathers her brood, and returns home without attending her GED class. She borrows a

neighbor's phone and calls her caseworker to explain why she must drop out of school, and is informed that she that her check will not be issued until she comes into compliance with her self-sufficiency plan. Now sobbing, Melinda hangs up the phone and allows her lecherous neighbor to console her.

"You know," he states, "You could earn $200 a night with that cute little body of yours while your kids sleep in their own beds if you weren't so uppity. An education ain't gonna feed your babies until sometime next year. They look like they are hungry now!" Can you guess what this young mother decided to do?

Poor Seniors at Risk

Congressional hearings were conducted in 1984 to look into the plight of impoverished seniors who are denied nursing home care. An excerpt from the Opinion Paper abstract reads:

This Congressional oversight hearing was convened to examine evidence that many of the nation's nursing homes restrict or deny access to the elderly poor and disabled, leaving the 18 million Americans dependent on Medicaid especially vulnerable to neglect and exploitation. Evidence was heard on discriminatory admissions, on the practice of demanding cash payments before accepting a Medicaid patient, on the eviction of residents once they become eligible for Medicaid, and on racial discrimination. Witnesses include a former nursing home admissions director, two citizens with experiences of nursing home malpractice, an attorney from the National Senior Citizens Law Center, the attorney general of Maryland, and the deputy executive vice president of the American Health Care Association.

Mika. (March 9, 2018). *Man next to a wall.* [digital image]. Retrieved from https://unsplash.com/photos/8qqYd1b_eAI

To this day, nursing homes find reasons to deny admission to those who pay using Social Security Insurance (SSI) and/or Medicaid/Medicare as their sole means of payment. When middle class people enter a long term care facility, their home is attached with a lien. When the family's money runs out, the home is sold and the proceeds are confiscated by the facility. Poor people typically do not own property, so their stay in a long term care facility is compensated by only a government pittance. There is no profit margin in serving this population.

Seniors and disabled individuals who must continue living in impoverished neighborhoods despite their declining mental and physical capacities can quickly become targets for neighborhood criminals. If there is no one to look out for their best interests, unscrupulous others will exploit them financially, physically, sexually, and emotionally. Sometimes their own children are the culprits.

The Real Deal

"Don't call me Mama, because I am not your Mama," Sally screamed as the landlord looked on. "She is confused again today, Alzheimer's you know," explained Marcia, Sally's self-proclaimed daughter. "Just don't let her pee on the floor anymore," the landlord replied before heading for his pick-up truck.

Eviction time came seven months later, three months after Marcia quit paying the rent, and the landlord returned to the home to make sure the family had cleared out as ordered by the court. He found that only Sally had been left behind. At the age of 93 she was unsteady on her feet, and yet, there she was, wading through trash up to her knees. As she turned to see who was sneaking up on her, the landlord noticed that she was covered with bruises, and her eyes were nearly swollen shut. "What happened?" the landlord inquired.

"They beat me with a 2" by 4" and then they moved out while I was unconscious," replied Sally. "I think they stole my radio. I can't find it anywhere."

"Your daughter did this to you?" asked the disbelieving man. "She isn't my daughter." the feisty woman corrected." She was my neighbor when we lived over on Howard Street. She kidnapped me when she moved over here so she could have my social security check. Yesterday I snuck and used Marcia's cell phone to call the law. She and her kids beat me silly after the police left."

“And by the way,” Sally added, “It wasn’t me that was peeing on the floor.”

The Impact of Poverty on At-risk Populations

Children, youth, women, the disabled, and the elderly can all be considered “at-risk” populations if they are forced to live in irreversible poverty. These individuals are routinely exploited by the system, their community, and sometimes even their own families.

Generational poverty culture is a place where “survival of the fittest” is the unspoken credo. Only the strong survive. Whether you are referring to The Hood, The Barrio, The Ghetto, The Reservation, Chinatown, The Inner City, Little Italy, The Slums, The Trailer Park, or any other known impoverished area in the United States, there are certain commonalities. These commonalities are not due to race, religion, sexual orientation, ethnicity, or gender because these diversity factors are present in most all impoverished neighbors. They are due to circumstance, and the circumstance is generational poverty.

It matters little if you are talking about urban, rural, or suburban areas, anywhere the poor are gathered is an area at-risk. Without fail, these are areas where food and gas prices are high, and opportunists are plentiful. Guns are easily available, and frustration is high. The crime rate is the highest in the area, and the easily victimized go unprotected. Single woman heads the majority of the households, and the children regularly “go without.” Drug and alcohol abuse is prevalent, and people have little money to feed their habits. If that isn’t risk, what is?

What is Poverty?

Poverty is hunger.

Poverty is lack of shelter.

Poverty is being sick and not being able to see a doctor.
Poverty is not being able to go to school, not knowing how to read, not being able to speak properly.

Poverty is not having a job, is fear for the future, living one day at a time.

Poverty is losing a child to illness brought about by unclean water.

Poverty is powerlessness, lack of representation and freedom.

Unknown

Yes, there are families in America drinking from unsafe wells, obtaining their water supply from a muddy creek, and hooking a lead-lined water hose to their neighbor's spicket to use for cooking, drinking and showering. The number of those who are homeless to grow annually. A lack of health insurance and the lack of transportation to get to the doctor cause people to suffer and die from treatable medical conditions. A felony on one's record will lock a person out of consideration for even a minimum wage job.

Hungry children go unfed, yet no one seems to listen. No one in power seems to care. The impoverished feel that they have no voice, no power and no allies.

C. Past, Present, and Future Perspectives

In every conceivable manner, the family is link to our past, bridge to our future.

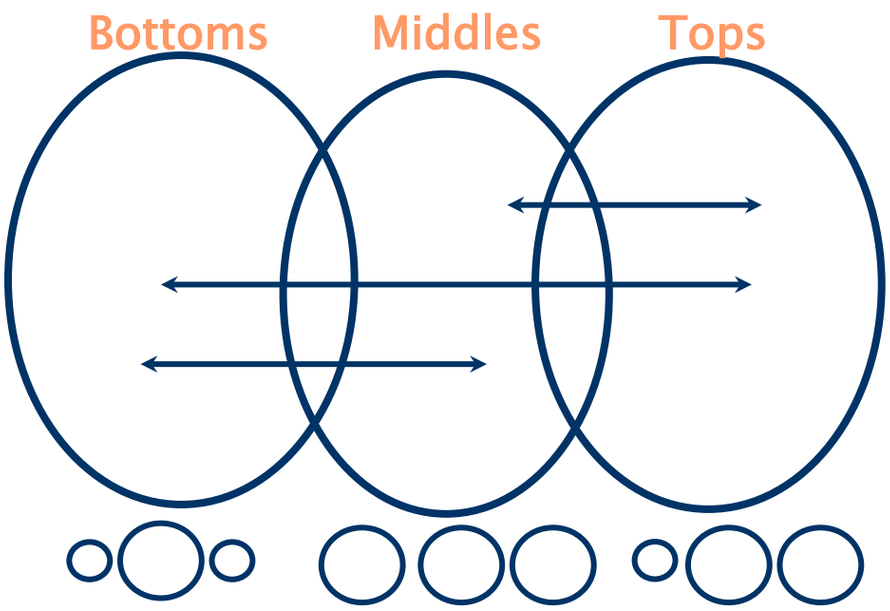
Alex Haley

The only thing the generationally impoverished have ever known is deprivation. They have lived from one day to the next wondering how they will get by. If ever economic security existed in their family history, it was so far back that they were not exposed to it. Some U.S. families are now on their seventh generation of poverty reaching back to before the advent of social welfare programs. They have inherited a legacy of hopelessness, a life where today doesn't look much different than yesterday, and tomorrow is destined to be a continuation of the same.

Differences Between Class Perspectives

The poor, the middle class and the wealthy view their past, their present, and their future in very different ways. The illustration in Figure 2 will provide a graphic illustration of these perspectives with relationship to those who live at the top, middle and bottom of the economic spectrum.

Figure 2: The Social Economic Model (1997)



Those at the top, middle, and bottom do get a chance to encounter one another from time to time. Predominately, the upper middle class meet the wealth class in their place of worship, high-end department stores and boutiques, at social gatherings, and at private clubs. The middle-class encounters people from poverty class in their place of worship, in shopping malls, movie theaters, at community events, and at public recreation facilities such as public parks and pools. Additionally, all three classes encounter one another in the course of their workday.

Butlers, gardeners, nannies, domestic staff, drivers, security guards, and delivery personnel often hail from poverty class, and are hired by the wealthy to oversee the more mundane duties of daily living. The middle-class encounters people of poverty class when

they order a meal at a fast-food restaurant, hire a home health aide, purchase items from a Big Box store, or pick up their dry cleaning thanks to the fact that the working poor fill the front-line positions in these establishments and service areas. When the wealthy require police protection, healthcare services, education for their children, require clerical assistance, and make purchases from high end stores they again encounter those from the middle class who provide professional services needed by the rich.

The fact that the classes brush against one another in the course of daily living does little to diminish the fact that they live in separate worlds, sometimes barely noticing one another as they interface. Seldom are close relationships forged that would serve to influence the thinking of those of other classes.

The division becomes even more apparent when you notice the size of the past, now, and future circles at the bottom of the illustration. As mentioned earlier, **the poor think only about the present. Their future holds little promise, and their past is not usually filled with happy memories, so they take life as it comes with little focus on future planning.** They seldom put back anything to save for tomorrow and use up whatever resources they come by almost immediately after receiving them, because life is so uncertain that tomorrow isn't guaranteed to come.

The middle class are constantly reminded to remember where they came from, and are encouraged to preserve the traditions of the past that got them where they are today. Their past is as important to their future as is their present, so they budget, put away a bit of savings, maintain their possessions, organize their affairs, and preserve long term relationships that add stability to their lives.

Where the poor are survival oriented, the middle class is responsibilities oriented and attend to their present so they can build on it in the future. Retirement planning, for example, is valued primarily by the middle class who aim to live out their lives free of government dependence, with some left over to pass along to their offspring. Since most in the middle class live primarily from paycheck to paycheck, a fear of falling into poverty is a strong motivator to act responsibly now in an attempt to hang on to all they have and hold dear.

The wealthy are often too busy enjoying today to worry about what happened in their family's history. An embarrassment of riches and powerful connections keeps them from having to worry about falling out of their social class, so it matters little where the wealth came from in the first place. The wealthy are forward thinking individuals who

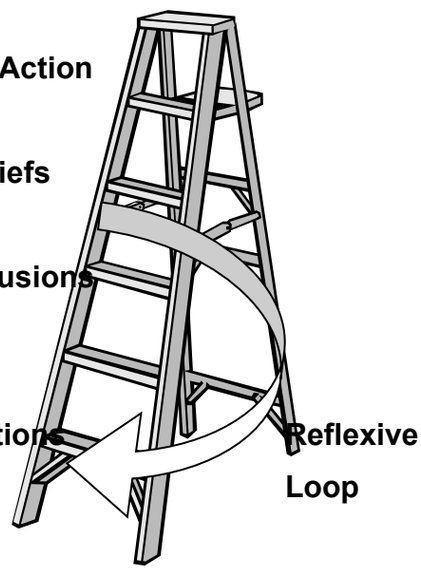
are sometimes more rights oriented than responsibilities oriented. They are looking out for their future rights, and the rights of their children and grandchildren as they look for ways to extend their good fortune beyond this lifetime. They plan strategically for the future by funding endowments that will bear their name as living legacies of themselves in the world of art, commerce and culture.

It is with relative ease that those in one class cast aspersions on those in other classes due to their differing past, present and future perspectives, each judging their way of thinking to be superior to the others. The poor can't figure out why the middle class would spend their whole lives working just to die and pass their hard-earned possessions onto someone else. Why they barely have time to enjoy today because they fear what will happen tomorrow! The middle class lacks an understanding of why the wealthy spoil their children instead of cultivating an earning mentality as they have done with their own children, and why they spend so irresponsibly, much like the poor, who seem to run through resources as if tomorrow will never come.

Are the Classes Climbing Different Ladders?

The *Fifth Discipline Fieldbook* contains an interesting model, ***The Ladder of Inference*** **that explains the ways in which culture, beliefs, and thinking interact to produce action.**

Figure 3: The Ladder of Inference



might capture it

In any given environment, there is more to observe than the human mind can capture. Imagine a video camera recording a scene, and notice how much more the camera might see compared a human in the same environment. Each of us selects which environmental data we will focus on, and what we will attend to. Once our mind has selected the data, we find relevant, we will begin to add meaning to that data based on our personal experience and acculturation. Based on the meaning we perceive, we make assumptions, which lead us to draw conclusions about the world. Our conclusions cause us to adopt beliefs about the world. The actions we take are based on our beliefs.

Let's look at how the Ladder of Inference might play out if a person from wealth class, middle class, and poverty class were all present in the same circumstance. Each of the three people arrives at a hospital to visit an elderly loved one. Upon entering the loved one's room, they notice that the person they are visiting has a bruise on their arm. The person from wealth class might notice the bruise and decide that someone has injured their loved one. They assume that the injury has been caused by the carelessness of the nursing staff. Drawing the conclusion that the staff is inept; they may adopt the belief that their loved one isn't safe in the facility and take the action of moving the person to another facility.

A person from the middle class might see the bruise and decide that their loved one has had an accident. They decide that the injury occurred due to a fall or a bump. They assume that the nursing staff is competent, but stretched too thin to observe the patient closely, and that their loved one is growing too weak to move about on their own, and draw the conclusion that the loved one needs assistance to ambulate. They adopt the belief that it is time to procure a walker for their loved one and ask the staff to order a walker for the patient.

A person from poverty class might see the bruise and decide that their loved one was assaulted by his/her roommate. They assume the injury occurred while the roommate was attempting to steal their loved one's watch. They draw the conclusion that their loved one is being victimized by his/her roommate, and adopt the belief that the loved one is unsafe with the current roommate. They insist upon talking to the head nurse to expedite the transfer of their loved one to a room on a different floor of the facility.

The ladders of these three people are all drawn from different paradigms. Paradigms develop due the reflexive loop. After being acculturated to make assumptions and draw

conclusions by habitually viewing matters through their programmed cultural lenses, those steps are skipped in future analysis of a situation. They respond reflexively in much the same manner to every future situation that is similar to what they have experienced in the past. Thusly, people from different social classes learn to view the world in very different ways.

Does the Middle Class Exploit and Oppress the Poor?

One might argue that the rich oppress the middle class by levying taxes that include loopholes for the wealthy, and by introducing them to schemes where the rich person makes far more money than the middle class middle-man. Stories abound about people who have won the lottery only to see their money dissipate rapidly as those in wealth class sell them overpriced objects, or set them up with faulty investments. It appears that the rich like to protect the exclusivity of their class, and are skilled at doing so.

Does this urge to protect entrance into one's own class extend to the middle class as well? Is the middle class cheering for the underdog, and embracing those who rise out of poverty? Some do and some don't. Similarly, there are some folks living in wealth class who are more than willing to give a middle-class person a leg up when they see potential in the individual. A recent boom in new millionaires in America speaks to that fact. Not all "self-made" millionaires became so without backing from those who were already wealthy.

While it is dangerous to make sweeping assumptions about people in any class, it is noteworthy to examine the ways in which the middle class exploit the poor, as well as how the poor exploit one another.

Middle class business men and women have long known how to capitalize on the spending habits of the poor. It is no secret that money arrives in impoverished neighborhoods on the first of each month. As a matter of fact, in some poor neighborhoods the first of every month is known as "Mother's Day," because it is the day that mother can buy the things she has wanted and needed over the past four weeks.

It is no coincidence that big sales spring up in and near impoverished neighborhoods on the first week of each month. Rental stores offer "easy weekly payments" on items such as computers, appliances, furniture, big screen televisions, and stereo equipment the first week of each month. The "buy here—pay here" car lots put their cars on sale at "deep discounts." Bingo parlors offer a deal on bingo cards, five for the price of four. Pawn shops

offer two items for the price of one. Vendors display their wares on street corners and sell carpet by the roll, gold by the inch, and Velvet Elvis paintings.

Neighborhood taverns extend the length of happy hour, and the local groceries mark up the price of snack foods, cigarettes, and liquor to capitalize on the fact that the poor have money to spend. Casinos offer discounts on food and drinks. Cut rate telephone companies will restore phone service with a minimal down payment, and throw-away cell phones are on sale everywhere. Door to door salesmen hustle for fast sales on vacuum cleaners, insurance policies, burial plots, laundry soap, and cosmetics.
Between the third and fifth of each month the money is gone, and things go back to normal for the next three more weeks. Where does the money come from to make these non-essential purchases? Social security and Aid to Dependent Children checks fall quietly into the mailboxes of impoverished families. The working poor get their first paycheck of the month. Retirement checks come to others who have worked in the past, but are now in their golden years.

Between January and April each year the IRS issues “Earned Income Credit” checks that range from a few hundred to a few thousand dollars in value. During this period the check cashing companies offer instant refunds and will even do a person’s taxes for free if they sign up to pay almost 30% interest on the advance. The “buy here—pay here” car lots will also fill out one’s tax forms and take the entire refund as a down payment on a used car that is valued at two to three times its’ Blue Book value. The interest rate for these cars runs about 28%.

Unscrupulous real estate investors offer lease-purchase options at 15% interest and those who flip homes throw a little paint on a rundown property and sell it to unsuspecting buyers for twice its value. Mortgage lenders offer loans for 125% of a home’s value to give mortgage holders a little spending money. The result is that the poor find themselves “upside down” on home and car loans, meaning that they owe more than the house or car is worth. Bad credit? No credit? No problem! Whether or not you have the ability to pay, there is someone out there who is willing to take their chances on you.

If middle class vendors are unsuccessful in sucking all of the cash out of impoverished homes, other poor folks are more than willing to lend a hand. Neighborhood drug dealers offer outstanding buys on marijuana, cocaine, heroin, meth amphetamine, crack, and club drugs. Observably, the men return to the neighborhood bearing gifts of diapers, milk, and jewelry to lure the woman who live there all month long into giving up their government checks. The area pimps even put their stable on sale so that buying a woman’s company

is a more affordable luxury. Illegal weapons can be purchased for half their normal price. After hours clubs reduce their cover charge and offer a free drink to lure in customers that will gamble away the remainder of their checks.

Even the neighborhood churches sometimes get in on the act, holding ice cream socials, fish fries, carnivals, and tent revivals where the plate is passed not once, but several times during the event. Festivals are held at area parks on the first weekend of the summer months in impoverished areas of the community. Drag races spring up at area speedways, and demolition derbies and tractor pulls are held at the local fairgrounds. Area bowling alleys, skating rinks, and game rooms offer incentives to boost attendance. Entertainment opportunities abound to brighten an otherwise dark existence. Sometimes the allure of these events is simply too tempting to resist.

The Hidden Rules of the Middle Class

You might inquire, “What hidden rules could possibly exist in the middle class?” Often referred to as “common sense,” these rules reside in the reflexive loop of most middle-class people, and have become mindless common practices in mainstream America. The middle class might selectively break these rules, but they definitely know they are breaking a rule when they do so.

Not knowing the hidden rules of the middle class can cause a person living in poverty culture to lose a job, ruin a friendship, or even get arrested in mainstream. Not all of these rules are unknown to all people who live in generational poverty, but generally these values, activities, and sensibilities might not be common knowledge as those in the middle class assume that it is. Here is a sampling of the hidden rules.

- Budget—Save some for later, whether it is a piece of cake, or a few dollars from your paycheck. You might need it worse later than you need it now. Have a fund to cover future emergencies.
- Analyze your risks—Decide what might go wrong when you make a decision, then modify your approach to mitigate as much of the risk as possible.
- Company Manners—Put on your best face when you are in the presence of someone you wish to impress. Speak politely, don’t swear, and use table manners when you eat.
- Table manners—These include putting a napkin in your lap, keeping your elbows off the table, taking small bites, and not talking with your mouth full.
- Be honest, but not brutally so—Consider the feelings of others when you speak.

- Privacy is protected—Keep personal things to yourself in public. Don't ever make a scene, and don't talk loudly in quiet places.
- Never point at anyone—It is impolite. And, don't stare at people who look different or odd to you.
- Pay your bills before you play—It is irresponsible to entertain yourself with money needed to pay the bills. Pay the bills first, then indulge yourself with what is left. Pay your bills on time. Never wait for a second notice.
- Get a checking account—Never, ever get a payday loan, and don't use a check cashing store to cash your paycheck. They keep 10% of your money.
- Keep your clothes and your body clean—Don't put dirty clothes on after you shower, only put deodorant on only after you have cleaned your under arms with soap and water, wash your hair before it looks dirty, and be sure your clothing is not stained or ill-fitting.
- Don't rent your furniture, electronics and appliances—Go to a second-hand store, a yard sale, or an auction if you must, but buy these things, don't rent them.
- Don't waste anything—It doesn't matter whether you have to pay for it yourself or not, don't waste it.
- Have boundaries—Don't ask strangers personal questions, and don't be too self-revealing too early in a new friendship or relationship. Don't stand too close to strangers when speaking to them. It makes them uncomfortable.
- Don't take it unless it's offered—Do not help yourself to things that belong to others even if you think they don't want them anymore. Always ask before you take something.
- Don't throw a party in your front yard—Keep your music at a reasonable volume, and take pains to make sure that your social gatherings do not disturb the neighbors

There certainly are a lot of "don'ts" in the middle class, aren't there? Perhaps it even looks to the poor like the middle class is "putting on airs" when they automatically abide by these rules. The poor have no idea that the middle class doesn't know any other way to do things. Most of these rules were taught to them as children, and are reinforced by societal expectations. Unfortunately, not knowing these rules can cost the generationally impoverished dearly.

The Real Deal

Kari had been working the counter at a popular fast-food restaurant for three weeks. During the lunch rush one Tuesday, Kari's crew leader noticed that she was squirming uncomfortably behind the counter. She approached Kari and whispered discretely in her ear, "I will cover your register if you need to leave to go to the restroom."

Kari replied in strong, clear tones, "I don't have to pee, I have a yeast infection and it itches!" Appalled, the supervisor took Kari by the arm and led her to the back of the restaurant while the customers fled to their cars, their appetites dulled by Kari's revelation.

Ten minutes later Kari was seen leaving the restaurant by the back door, carrying her possessions and crying. She had been fired for violating the rules of the middle class, and in all likelihood, she left the restaurant that day still not understanding what she had done.

D. Life in the Neighborhood

"Every man is surrounded by a neighborhood of voluntary spies."

Jane Austin

On the rather rare occasion that an impoverished family does escape to the middle class, the others who are left behind will likely not offer hardy congratulations to the newly middle class. "You'll forget where you came from and become one of THEM," they warn. "Oh no, we will have a house warming party and invite you up to visit us all the time," the departing family will assure their neighbors and friends.

On the day of the house warming party the quiet middle-class neighborhood where the formerly poor family has moved may get quite a shock. As cars and trucks begin pulling up to celebrate with the new home owners, their presence will be noticed, if not for the music blaring from their car radios, then for the puddle of oil leaking from each of them onto the surface of the street. The half-barrel BBQ grill will be unloaded and stereo speakers will be placed on the front the porch. Within moments the grill will be erected up in the front yard and set ablaze, and someone will break out the libations.

Curtains will sway and blinds will bend as the neighbor's spy to see what in heaven's name is going on at the new neighbor's house, and they won't like what they see. There is way too much skin showing at that gathering and those cigarettes smell funny. The new neighbor is about to learn that the police respond much more quickly to calls sent from a middle-class neighbor than the one where they used to live. If the newly middle-class family wants to stay in the neighborhood they will think twice before they hold another picnic.

The Environment of Poverty

Thomas, A. (January 30, 2020). *Homeless*. [digital image]. Retrieved from https://unsplash.com/photos/FB1n9kXP7WA

Although the terminology, accents, language, slang, and cooking fragrances might vary from one impoverished neighborhood to another due the race or ethnicity of those who occupy it, the living conditions are very similar. People learn their life lessons through humiliation, retaliation and hard knocks. Instead of supporting one another with compliments and kindness, they challenge one another with insults and dares to build strength of character. They build themselves up by putting others down instead of striving to come up to the level of success that they envy. It is the harsh reality of the neighborhood, and no one who dwells there escapes it.

Even babies become fodder for insult. "Where did you get that monkey you've got wrapped up in a blanket?" a new mother might be asked. "Yeah, we almost sent him back when we saw he looks like you," the mother might reply. Later, when the mother becomes frustrated by the baby's unrelenting crying she might be heard to say, "Just shut-up, you little monkey-looking moron! You get on my last nerve even when you're asleep!" Those from the middle class might judge her as cruel. After all, the child will lack appropriate levels of

self-esteem if he must tolerate ongoing criticism and taunting from his own family members. The mother, however, is attempting to make the child strong enough to hold his own in the face of societal discrimination and neighborhood bullies. Such thinking, of course, perpetuates the cycle of generational poverty. It also reinforces the cycle of internalized oppression.

Compliments are generally regarded with suspicion. “Why are you trying to butter me up? What have I got that you want?” is not an uncommon response to praise. Those who fall for compliments are often being set up to be somehow ripped off, so they become proficient at seeing it coming. Tough times call for tough measures, and for people who grow up in generational poverty, the times are always tough.

There is an old joke that is not very funny when you view it from the long-term ramifications it has for the child...

A pediatric nurse was mortified when the small boy she was caring for told her to remove the milk from his meal tray. “I don’t want this damn milk,” he proclaimed. When his mother came to visit later in the day, the nurse reported the little boy’s remark to her expecting that she would discipline the potty-mouthed child.

Well, to hell with him if he doesn’t want his damned milk!” the mother replied.

Common Tenets and Norms of Generational Poverty Culture

Not all of the norms listed are present in every generationally impoverished neighborhood, but it is good to be able to spot them when they present themselves to the middle class, and to know what inferences lie behind what is being observed.

1. Background noise—The TV is always on, no matter the circumstance. In impoverished neighborhoods the walls are thin. You can either listen to your own noise, or that of your neighbors. Also, if you turn your TV off when you leave your home, intruders will know the house is empty. The television is on regardless of whether the family is away, asleep, or conversing on the telephone.
2. Importance of personality—The ability to entertain, tell stories and have a sense of humor is highly valued. Being the life of the party is one sure way to get invited to future social gatherings. There is food at these gatherings and if you are invited your family gets to eat.

3. Significance of entertainment—Respite from survival is important. The human mind typically tries to free itself from a state of constant need. Fantasy and fun are thought necessary to prevent insanity.
4. Importance of relationships—One often has favorites and has only people to rely on. The middle class believes that parents should love all of their children to the same degree. In poverty class this is not a strongly held value. The child who has the most potential to be an income producer is often told s/he is more cherished than the others.
5. Matriarchal structure—The mother has the most powerful position in the society if she functions as a caregiver. Leaving your family to go off to work is not considered the best way to provide for your family if you are a woman. Mothers who take their children with them when they work are thought to be better mothers than those who would be willing to leave their children with strangers who provide daycare. Once at work, the children are often called upon to share in the labor. This is thought to teach the children a work ethic.
6. Oral language tradition—Slang or casual register is used for everything. The communication in the neighborhood is filled with emotion and color. Slang, swearing, and casual register is used for emphasis, and to demonstrate the commonly understood language that binds them as a community.
7. Survival orientation—There is little room for the abstract, so most of what is communicated is fairly concrete. Discussions center on people and relationships. A job is about making enough money to survive, not about a career.
8. Identity is tied to the lover/fighter role in men—The key issue for males is to be a man. The rules are rigid and a man is expected to work hard physically, and be a skilled lover and a fierce fighter.
9. Identity is tied to rescuer/martyr role for women—A good woman is expected to take care of and rescue her man and her children as needed. The more obstacles a woman has to overcome to care for her family, the more respect she wins from the other women in the community.
10. Importance of non-verbal communication—Touch is used to communicate, as is space, gestures, facial expression, and other non-verbal forms of communication. There is no such thing as a “personal zone” in poverty culture, and people stand more closely to one another in public spaces than those who live in the middle class.
11. Ownership of people—People are possessions. There is a great deal of fear and comment about leaving the culture and “getting above your raisings.” Ownership mentality over their children, spouses, and friends is a form of control used to prevent the loss of those they hold dear.

12. Discipline—Punishment is about penance and forgiveness, not change. Getting caught is the mistake, not the behavior that got you in trouble in the first place. An effort is made not to get caught when repeating the behavior in the future.
13. Belief in fate—Destiny and fate are the major tenets of the belief system. Choice is seldom considered. People who live in poverty wait to be "discovered" to find success. They fail because they are victims who were "set up." The lottery is called "Ghetto Insurance" in poverty culture. One will spend half their paycheck on gambling to hit it big, or on visits to a reader/advisor to have their fortune told. "Go for bust," is the slogan that is embraced.
14. Polarized thinking—Options are hardly ever examined. Statements such as "I quit" and "I can't" are common. Difficult things are more frequently abandoned than conquered.
15. Mating dance—The dance is about using the body in a sexual way to attract the opposite sex. Clothing may be revealing as opposed to expensive. Despite welfare reform efforts, the system still pays young women to have children and extends their allotted time on the system. One must have a mate to have a child, and to find one on a limited budget may mean that you have to show some skin.
16. Time—Time only occurs in the present. The future doesn't exist except as a word. Time is flexible and not measured. "Compass time," not "clock time" governs the activities in the neighborhood. "Give me a minute," may actually be a request to delay an activity for several weeks or months.
17. Lack of order/organization—Many of the homes of people in poverty are unkempt and cluttered. Devises such as drawers, shelves and filing cabinets that help to organize things don't exist. Lots of time is spent looking for lost items.
18. Lives in the moment—Most of what happens is reactive and in the moment. Little planning or goal setting takes place. When your attention is completely focused on how to survive today, and little thought is given to what tomorrow may bring.

Redefining Work, Rest and Play

There is a major misconception in the middle class that contends that those who are unemployed and impoverished do not work. The poor work consistently even if they don't have a formal job. Often, work isn't called "work," but is known as "hustling," or "rustling." The poor sell both their skill sets and their muscle in order to get by. Raising poultry for eggs and to eat (even in the city), gardening to grow their own food, and breeding and selling animals to raise a bit of money are common "hustles." The health food store will pay well for ginseng root and homegrown herbs. The pet store will buy baby ferrets,

puppies, kittens, exotic birds, pot-belly pigs, rats, gerbils and guinea pigs that are raised in shacks, house trailers and sheds. Vegetable stands will buy fruits and veggies raised in area gardens.

Shade-tree mechanics fix the cars in the neighborhood and kitchen barbers cut hair. The local nail salon may be located in someone's bedroom. Home-based restaurants, catering services, and after-hours clubs are easy to locate. Those who have been provided free laundry facilities by their landlord take in laundry and do wash from sun up to sundown, or longer. Not all "underground" business involve criminal activity. These "quasi-legal" businesses only violate the lesser laws that are enforced by the health department, but not by police. Unlicensed establishments abound, and offer an affordable alternative to more legitimate businesses run by the middle class. Poverty culture is a culture of entrepreneurship. The life skills and talents of those in the culture are used to support the families who live in it.

Poverty culture is also a barter culture. If you baby-sit for my children, I will let you use my washer. If you drive me to the grocery, I will cook dinner. Goods and services are traded, thereby meeting needs without spending money. Resources are shared until they are exhausted. If you can't pay your electric bill and your service has been discontinued, you simply run extension cords to your neighbor's house and tap into their current. Water hoses are sometimes used to supply water to an entire block, particularly if the landlord pays the water bill.

Poverty culture is a culture of entitlement. Utilities should be free. Community Action agencies are expected to pay the heat bill. HUD is expected to provide free or low-cost housing. It is fine to steal cable by tapping into your neighbor's service because if everyone was together in the same room watching TV it would be free to everyone watching except the subscriber. What could be the problem with extending the service to 12 individual apartments by drilling through the walls and stringing the cable through to everyone? Now the bill can be divided 12 ways and it isn't nearly so pricy.

To the poor, those living in the middle class are wealthy. Their "Robin Hood" mentality is just a way of neutralizing unjust discrepancies between those who can afford things and those who can't.

When people work in the middle class, they earn money. Poor people earn rest and play. Rest, sleep, and play are highly valued as compensation for effort. Time to enjoy the fruits

of one's labors is savored. A nap is a necessity, not a luxury, especially if one has hustled long into the night to finish a job. Sleeping late in the morning is flex-time.

Drugs and alcohol are sometimes viewed as a "vacation" if done intensively for days at a time. Intoxication is an economical way to "get away from it all." Recovery time is built into the vacation period, and one does not return to work until the hangover passes.

A poem written by a social services worker who visits the "hardcore unemployed" in the Appalachian area of Ohio wrote the following poem after one particularly sad home visit. Wil Mayne uses his skill as a poet to "detoxify" after a long day of visiting the helpless and the hopeless that are deeply entrenched in generational poverty. What Wil sees is simply too demoralizing to carry home with him each evening.

Fat Lady Smokin' Pot

Cockatiels singing their songs
Finches singing along
Rotten toothed boyfriend walks in
She makes her livin' babysittin'

Metropolitan Housing Authority low rent bliss
Where the hell else can you live like this?
Food stamps to satisfy her munchy need
Wait a minute while I toke on my weed

I'm gonna exhaust my welfare cash
Yeah, I know, I'm just ordinary white trash
I ain't got no goals other than to maintain
This temporary high while outside it rains

But I am dry, so I really don't care
This is my life although I ain't goin' nowhere
I know what tomorrow will bring
More of the "same ole, same ole" thing

Wil Mayne
11/09/00

The Real Deal

Sherry, a middle class woman who dedicates her spare time to charitable causes, was driving several poverty class men to a Narcotics Anonymous meeting. "Stop please Ma'am," one man requested upon seeing his friend walking along the sidewalk, "I want to say hello to my buddy."

Sherry couldn't help but notice that the man was staggering; obviously his gait was impaired by substance abuse. "Why don't you invite your friend to come along with us?" Sherry suggested, sure that the man could benefit from a twelve-step program.

Upon receiving the invitation the stranger staggered towards the car. "Ma'am, did you take a vacation this year?" he inquired. "Why yes," Sherry replied. "My family went to Florida for a week."

"How much did the trip cost you?" the man persisted. Taken aback, Sherry stammered, "Uh, about $1500."

"I couldn't raise the money to make the trip myself this year," the man explained, "But I did manage to come up with ten bucks for this vial of crack. I can get away for about three days for my investment. I can't go to a meeting today because I am on vacation."

I Need What You've Got: Share or Suffer

The working poor who have been helped by welfare reform often become victims in the neighborhoods where they live. If they get a minimum wage paycheck on the second or third week of the month when cash is almost non-existent in the neighborhood, they begin to look like The Bank of America to their neighbors. "Can you spare me, lend me, give me...?" confronts them on payday. This puts those who have legitimate jobs in a precarious position. If they relent to the requests, they will lack the money to pay their own bills. If they fail to give up the money, they stand a good chance of being robbed of it. Whether the cash is tucked under a bra strap, or hidden between mattresses, it won't be there for long.

The “selfish” poor risk being cut out of the barter loop that they depend on to stretch their meager income. If the wage earner fails to spread the wealth around, they may find that no one is willing to provide free baby-sitting or laundry services. Their ride to work, or to the grocery is suddenly unavailable. The next time they plead for help because of an incident of domestic violence, no one will hear their cries.

Race, Ethnicity and Poverty: Are they Connected?

Rmah, L. (March 3, 2017). *Happiness of the poor children.* [digital image]. Retrieved from https://unsplash.com/photos/AEaTUnvneik/info

Those who define you, control you. Historically, wealthy white men have controlled mainstream culture by defining the norms and distributing the resources in such a way that their values systems are satisfied and their needs are met. The women’s liberation movement of the 1970’s spoke to this issue, and was ultimately designed to free women from the domination of the wealthy men who set the rules, and the oppression of the middle-class men who enforced them.

It appeared that nonviolent protest worked well to gain middle class women more power in society, but it didn’t work nearly as well for African-Americans. Today’s protests being staged by Hispanics around the immigration issue is not incurring much societal sympathy for their cause either. Some populations in America are easier to disempower than others, and minority populations are the easiest of all.

Women have historically made up more than 52% of the American population, but minorities are thusly named because their numbers are smaller than those of others in the dominant culture. Power is not easily wrestled from those who have it, but strength in numbers is one means of overpowering the status quo. Only 12.6% of America’s inhabitants live below the poverty line, yet 20-25% of African-Americans, American Indians, and Hispanics live in poverty. Immigrants fair only a little better, at 16%.

When a fifth to a quarter of a population is impoverished the norms of poverty culture tend to commingle with native racial and ethnic norms. Many of those who have come to the U.S. have done so to escape the lack of opportunity in their native land, and come into the country with poverty culture blended into their family traditions and ways of thinking. The norms of poverty culture are designed to block the success of the people who live in it. Both inside and outside of poverty culture, pressure exists to keep the poor down. It is likely not a coincidence that people of color and non-English speaking citizens are swept along in this tide of oppression.

Despite these conditions, people who live in poverty culture have pride. When they speak about their family, they qualify their impoverished condition with “buts” that reflect their attention to mainstream values;

“We may be poor, BUT we are...”

- Clean
- Happy
- Hard working
- Fun to be around
- Helpful to others less fortunate than ourselves
- Friendly

Most every impoverished family has a way of defining themselves that expresses a value that is common to the mainstream American experience.

During the Great Depression, the American middle class disappeared into poverty, but they did not, in large numbers become part of the generational poverty class. They used their middle-class values, traditions, norms, and sensibilities to pull themselves back to their pre-war economic status. The generationally impoverished have little of such programming to rely on.

Live Poor, Die Poor

Death is expensive in today’s society, and so is life insurance. Those in poverty seldom have the extra money to buy insurance of any sort, and life insurance is a very low priority purchase. Since most don’t have jobs with benefits, when death occurs there are no funds

available to bury the dead. The welfare system does not cover funeral costs, and social security only pays about $250 for a funeral. The average funeral is priced $7,000-$10,000 for a “no frills” send-off.

Some communities have a small funeral fund to assist members of their community in paying for funerals, but they limit the number of people they can serve each year to less than a dozen. In short, if you live in poverty, money must be raised immediately after you die to bury you.

Folscher, C. (February 3, 2018). *Untitled.* [digital image]. Retrieved from https://unsplash.com/photos/iZ2v4FwtMLc

Friends and family of the recently departed set to work putting together cash for the funeral expenses immediately upon experiencing the loss. Gambling parties are a common way of raising some fast cash. A friend, neighbor, or family member hosts a party. A cover charge is collected at the door, homemade food is sold for a few dollars a dish, and games of chance are played. The winner of each game splits the winnings 50-50 between themselves and the funeral kitty. The party is repeated night after night until the needed funds are collected.

If the departed was a member of a place of worship or an organization such as the VFW, donations will be taken, or an event held to assist the family with burial expenses.

Two other options also exist for disposing of the remains. The family can donate the body to science. A medical school will claim the body and use the cadaver as a teaching aid for students. This is an option of last resort. In poverty, often all a person actually owns is his/her body, and the thought of having medical students experiment with it appears to be the final insult. A second option is cremation. It costs less, only about $1000-$1500, but this process sometimes runs counter to the religious or ethnic beliefs of the family.

Recently, some attention has been paid to a trend towards “suicide by cop.” Departing this life in a blaze of glory will almost assure that money will be easily raised to bury the body. Getting one’s self shot by the police will bring publicity, sympathy, and cash for the family from others in the community who feel sorry for the family because of their high-profile loss.

A 1983 article which appeared in Time Magazine describes how The Big Apple handles burial of the indigent who have no family or friends to raise money for a funeral. It describes “Potter’s Field” in the city.

The city's department of corrections has charge of Hart Island, and inmates bury the dead. In most instances, it is a case of the poor burying the poor, and over the course of decades there have been many former gravediggers who were laid to rest in the very soil they had once turned. And, as is always the way here, they did not go down into the earth alone, for burial in this field is like life in New York City: crowded. One goes to the grave in a gang, ten across, three deep, 148 bodies to the plot.

The cemetery occupies but 45 acres, and yet there is no risk of exceeding capacity. "I am told at some point you can use the same space twice," says Assistant Corrections Commissioner Edward Hershey. "You know, ashes to ashes, dust to dust, and all that."

A department pamphlet says that point is reached after a plot has been let alone 25 years, which is "sufficient time for the complete decay of the original remains."

In cities and towns across the country the homeless, the poor, and those who have lived their lives behind bars are laid to rest much like they lived, alone, and with nothing, not even a grave of their own.

E. It’s a Crime

> *“One way to make sure crime doesn't pay would be to let the government run it.”*
>
> ***Ronald Reagan***

Does poverty cause crime, or does crime cause poverty? It is well known that the highest crime rates in any city or town occurs in the most impoverished areas of the community.

Professor Michael Rosenfeld has done extensive research that demonstrates that it is inequality more so than poverty that breeds criminal behavior. Below are excerpts from a 2006 White Paper where the Professor explains:

Poverty is defined as the lack of some fixed level of material goods necessary for survival and minimal well-being. For example, the government's official measure of a poverty rate only counts cash income in determining whether a family is poor; cash welfare programs count, but benefits from non-cash programs, such as food stamps, medical care, social services, education and training, and housing are not included. Taxes paid, such as social security payroll taxes, and tax credits, such as the Earned Income Credit, are also excluded from poverty rate calculations. Inequality, on the other hand, refers to a comparison between the material level of those who have the least in a society and the material level of other groups in that society.

There are at least twenty different ways to measure poverty and inequality (e.g., unemployment, high rates of divorce, single-parent households, high population density, dilapidated housing, poor schools, residential mobility, population turnover, concentration of minorities, etc.) The problem is that all these things are highly correlated with one another.

Perhaps the most common association is with "conventional" or street crime. For example, when unemployment goes up 1%, there's a 4% increase in homicides, a 6% increase in robberies, a 2% increase in burglaries, and measurable effects on rape and other crimes.

Unemployment does cause crime among ex-offenders. Unemployment also has stronger effects at the neighborhood rather than aggregate level. It also depends on how you define unemployment. Official rates only count people who are looking for work, so a whole lot of people who aren't looking, but are still unemployed don't get counted. There's also the existence of underemployment, low-wage, dead-end jobs with terrible working conditions, and these people get counted officially as employed when maybe they shouldn't. Some people may mix crime and employment in various ways, thus confounding any research efforts.

Impoverished neighborhoods are more likely than middle class neighborhoods to have a high concentration of ex-offenders living there. According to Paul Street in his Z Magazine

article, “Incarceration deepens a job-skill deficit that a significant body of research shows to be a leading factor explaining criminal behavior among disadvantaged people in the first place. "Crime rates are inversely related," Richard B. Freeman and Jeffrey Fagan have shown, "to expected legal wages, particularly among young males with limited job skills or prospects."

Why do the Poor Rob the Poor?

Hopman, M. (November 20, 2020). *Held at gunpoint.* [digital image]. Retrieved from https://unsplash.com/photos/PEJHULxUHZs/info

If inequity is the primary motivator underlying criminal behavior, then why do poor people more often become victims of crime than those living in the middle class, or in wealth class? The lack of resources and planning strategies that typify poverty culture can contribute to an explanation this phenomenon. Crimes of opportunity occur on the spur of the moment. A would-be thief, for example, might see a person walking alone in an isolated area, or notice an open car warming up on a cold morning in his neighbor’s driveway. No planning is needed. One may simply act on impulse and procure the needed resource, perhaps even rationalizing that the victim should have been more protective of their resources if they really wanted to keep them. Perceived inequity can occur even between those who have little.

The more complex the crime, the more skills and resources are needed to successfully commit the crime. If you wish to steal someone’s identity, it is helpful to have a computer, or at the very least a credit card scanner, the most common tools used to commit identity theft. If you wish to rob a mansion, you will need transportation to the wealthy neighborhood, tools to cut through or scale a fence, tools to disable the home’s alarm system, and perhaps even safe-cracking skills. Chances that you will be detected are high, and the likelihood that one can gather all of the resources to commit the crime are low.

Crimes of passion occur when one person becomes enraged by another. Crimes of passion generally occur in one’s own home or neighborhood. In impoverished neighborhoods tensions run long and tempers run short. Assault, rape and murder occur

more frequently in or near impoverished neighborhoods or homeless areas than in any other part of town.

Crimes of necessity occur in places where need is great. Traffic misdemeanors such as driving without insurance, or while under license suspension, or without proper authorization, can be viewed as the necessary risks that one must take in order to get to where they need to go. Shoplifting food to feed one's hungry family, becoming a prostitute to support those hungry children, passing bad checks, and defrauding the social welfare system are all crimes rooted in need.

The Link between Crime and Poverty

It is a short and slippery slope from living in poverty to pursuing a life of crime. Illicit drug activity and drug and alcohol addiction is also more highly concentrated in impoverished areas than in any other segment of society. Addicts often resort to crime to support their habit, and those who use drugs also operate under impaired judgment and a lack of impulse control. Alcohol and common street drugs such as meth amphetamine and crack cocaine induce feelings of anger, emotional labiality, and temperamental outbursts. Add these elements to the pressure cooker of poverty, and the lid begins to rattle.

Crack cocaine continues to be the drug of choice in inner city neighborhoods, even though the DEA reports that the swell of cocaine use in America peaked in the early 1990's. An anonymous addict asked that his poem be included in this course book "to help the helpers understand why coke addicts live in poverty and commit crimes."

My Name is Cocaine
Beware my friend; my name is cocaine, coke for short *I entered this country without a passport* *Ever since then I've been hunted and sought* *By junkies, and pushers, and plain clothes dicks* *But mostly by users who need a quick fix* *I'm more valued than diamonds, more treasured than gold* *Use me just once and you too will be sold* *I'll make a school boy forget his books* *I'll make a beauty queen forget her looks* *I'll take a renowned speaker and make him a bore*

I'll take your mama and make her a whore
I'll make a teacher forget how to teach
I'll make a preacher not want to preach

All kinds of people have fallen under my wing
Look around and you'll see the results of my sting
I've got daughters turning on their mothers
I've got sisters robbing their brothers
I've got burglars robbing the Lord's house
I've got husbands pimping their spouse
I'm the king of crime and the prince of destruction
I'll cause the organs of your body to malfunction
I'll cause your babies to be born hooked
I'll turn an honest man into a crook
I'll make you rob, steal and kill
When you're under my power you'll have no will
I'm a bad habit, too much for the man
Police had to invest in a new batter-ram
I've got 'em standing on the corner yelling "Rock"
Shooting and stabbings are common on the block
If you jump into my saddle, you had better ride well
On the white horse of cocaine you will ride straight to Hell

Throw in the fact that weapons are readily available in impoverished areas, police response is typically slower than in middle class or wealthy neighborhoods, and witnesses to crime generally decline the opportunity to speak with police out of fear of retribution from the criminal or their associates, and the lid comes flying off the cooker. Criminal deterrence activities are scarce or absent in impoverished areas; no neighborhood watch committees, no witnesses, no security systems, and no video cameras, means no strong evidence to prosecute a suspect, so they remain on the streets unpunished.

Gang activity draws children into a life of crime at an early age by dealing drugs to school children and bullying them into the gang through intimidation methods that convince them that they are in need of gang protection. Broken homes, hunger, fear, and oppression present in poverty makes the gang an attractive alternative to children who live loveless lives. The gang becomes the surrogate family the child longs for, and another criminal is born. The good people of the impoverished community stay behind locked doors, and the thugs roam the streets pushing their poison and victimizing their prey.

Speaking of the prey, impoverished neighborhoods provide a plentiful supply of easy prey. People with low incomes and no insurance are nearly twice as likely as the general population to have psychiatric disorders, according to a study presented in the 2001 Journal of Family Practice. The researchers point out that if untreated, psychiatric disorders may lead to higher rates of disability which then leads to further poverty. Without treatment, the mentally ill often lack the reality contract and level of awareness needed to avoid being exploited or victimized. Most impoverished people with diagnosed psychiatric disorders receive SSI checks monthly, making them attractive targets for criminals.

Add in the fact that the ex-offender population is high, and it creates the perfect storm. Those with more advanced criminal skills gained in prison serve as tutors, mentors, coaches, sponsors, and role models for young criminals that are just starting their felonious careers.

Re-entry from Prison to Poverty

The Department of Corrections and Rehabilitation in any of the 50 States is commonly known to put more emphasis on correction than rehabilitation. Prisons offer GED classes, occupational skills training, pre-release substance abuse classes, college degrees, and life skills training, but the desired results are seldom achieved with these programs. When former felons are bused from the prison door back to their community of residence, their chance of finding gainful employment is nearly nil. One of the major unintended consequences of the prison system is that it functions as a crime school where lower-level criminals learn how to advance their criminal career from more savvy felons. This becomes the primary educational force that propels their success once they are returned to society.

State prisons are like graduate school for criminals. Most inmates are incarcerated in local jails for lesser offenses before they make their first jaunt to a State or Federal facility. Almost none of the rehabilitation programs present in state prisons are available to jail inmates. “The national discussion about reentry has ramped up in recent years as legislators, community officials, and corrections leaders have come together to discuss how to keep the inmate population from coming back to prison or jail. But largely missing from the conversation is how jails can be a part of this effort,” stated Michelle Gaseau, Managing Editor of Corrections.com.

Kalil, N. (March 25, 2018). *Untitled.* [digital image]. Retrieved from https://unsplash.com/photos/LfMX2f9ABhg/info

Her article goes on to explain that jail inmates have an even higher rate of recidivism than State prisons, and the revolving door spins faster. Inmates being quickly returned to their community after a short stint in jail could benefit from GED classes, and substance abuse treatment, while incarcerated and establish links to community resources to help them find a job, housing, and educational opportunities upon release. Unfortunately, most jail inmates do not receive such resources, and simply “do time” to serve out their jail sentence.

Many street criminals enter the penal system as juvenile delinquents. They get picked up for truancy, fighting, underage intoxication, theft, possession of a weapon, and a myriad of starter offenses. There they learn to be tougher, angrier, and bolder than they were before entering the detention center. As they grow to be adults their crimes grow along with them, and before they know it, they find themselves in the local jail, and then on to prison. During their brief stint on the streets between incarcerations, they pull scams, terrorize and exploit their neighborhoods, recruit young people to participate in criminal acts, and look for the perfect crime that will make them rich and happy, because they are certain that they will never get caught again.

Jobs for ex-offenders, particularly felons seldom exist in middle class culture. As a condition of their parole, felons must list their offenses on job applications and submit to background checks that reveal their criminal past. What businessman or woman would take the risk of hiring a former drug dealer, con artist, or rapist to work in their place of business? Even with a college degree earned in prison most ex-cons cannot locate a living wage job. A return to poverty almost always means a return to crime.

My Daddy is in Jail: The Cycle Continues

Sadly, 80% of the inmates incarcerated in State prisons are parents. The children of these men and women are cared for by relatives, placed in the State foster care system, or reside with the incarcerated parent and visit the state penal facility to visit a few hours each month, or each year, with their absent parent. For these children having a parent in jail is a fact of life, one that might even seem like a normal occurrence.

According to the Child Welfare League of America, children of inmates are six times more likely to end up incarcerated themselves than those in the general population. There is a lack of mentoring programs available to assist these children in the issues that arise in their life due to the fact their parent(s) are incarcerated. In major cities where mentoring programs do exist, it is difficult to recruit children into the program. Parents are sometimes suspicious of the offer of assistance, or even feel jealous because their children are being given opportunities with the mentor that they themselves can't give the child.

AMACHI, a mentoring program for children of prisoners in Philadelphia, believes that their program is well worth the investment of private and public funds to accomplish the outcomes that they are able to produce with children of inmates. AMACHI opened its doors in 2003. Results after their first two years in operation the children in the program showed the following successes.

- Felt more confident about doing their school work,
- Skipped fewer days of school,
- Had higher grades, and
- Were less likely to start using drugs or alcohol.

Unfortunately, AMACHI is one of only a handful of such program in the U.S. The majorities of children who belong to prisoners simply follow in their parents' footsteps and leave their own children behind to enter penal facilities themselves.

Over 600,000 inmates, both violent and non-violent are released into society each year. Approximately two-thirds of those inmates are released into poverty according to a lawyer who appeared on the Oprah Show to discuss “pro-social” re-entry programs. One such program, *Beyond Conviction* invites criminals to meet with their victims, or their victim’s family, and answer their questions about the crime perpetrated against them. This is a victim-driven program, for those who have been victimized often want to know why they were targeted. The happy side effect of this program is that the inmate is able, sometimes for the first time, to confess the crime and talk about it without rationalizing.

In poverty culture, responsibility is something that is escaped too often. Pro-social re-entry programs teach inmates to feel, to care about themselves, their victims, their families, and their community. If the cycle of poverty is to ever be interrupted, the process will begin with the impoverished taking more responsibility for their own future. These programs, although still scarce, are a good start.

The Real Deal

Josh saw himself as a person without a future. His mother was recently sent to jail for prostitution and his father had been incarcerated in State prison since he was a small child. At age 12, Josh had been shuffled from one home to another by his mother along with his three younger siblings. They had spent months in homeless shelters between short stays with relatives and family friends, but at least they had all been able to stay together.

With his mother away for the next three years, he had no idea how he would survive. His siblings had been placed in foster homes, and his paternal grandmother, a woman he barely knew, had accepted him into her home. After the social worker left, his grandmother informed him that she had taken him in primarily for the ADC check that she was permitted to receive for his care, and suggested that he find some blankets to put down on the basement floor so that he would have a place to sleep.

Over the next three weeks Josh was given chores to do each day to care for his ailing grandfather, and never did make it to school in his new school district. At the beginning of the fourth week Josh escaped the drudgery of his grandmother’s home by running away. That night, Michael was awakened while sleeping on a park bench by a guy who said, “Hey kid, I’ll buy you a hamburger if you run a little errand for me.” Scared, hungry, and alone, Michael was grateful to the kind stranger and accepted the offer.

Moments later Josh was apprehended by police carrying a paper sack containing crack cocaine and got his first ride in a police car to the juvenile detention center. At least it was a place where they fed him three times each day, and gave him a cot to sleep on. Maybe being in prison someday wouldn't be so bad after all.

F. Welfare, Working Poor, and the Homeless

"Welfare is hated by those who administer it, mistrusted by those who pay for it and held in contempt by those who receive it."

Peter C. Goldmark Jr.

Is welfare reform working? It depends who you ask, and when you ask them. Google the question and you will find 14 pages of results to your search, each article, white paper, or analysis claiming differing levels of success or failure from the initiative that began in 1996. Perhaps it is a case of "figures don't lie, but liars can figure." Depending on the political perspectives of the authors, welfare reform statistics can be found to support most any viewpoint that one wants to infer from them.

Welfare reform was instituted by the *Personal Responsibility and Work Opportunity Reconciliation Act of 1996.* The act replaced the failed social program known as Aid to Families with Dependent Children (AFDC) with a new program called Temporary Assistance to Needy Families (TANF). The reform legislation had three goals: (1) to reduce welfare dependence and increase employment; (2) to reduce child poverty; and (3) to reduce illegitimacy and strengthen marriage.

Unquestionably, the first goal has been at least partially met. There are less people in the U.S. now that are receiving cash assistance than prior to the reforms being enacted. The question remains, why? Although cash assistance caseloads have decreased by roughly 50% in most States, spending for childcare, transportation, medical care, job readiness classes, and household necessities has increased dramatically. Some believe that the emphasis placed on providing supports needed to overcome barriers to employment is responsible for moving people from welfare to work. More cynical analysts owe this success to the fact that a goodly number of ADC recipients simply signed off on cash benefits, not wanting to jump through the hoops necessary to earn cash grants. A

significant number of cash recipients also fell off the rolls when their time on the system expired at the end of the 3–5-year (time limits vary from state to state) benefits period. The success statistics looked good in the early 21st century due to the exodus from cash assistance, but between 2000 and 2007 the rolls have begun to eek up again.

Spin the numbers in any direction you wish, the cold hard facts for those living in poverty is that they are no better off economically than they were at the onset of welfare reform.

The 1996 TANF law expired after five years. Although its expiration was standard, it took another five years of temporary extensions before the government voted for reauthorization. As part of the Deficit Reduction Act of 2005 (passed July 2006), Congress reauthorized the TANF block grant program through 2010. The reauthorization of TANF brought with it a number of new rules that states must conform to in order to receive federal funds.

- States now face a higher hurdle in order to maintain federal TANF funding by meeting a 50% participation rate for all families receiving assistance and a 90% participation rate for two-parent families. The new regulations curb state flexibility by limiting the set of work activities that can count towards participation rates. For states this could mean:
  - Efforts to keep more working families on the rolls by extending TANF benefits for adults who have found work;
  - A reduction of caseloads, without restricting eligibility, such as by making the application process more challenging, or;
  - A removal of those who cannot meet the rate from TANF and shifting this population to a state-funded program.
- States are now responsible for providing the federal government with a "Work Verification Plan" -- a document containing status verification and updates on recipient participation in work activities.
- Substance abuse, mental health and other rehabilitation services are limited to a maximum of 6 NON-CONSECUTIVE weeks during a 12-month period that may be counted towards the work participation rate.
- Higher education programs as well as related non-supervised study time will NO LONGER count towards participation rates.
- Vocational education and ESL programs have an increased priority and more readily count as participation.

In layman’s terms, these reforms mean that fewer TANF applicants will be able to receive assistance because the application process has become more complicated and

restrictive, effectively screening out those who are unable or unwilling to pursue the more rigorous application activities.

The working poor will receive extended support, but those suffering from disabilities, mental illness, or substance abuse issues will find themselves without TANF cash assistance if they require treatment that extends beyond a week, or must be treated more than six weeks in a one-year period.

Going to college will no longer count as a legitimate pursuit if you wish to receive TANF. On the other hand, if you wish to enroll in vocational education, or learn to speak English, the system will be more generous with you. Certainly, these reforms will make the national numbers look better, but what impact will they have on the lives of the poor?

Earning and Learning

As a result of the latest welfare reforms most States are placing an emphasis on transitional jobs programs instead of encouraging self-directed job search to move recipients from welfare to work. Transitional Jobs (TJ) is a successful strategy to employ the hard-to-employ by building skills, addressing barriers, and providing real work experience. TJ programs combine meaningful work experience with valuable life and job-skills training, intensive case management, and job retention services in order to help participants successfully enter and compete in the workforce.

Participants in these programs receive intensive job and life-skills training and case management while they work in temporary jobs in community-based organizations, government agencies, or private businesses. During the transitional job, which typically lasts two-to-six months, but can extended up to two years, participants earn a salary at the federal or state minimum wage, which enables them to pay into Social Security, qualify for the Earned Income Tax Credit, and start earning a paycheck.

TJ programs target current and former TANF recipients, ex-offenders, and other individuals with significant barriers to employment. These individuals often experience difficulty finding and holding jobs due to multiple barriers, including a lack of an employment record, low education levels, lack of job skills, substance abuse, past criminal offenses, or domestic violence. TJ programs help participants manage these obstacles to promote success in the workplace.

Through the program, participants transition out of the temporary jobs and move into permanent, unsubsidized jobs. TJ programs have an extremely high success rate of placing participants into permanent jobs. According to national data, 81% to 94% of transitional jobs participants go on to secure unsubsidized employment.

This is not a new concept. Those who have spent their careers in social services will recognized this program as a recycled version of the Job Training Partnership Act of 1982 (JTPA) that sponsored the “Work Experience Program” in the 1980’s. JTPA was replaced by the Workforce Investment Act of 1998 (WIA). WIA funds workforce development activities provided in local communities that can benefit job seekers, laid off workers, youth, incumbent workers, new entrants to the workforce, veterans, persons with disabilities, and employers.

Since its’ inception WIA has given the lion’s share of its’ funds to people who are seeking short term occupational skills training, and has provided training opportunities for high demand jobs such as truck driving, licensed practical nursing, certified nurse aide, clerical and office skills, peace officer training, and cosmetology. While preparation for these occupations looks to be helpful to the poor at first glance, a significant number of impoverished individuals cannot qualify for such occupations. Former felons, the mentally ill, those with spotty driving records, and substance abusers will have trouble finding work in the fields of trucking, nursing, and law enforcement.

Also of concern is the fact that many of the jobs available in these fields are part of today’s “casual labor market.” These jobs are commonly staffed through temporary agencies which provide a steady flow of workers to employers without the employer having to hire them. This is a pretty good deal for employers who don’t have to invest in benefit packages for these employees, but is less sweet for the workers who work sporadically and may average only 8-32 hours a week, and have no way to foresee how many paid hours they will be offered from one week to the next.

Who will Pay the Light Bill?

There are a number of programs that help both the unemployed and the under-employed pay their utility bills. This assistance is purported to sustain self-sufficiency and prevent homelessness. Although this is a tactic that is effective in preventing homelessness, preservation of self-sufficiency requires greater definition to assess its effectiveness. The

practice of depending on the government to pay for life's essentials such as heat, light, and water tends to foster the idea that it doesn't matter who pays your bills as long as someone does. This notion fosters an entitlement mentality, and does little to cultivate true self-sufficiency thinking and behavior.

There is no doubt that the poor do need help from time to time in paying their bills, but the requirements of programs such as the Home Energy Assistance Program (HEAP) insist that impoverished applicants wait to get a shut-off notice before receiving aid. When aid comes it is in the form of a full payment of bill that is due. This annual rescue reinforces the belief that one doesn't need to take responsibility for paying for the utilities that they use.

Programs such as the Percentage of Income Payment Plan (PIPP), is an extended payment arrangement that requires regulated utility companies such as gas and electric providers to accept a set percentage of a family's income (15%) per month to keep the utilities on. Families at or below 150% of federal poverty guidelines are eligible to apply, but once a family leaves the program the full amount still owed on the utility bills comes due. This means that when a family's income finally rises above the program's eligibility level, they may possibly be slammed with a huge debt almost immediately. Such a punch in the wallet might make a person think about quitting their job, or reducing their work hours to get the benefit back. It is not uncommon for employees to refuse pay raises or promotions at work out of fear of losing their utilities assistance.

A number of urban renewal programs now exist that help low-income homeowners insulate their homes, replace leaky windows, and install energy efficient heating and air conditioning units. These efforts not only control utility costs, but also boost property value. Again, these programs appear to be "giveaways" instead of "earn-your-ways," but they do provide a long-term investment that will aid the family long into the future.

A Plethora of Programs

At first glance it looks as though the poor pretty much have it made, considering the numbers of non-profit and governmental agencies that exist to provide assistance to them. Even when these programs attempt to evaluate their success, they often fail to ask, "If we are meeting our goals, why are there so few people moving out of poverty?" Perhaps the programs themselves function in a way that sabotages their own efforts by

snatching away the safety net while the impoverished family is still flying through the air, and does not yet have the trapeze that is the middle class in their grasp.

Homeless shelters now offer a wide range of services to aid residents in becoming self-sufficient including shelter, food, counseling, and job skills programs. They also require the homeless to be drug-free gain entrance into their facilities. Unfortunately, families are separated, the men go to one shelter, and the woman and children to another, and often, the doors of the shelter are locked in the early evening, preventing second and third shift workers from gaining access to a bed when they really need one. Given the fact that the poor often have to work jobs on the later shifts, or on split shifts, this practice tends to discourage the notion that “any job is always better than no job,” a philosophy that is common in the middle class.

Another problem exists in that many homeless shelters do not offer daycare services. Non-profit agencies seem to do a bit more about daycare provision for the homeless than do government agencies. Daycare is essential for the homeless to keep appointments, search for jobs, and locate housing. It makes a poor impression with a middle-class employer if a job applicant brings their children to a job interview.

In many cities homeless shelters have a lengthy waiting list to gain entry. As the homeless wait for their name to come up on the list, their situation is sure to deteriorate further. Some resort to committing crimes to feed their family, others fall ill, or become victims of crime. Their connection with mainstream society slips away while their encounters with the underground society strengthen.

As the homeless population continues to grow, shelters are overwhelmed with demand for their services, and are often forced to set short time limits for a resident’s stay. This means that the homeless move from one shelter to another, barely getting to know one area of the city before they are forced to move across town and reinitiate another job search, locate social service resources, and begin their move towards self-sufficiency anew.

The need for transitional housing that takes the homeless from the shelter into short-term apartment living is great, but the programs that provide transitional housing services are few. Recently Section 8 HUD funded rental assistance that pays about 30% of one’s monthly rent has undergone significant reduction at the federal level. This means that many families who need rental assistance to get on their feet will not be able to receive

the assistance. In Cincinnati, Ohio for example, the city cut assistance to 300 families and reduced the number of vouchers being issued from 7600 to 7300 in 2006.

Over 100 U.S. cities that have recently formed community partnerships between non-profits, associations that aid the homeless, and local, state, and federal agencies to end homelessness in their cities within the next decade. Their 10-year plan to end homelessness is based on the following strategy:

A 10-Year Strategy to End Homelessness is:

- ***Designed to address the critical problem of homelessness and all related issues through a coordinated community-based process of identifying needs and building a system of care to address those needs.***
- ***Predicated on the understanding that homelessness is not caused merely by a lack of shelter, but involves a variety of underlying, unmet needs—physical, economic, and social.***
- ***Supported by a community-wide public and private strategy with a goal of ending homelessness that is based upon the successful implementation of three major community-coordinated actions—(1) building infrastructure; (2) strengthening an existing continuum of care system; and (3) planning for sustainable outcomes.***

This comprehensive approach to homelessness is significantly more effective than a fragmented system where the churches, charitable organizations, government, and non-profits struggle to interface and lack an organized approach to meeting the needs of the community's homeless children and adults. Most notably, the entire community benefits from the efforts put forth to save families from the mean streets of metropolitan areas.

Metropolitan housing, the low-cost or no-cost strategy using large housing projects to provide homes for those who would be potentially homeless without such assistance is seen by many as a failed strategy. Although such "projects" still exist, there is a three to seven year wait to enter these housing units. The "projects" have been shown to provide breeding grounds for criminal activity by grouping together the "have-nots" together, often in substandard structures. In large cities the "projects" have become war zones where paramedics and fire fighters will not respond to emergencies without police protection. Children raised in these environments have a slim chance of ever moving to the middle class. Some of them will never have a chance to see adulthood.

Habitat for Humanity homes are a wonderful alternative to life in the projects. These homes are being built in both impoverished and lower middle-class neighborhoods throughout the country. Habitat for Humanity International is a nonprofit, ecumenical Christian housing ministry. HFHI seeks to eliminate poverty housing and homelessness from the world, and to make decent shelter a matter of conscience and action. Habitat invites people of all backgrounds, races, and religions to build houses together in partnership with families in need.

Habitat has built more than 225,000 houses around the world, providing more than 1 million people in more than 3,000 communities with safe, decent, affordable shelter. Through volunteer labor and donations of money and materials, Habitat builds and rehabilitates simple, decent houses with the help of the homeowner (partner) families. Habitat houses are sold to partner families at no profit and financed with affordable loans. The homeowners' monthly mortgage payments are used to build still more Habitat houses.

Habitat is not a giveaway program. In addition to a down payment and the monthly mortgage payments, homeowners invest hundreds of hours of their own labor — sweat equity — into building their Habitat house and the houses of others. Now that is a definite move towards helping to make families self-sufficient, but again, the waiting list is long for a Habitat Home, and not everyone on the list will be served.

Soup kitchens and food pantries, often sponsored by churches and civic groups also help the homeless, and those at risk of homelessness, to meet their daily needs, but many of these agencies are now facing a funding crisis that have caused them to limit aid as well.

Linking, Referral and Follow-up

It only seems to make good sense that the poor would follow-up on referrals to get on housing lists and reduced cost utility plans, and get in on food giveaways, job training, and government paid medical assistance. It seems that they would be visiting their local welfare department with regularity to check to see what sort of aid is currently available, but this is not always the case.

Some are too proud to take assistance, others may not even know that it exists, or may not have the needed skills to navigate through the many application processes, income

verifications, and waiting protocols that provide gateways to resources. Frequently there is no follow-up to the referrals given by one agency to another, and the needy simply get lost in the cracks without notice. Sometimes the “directory of services” is so massive, or antiquated, that it is of little use at all to those who don’t even know how to use a telephone book.

The Real Deal

Randy dropped out of community college to care for his aging mother who had Alzheimer’s Disease shortly after his father passed away. The family had always been poor, and secretly, Randy had always wished for a more financially secure life than his parents had known.

While working as a warehouse manager in a local department store, Randy met and married a woman with a young son who was also employed at the store. When word of their nuptials became public, both Randy and his wife Karen were terminated from the store that, unbeknownst to them, had a policy against employing spouses.

After a protracted job search Randy found another job at a big box store, but the entry level position he took paid only minimum wage. Karen became a maid at an area motel. Because of Karen’s epilepsy, the medical bills began to mount the minute they left the welfare system to again become wage earners. Without medical insurance, Karen’s medication ran the couple $350 monthly, the same cost as their rent. Unable to pay for her prescription, Karen quit taking her medication and had a seizure while on her job. The next day she was fired for being three minutes late for work.

Karen’s young son Tom, who is enrolled in the free lunch program at school is the object of taunts daily from the more well-off children that he attempts to socialize with. His experience with the middle-class kids seems to have triggered a rebellious streak in him and he has begun committing petty crimes such as stealing books from the Book Fair at school.

Randy had begun working two jobs to make ends meet, but recently lost his driver’s license for allowing Karen, an unlicensed driver due to her disability, to drive the family car on a snowy winter morning to deliver her paper route. Since the buses only run during the day in the town where they reside, Randy had to quit his second job because he couldn’t get to the factory located just outside of town.

One night, in a fit of rage, Tom was heard to tell his mother and stepfather, "You guys are pathetic losers. You can't even pay for me to eat lunch at school. I wish I never met either of you." So much for Randy's dream of a better life for his family.

G. Common Sense is not all that Common

"Common sense is the collection of prejudices acquired by age eighteen."

Albert Einstein

The middle class has various reactions to issues of poverty. Emotional responses range from pity to anger, fear to intolerance, disgust to embarrassment. Although some hold well ingrained stereotypes through which they regard the poor harshly, the majority of Americans respond differently to the poor based on their perceptions of what caused the poverty.

Homeless elderly or children might incur sympathy from mainstream America, while an apparently healthy adult living on the streets is likely to be scorned. Someone who loses everything they ever owned due to excessive medical bills gains the empathy of the middle class. Someone who returns from prison and can't find a job due to their criminal record, not so much. Women who work in the sex trade to support their children are not viewed with nearly so much charity as those who recycle cans found on the roadside to feed their kids. The middle class tends to judge the poor through their own paradigms of worthiness.

The poor are referred to as "the great unwashed," deadbeats, do-nothings, lazy, lacking in pride, and "trash" by those who lack tolerance for them. Seldom, however, does the average citizen make a concerted effort to intervene and help the poor live by the conventions that will make them more acceptable to the middle class.

The Burden of Educating the Poor Rests on You

Even those who work in healthcare and social services often refrain from offering suggestions to people they encounter whose cultural norms, appearance, or behavior is outside mainstream norms. Often those in the middle class feel more comfortable talking

about these folks than to them. The old adage that states “if they knew better, they would do better,” sometimes alludes those in the helping professions as their discomfort prevents them from addressing obvious barriers that will certainly keep the poor from transcending class.

Burden, A. (April 11, 2017). *Untitled*. [digital image]. Retrieved from https://unsplash.com/photos/6jYoil2GhVk/info

The word “class” itself is a term that is slow to roll off middle class lips. In this conspiracy of silence, the middle class rationalizes their hesitancy by explaining that they don’t want to make anyone feel self-conscious by pointing out the obvious. Even when middle class helpers attempt to address these factors, they sometimes show their discomfort through their hesitancy, and clumsily try to make their comments without directly addressing the issue at hand. “Do you live near a dry cleaner?” is muttered instead of “You need to have that coat cleaned because it carries an odor.” A single mother with six children might hear the comment, “My, you have a big family!” as opposed to “Let’s talk about ways to prevent future pregnancies since you currently appear to be struggling to keep up with the demands of a large family.”

Keeping in mind the tenets of poverty culture, here are some tips on communicating effectively with the poor.

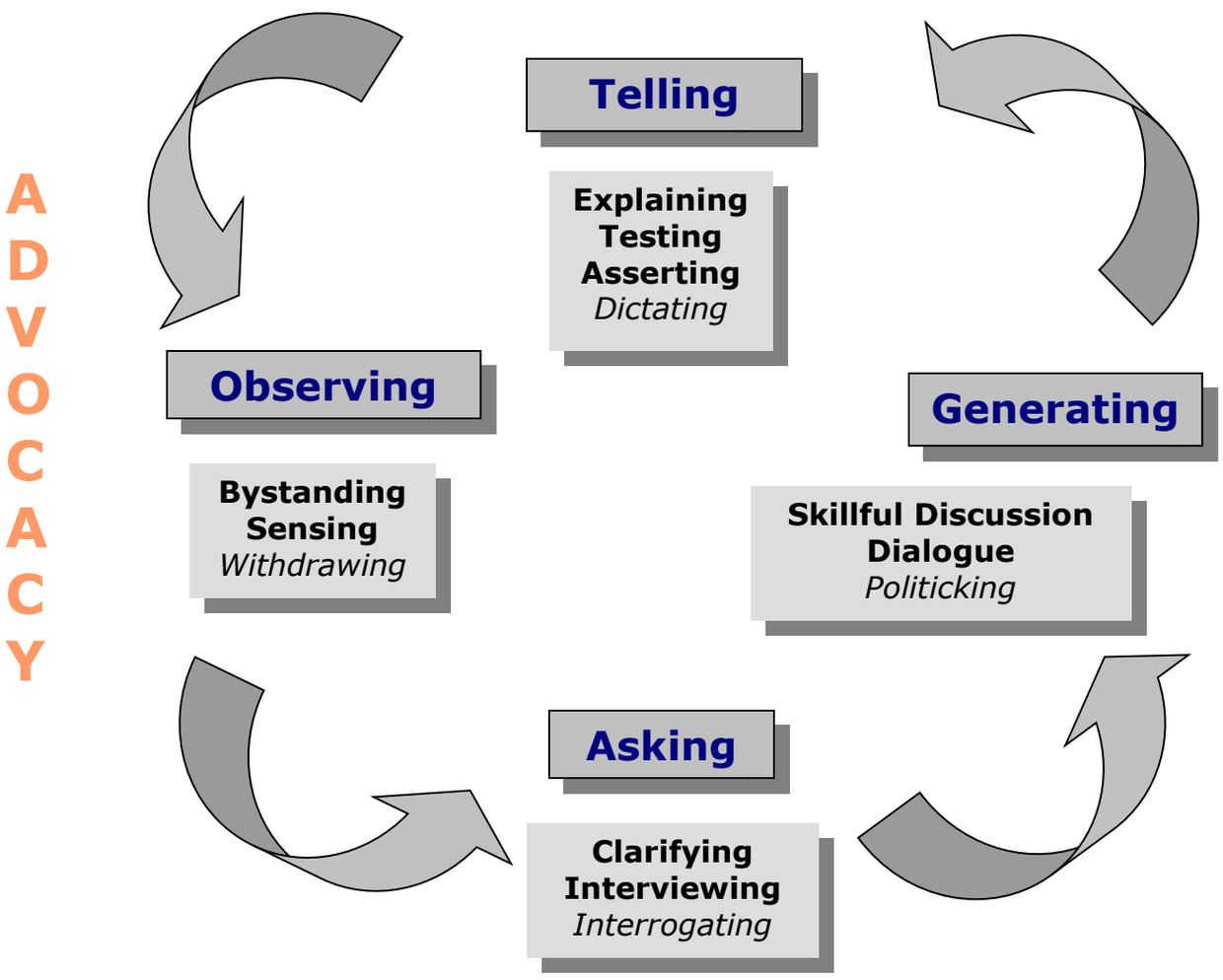
- Use inquiry mode to begin the conversation and ask how the person views their current situation.
- Provide firm, kind direction by speaking plainly, yet in a non-abrasive manner.
- Avoid the words “should, ought to, got to and must.” The words “want to” or “need to” will be suitable substitutes for the other phrases that are more likely to induce guilt and resistance.
- When you encounter resistance, do not be deterred by it. State “I know this is difficult to discuss, but we need to talk about these issues before we can resolve them.”
- Avoid sending mixed messages by smiling while discussing serious issues. Appear concerned if that is how you feel.

- Do not allow the person you are speaking with to manipulate you or change the subject. Redirect the conversation back to the topic at hand if the discussion gets off track.
- Display empathy and allow your support for the person to be apparent. Make support sounds such as “Ouch, Aaaah, oh no,” when the person reveals a sad circumstance.

On the following page you will notice a model entitled *The Pallet of Inquiry and Advocacy*. This model is a companion piece to *The Ladder of Inference* shown on page 25 of this course. It is also taken from *The Fifth Discipline Fieldbook.* The purpose of this model is to help a person make their *Ladder of Inference* obvious to the interviewer, thereby giving the interviewer insight into how the person thinks and behaves. There are both functional and dysfunctional methods listed on the model in each of the 4 quadrants. The dysfunctional methods are *italicized* to differentiate them from the more effective methods listed.

Clarification as to how to use the model appears immediately after the model itself.

Pallet of Inquiry and Advocacy



I N Q U I R Y

The Pallet of Inquiry and Advocacy can begin in any quadrant of the model, but for purposes of interviewing the impoverished, it is generally best to begin with “observing” techniques and work around the model counter clockwise.

Observing--Don't just do something, stand there! Study the person.

- **Sensing--Watching the person without comment long enough to get a feel for their emotional state.**
- **Bystanding--**Making comments that pertain to the person's demeanor or affect, not his/her verbalizations. "You seem upset. Long day, huh?
- *Withdrawing*-- (Dysfunctional) not really seeing the person at all.

Asking--Seek first to understand, then to be understood.

- **Interviewing--**Exploring the person's point of view and the reasons behind it. "What causes you to say that?" "How is that important to your current situation?"
- **Clarifying--Refocusing on the questions to be answered and gaining increased understanding of the person's answer.** "So, what you are actually saying is…" "Am I correct in understanding that…"
- ***Interrogating--*** (Dysfunctional) “Why can't you see your point of view is wrong?" (Avoid this strategy!)

Generating--Finding solutions by combining the person's ideas with the interviewer's ideas.

- **Dialogue--**Suspending all assumptions to create a "container" in which collective thinking can emerge. "From what you tell me, I assume that…" "Let's think about this for a moment…"
- **Skillful Discussion--**Balancing advocacy and inquiry by being genuinely curious, asking the person about his/her assumptions without being critical or accusing, and making one's own reasoning explicit. "Tell me what you think of this idea." "Do you think this will work?
- ***Politicking--*** (Dysfunctional) Giving the impression of balancing advocacy and inquiry while being closed minded. "You are probably right but we still need to do it this way." (Avoid this strategy!)

Telling--Concluding the discussion by summarizing and deciding what actions to take.

- **Testing--**Issuing a trial close. "Here's what I say. So what do you think of it?" "Which of these three options do you think will work best?"
- **Asserting--**Stating your ideas and explaining your reasoning explicitly. "Here's what I say, and here's why I say it." "I have come to these conclusions and I want to make this recommendation based on them."
- **Explaining--**Stating your impressions and your rationale for your assumptions. "Here's how I see it working and here's why I see it this way." "It's been my experience that…"
- ***Dictating*-- (Dysfunctional) Imposing your view or solution on the person without regard for their thoughts or feelings**. "Here's what I say, and never mind why I say it." "This is what you are going to do." (Avoid this strategy!)

When using inquiry mode to ask the person about themselves, there are five questions that can assist the person to develop skills needed for success in the middle class while gathering information that promotes an understanding of the person. These questions have been known to get “magical” results when attempting to make plans with the generationally impoverished, and thus, their title. The questions listed teach risk analysis and allows a person to think through his/her situation in a systematic manner. It is beneficial to write down the answers for consideration by both the interviewer and the impoverished person.

Five Magic Questions

1. Given the situation that you are in, what do you want to see as a result?

2. Can you tell me three options that you have for getting the result you want?

A)

B)

C)

3. What are the risks involved (what might go wrong) in each of your options?

A)

B)

C)

4. Which set of risks are you best able to control and how will you control them?

5. What is your plan?

Activities	Timeline	Person Responsible
1.		
2.		
3.		
4.		

To surface the plan, it helps to ask the person, “What are you going to do?” “When are you going to do it?” Who will be responsible to see it gets done?” “What are you going to do next?” Provide the person a written copy of their plan when it has been composed. Before ending the interview or conversation ask, “What rewards will come to you if you follow this plan?” This question focuses the person on the benefits of following through with the plan.

Teaching the Hidden Rules of the Middle Class

Perhaps the most perplexing aspect of communicating across class lines involves being able to teach the hidden rules of the middle class without offending the person who requires the instruction. It is best to begin by explaining that in order to achieve and sustain any level of economic success in America; a person is expected to conform to certain norms in the mainstream culture. Be certain to mention that this requires everyone who works, socializes, or lives among the middle class to behave differently in public than they might in private.

Again, using inquiry mode will help establish the needed rapport and understanding needed to discuss these sensitive issues. Here are some questions that will help to introduce the hidden rule that needs to be discussed. These questions directly correspond to the hidden rules mentioned on pages 29 and 30 of this course. After each set of queries the interviewer will offer information as to what those who were raised in the middle class learned to think, act, or respond in each area.

- Have you ever attempted to budget your money? How did that work for you? How did you go about it? Would you be willing to try it again? If you were able to save just 10% of your income, how much would you have accumulated by the end of one year? Where will you keep your savings so it will be safe? What are some of the things that you would like to save for?

- Have you ever heard about something called “company manners?” What does this term mean to you? How were you taught to address people you meet who are older than you or in a position of authority? When you think about acting “politely” what sort of behaviors does that bring to mind? How do you protect others from embarrassing bodily functions such as burps, gas, coughs, or sneezes that you might feel coming on? Is it okay to swear in front of people you don’t know well, or who don’t swear themselves?

- Were “table manners” considered to be important when you were a child? What did it mean in your house to have table manners? When you try to teach your children table manners, what kinds of things do you ask them to do, or not do?

- Is personal privacy important to you? What kinds of things might you wish to keep private? Do you ever feel embarrassed or uncomfortable when others tell you personal things about themselves? What kinds of things do you feel are no one else’s business? Is it okay to openly discuss such issues as sex, bodily functions, finances, prices, or family problems? How well must you know someone before you would consider bringing up such topics? What kinds of things do you consider rude, lewd, or crude? Have you ever seen anyone make a public seen by getting loud or angry in public? If so, how did it make you feel?

- When you see someone who is significantly different than you, how do you react? What kinds of people make you want to stare at them? What sort of people make you want to look away?

- What is the first thing you do after you get paid to assure that you spend your money wisely? Everyone deserves a little fun, so how do you assure that you get at least a small treat for yourself out of what you earn? Do you know what a credit rating is? Did you realize that it affects your credit rating negatively if you don't pay your bills on time? What would be the advantages to you to have a good credit rating?

- Where do you cash your checks? Have you considered opening a checking account? Is anything preventing you from doing so? How will you begin clearing up your past debt or outstanding warrants so that your money will be safe in a bank?

- Do you have access to low cost or no cost laundry facilities? How often do you think you should wear an outfit before laundering it? Do you have enough underwear to put on a fresh pair every day between trips to the laundry? Do you generally put on clean clothes after a shower? What sort of toiletries do you use to keep yourself smelling and feeling fresh? Would you like to know how I go about making sure I don't carry an offensive odor or looking disheveled?

- Do you rent furniture, appliances, or electronics for your home? Are you aware that rental fees cause you to pay much more than any of the rented items are worth? Do you know how to purchase reliable used appliances, electronics, or furniture? What might you look for before purchasing a used item such as a television, a refrigerator, or a car?

- How do you prevent waste in your household? How do you make use of leftover food? What measures do you take to try to keep your utility bills low? What kinds of things do the people you know best waste? How do save or protect these things in your home?

- Have you ever heard the term "personal boundaries?" What does the term mean to you? How do you attempt to keep appropriate boundaries between yourself and others? If someone invades your boundaries how do you generally react? If someone physically invades your space how do you respond to them?

- Have you ever helped yourself to something at work, or in public because no one else seemed to want it? Is it okay to take things before someone else offers them

to you? If you see something you want that hasn't been offered to you, what do you do?

- When you entertain your friends for a yard party, do you use your front yard or your backyard? How do you assure that your neighbors are not bothered by your entertaining? Do you impose rules on your party guests? If so, what are your rules? Do you impose rules on your own conduct when you attend a party thrown by someone else?

This list doesn't represent all of the hidden rules of the middle class, but it does give some suggestions as to how to open delicate conversations with the impoverished when you notice someone is violating the hidden rules of the middle class.

Capitalizing on Poverty Culture Norms

One means of crowding out bad habits and unwanted behaviors is to extend desirable behaviors. Some of the strengths that exist in poverty culture can be used to fuel transition from one class to the next. The suggestions listed below correspond with the tenets and norms of generational poverty listed on pages 32-34 of this course.

- People who live in noisy environments generally develop the ability to speak loudly and project their voice well. This is an asset in certain occupational environments. Factory work, arcade jobs, amusement parks, sports stadiums, and pet shelters are examples of environments where these folks might do well, and will excel over others in screening out background noise to concentrate on the job.

- People who know how to be humorous, or tell great jokes or stories might do well in environments where tension needs to be dispelled such as customer service jobs, or telemarketing. They are also welcome in places where people go to have fun, such as clubs, restaurants, or entertainment venues. People who like to entertain, or be entertained usually enjoy jobs where they know some of the existing workers, or are able to make contact with their friends while working.

- Parents, particularly mothers, who do not want to leave their children with daycare providers, can find jobs as Head Start teaching assistants, school bus drivers,

school lunchroom staff, school janitorial staff, or as daycare providers themselves. This allows them to be near their own children while they work.

- People who live in the present and have a strong focus on daily survival can benefit from suggestions to take immediate action. “What are three things you could do today to improve the situation at hand?” is a good question to ask that will move these folks into action. This prospective can be extended by asking, “What will you do tomorrow to keep the ball rolling? How about next week, next month, next year?”

- Women who define themselves with the roles of rescuer or martyr will want to hear how what you are asking them to do will help them better care for others, or gain the admiration of others. Challenge women who see themselves as martyrs by telling them that what you expect of them will be difficult, but that you are certain a strong person such as themselves will be able to accomplish it.

- Men who see themselves in the lover/fighter roles will enjoy jobs that involve demonstrating some machismo. Life guarding, security work, being a bouncer in a local club, policing jobs, enforcement jobs, the military, dangerous jobs, and heavy physical labor might suit such men well.

- People who are “high touch” and excel in communicating nonverbally might be well suited for jobs in crowded places such as subways, airplanes, bus stations, malls, and entertainment venues where one must “press some flesh” in order to do their job.

- Those who believe in fate will be pleased to hear that it is indeed their fate to be successful. Statements such as “I see great things in your future!” or “This was really meant to be!” will be readily believed by those who are looking for a little magic in their life. Use phrases such as “this is no coincidence…,” “we finally discovered each other…,” “destiny has intervened…” to trigger heightened levels of cooperation or decrease resistance, or to inspire compliance.

- People who like to dress in a revealing manner might feel comfortable in a job as a dancer, a singer, a bartender, a Hooter’s waitress, a casino, or an employee in an adult establishment. Do keep in mind that someone enjoys these jobs, and your values need not enter into another’s employment decisions.

The tenets of poverty culture that cannot be seen as strengths in moving towards self-sufficiency, or middle-class level economic success, need to be addressed. Here are some ideas as to how to focus these discussions.

- Polarized thinking that interferes with effective problem solving is not a strength in poverty culture, but something that must be overcome to gain and sustain success in mainstream culture. When an impoverished person says, “I can’t,” or “I quit” there are a couple of good questions to ask to help the person build persistence. “What can you do then, if you can’t do this?” will help a person find his/her top and bottom limits. “If you quit doing what you are doing, what else will you be quitting at the same time?” This question assists in linking the consequences of quitting with the act of quitting. If you quit your job, you are also quitting at buying groceries, paying the rent, keeping the lights on, and putting gas in the car.
- An oral language tradition of using slang is not a strength in many employment and social situations, particularly if the slang includes profanities, or words that are not understood by mainstream culture. To help a person evolve from casual register to the more formal mainstream chatter, paraphrase what the person has stated to you using simple English. Then ask the person how the statement sounded different when you said it, and suggest that they parrot your phrasing the next time they repeat the statement in the presence of middle-class listeners. Explain that people in the mainstream often judge a person’s intelligence by the way they speak, and you are eager to see them make a good impression and represent their intellect well. To capitalize on the use of casual register, social service organizations can rename their programs to have greater appeal to poverty culture. “Parenting Class” can be re-titled “Surviving Your Kids” to gain more buy-in from those they hope to attract to the seminars.
- Discipline is seen as punishment and penance, not the impetus for change, so be specific as to the changes you wish to see as a result of any disciplinary measure you may be required to take against an impoverished person. Spell out exactly what behaviors a person must exhibit, or refrain from exhibiting, to avoid experiencing the same, or worse, consequences in the future. Attempt to engage the person in a round of impromptu planning to explore the available change options.

- People who live in poverty operate more on “compass time” than “clock time.” They tend to do things when they feel moved to do so, as opposed to being obedient to a clock, like folks who live in the middle class. Although cultures who follow compass time (the Caribbean Islands, Hawaii, and Central and South American

countries for example) exhibit significantly less stress than does mainstream U.S. culture, this practice becomes problematic if one is employed in the mainstream. Being timely and being dependable are practically synonymous in the middle class, and that interpretation must be carefully explained to those who are newcomers to the class. Using time landmarks (for example, when a certain TV show ends, or meal times, or sleep schedules) to mark time and associate compass time norms with clock time measures will assist people who live on compass time to arrive on schedule, and learn to measure time in a new way.

- A lack of order and organizational skills can be a real deficit in navigating mainstream demands. To teach these skills to impoverished people you must first assure that they have the needed organizational tools and that they know how to use them. An appointment book or calendar, a partitioned accordion file, large manila envelopes in a file box, a refrigerator magnet with a clamp affixed to it to hang an envelope full of receipts, any of these tools will help those without tools to get organized. After the required equipment is provided, a class or tutorial should be given to help learners become proficient at color coding, dating, or alphabetizing the contents of the organizational tools for ease of information retrieval.

- Little goal setting is apparent in poverty culture, and people tend to live in the moment. Helping the poor learn to use Stephen Covey's SMART goals criteria will help give them a glimpse into future possibilities. Start with relatively short-term goals—one week, one month, one year, to build on the cumulative impact of short-term successes. Covey's goal criteria appear below.

SMART Goals are…

- **S**PECIFIC
- **M**EASURABLE
- **A**TTAINABLE
- **R**ELEVANT
- **T**IMELY

Legitimizing Transferable Skills

Despite the many jobs programs that are designed to equip the impoverished with marketable job skills, there are few programs that attempt to capitalize on existing skills that a person might possess and use frequently to pay the bills. A "shade tree" mechanic

or a “kitchen barber” can be enrolled in an auto repair certification program or barber school to obtain a legitimate license to cut hair. Once the skill is legitimized, the person who is now certified or licensed might wish to enroll in an entrepreneurial program to learn how to run his/her own business in a legal, and socially recognized manner.

It is often difficult to get social service clients to reveal their informal sources of income, so many times the helper who is empowered to make decisions about what occupational skills program to channel job seekers towards are unaware of the skills that a person might already possess. Even aptitude and interest testing may not be sufficient to identify a skill set that one is seeking to keep hidden. Here is a non-threatening tool that can be administered to reveal skill sets that are foundational to successful occupational skills training, or to a successful job search.

Transferable Skills

Check all statements that apply to your own experience. Do not check a statement unless you have done the activity at least three times.

Have you ever…

- Cleaned a house
- Mowed and trimmed a lawn
- Cared for a pet
- Cared for children
- Fixed a mechanical problem with a car
- Done body work on a car
- Repaired an appliance or electronic equipment
- Washed windows
- Cooked a meal
- Used a sewing machine
- Operated a cash register
- Balanced a check book
- Operated a video camera
- Mastered making an art object or a craft item
- Washed or styled someone's hair
- Learned to type

- Used a computer
- Cut firewood
- Sold retail products in person or over the phone
- Stocked shelves or taken an inventory
- Cared for an elderly person
- Obtained a chauffeur's license
- Operated a switchboard
- Served food, bused tables or washed dishes
- Done factory work
- Grown plants, flowers, vegetables or done other gardening work
- Painted or wall-papered a room
- Installed floor covering
- Done office work such as filing, making copies or taking messages
- Operated farm equipment or worked on a farm
- Performed as a musician, singer, dancer or model
- Been a sports fan
- Tended bar
- Had an interest in music or musicians
- Had an interest in fashion
- Had a hobby or a collection

Circle the five skills that you feel you are best at doing. Then put a star next to three skills out of the five you selected to indicate which skills you most enjoy performing. Finally, choose between the top three items to decide which set of skills you might like most to perform on a future job.

Once the person has selected a skill area to pursue, an assessment will occur to determine if the field chosen has viable employment opportunities and if the chosen profession requires formal schooling, certification, or licensure. The person is then either enrolled in the appropriate training course, or begins a directed job search. The components of such a search appear below.

Matching Skills Profile to Employment Opportunities

Once employers or jobs are targeted how do you direct the search?

1. Update the person’s resume to reflect the transferable skills possessed by him/her

2. Organize perspective employers geographically to save time and transportation costs.
3. An earnest job search is conducted 3 hours/day, 6 days/week. Chunk the list down into 3-hour increments.
4. Give the person a sheet to track each job contact and note the result of each.
5. Review the tracking sheet with the client on a weekly basis to plan the following week's search. Prioritize return visits to promising employers and add new leads.
6. Move the search to a new occupational or geographical area once all efforts in a targeted field or area have been exhausted.

What concerns do we need to discuss with job seekers at the weekly debriefing meeting during the job search?

1. Ask which employer contacts were most promising and why they appear so.
2. Suggest appropriate follow-up activities (re-contact, thank you note).
3. Conduct a mock interview to practice for specific upcoming employer interviews and give feedback regarding verbal responses, body language, eye contact, posture, affect, and social skills.
4. Plan the grooming efforts and attire for upcoming interviews.
5. Discuss methods to assure a timely arrival for upcoming interviews (travel time, when to leave, time to set the alarm clock, daycare arrangements).
6. Review the least promising employer contacts of the past week and surface learning points to be derived from those experiences.
7. Provide the client with a written copy of the points covered during debriefing.

H. Overcoming Obstacles to Helping

> *"Change the thought that creates the resistance, and there is no more resistance."*
>
> ***Robert Conklin***

Helping the poor isn't as easy as it sounds. Not all impoverished people want a different life, and of those who do, not everyone wants to do the things that they must do to gain economic security. The right to self-determination is extended to all Americans, and helpers must keep that in mind when making their best efforts to rescue the poor from the shackles of poverty.

As the above quote suggests, in order to reduce resistance to anything, one must change their thinking about that thing. Professional helpers are generally skilled at assisting others to think about their lives in a different way. They are trained to take the person in need of assistance from a “point of view” to a “viewing point” from which they can view themselves and their situation more objectively. Distancing an individual from their current circumstance is the essence of change management.

To reach a “viewing point” one must rise above their fears and notice things about their situation that they can’t see when they are in the midst of their dilemma. This is why it is so vital that professional helpers do their best to be “uplifting” in their interactions with the poor. This doesn’t mean to make light of their situation, but it does indicate that the helper would do his/her best to extend hope to the struggling person.

It is also helpful if everyone is invested in making changes, not just the impoverished person. Employers who hire low wage earners might introduce strategies that correspond to the needs of impoverished employees (i.e. ride sharing programs, discount club memberships, a company store where items are purchased with performance points, short term reward systems, and swift developmental feedback at the moment a performance deficit arises.) Such programs have been shown to reduce absenteeism, employee theft, turnover rates, and discrimination complaints, and increase employee loyalty.

Employers could also offer day work, job shares, family work sites, telecommuting opportunities, work at home projects, and neighborhood business collaboratives as alternatives to full or part time employment. There is much less resistance exhibited to small changes than large ones, and such strategies can provide opportunities for incremental change.

Cons, Hookers, and Thieves, Oh My!

To be blunt, there are some scary people living in poverty today. Wild-eyed drug addicts high on crack or methamphetamine are volatile and unpredictable. Criminals are notorious for their ability to lie convincingly, and may be carrying weapons. Seldom will an impoverished prostitute own up to how she is earning her living when speaking to a helper from a middle class. Helping the poor frequently entails dealing with people who are manipulative at best, and dangerous at worst. In order to make society less dangerous, professional helpers are tasked with making dangerous people less

dangerous, and there is a myriad of different kinds of dangerous people inhabiting impoverished neighborhoods.

Each year, attacks against social service and healthcare workers rise in numbers and severity. From shoot-outs in emergency rooms of hospitals, to rapes and assaults against home visitors who do their work in impoverished neighborhoods, crimes against helpers are becoming more frequent. Being a professional helper is not for the faint of heart, nor is it for those whose don't take the time to calculate their risks. Here are some tips for working with dangerous individuals.

Dangerous Individuals

When you have to respond to a dangerous person, you need to react in a manner that reduces the danger inherent in the situation and adheres to your agency's threat management policies. If your agency does not have a policy that gives specific guidance about the management of dangerous individuals, these guidelines are recommended:

- Hostility and anger are often reaction to fear. Do whatever possible to lessen the individual's need to be afraid of you.
- Maintain an attitude of confidence. A violent person is more likely to attack someone who appears weak, afraid, or easily intimidated. However, do *not* do or say anything that the interviewee might interpret as aggressive or challenging.
- **Do not raise your voice, argue, lecture, confront, accuse, or give advice.** Instead, remain composed and speak in a gentle, soothing manner**.**
- Demonstrate empathy for the interviewee's feelings of frustration and anger. Use both reflecting and paraphrasing skills to ensure that you accurately understand the individual's thoughts and feelings.
- If the individual is angry because of a mistake or inappropriate statement you made, admit your error and apologize.
- Do **not** move into the individual's space. Do **not** touch an angry individual. Try to sit rather than stand, because sitting is a less confrontational posture. Encourage the individual to sit as well; that usually has a calming effect.
- Position office furniture—and yourself—so that you have easy access to the door or an escape route. Avoid seating the individual between you and the door. Make certain that the individual also has easy access to the door so that he or she doesn't feel trapped.

- When you enter a room containing a potentially violent individual, move slowly.
- Remain on the periphery until you have sized up the situation. Watch the individual's body language for any signs of potentially violent behavior.
- When in the home of a potentially violent individual, try to interview the person in the living room. Avoid both the kitchen and bedroom, since weapons are often kept in those rooms. If the person moves quickly to one of those rooms, leave immediately.
- *Never* attempt to disarm an individual with a weapon. If the person has a weapon, explain calmly that you intend no harm and back away slowly, or try otherwise to get out of the situation.
- *Never* enter a potentially dangerous situation alone or without first informing others of your plans. When making home calls, always leave an itinerary with coworkers, and check in by phone according to a prearranged schedule. Never hesitate to call the police for assistance.
- Review the case history of potentially violent individuals. Advance knowledge and preparation can help you avoid a dangerous situation—or, at least, better prepare for it.
- Set up a code at your agency to alert coworkers and supervisors about potential danger in your office. For example, calling a coworker or supervisor and asking for "the green file" could mean "Danger—come fast!" Likewise, a buzzer system could be used to alert coworkers and supervisors that you are in a dangerous situation.
- Never **overestimate** your ability to handle a dangerous situation.
- Never **underestimate** the paralyzing effect of fear.

We Don't Want Your Help...

There are many ways to reject the unwanted help of others, but not all of them are blatant, or even conscious for that matter. Some folk think they want help initially, and then decline every opportunity that is extended to them. Others, wanting to be polite, say that they appreciate the helper's efforts, but then fail to follow-up on the help they have been given. Yet others adamantly refuse help from the start.

No everyone who lives in poverty wants to escape it. Some are rather comfortable where they are, and feel secure in the predictability of their situation. Regardless the reason, help should never be forced upon the poor, or anyone else for that matter. Some people fail to report crimes out of fear of retribution from the criminals. The ill may refuse medical treatment that could restore quality or comfort to their lives. The homeless may prefer to

live on the streets rather than to accept a bed at a shelter. Although these may seem like unwise choices, they are choices, nonetheless, and everyone has a right to choose as they see fit.

Allowing the impoverished to reject help doesn't mean that one should find ways to exempt them from the logical consequences of their decision. Those who are offered a job and refuse it should be cut from the jobs program that helped find them the job. People who fail to keep their children safe and free of neglect should have to relinquish their offspring to the care of relatives or a foster home. Those who choose to use drugs and alcohol should be expelled from treatment centers if they refuse to comply with the program. People who violate their parole should be returned to prison. The poor, as well as those in middle and wealth class, make bad decisions every day, but they are their decisions to make.

When possible, the helper is responsible for explaining the unwanted ramifications and potential side effects of an impoverished person's decision to reject help, but that is where the helper's responsibility ends. After that point the helper must follow the rules of their workplace, take legal action when it is mandated, or simply let go, and walk away from a person who has the potential, but not the will to succeed.

Are poor people invested in staying poor? Yes, and no. Yes, there are some who don't want to do the hard work required to move up in class. They are waiting for the easy money to arrive, and will continue to wait, whether it ever comes or not. And no, the majority of people who live in poverty would do most anything to climb out of the hole their family has found themselves in for generations. There are so many of these willing individuals and families to help, that there just isn't time to waste on expending a great deal of time and energy on those who are satisfied with their lot in life.

This pronouncement may sound harsh, and it may be just exactly why "the poor will be with us always," but it is a sad reality that exists, whether we in the middle class are comfortable with it or not. The values systems exhibited by the poor tend to baffle the middle class on a number of fronts, and the rejection of help by those who seem to really need it is one of those mysteries that the middle class may never be able to solve.

Ouch, Another Cultural Collision

It is imperative to remember that when a middle-class helper is communicating with a generationally impoverished person or family, they are interacting across cultural lines.

Think for a moment how common misunderstandings are when people of different nationalities attempt to communicate. Language differences, behavioral norms, rituals, traditions, values, and differing ways of thinking all create barriers to mutual understanding. So, it is also when talking to those whose class is different than your own.

Don't give up too quickly when trying to resolve misunderstandings and seek common ground until you exhaust all efforts to reach agreement. When cultural collisions occur;

- Immediately apologize for any role you may have had in the misunderstanding.
- Say that it was not your intention to insult or upset the person to whom you are speaking.
- If you need to give the person instructions, begin your instruction with the word "I," not the word "you."
- Detail the benefits to the person to be had from following your instructions.
- Detail the unwanted consequences to the person if s/he fails to follow your instructions.
- **Ask the person to tell you what s/he plans to do in order to comply with your direction and when they intend to do it.**
- Restate your instructions if the person does not appear to have a good grasp of the instruction or how to follow it.
- Write down the instructions and the timelines that have been set to accomplish the task that is to be done.
- Throughout the process be sure to use plain language that can be easily understood.
- Provide contact information so that the person can contact you with questions or problems they may have when attempting to follow your directions.

Remember never to personalize the rejection of your help or ideas. The person across from you views you as a representative of your organization, not a real individual with feelings. They may even hurl insults at you that are very personal in nature, yet, since they don't know the real you at all, it is not possible for their comments to be aimed at you as a person. Don't take the bait, and remain composed when you unwittingly evoke an angry response from someone who has no understanding of how you think or feel.

A phenomenon known as "middle class guilt" sometimes comes into play when working to help the impoverished. On a subconscious level some in the middle class may feel badly because they have more blessings to count than those living in poverty, and will be inclined to let themselves be manipulated because of these feelings. Allowing oneself to

be used for the financial gains of another who is unwilling to earn their own way does not help anyone. It simply reinforces the message that those living in the middle class owe something to those in poverty.
Feeling that one is owed can interfere with one's motivation and ability to do what they can for themselves, and robs them of the pride that comes from earning, learning and accomplishing goals that are meaningful in their own lives.

Money does not solve poverty. Changing the way in which one lives their life does.

Go Forth and Conquer

Daily thousands of Americans transcend class. They get a great job, or win the lottery, or file bankruptcy, or "marry up" or down. They make connections with powerful or helpful others who invest time, or money, or advice in them, and their lives are transformed in an instant. More often though, people who transcend class do so inch by inch, and creep slowly along to a better life, or a worse one, depending on their perspective. Sometimes the climb, or decline is so slow that they don't even realize that they have moved at all.

Transcending class always comes with a new set of sensibilities, responsibilities, and obligations. It is the job of the professional helper to prepare a person for the transition, and support them as they make the difficult journey from the known to the unknown. One thing is for sure, the transition is always easier when someone else cares whether you make it or not, and helping professionals usually care a great deal. Kudos to you for taking this course, and for making a difference in the lives of those who, without your caring assistance, would be lost.

The Real Deal
Jenny was born in poverty, as was her mother and grandmother. Although she was a bright child, her opportunities were limited, and there was never enough money to send her on school field trips, or even buy her a gift on her birthday. At age 17, Jenny gave birth to a daughter of her own, knowing that the burden of single parenthood would likely cause her to drop out of school to support her child. Before leaving the maternity ward, the labor room nurse who had taken a liking to Jenny came into her room to see her one last time before she and the baby were released from the hospital.

Nurse Abby smiled down at the young woman and her child and remarked, "That baby that you are holding is destined for greatness," she said. "I can feel it."

"You can?" responded Jenny in amazement. "Oh yes! How could she fail with such a wonderful mother?" Abby replied.

"I had this baby out-of-wedlock, and I haven't even graduated high school. How will I ever provide her with the kind of life that it will take to make her become great?" Jenny wondered aloud.

"You will want a better life for her than the one you have had so far," Abby stated confidently, "And you will stay in school, graduate, find a way to go to college, and get a great job like mine to assure you can provide opportunities for her."

With that declaration Abby handed Jenny a brochure for the nursing school that she herself had attended. "Just keep your grades high, and you can get a scholarship like I did," Abby offered. "One day I want to look up and see you standing next to me as we both attend to bringing a new baby into the world." She went on to explain that nursing school only takes two years, and that in just three years from now Jenny could be making $20-$30 an hour, enough to raise her child in a safe neighborhood, and begin a college fund for her years before she would need it.

"Do you really think I am that smart?" Jenny inquired. "Of course, you are! Abby effused. "Now get busy on that stack of school books, and enroll in college prep classes as a senior. Oh yes, and if you need advice and encouragement along the way, just call me. My number is on the back of the brochure."

Jenny did phone Abby many times over the three years she struggled to live on welfare, stay in school, and complete a nursing degree. Abby always found time to reassure her, comfort her, and help her think through her problems. Today, nearly two decades later, Jenny is a Nurse Midwife with a Master's Degree in her specialty area, and her daughter is graduating high school this spring as valedictorian of her class. The college money is in the bank, although, with all of the academic scholarship opportunities available to her daughter, Jenny probably won't need to spend much of it on tuition.

The cycle of generational poverty has been broken, all because of the kindness of a nurse who put her nose where it didn't belong, and had the audacity to plant a dream in the mind of a young woman in whom she saw potential.

Chapter 3: Poverty, Homelessness and Mental Illness

The following are excerpts sourced from:

A. Introduction

This TIP Is for You, the Behavioral Health Service Provider

This Treatment Improvement Protocol (TIP) is for you, the behavioral health service provider or program administrator who wants to work more effectively with people who are homeless or at risk of homelessness and who need, or are currently in, substance abuse or mental health treatment. The TIP addresses treatment and prevention issues. Some aspects of the TIP will be of primary interest to counselors across settings, whereas others will be of primary interest to prevention professionals or providers in primary care settings. However, the approach advocated by the TIP is *integrated* and is aimed at providing services to the whole person to improve quality of life in all relevant domains.

The information in this TIP can be useful to you if you wish to:

- Be a more effective clinician for people facing potential or actual homelessness.
- Recognize and address homelessness as a special dynamic that affects your clients.
- Help prevent potential crises that result from becoming homeless.
- Provide preventive services for individuals and families who are homeless, especially as they relate to emergent substance abuse or mental disorders.
- Be more aware of the effects of psychological trauma and co-occurring disorders (CODs) among people who are homeless.
- Provide integrated, more effective services to people who are homeless.
- Understand and know how to utilize resources for homelessness (e.g., permanent supportive housing [PSH]) in your community.
- Understand the significance of cultural competence in your work with people who are homeless and experience substance use and mental disorders.
- Influence the understanding of others in your community regarding the interrelationship of homelessness, substance abuse, and mental illness.

Behavioral health service providers work today in a variety of settings: publicly funded treatment programs, primary care organizations, hospitals, criminal justice settings,

private practice, the military, schools, the community, and programs specifically for people who are homeless. You will find the information in this TIP useful regardless of the setting in which you work. Although some content may be more relevant to your work than other content, it is important to have an overall view of how homelessness, substance abuse, and mental illness interact to hinder recovery and rehabilitation; how to form a conceptual model to address homelessness in your work; and how to access services available in your community.

This chapter introduces you to homelessness in America. It illustrates how homelessness affects people, why it often occurs in conjunction with other social and health problems, and why it cannot be addressed in isolation. It also provides a brief overview of how communities address homelessness and discusses different types of homelessness and how each interacts with substance use and mental disorders.

In addition, the chapter discusses your role(s)as a provider in working with this population. Some of the topics addressed include:

- The special competencies you will need in your work with people who are homeless.
- Knowledge, skills, and attitudes in working with specialized community resources that can support treatment and prevention for people who are homeless.
- How to build responses for homelessness or the threat of homelessness into individualized service or treatment plans.
- How to adapt services to the changing needs of people who are homeless as their life situations change.
- How to help individuals without permanent housing integrate with other people in behavioral health service settings.
- The types of preventive services people who are homeless may need.
- Provider self-care when working with the problems of homelessness.

The chapter closes with a discussion of how communities can address homelessness and acquaints you with services that may be available in your community for people who are experiencing or who may be at risk for the overwhelming problem of homelessness. Many resources already exist, and it is important for you as a behavioral health service provider to understand and actively interact with existing organizations to provide integrated, continuous, and nonduplicative service to clients who are homeless.

Did You Know?

There is no typical profile for persons experiencing homelessness. A person who is homeless may be, for example: Someone who has lost his or her job or experienced mortgage foreclosure and has been evicted along with family members.

- A loner who sleeps in the park in a sleeping bag.
- An individual leaving jail or prison who has an untreated drug problem and no place to live.
- A runaway teen who trades sex for food and drugs.
- A person in early recovery without enough money to pay the rent.
- A person with serious mental illness (SMI) who needs long-term permanent supportive housing.
- A person kicked out of the family home due to problems accompanying substance abuse.
- More than 1 in 10 persons seeking substance abuse or mental health treatment in the public health system in the United States is homeless (SAMHSA, Office of Applied Studies [OAS], 2006).
- Keeping things together while being homeless takes considerable skill and resourcefulness. People who are homeless often have well-developed street skills, resourcefulness, and knowledge of the service system—important strengths that can be built upon in treatment.
- People who are homeless, particularly those with co-occurring mental and substance use disorders, present particular challenges in treatment. All issues must be concurrently addressed for treatment to be effective.
- People with substance use or mental disorders who are homeless are more likely to have immediate life-threatening health conditions and to live in life-threatening situations. The first steps toward healing may be access to medical care and a safe and healthy place to live.
- Trauma is another major co-occurring problem for people who are homeless and have a substance use disorder. One study found that about one fifth of men and one third of women who are chronically homeless and have substance use disorders also have posttraumatic stress disorder (PTSD; Jainchill, Hawke, & Yagelka, 2000).
- Safe housing is a point of entry into treatment for many individuals. When safe housing is combined with services, the client has the opportunity to build strengths to move from the precontemplation stage through the contemplation stage to an active stage of change concerning recovery from mental illness and substance abuse.

- Many individuals in early recovery are only a paycheck away from homelessness.
- People leaving prison or jail with no place to live who have an untreated substance use or mental disorder may lack familial, occupational, and social resources and supports.
- People who have experienced multiple episodes of homelessness or who have been chronically homeless may be especially demoralized and depressed. In addition, in prior contacts with service systems, these individuals may have experienced alienation that will require behavioral health service providers to exercise a full battery of professional engagement and customer service skills.

B. Why Address Homelessness in Substance Abuse and Mental Health Programs?

Serving people who are homeless in behavioral health agencies is challenging. So, why do it? It is crucial. Housing instability is common among people diagnosed with substance use or mental disorders. This instability may take the form of: Risk of eviction and/or estrangement from families. Risk of homelessness after a stay in jail, prison, or residential treatment. An inability to maintain adequate housing over a period of time.

Miller, BP. (February 22, 2021). *Untitled.* [digital image]. Retrieved from https://unsplash.com/photos/CvElceDVH70/info

Housing stability is key for long-term recovery from substance use and mental disorders; providing housing with treatment and other services reduces relapse (Kertesz,Horton, Friedmann, Saitz, & Samet, 2003) and improves outcomes (Milby etal., 2008; Sosin, Bruni, & Reidy, 1995).

- It is good for your organization. Addressing the root causes of crises caused by homelessness results in better client retention, efficient organizational functioning, and greater program service diversity.

- Participation in your community's continuum of care for homeless assistance services fosters professional relationships, funding opportunities, innovative programming, and access to a broader range of services for the people you are serving.
- It is good for your community. As communities develop plans to end homelessness, increased funding and resources become available to implement programs and coordinate services. Programs are able to target and respond to specific community needs more efficiently and effectively, and some of the problems intensified by homelessness—such as aggressive panhandling—are reduced.

Preventive Services for People Who Are Homeless

People who are homeless are at elevated risk for substance abuse, mental disorders, and various other physical ailments and social problems (e.g., unemployment, poverty, victimization). Preventive services can reduce these risks before problems occur or when early signs of the problem are evident. As shown in Exhibit 1-1, **the Institute of Medicine (IOM;2009) divides substance abuse and mental health services into four broad categories: promotion, prevention, treatment, and maintenance.** Prevention services are further divided into:

- **Universal prevention services, which target entire populations (i.e., a community, State, or country).**
- **Selective prevention services, which target subsets of the population considered to be at risk.**
- **Indicated prevention services, which are delivered to individuals and target people who are exhibiting early signs of problem behaviors.**

By definition, universal prevention efforts are not specifically targeted to persons who are homeless because they are part of a larger community, State, or national population.

Exhibit 1-1: Types of Prevention as Described by the Institute of Medicine

Source: IOM, 2009. Adapted with permission.

However, People who are homeless may be the beneficiaries of these prevention efforts (e.g., workplace programs, recreation programs, enforcement efforts to reduce crime, school-based prevention programs for children enrolled in school). Because of their high-risk status, these efforts may be especially important to persons who are homeless or at risk of becoming homeless.

This TIP focuses primarily on selective and indicated prevention, referring to them collectively as "clinical preventive services," as they are often provided in clinical settings (primary care, hospitals, counseling centers, etc.). Clinical preventive services include life skills development, stress and anger management, anticipatory guidance, parenting programs, and screening and early intervention. These programs may be designed to directly prevent substance abuse and/or promote mental health and may strengthen individuals and families and enrich quality of life to build resiliency.

The categories in Exhibit 1-1 are tools for considering prevention initiatives; they aren't hard and fast. In practice, they often blend, and a given initiative may fit into more than one category.

Housing as prevention

Providing housing to people who are homeless can help prevent the exacerbation of substance use and mental disorders or the transition from normal functioning to the first phases of problem development. A number of considerations support this assertion.

Homelessness itself is a risk factor for mental and substance use disorders, given the many life challenges and disruptions that people who are homeless face: for example, stress, loss of social connectivity, increased threats, harm through victimization and exposure, and deterioration of health status. Indeed, these risk factors for adults and youth are one reason this TIP emphasizes the importance of preventive services for people who are homeless.

Effects may be especially acute in children, for whom homelessness may mean a loss of family stability, disruptions in school attendance or performance, and being ostracized by peers. Brokering prevention services in the community can help mitigate the impact of these circumstances (see the "Case Management "section later in this chapter as well as Vignettes 4 and 6 in ,)

Are you a prevention worker in the behavioral health field?

When many professionals think of prevention service providers, mental health and substance abuse workers come to mind. In truth, a broad array of professionals in the community contributes to the treatment and prevention of mental illness and substance abuse. The community agencies and organizations listed in Exhibit 1-2 have a part to play in the prevention of these problems. If your agency or organization is on this list, you are a prevention worker.

Not only does your community benefit when professionals from a wide range of sectors participate in prevention; you may also find your job to be easier as well. People with substance use or mental disorders often present significant treatment challenges in the community agencies and organizations with which they have contact. When substance abuse and mental health issues are prevented or identified early, quality of life improves for everyone.

It is beyond the scope of this TIP to provide an introduction to prevention theory and practice. Instead, it focuses on preventive services for persons who are homeless.
9

Exhibit 1-2: Agencies That Provide Substance Abuse Prevention and Mental Health Promotion Services

C. Recommendations of the Consensus Panel

You are a behavioral health professional working with people who are homeless or at risk for homelessness, but most likely, your background does not include detailed training in addressing this aspect of their lives. This TIP is designed to fill that gap and increase your understanding of how homelessness affects a person's ability to engage in treatment or benefit from prevention. In particular, the consensus panel recommends the following:

- Housing access is the bulwark of recovery for a person who is homeless and has a substance use disorder and/or a mental illness. Various housing models can be effective in addressing homelessness and substance abuse or mental illness. You must be active in identifying housing resources as you assess and work with abstinence readiness in your clients.
- Solving homelessness is more than just having a safe place to live. Homelessness typically presents along with multiple, complex other problems: substance abuse, mental health issues, medical problems, legal/criminal justice issues, social challenges, and so forth. You must be able to prioritize these factors when creating a person-centered treatment or prevention plan and know how to access appropriate supervision concerning these complexities.
- People who experience homelessness can be particularly demoralized, needing active and often persistent engagement; be flexible in engaging them, especially in earlier stages of work.
- **Income stability through access to Federal or local income benefits is a critical ingredient in helping a person who is homeless reintegrate into the**

social mainstream. Clinicians and prevention workers must know how to help the people they serve gain access to these benefits.

- Work and/or education are basic goals for the majority of people who are homeless. These are sources of significant self-esteem, counteracting demoralization and providing daily structure and a long-term foundation to prevent subsequent homelessness. You will want to be familiar with community resources for vocational and educational training and placement.
- Many people who are homeless have no social supports, but some do—especially those with brief intermittent periods of homelessness. Family or close friends can offer support; be alert to these resources when helping people repair their social networks. For someone with a history of chronic homelessness, you may need to re-conceptualize how to help rebuild his or her social supports.
- People who experience homelessness encounter a range of problems. You can apply the skills gained from serving this population to your work with anyone experiencing biopsychosocial challenges. Conversely, the techniques you have already mastered can be applied in your work with people who are homeless, depending on the stage of change they are in.

D. Homelessness in America

How Is Homelessness Defined?

There is no single definition of homelessness; however, most Federal homelessness programs use the definition of a homeless individual provided by the McKinney-Vento Act (P.L.100-77):

An individual who lacks a fixed, regular, and adequate nighttime residence; and a person who has a nighttime residence that is
(a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
(b) an institution that provides a temporary residence for individuals intended to be institutionalized; or
(c) a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings. (42 U.S.C. § 11302)

In other words, a person experiencing homelessness has no fixed place to live and often dwells in public spaces, shelters, or drop-in centers or may double up in others' homes in

a temporary or makeshift way. The more recent Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 (P.L. 111-22), which amends the McKinney-Vento Act (see, Chapter for further detail), expands the definition (Sec 103, 42 U.S.C. § 11302) of a person or family who is homeless to include anyone who:

- Resided in a shelter or place not intended as a home and is now leaving an institution where he or she temporarily resided.
- Is losing his or her housing in 14 days or fewer; cannot obtain housing through his or her support networks or other resources.
- Has, at some point, lacked independent permanent housing for a long period of time; has moved frequently; and is likely to continue doing so as a result of physical disability, mental disorder, addiction, or other barrier.
- Has experienced domestic violence, sexual assault, and/or other dangerous or life-threatening conditions in a housing situation that he or she is leaving.
- Is an unaccompanied youth who is homeless.

HUD (2001) defines a person who is chronically homeless as “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four [4] episodes of homelessness in the past three [3] years” (p. 6). Unaccompanied individuals who are homeless are men and women not accompanied by children or a partner. Disabling conditions include mental disorders, substance use disorders, and medical conditions.

How Many People Are Homeless?

It is difficult to count the number of people who are homeless accurately because they move frequently. This means they can be counted more than once or missed. HUD has estimated, based on point-in-time counts, that 643,067 persons were homeless at a single point in time in January 2009, of whom 237,934 were on the streets, in abandoned buildings, or in other places not meant for human habitation (HUD, 2010). Sixty-three percent of people who were homeless were single individuals and the rest were members of families experiencing homelessness. Another estimate using these data arrived at a slightly higher number: 656,129, a 3 percent increase over the previous year. The number of families facing homelessness increased by 4 percent over the same period, although the figures are much higher in some States (Sermons & Witte, 2011). The full extent of the effects of the 2008 recession on homelessness may not be measured for some time.

On a single night in 2009, an estimated 75,609 veterans were homeless; 57 percent were staying in an emergency shelter or transitional housing program, and the remaining 43 percent were unsheltered—that is, living on the street, in an abandoned building, or in another place not meant to serve as a human dwelling. Of veterans in shelters, approximately 96 percent were individuals and slightly less than 4 percent were part of a family that was homeless (HUD & VA, 2010). For more information, see the online literature review in Part 3 of this TIP.

Who Is Homeless?

People who are homeless come from all strata of society, although the poor are most certainly overrepresented. The high percentage of people of color in the homeless population is related to their chances of being poor, not to their race/ethnicity (Burt, 2001). The National Survey of Homeless Assistance Providers and Clients (Burt et al., 1999) reported that:

- About 40 percent of clients who are homeless are African American, about 40 percent are White, about 11 percent are Hispanic, and about 8 percent are Native American.
- About 61 percent of clients are men by themselves, 15 percent are women by themselves, 15 percent live with their own children under age 15, and 9 percent live with another adult.
- Clients who are homeless are concentrated in central cities (71 percent), with fewer in urban fringe areas and suburban areas (21 percent) and rural areas (9 percent).

Dumlao, N. (November 11, 2020). *Untitled*. [digital image]. Retrieved from https://unsplash.com/photos/i__uqGnARyI/info

E. What Factors Contribute to Homelessness?

Both the environment and individual factors contribute to homelessness.

Environmental factors

Poverty predisposes people to homelessness through a range of environmental factors; 5 to 10 percent of people who are poor experience homelessness in a given year (Burt, 2001). Since the 1970s, vulnerability to homelessness has increased among the poor as access to affordable housing, social safety nets (e.g., housing/income subsidies, affordable health care, hospitalization), and adequate income have decreased. In addition:

- Housing costs price many people with below-poverty incomes (e.g., very low-income families and single adults) out of the market (Burt, 2001). More than 14 million families have "worst-case housing needs," defined as spending more than 50 percent of monthly income on rent (Lipman, 2002).
- The removal of institutional supports (e.g., deinstitutionalization) has resulted in fewer housing options for people diagnosed with SMI (Burt, 2001). It is critical that housing issues be addressed in disposition planning when individuals are discharged from inpatient or outpatient mental health or substance abuse treatment settings. Clients leaving intensive treatment settings who do not have adequate housing to support their recovery have a significantly higher risk of relapse.
- Decreased job options for people with high school educations and increasing disparity between minimum wage and cost of living have made it increasingly difficult to earn enough money to afford housing (Burt, 2001).

Environmental factors affecting vulnerability to homelessness relate directly to community resources. Community solutions for preventing homelessness and ending chronic homelessness include affordable housing, access to permanent supportive housing for clients with mental illness and substance use disorders, improved schools, training, prison transition programs, job opportunities, and support services (Burt, 2001).

Individual factors

In addition to substance use and mental disorders, a range of complex, interrelated individual risk factors are related to homelessness, including trauma-related symptoms, cognitive impairment, medical conditions, lack of support from family, limited education and job skills, and incarceration (for more detail, see the literature review in Part 3 of this TIP, which is available online at the KAP Web site (http://kap.samhsa.gov). A significant

percentage of individuals who are homeless will likely experience at least one of these issues. For example:

- Mares and Rosenheck (2004) found that veterans who are homeless report that three aspects of their service contributed to their homelessness: substance abuse beginning in the military (75 percent), inadequate preparation for civilian employment (68 percent), and loss of structure (68 percent).
- People who have or have had mood disorders, schizophrenia, antisocial personality disorder, or any substance use disorder are at least two times more likely to have been homeless than those without these diagnoses (Greenberg & Rosenheck, 2010a,b).
- Of people who are homeless and in substance abuse treatment, 68 percent of men and 76 to 100 percent of women report trauma-related events (Christensen et al., 2005; Jainchill et al., 2000), similar to rates reported by general samples of people who are homeless.
- As many as 80 percent of people who are homeless exhibit cognitive impairment, which can affect their social and adaptive functioning and their ability to learn new information and new skills (Spence, Stevens, & Parks, 2004).
- People who are homeless have high rates of HIV/AIDS, hepatitis C, cardiovascular conditions, dental problems, asthma, diabetes, and other medical problems (Klinkenberg et al., 2003; Magura, Nwakeze, Rosenblum, & Joseph, 2000; Schanzer, Dominguez, Shrout, & Caton, 2007).
- Lack of familial support increases the risk of episodic and chronic homelessness and manifests as disconnection from family, childhood placement in foster care or other institutions (27 percent), and childhood physical and/or sexual abuse by family members (25 percent; Burt et al., 1999).

Mikki
Mikki is transitionally homeless. Her boyfriend (who is also the father of her youngest child) has left her. He promised financial support for Mikki and the two children, ages 7 and 3, but only provided money for a few months. Mikki was evicted from her apartment 3 weeks ago and has been living with her children in the family car, which won't start. When the children come down with bad colds, she takes them to the community health center. *Mikki has become progressively more depressed as a result of her breakup and the stress of homelessness. She has begun drinking at night to sleep. The case manager in the community health center helped her arrange temporary emergency housing until*

more stable transitional or permanent supportive housing can be arranged. He also referred her for a psychiatric evaluation and worked with the school system to provide supportive and preventive services to the children. One of his primary goals has been to intervene before a pattern of long-term homelessness is established. The case manager is also cognizant that Mikki's co-occurring depression and substance abuse must be addressed as part of a larger treatment plan that includes adequate housing, employment, financial support, child care, and services for mental health and substance abuse treatment.

A later vignette describes how the caseworker helps Mikki obtain these services. Behavioral Health

Services for People Who Are Homeless

- Thirty-eight percent of people who were homeless and received services in 1996 lacked a high school diploma or equivalent (Burt et al., 1999).
- Incarceration is common among people who have experienced homelessness (54 percent of those who received services in 1996; Burt et al., 1999). Many individuals leaving prison have no place to live and seek housing through community resources for homelessness.

Are There Different Types of Homelessness?

Surveys conducted with people who are homeless indicate that there is a continuum of homelessness (Burt, Aron, Lee, & Valente, 2001). This section offers brief explanations of the types of homelessness, the prevalence of each, and illustrative vignettes.

Transitional homelessness

A first or second episode of homelessness, ranging from a few weeks or months to less than a year, is considered transitional homelessness. About half of the homeless population falls into this category, including many families who are homeless. Families are likely to qualify for public assistance programs, so they are less likely to be

homeless or to be homeless for long periods. People leaving prison or jail may be transitionally homeless.

Episodic homelessness

Episodic homelessness means entering and leaving homelessness (e.g., shelters) repeatedly. Between episodes of homelessness, a person might be tenuously housed (in his or her own housing or living with friends/relatives) and at high risk for becoming homeless again. About one fourth of people who are homeless have gone in and out of homelessness numerous times (Burt et al., 2001).

Chronic homelessness

About a quarter of people who are homeless have been continuously so for at least 5 years (Burt et al., 2001). Engaging people who are chronically homeless in housing and other services requires willingness to provide housing and services that are attractive to clients.

Francis
Francis is chronically homeless. He has lived in a subway tunnel for some time and is known to the staff of the local homeless program. It's been more than 5 years since he had a home. His medical records indicate that he has an intelligence quotient (IQ) of about 70, possible cognitive impairment from an old injury, and diabetes. With cold weather predicted, the outreach and engagement team want to see how he is functioning, if he has immediate needs, and whether he will accept shelter. *Techniques for engaging Francis into appropriate services are illustrated in a later vignette, The importance of cultural competence in working with Francis is shown in the vignette.*

Roxanne

Roxanne is episodically homeless. She has a history of illicitly using and selling extended-release oxycodone and other opioid drugs. She has been diagnosed with antisocial personality disorder. She lived with friends until they tired of her drug use and erratic behavior. Roxanne now lives in single room occupancy (SRO) housing. Roxanne's drug use and erratic behavior make it hard for her to hold a job. She occasionally engages in prostitution and sells pain pills for income. She's been told not to bring customers to the SRO but sometimes brings them anyway. Failing to follow the rules puts her at risk of ending up back on the street. Roxanne's behavior and risk of eviction predispose her to victimization. Although currently housed, Roxanne has a long history of episodic homelessness beginning in childhood. As an adult without family, she is ineligible for most safety-net programs, so she is at risk for continued episodic homelessness.

A later vignette shows how her counselor helps ready her for services to reduce risk of homelessness, address pervasive trauma symptoms that interfere with life functioning, and maintain commitment to mental health and substance abuse treatment and recovery.

How Do Communities Respond to Homelessness?

Homelessness is a broad social problem and communities have established a range of strategies to manage it. On one hand, faced with demands from business owners and other citizens, some public officials have turned to criminal justice solutions to respond to street homelessness. Legal measures include prohibition of sleeping, camping, begging or panhandling, and storing personal possessions in public areas. Other trends restrict serving food to the poor and homeless in public places. Such measures can impede provision of services and create additional barriers to recovery (such as criminal records), which can delay access to housing and decrease eligibility for employment.

On the other hand, a growing number of States and communities are adopting progressive initiatives, including the development of drug, mental health, and homelessness courts, which divert people who are homeless from incarceration; mobile crisis teams working in tandem with police trained to respond to people who are homeless; programs to bridge reentry into the community for people exiting the criminal justice system; and specialized community services, such as crisis intervention beds, sobering stations, and homelessness assistance centers. As of August 2007, more than 300 communities had formal plans to end chronic homelessness (see the U.S.

Interagency Council on Homelessness [USICH] Web site at http://www.usich.gov) and were offering a wide range of treatment and housing services to meet this goal.

A particularly progressive initiative is the provision of permanent and transitional supportive housing, which offers stable, safe, affordable, long-term housing for individuals and families who would otherwise be homeless. Permanent supportive housing provides long-term housing and supportive services to people with physical disabilities, mental illness, or other long-term impairments (such as developmental disabilities) that limit the individual's ability to maintain housing without assistance. Transitional supportive housing provides stable housing along with social and health services but is more often used with individuals and families in crisis or transition.

PSH helps eligible people find a permanent home and obtain needed mental health and substance abuse treatment services. An important component of PSH is that housing is not contingent on whether an individual obtains mental health, substance abuse, or other services, but rather, allows the individual to decide when and how to seek out services. PSH supports individuals in choosing their own living arrangements and helps them access services based on the support they need at any given time.

An example of a candidate for transitional housing is an individual leaving addiction treatment who has no place to live, needs a sober environment to support recovery, and can be expected to regain employment in the near future. Transitional housing is normally limited to 2 years. Some of the social and health services frequently offered in supportive housing include mental health and substance abuse treatment, employment services, job training, life skills training, interpersonal skills development, medical case management, and coping skills training. Transitional and permanent supportive housing can range from a rooming house with individuals having their own rooms to clusters of small apartments in a single location to scattered-site programs in which rent subsidies are provided for individuals and families to have a home in the greater community.

A major support for persons in need is SAMHSA's Projects for Assistance in Transition from Homelessness (PATH)program. Administered by the Center for Mental Health Services (CMHS), PATH is part of a formula grant to States and provides minimal housing assistance for individuals. PATH funds help individuals with SMI and co-occurring mental and substance use disorders access needed services. PATH provides technical support and funding for outreach, screening and diagnostic treatments, community mental health services, alcohol and drug treatment, staff training, case management, health referrals, job training, and educational and housing services.

There are approximately 600 local PATH organizations that work to engage behavioral health service agencies and housing programs. Nearly all States use money from PATH formula grants to contact and engage people who are disconnected from mainstream resources. This includes collaboration with the Social Security Administration to support access to Social Security Income benefits among homeless populations with mental illness, as well as collaborative planning efforts with local continua of care to coordinate homelessness services and to end homelessness. According tothe PATH Web site (http://pathprogram.samhsa.gov/), PATH providers work with service delivery systems and use effective practices by:

- Partnering with Housing First and permanent supportive housing programs.
- Providing flexible consumer-directed and recovery-oriented services.
- Improving access to Social Security and other benefits.
- Employing consumers or supporting consumer-run programs.
- Partnering with medical providers, including Health Care for the Homeless and community health centers, to integrate mental health and medical services.
- Improving access to employment.
- Using technology, such as handheld electronic devices, electronic records, and Homeless Management Information Systems (SAMHSA, n.d.; USICH, 2011).

Vignette 7—Sammy later in this TIP—illustrates how PATH can be of assistance for clients with SMI who are homeless. For more information about PATH, related resources, and a list of PATH grantees, visit the PATH Web site (http://pathprogram.samhsa.gov).

Chapter 4: Homelessness and Behavioral Health Services

Behavioral health problems are common among people who are homeless, and the risk of chronic homelessness increases when substance use or mental problems are present. Substantial progress toward recovery and self-sufficiency may require significant engagement efforts and repeated attempts at treatment and housing rehabilitation. In addition, relapse during substance abuse treatment may create barriers to a variety of services, including transitional and permanent supportive housing (Kertesz et al., 2007). Furthermore, clients who relapse and exhibit symptoms of their mental disorder (e.g., a person with bipolar illness who relapses into a manic episode) may find their opportunities for housing restricted. People who are homeless or at risk for homelessness and have a substance use or mental disorder are often cut off from social supports and need services

ranging from safe and stable housing, food, and financial assistance to medical care, mental health treatment, child care, education, skills development and other preventive services, employment, screening and early intervention, and recovery support. It is important that you, as a behavioral health service provider, participate in a system of care that responds specifically to your clients' wide-ranging needs. Comprehensive recovery efforts must include not only housing, but also supportive mental health, substance abuse, medical, occupational, and social services.

A. The Special Rewards of Working with People Who Are Homeless

Gillis, D. (January 27, 2018). *Team work makes the dream work.* [digital image]. Retrieved from https://unsplash.com/photos/KdeqA3aTnBY/info

As a behavioral health service provider, working with individuals who are homeless may mean entering a world you have previously seen only from a distance. It is common to have concerns and anxieties when first beginning to work with people who are homeless. In providing services for this population, you will likely face some complex and challenging problems. At the same time, however, your work with people who are homeless can be quite rewarding; their gains can be dramatic as they move through their personal recovery processes.

For many, working with clients who experience homelessness provides the opportunity to look inside a world that may be very different from their own and to learn life histories that depart substantially from those of most people they know. Living on the streets requires substantial skill, strength, and resourcefulness. People who are homeless have lessons to teach about being survivors in difficult and often hostile environments.

Perhaps surprisingly, some people who are homeless are de facto experts on the service systems in their communities. These individuals have valuable firsthand information about where to go (and not go) to seek food, shelter, medical services, and other resources. You can gather valuable information about community resources from these people.

In working with this population, you have the opportunity to make a real difference for some of your community's most vulnerable and disenfranchised citizens:

- *With your help, a person's immediate risk of harm can be substantially reduced.* Assisting
- Behavioral Health Services for People Who Are Homeless
- your clients in obtaining even temporary housing will substantially reduce their risk of victimization, morbidity or mortality from exposure, and exacerbation of mental illness. For clients with existing health problems, temporary housing can mean the opportunity to obtain needed medical care.
- *You can help people realize elusive lifelong goals.* For many persons who are homeless, life in stable housing may feel like a distant or unattainable dream. But this transition can be made, and you can be one of the change agents that makes it happen. See Vignette 1 in (Juan).
- *You can help people transform their lives.* The difference between being homeless and being housed affects almost all aspects of a person's life, including increasing the likelihood of advancing personal recovery from mental illness and substance abuse, as is the case with René in Vignette 5 in the next chapter, and reducing the risk of future substance abuse and mental disorders, especially for children who are homeless (see Troy and Mikki in Vignettes and 6, , , of this TIP).
- *You will come to understand, firsthand, one of our Nation's pressing social problems.* The Francise's, Roxanne's, and Mikki's of your community are not able to work for change, at least not until they are further along in recovery. Working with them and actively helping them navigate and benefit from a layered service system is rewarding work. Moreover, through your experiences and your understanding of their world, you can help improve the behavioral health system that reduces homelessness and the hardships faced by people who are homeless.

B. Counselor Competencies for Working with People Who Are Homeless

The knowledge, skills, and attitudes for working effectively with people who are homeless in all phases of rehabilitation are presented in this section (see also the Center for Substance Abuse Treatment's [CSAT's] Technical Assistance Publication 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* [CSAT, 2006a] for more information on counselor competencies).Some specific

knowledge, skills, and attitudes helpful for your work with clients with a substance use disorder and/or mental illness and facing or experiencing homelessness are listed below. All of the discussion below presumes that you, as a behavioral health service provider, possess sufficient knowledge and skills and appropriate attitudes for working with people with mental illness and/or substance use disorders. Some competencies will be more relevant to either treatment or prevention workers. However, anyone who provides behavioral health services needs at least a basic level of competence in each area discussed in this section to ensure the delivery of *integrated* care and services to the whole person.

Knowledge

To provide effective services to people who are homeless or at risk of becoming so, behavioral health workers should possess knowledge of:

- Homelessness: its impact on people and families, how it acts as a barrier to services for other problems, such as substance abuse and mental illness, and how, without intervention, it can become self-perpetuating.
- How substance abuse, mental illness, and homelessness interact to limit clients' opportunities for growth and change.
- Medical comorbidity in homeless populations and how to help people address physical wellness.
- The pervasiveness of physical and sexual trauma within homeless populations and the effects of trauma in limiting opportunities for recovery from mental illness and substance abuse.
- The effects of experiences of incarceration among clients who are homeless.
- •Local homelessness assistance services and available community resources and how to help clients with a mental illness or a substance use disorder access them.
- The process of recovery from substance abuse, mental illness, and homelessness, including appropriate interventions at different stages in recovery.
- The interaction of co-occurring substance use and mental disorders and homelessness.
- Prevention and treatment methods that have been shown to be effective or promising with people with substance abuse and/or mental illness who are homeless.

- The fact that having a substance use disorder or mental illness can itself affect the process of relationship development and trust in others.
- Types of housing services that might be useful and how to access these services.

Skills

Using the following skills will allow behavioral health service providers to work more successfully with clients who are experiencing homelessness or the threat of it:

- Use techniques for creating trusting, collaborative relationships with members of a population that experiences high rates of social disaffiliation; for identifying client strengths; and for helping clients empower themselves to initiate and sustain stable housing and recovery
- Demonstrate specific outreach skills for people who are homeless, particularly those who are chronically homeless and have a substance use and/or mental disorder
- Conduct an initial screening and needs assessment for clients who present with a substance use and/or mental disorder and are homeless or are facing homelessness
- Recognize the effects of psychological trauma on trust, willingness to persevere and accept help from others, and a variety of other personal and interpersonal dynamics that are important in treatment and recovery
- Support clients' early changes (e.g., entering treatment, recognizing/addressing mental and substance use disorders, finding temporary housing, obtaining needed medical care, getting financial support)
- Develop person-centered treatment and/or prevention plans that consider the whole person and his/her individual needs, including early intervention for emerging mental and substance abuse problems, mental illness and substance abuse treatment and rehabilitation, and programming to build resiliency and enhance quality of life by developing social and occupational skills
- Use case management skills in helping people make contact with and continue accessing needed community resources, including prevention programs
- Retain clients in treatment and prevention programs by maintaining rapport, motivation, and hope and by helping them work through the obstacles they face in recovery.
- Develop realistic, individualized relapse prevention and recovery management plans that include specific "how-to" steps to follow if the client experiences a recurrence of behavioral health symptoms, homelessness, or other life problems.

Collaborate with other service providers, family members, and social supports to:

- Help people who are homeless access services.
- Better understand needs and strengths.
- Ensure appropriate care and smooth transitions.

Attitudes

- Behavioral health workers engaged in providing services to clients who are dealing with homelessness can benefit from certain attitudes. For example:
- Accept and understand powerful emotional responses to client behavior and address these responses in supervision.
- As a precondition to a positive working relationship, meet clients where they *are* rather than where they *should be.*
- Appreciate that people must assume responsibility for their own recovery trajectories, although they sometimes make choices that do not appear to be in their own best interests.
- Trust that change begins with small steps that are self-reinforcing and aggregate to larger changes.
- Understand that all change is incremental and that many clients who are experiencing homelessness are on a long recovery pathway.
- Recognize that consistency and reliability can counteract the disaffiliation and mistrust experienced by many persons who are homeless and have substance use or mental disorders.
- Appreciate that work with people who are homeless and in need of treatment requires collaboration and cooperation among a range of service professionals and peer supports.

Self-Assessment of Attitudes Toward People Who Are Homeless

Attitudes toward homelessness, substance abuse, and mental illness vary widely. Many of these beliefs originate in childhood and influence your perception of these problems. These perceptions, whether beneficial or limiting, tend to be reinforced as you encounter people dealing with substance use or mental disorders and homelessness. It is important for you to be particularly aware of your attitudes and beliefs regarding these topics. Likewise, it is important to remember that not everyone holds your particular views or attitudes.

Behavioral health service providers work with people who are homeless and have a substance abuse or mental health diagnosis in many different settings: street outreach, mobile crisis teams, drop-in centers, shelters, assertive community treatment (ACT) teams (see p. 143), permanent supportive housing programs, criminal justice environments, healthcare facilities, and other community behavioral health prevention and treatment programs. This work presents many challenges along with opportunities for professional growth. One of the important challenges is to monitor and be aware of your personal attitudes and beliefs about your clients. This section presents:

- Opportunities to consider your reactions to and assumptions about people who are homeless
- Myths people often believe about people experiencing homelessness
- Methods for managing responses when working with this population.

Reactions and assumptions about people who are homeless

Three people with mental or substance use disorders who are homeless were described earlier in this chapter. Your reactions, assumptions, and beliefs influence how you might interact with each one. After reading their descriptions, some of the reactions you might experience as you imagine a conversation with Mikki, Roxanne, or Francis include:

- Empathy (I have an emotional understanding of what it's like to be in his or her shoes).
- Sympathy (I feel sorry for him or her).
- Fault finding (Why doesn't he or she… like everyone else?).
- Curiosity (I wonder what his or her story is?).
- Aversion (I don't want to meet him or her).
- Fear (This person may hurt me in some way). Your personal experiences and history play an important role in how you perceive and work with people who are homeless and have substance use or mental disorders. Ask yourself the following
- What is my personal and family experience with substance abuse, trauma, mental illness, and homelessness?
- What personal experiences do I have with these problems, and how do those personal experiences—for better or worse—affect my work
- What is my emotional reaction to people who have a mental or substance use disorder and are homeless?

- How comfortable do I feel providing services to people with these problems, and what are the areas of discomfort that I experience
- What did I learn about homelessness, substance use, and mental illness growing up?
- What beliefs and attitudes do I hold today that might challenge or limit my work with persons who are homeless and have a substance use or mental disorder?

Myths and realities about people who are homeless

When providers have insufficient information about social and health problems, myths may arise about the nature of the problems, the kinds of people who are likely to be affected by them, and how the problems are best addressed. Homelessness, and the relationship between homelessness and behavioral health problems, are not exceptions. Care providers are not exempt from the myths that universally abound. Your awareness and management of attitudes and beliefs that may interfere with your work will result in personal growth and better relationships with clients. Following are some common myths about people who are homeless.

Myth #1. People choose to be homeless.
Reality: Most people who are homeless want what most people want: to support themselves, have jobs, have attractive and safe housing, be healthy, and help their children do well in school.

Myth #2. Housing is a reward for abstinence and medication compliance, and society shouldn't house people who have active substance use or mental disorders.
Reality: Housing may be the first step to becoming abstinent and/or entering treatment to address a variety of problems. From a public health perspective, adequate housing reduces victimization, hypothermia or hyperthermia, infectious diseases, and other risks to the population as a whole.

Myth #3. People who are homeless are unemployed.
Reality: Many people who are homeless are employed full or part time. According to data from the National Survey of Homeless Assistance Providers and Clients (Burt et al., 1999),44 percent of people who were homeless.

C. The Impact of Homelessness on Children and Families

Homelessness results in a loss of community, routines, possessions, privacy, and security. Children, mothers, and families who live in shelters must make significant adjustments to shelter living and are faced with other problems, such as feeling ashamed of being homeless and accepting help, the anger and confusion of being relocated, and having to adjust to a new school and other new routines.

The stress related to these risks adds to the stress resulting from homelessness itself and can impede recovery due to ongoing traumatic reminders and challenges:

- The experience of homelessness puts families at greater risk of additional traumatic experiences, such a s assault, witnessing violence, or abrupt separation.
- Children, parents, and families are stressed not only by the nature of shelter living and the need to reestablish a home, but also by interpersonal difficulties, mental and physical problems, and child-related difficulties such as illness.
- The stresses associated with homelessness can worsen other trauma-related difficulties and interfere with recovery due to ongoing traumatic reminders and challenges.

Children are especially affected by homelessness:

- Children who are homeless are sick twice as often as other children and suffer twice as many ear infections, four times the rate of asthma, and five times more diarrhea and stomach problems.
- Children who are homeless go hungry twice as often as children who have homes.
- More than one fifth of preschoolers who are homeless have emotional problems serious enough to require professional care; less than a third receive any treatment.
- Children who are homeless are twice as likely to repeat a grade as those with homes.
- Children who are homeless have twice the rate of learning disabilities and three times the rate of emotional and behavioral problems compared with children who are not homeless.
- Half of school-age children who are homeless experience anxiety, depression, or withdrawal compared with 18 percent of children who are not homeless.
- A third of children over age 8 who are homeless have a major mental disorder.

These are not only challenges in themselves, but also may act as “secondary adversities,” putting a child at greater risk for trauma reactions and making recovery difficult. For more

information and a list of resources about providing care and improving access to services for children and families who have been traumatized and/or are homeless, visit the National Child Traumatic Stress Network Web site (http://www.NCTSNet.org).

Source: Bassuk & Friedman, 2005. Behavioral Health Services for People Who Are Homeless received services did some work for pay in the month before being surveyed. A single-day count of people who were homeless in an urban area of Washington State found that 20 percent were employed at least part time (Putnam, Shamseldin, Rumpf, Wertheimer, &Rio, 2007).

Myth #4. There are few homeless families.
Reality: To describe the full impact of homelessness, episodes of homelessness, and the effects on children of tenuous living situations (such as the “doubling up” of one family in the home of another family), the National Center on Family Homelessness (NCFH) used refined methods for estimating the number of children exposed to these burdensome and stressful difficulties. NCFH determined that in 2010, 1.6 million children in America were exposed over the course of the year and 200,000 on any given night (NCFH, 2010).

Myth #5. People who are homeless aren’t smart enough to make it.
Reality: Keeping things together while homeless takes ingenuity and experience. People who are homeless often have well-developed street skills, resourcefulness, and knowledge of the service system.

Myth #6. Those with substance use or mental disorders need to “bottom out,” so homelessness is okay and provides a motivator to make behavioral changes.
Reality: People who have substance use and mental disorders are more responsive to interventions before they become homeless or when placed in housing.

Myth #7. Everyone stands an equal risk of homelessness.
Reality: Although any of us could find ourselves homeless in our lifetime, some people are at higher risk than others. If we can identify people at special risk of homelessness, we may be able to intervene earlier and prevent the devastating effects experienced by people who are homeless and have accompanying mental and/or substance use disorders.

Myth #8. All clients with substance use and mental disorders who are homeless require extensive, long-term care.

Reality: The process of recovery from substance abuse and mental illness is an ongoing and sometimes lifelong process, yet healing often begins with short-term, strategic interventions. **Screening, brief intervention, and referral to treatment (SBIRT; see the section on p. 35 for more information) is a proven method for early intervention with substance use and mental disorders, and it can significantly reduce the impact and progression of illness.**

Self-Care for the Behavioral Health Service Worker

The intensity of the work with people who are homeless and have mental and/or substance use disorders can lead to burnout, ethical dilemmas, and a sense of being overwhelmed by your work. Your personal history is unique; however, commonalities of experience inworking with people who are homeless allow some generalizations about the need for self-care. Some of the actions you can take are consistent across a variety of roles, personalities, and circumstances.

Common responses to working with people who are homeless

Working with people who are homeless may entail addressing emergency situations, complex case management demands, severe and persistent symptoms, and refusal of services. The pace of the work may be a stressor, as some people who are homeless are reluctant to engage in services and require a lot of time and patience to develop trusting relationships. You may experience stress or unrealistic expectations when working with this population. Other common reactions include:

- Considerable anxiety regarding clients in dangerous situations (e.g., refusing shelter on frigid nights).
- A strong desire to repeatedly try to persuade someone to go to treatment because you are concerned about his or her pace in recovery.
- Frustration and strong urges to use involuntary measures (e.g., police transport to the hospital) despite no clear risk of imminent danger to self/others when a severely impaired person is slow to engage.
- Conflict over family members' reactions, given their experience (e.g., burnt bridges, extreme feelings of guilt) with an individual's past behavior.

- Feeling overwhelmed or frightened by your client's irritability, anger, and frustration. An example of deescalating a person in the midst of an intense emotional reaction is given in Vignette 3 (Roxanne, Part 1,).
- Thinking about violating ethical boundaries or agency policies to meet the immediate needs of a person who is homeless (e.g., give them personal funds). Feelings of helplessness or a sense of guilt about a person's situation may add to the temptation to violate boundaries and policies.
- A struggle to understand and appreciate the survival skills of a person who is homeless, particularly when his or her choices and behaviors (e.g., distrust, agitation) create barriers to receiving services.
- Guilt about going home at night while a client is sleeping on the street.
- Anger or frustration about missed appointments, which indicate resistance to engaging with services.
- Reluctance to continue providing services to someone whose priorities conflict with your ideas about their needs (priority to find drugs rather than adequate housing, resistance to obtaining medical care for an immediate problem).
- Frustration and feelings of ineffectiveness when your efforts to help seem to be unappreciated.
- A sense of disconnection from clients who seem demanding, needy, miserable, or overwhelmed.
- Your own experiences also play a role in your responses to people who are homeless, and these experiences may interfere with your work, particularly if:
- A member of your family has a substance use or mental disorder and/or has experienced homelessness.
- You have trouble differentiating your own recovery process from that of your client.
- You have ever been homeless or faced with the prospect of being homeless.
- You see yourself as someone who has overcome the odds and pulled yourself up "by the bootstraps."
- It is difficult for you to work with people who are overtly angry, excessively passive, or insistent about doing things their way.
- The experience of working with people who are homeless is new to you.

Whether or not you have had these types of personal experiences, you may struggle with your reactions when working with this population, especially when dealing with stressful situations.

Managing responses to working with people who are homeless

Managing your responses to feelings and stressors is easier if you develop and maintain sources of personal support (CSAT, 2006a):

- **Learn to recognize when you need help (both technical and personal); ask for it.**
- Work in teams and establish networks; discuss feelings and issues with teammates to lower stress and maintain objectivity.
- Be open and sensitive to differences of attitude or opinion among your colleagues regarding individuals who are homeless and the problems they face.
- When you find yourself being angry, critical, or dismissive toward the feelings or needs of a person who is homeless, consider whether this is a sign of an attitude conflict, job burnout, or some other dynamic related to your work.
- Work closely with your supervisor and be open about any difficulties (for more information about the benefits and process of clinical supervision, refer to TIP 52 *Clinical Supervision and Professional Development of the Substance Abuse Counselor* [CSAT, 2009b]).

Managing feelings and stressors is easier if you maintain healthy boundaries between your work and personal life:

- **Resist the urge to bring work home.**
- Don’t spend your free time at work or with your clients.
- Resist the urge to be a friend or feel responsible for rescuing the people you serve from homelessness.
- Recognize that your role is to help people help themselves and enable them to address their life problems, not to take responsibility for their problems.

D. Stages of Change, Recovery, and Rehabilitation

This section presents several frameworks for helping people who are homeless by describing three important aspects of a trajectory out of homelessness:

- **Stages of change (Prochaska, DiClemente, & Norcross, 1992). This transtheoretical model describes the process of behavioral change, beginning with precontemplation and continuing through maintenance. It is**

often used to reflect the process of change for people with substance use disorders.

- **Critical stages of recovery (Townsend, Boyd, Griffin, & Hicks, 2000). The critical stages of recovery model, often applied to describe the change process with serious mental illness, emphasizes social and interpersonal connectedness and the relationship of the individual with systems that provide care. The model describes movement through four levels, from dependence through interdependence.**
- **Stages of homelessness rehabilitation (McQuistion & Gillig, 2006). This model describes the logical progression of rehabilitation—a process of moving from engagement though intensive care and into ongoing rehabilitation. It describes the consequences of homelessness in a holistic manner, recognizing that homelessness is not only the lack of adequate housing but also the psychological, emotional, occupational, interpersonal, health, and other effects on an individual's or family's ability to function.**

Stages of Change

White, B. (January 21, 2017). *Tough Times.* [digital image]. Retrieved from https://unsplash.com/photos/e92L8PwcHD4/info

Stages of change, which comprise the key organizing construct of the transtheoretical model of change, inform effective interventions to promote behavior change. Although they have traditionally been associated with substance misuse, they may also be applied to a person's experience in coming to grips with serious mental illness. The stages of change are equally applicable to prevention or treatment interventions, although in prevention, behavior change may involve risk or protective factors (e.g., parenting skills, physical inactivity) rather than problem behavior per se.

Most people cycle through the stages more than once, and movement through the stages can fluctuate back and forth (Exhibit 1-3). The stages are:

- Precontemplation—Clients view behavior (e.g., substance use, psychological symptoms, healthcare choices) as unproblematic and do not intend to change.
- Contemplation—Clients think about whether to change behavior, become aware of problems their behavior causes, and experience ambivalence about their behavior.
- Preparation—Clients decide to make a change and have perhaps already begun to change problematic behavior.
- Action—Clients make a clear commitment to change; they engage in activities as alternatives to problem behaviors, avoid high-risk situations, and develop relationships that reward their changed behavior.
- Maintenance—Clients have sustained new behaviors for at least 6 months. They sustain and further incorporate changes achieved in the action stage and are actively working on supporting their recovery.

Two other stages of the transtheoretical model are sometimes identified: relapse and termination. Relapse is a return to problem behaviors. Most relapses to substance use occur within 3 months of behavior change; risk of relapse then begins to decline (Connors, Donovan, &DiClemente, 2001). Termination occurs when new behaviors are thoroughly stabilized and there is a compelling belief that a return to the problem behavior is highly unlikely (see TIP35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT, 1999b] for an in-depth discussion of stages of change).

Regardless of the model for understanding change, it is important to remember that people are often in different stages of change for different issues. For example, a person may be willing to accept housing or medical care (preparation stage of the transtheoretical model) while not yet thinking about substance abuse or mental health treatment or broadening coping skills or community involvement (precontemplation stage). The provider's challenge is to understand and respect the service recipient's stage of readiness and provide interventions and services that facilitate forward movement. Skilled providers recognize that readiness to change some behaviors might provide an opportunity to explore ambivalence and enhance readiness to change others; for example, persons may be willing to seek housing but not immediately address substance use behavior. When they do recognize that housing issues are intertwined with substance use, they may be more willing to explore the pros and cons of their use.

As people move toward the action stages in any model, they become ready for more intense services, which often require more active collaboration with clients and may be

offered in more structured housing and treatment or prevention programs where individual responsibility for completion of tasks and behavior change yields successful outcomes.

Critical Stages of Recovery

Whereas the stages of change model address psychological readiness for behavioral change, the stages of recovery model addresses developmental goals that are more closely related to mental health recovery, the degree and nature of social connectedness, and the relationship between an individual and the service delivery system. As clients engage in their recovery process, they begin in a state marked by high dependence on the human services system and other community supports but are paradoxically unaware of that dependence. As they gain greater mastery over their recovery, they may remain dependent on support from others, yet become *aware* of that dependence. Following this is a stage of awareness and relative *independence* from these structures, and finally, a stage characterized by a sense of *interdependence,* in which they are aware of challenges and can use natural support systems, both formal and informal, realizing that they are also actively contributing to the social environment. (Townsend et al., 2000.)

The stages of recovery model recognize the right of people to live in the community and to choose their lifestyle. It is premised on a number of additional guiding principles. Perhaps most important is that a client directs and manages his or her recovery process. A corollary of that is that behavioral health service providers need to be wary of their tendency to encourage clients to be dependent on the treatment system (Townsend et al., 2000). As part of a community system of care, the behavioral health service provider has an important role in each of these stages to promote recovery (Exhibit 1-4).

Processes in recovery from substance use and mental disorders

In recovery, people actively manage substance use and/or mental disorders and seek to transcend these experiences as they build or reclaim meaningful lives in the community (Davidson Exhibit 1-4: Behavioral Health Service Provider Roles and Best Practices According to Stage of Recovery Stage)

Service Provider's Role
Best Practices to Facilitate Recovery
Dependent/Unaware

- Demonstrate hope
- Encourage self-acceptance
- Educate about behavioral health problems and the benefits of a recovery plan
- Engage family and other social supports
- Build relationship by listening, valuing, and accepting client as a worthwhile person
- Collaborate with client in managing behavioral health problems
- Build rapport with family/others

Link to services and benefits
Dependent/Aware

- Promote readiness to make choices about life roles/goals
- Educate family about available choices
- Offer support in designing a recovery plan
- Involve client with groups that address his or her specific needs
- Educate about behavioral health problems and relevant coping skills

Help with choosing goals
Independent/Aware

- Help develop life roles/goals
- Encourage individual coping strategies to deal with symptoms and distressing experiences
- Support medication management and use of recovery plan
- Encourage appropriate support from families and others
- Assist with connection to community resources

Work on recovery plan, recovery support, coping skills, and crisis plan
Interdependent/ Aware

- Work with client and support system to support life goals
- Help with community resources
- Review recovery plan regularly
- Support interdependence in community
- Support continuing recovery
- Advocate use of community resources
- Encourage involvement in community activities

The term “recovery” may have somewhat different meanings in substance abuse treatment settings than it does in mental health settings. For instance, many clients in substance abuse recovery may say they are never fully recovered from their illness and are “only one drink away from a drunk,” whereas individuals with a single major depressive episode in their history may consider themselves recovered, even “cured” of their illness. In either case, it is important to know how each individual client understands these terms and how they apply to the recovery process for the specific individual.

Considering the broader framework of recovery—integrating the recovery process from substance use disorders with that of mental disorders—Davidson et al. (2008) obtained information from people in recovery about their experiences. For most of the respondents, recovery meant taking an active role, profoundly changing the way they lived their lives, opening up to new learning, and becoming more flexible. The processes the authors describe are presented in Exhibit 1-5. The authors recognize that recovery is not linear, but they believe that processes represented together on a single line in the exhibit occur more or less simultaneously. This progression also suggests that some recovery strategies may be more useful at some points in the process than others. For example, early in recovery, a behavioral health service provider might want to focus on strengthening mutual support systems and fostering a belief in recovery.

These processes are also valid for clients entering homelessness services from the criminal justice system. Developed in partnership with people in recovery, these processes reflect challenges people face in recovery and solutions for them. Your role and that of the program administrator is to help articulate and then support clients’ efforts in recovery by helping them identify acceptable strategies and resources to confront these challenges.

Prevention activities can play a central role in recovery, especially those that relate to skills.
Exhibit 1-5: Substance Use and Mental Disorder Recovery Processes

Source: Davidson et al., 2008. Initiating recovery and assuming control Creating and maintaining mutual relationships Renewing hope, confidence, and commitment Understanding, accepting, and redefining self. Becoming an empowered citizen Assuming control Overcoming stigma and promoting positive views of recovery Incorporating illness and maintaining recovery (including managing symptoms & triggers) Community involvement and finding a niche, *development* and wellness self-

management. In addition, prevention programs can adopt and benefit from a recovery orientation when working with individuals who are homeless.

The process, dynamics, and important interventions related to recovery are addressed in detail in the planned TIPs, *Building Health, Wellness, and Quality of Life for Sustained Recovery* (SAMHSA, planned b) and *Recovery in Behavioral Health Services* (SAMHSA, planned e). Refer to these TIPs for more information on supporting long-term recovery.

Stages of Homelessness Rehabilitation

Collamer, M. (February 12, 2018). *"What matters is what it means to you."* [digital image]. Retrieved from https://unsplash.com/photos/8UG90AYPDW4/info

Stages of homelessness rehabilitation refer to the different types of care a client with behavioral health problems, and his or her family, may receive while moving toward housing stability. Your work may involve clients at any of these stages. For individuals who are homeless, attaining housing and financial stability are inextricably tied to other aspects of social support and to rehabilitation from disabling behavioral health conditions. Depending on the services an individual who is homeless needs, stagewise interventions may emphasize outreach and case management, screening and evaluation, crisis intervention, clinical preventive services, preparation for treatment, treatment planning, relapse prevention or recovery promotion, or ongoing counseling.

Your existing skills in providing treatment and prevention services in behavioral health settings will be invaluable and can often translate directly into working with people with mental and/or substance use disorders who are homeless. Nevertheless, you may need to develop some specific skills for work in this area. It will be necessary to coordinate your services with those provided by staff in other homelessness programs and health and social service organizations. Your services and the services provided by other health and social service organizations are often delivered across stages, with service transition

points being particularly high-risk periods for dropout. The stages of homelessness rehabilitation are:

- Outreach and engagement.
- Transition to intensive care.
- Intensive care.
- Transition to ongoing rehabilitation.
- Ongoing rehabilitation.

The amount of time a person spends in any of the stages of homelessness rehabilitation depends on barriers to providing and accepting services—such as availability of appropriate housing options, severity and chronicity of substance use disorders and symptoms of mental illness, and availability and acceptability of social supports for changing problematic behaviors. Progress through the stages of rehabilitation is not steady. Clients may dropout, relapse in their substance use, and need outreach and reengagement several times before achieving ongoing homelessness rehabilitation. For this reason, this TIP assumes that motivation for changing problematic behaviors will fluctuate, that behavioral health symptoms may recur, and that a client may return to homelessness during any phase of rehabilitation.

Outreach and engagement

Engagement is the first stage of work with people who are homeless (McQuistion, Felix, & Samuels, 2008). Its goal is to facilitate the individual's movement through the early stages of behavior change (Prochaska et al., 1992). Approaches during this phase include active outreach to prospective clients and engagement services—including capturing prospective clients' interest in a variety of homelessness services, as well as substance abuse, medical, mental health, and social services; gaining the prospective client's trust; and increasing motivation for change. For families who are homeless, the prospect of preventive services for children may be especially attractive. During this process, you should identify and attempt to meet basic needs for shelter and safety, and you should attend to immediate health concerns.

For some persons who are homeless or at risk for becoming so—those coming from criminal justice settings or those being discharged from treatment programs—outreach may not be a particularly difficult issue, but engagement in social, health, and continuing prevention and recovery services may present more of a problem. Persons with

transitional homelessness may not perceive the need for additional services beyond lodging, seeing their stay in a shelter or other homeless housing program unrealistically as a temporary transition to getting a place of their own. Additionally, clients recently in treatment for mental and substance use disorders may not recognize the effect of their impending homelessness on substance abuse and mental health recovery and across all other aspects of their lives.

As a behavioral health worker, you can play an important role in outreach by acknowledging homelessness as a significant element in when and how people can access treatment, by recognizing the needs of people who are homeless for preventive and basic services, and by developing productive, trusting, and supportive relationships with people who are homeless and come to you for services.

Transition to intensive care

People enter the intensive care phase of homelessness rehabilitation when they agree to accept health and/or financial benefits; medical, substance abuse, and/or mental illness treatment and prevention services; and, frequently, housing. This transitional phase is a high-risk period during which a large percentage of individuals drop out of services. The transitional phase requires intensive support (e.g., intensive case management, critical time intervention) and your acceptance that some people may have increased ambivalence and may not attend program sessions or keep appointments or commitments. Essential elements in this phase include locating clients or program participants when they fail to make contact, making phone calls, and providing immediate tangible benefits (e.g., food, safe shelter, bus fare).

Accordingly, you may have to adapt traditional assumptions about and approaches to service provision when a client is in the transitional phase of homelessness rehabilitation (e.g., assuming clients will make and keep appointments; assuming program participants will attend sessions; assuming individuals have transportation to service settings; having standard time lengths for counseling, psychoeducational, or anticipatory guidance sessions). You may need to exercise greater persistence and advocacy with these individuals. On the other hand, the skills you regularly use, such as maintaining a trusting and supportive relationship, working with resistance, or adapting to specific needs or concerns can be a significant benefit in working with individuals in this stage who are homeless.

Intensive care

As its name denotes, the primary focus of intensive care is a comprehensive but carefully synchronized orchestration of homelessness rehabilitation, including treatment for mental and substance use disorders, access to benefits, active attention to medical problems, housing access, and preventive services, such as assessment of and training in necessary skills (e.g., money management, parenting, employment, and other life skills). Cattan and Tilford(2006) suggest that for younger people who are homeless, including young adults, mental health promotion activities that help create a sense of community and empowerment may be particularly important. Thus, prevention activities at this stage may include encouraging participation in positive community activities (e.g., sports and the arts) and community service.

Intensive care is implemented in a manner that emphasizes clients' participation in defining and managing their own goals. People in intensive care may drop out or return to homelessness and need to be reengaged several times. In some cases, people verbalize this choice; in others, it is evidenced by angry outbursts, disappearance from services, rule violations, or other behaviors. Appropriate responses include respecting personal choices, attempting to reengage, welcoming the person back, and revising treatment and prevention plans when he or she returns. Some people in this phase will accept higher intensity transitional housing models combined with behavioral health services as well as social and medical services. Others will only accept options that provide housing and voluntary participation in supportive services.

It is important in the intensive care phase of homelessness rehabilitation to ensure that people maintain the gains they have made through previous substance abuse and mental health services. Maintaining momentum for recovery and relapse prevention, continued use of new skills, and involvement in community activities can be essential at this point. Staying in touch with mental health, substance abuse, and other resources in the community is critical, even given transportation problems, employment considerations, multiple pressing needs, and financial constraints.

This phase requires behavioral health services that are integrated with other ongoing housing, healthcare, legal, and social services. Close collaboration among all providers is a priority. The case management skills that treatment, professionals use are highly applicable to serving these clients.

Transition from intensive care to ongoing rehabilitation

Before individuals move into the ongoing homelessness rehabilitation phase (when they are preparing for optimal social reintegration), it is important to ensure that they have a comprehensive and evolving plan for sustaining the process of recovery, including acquisition of stable housing, gains made in social and other skills, and involvement in community activities. Successful plans also include a realistic long-term plan for relapse and homelessness prevention, development of strong connections to social supports (e.g., family, faith, and recovery communities), stable income and health benefits (e.g., job skills and employment, health insurance, Federal disability benefits, local government cash supports, veterans' benefits, food stamps), and meaningful daily activities that complement their recovery plans.

Making the transition from intensive care to the open-ended stage of ongoing rehabilitation takes time. Increased risk of dropout from services (including behavioral health services) because of increased ambivalence is common and can be addressed by providing increased case management services, staff attention, incentives to remain engaged (e.g., paid vocational services contingent on abstinence and positive work behaviors, transportation), and increased relapse prevention efforts.

Some people may attain such improved functioning, coping skills, social support, and financial resources that they can maintain independent, affordable housing with follow-up services to ensure their gains in recovery and other areas of functioning. Others may benefit from 1 to 2 years or more of a supportive recovery and housing environment (e.g., Oxford Houses) to develop better coping skills for maintaining recovery and improving social functioning. Still others need weekly contact with a case manager from a multidisciplinary, community-based team to address any threats to housing stability and recovery as they arise. Transportation issues that limit participation in ongoing rehabilitation activities must also be addressed prior to exiting this phase.

Behavioral health counseling and anticipatory collaborative problem-solving for clients in transition to ongoing rehabilitation are particularly important. Helping clients stabilize in recovery, engage and maintain attendance in self-help programs, develop a realistic individualized relapse prevention/recovery promotion program, and begin to develop a healthy lifestyle are also important at this point.

Ongoing rehabilitation

Ongoing rehabilitation is an open-ended phase in which people gradually establish an identity as no longer homeless (McQuistion etal., 2008). This stage includes an active and continuing supportive counseling relationship and continued participation in prevention programs as appropriate (e.g., regular follow-up meetings to address any problems related to housing stability and recovery). In this stage, clients have a contact person in case of a crisis or relapse.

You can play a significant role as the program participant begins to depend less on services and service providers for assistance. Your consistent, ongoing collaborative relationship with clients may be especially beneficial as their self-concept, expectations for the future, self-esteem, and ability to manage life's problems evolve. Your support for the person's continued attendance at 12-Step and other wellness self-management programs and involvement in new community activities is also helpful. You can be a role model for appropriate abstinent behavior and help people share with others what they have learned in their transition from homelessness to an interdependent relationship with their environments.

E. Clinical Interventions and Strategies for Serving People Who Are Homeless

Behavioral health service providers working with people who experience homelessness need special skills. Specific knowledge about homelessness and its effect on recovery and change is important, as is careful assessment and modification of attitudes that affect your work with this population. Understanding the cultural context of clients and having the skills to adapt to a variety of cultures of people who are homeless is very important. The skills you normally use in providing behavioral health services are applicable but may also need to be modified or honed to address the specific needs of people experiencing or facing homelessness.

It is beyond the scope of most behavioral health programs to meet many of the urgent needs of people who are homeless. Inevitably, this means that you—who may be the point of contact or "first door" for a person who is homeless or facing homelessness—must have a working knowledge of resources in the community for these people, not only

for housing services, but also for services that address physical health care, financial crises, criminal justice constraints, and dietary needs, among other concerns. Ideally, a behavioral health program will maintain reciprocal alliances with other community resources that allow for efficient case management of persons with complex needs.

Additionally, people who are homeless may have special mental health and substance abuse treatment needs, including special trauma-informed treatment services, specialized, care for co-occurring disorders, services to ensure medication management, and close medical supervision while undergoing detoxification.

If not already integrated into programming, treatment programs must include prevention programs in their alliances, because many of these programs are designed to meet high-priority needs of persons and families who are homeless (e.g., skills development, parenting education, expanding recreational opportunities, community involvement). Larger programs, especially treatment programs, may also have a designated case management staff member who coordinates referrals and ensures that clients follow through on referrals and that services are provided.

This TIP discusses seven activities common to many behavioral health service situations along with special adaptations that are useful in working with people who are homeless:

- Outreach
- Initial screening and evaluation
- Early interventions and stabilization
- Treatment and prevention planning
- Case management
- Client retention and maintenance of continuity of care
- Relapse prevention and recovery management

Some of these areas may be more applicable to some settings than others, but unless you work in a very specialized setting, all will probably be applicable to your current or future work.

Outreach

Outreach plays a crucial role in work with people who are experiencing homelessness. It means making contact with individuals on their terms—where they live—rather than in an agency setting. It involves developing sufficient trust to help people consider receiving

services and the benefits they might accrue from them. It may well mean developing rapport with people who, because of their experiences, have no expectation of a positive outcome.

Outreach is particularly relevant to the engagement stage of homelessness rehabilitation. It involves deliberately and methodically cultivating a relationship with the person or family who is homeless. Effective outreach skills include:

- Expressing appreciation for survival skills as strengths and coping mechanisms.
- Understanding substance abuse and/or psychological symptoms from the client's perspective and understanding how those symptoms are interrelated.
- Addressing financial and health benefits as well as food, healthcare, housing, and other immediate needs.
- Expressing optimism that together you can create a plan that meets the person's needs.
- Empowering the client to set goals and create a plan for recovery and growth.

You will probably find that outreach efforts with people experiencing homelessness are more aggressive and proactive than those you use in traditional mental health and substance abuse settings. You may find yourself meeting your clients literally where they are rather than waiting for them to come to you. While taking care to respect people's autonomy, you may be more assertive in engaging people into services. In treatment settings, you may be more assertive in establishing the therapeutic relationship. You may find yourself responding more actively to crises or becoming more involved than you would with most treatment clients or prevention program participants. In effect, the skills of outreach are generic, but how you apply those skills may be different from your traditional role.

Initial Screening and Evaluation

This activity will generally be different for treatment and prevention professionals. Within prevention settings, a first contact with a person who is homeless may differ little from your first contact with other program participants. However, you will wish to pay special attention to constraints on participation (transportation, child care, etc.) and assist participants who are homeless in addressing these issues. Within your zone of comfort,

you may also want to inquire as to other services that your program participant is receiving and suggest community resources where additional services may be accessed.

Within treatment settings, a first contact with a person who is homeless or facing homelessness will ordinarily involve initial observations and, potentially, decisions about care. For instance, although a prospective client may not be forthcoming with information, it may fall to you to evaluate whether the individual is in immediate danger with consequences to health or safety as a result of his or her life situation. You might be in the position of having to determine whether the client needs immediate care as a result of drug use or mental illness or to evaluate his or her ability to make decisions about care. Frequently, it will be necessary to determine which other team members or program staff persons might be helpful in determining urgent client needs (e.g., primary care provider, housing specialist, other mental health professional).

People who are homeless typically engage gradually with services as trust is established. As opposed to techniques in more traditional settings (whether focused on treatment or prevention), gathering information may take more time and be ongoing; new information may surface as the client stays connected. To understand the client's level of functioning and identify appropriate services, screening and evaluation should gather information about:

- Substance use and/or mental disorders, including:
    - Evidence of a substance use disorder, which can include quantity and frequency of use, compulsive use, craving, and problems related to drug use.
    - The effect of specific symptoms (e.g., paranoid thinking, undue grandiosity, constraints resulting from depression) on a client's ability to seek and accept help with housing and other services.
    - Problematic substance use, symptoms of mental disorders, and client readiness for changing substance use behaviors and other areas of social functioning; specific screening instruments can be used to determine each of these.
    - Screening for the presence of a disorder (positive screens should be referred for further assessment and formal diagnosis).
    - The possibility of co-occurring mental and substance use disorders and the implications of co-occurring disorders for immediate and extended treatment and recovery.
- Current and past exposure to trauma and related safety issues.

- Primary care records, history of medical conditions and hospitalizations, list of previous and current medications, and the current need for medical and dental care, including risk of and treatment for HIV/AIDS and other communicable diseases.
- Onset and course of homelessness and how it relates to the course of other symptoms.
- Current skills and ability to maintain stable housing.
- Current and/or pressing criminal justice issues, including outstanding warrants that, might lead to incarceration; probation and parole status; and current behaviors that, if discovered, might lead to arrest.
- Social functioning in terms of social supports, literacy, education, job skills, employment, and income, as well as:
    - The client's family (as he or she defines it) and other social supports that the client wants to incorporate into the plan for recovery.
    - Immediate stressors (e.g., shelter living, housing instability, lack of money, debt, legal issues).
- Client interest in prevention-related activities, such as life skills development, stress and anger management, anticipatory guidance for youth, parenting programs, recreational or volunteer activities, and cultural enrichment programs. Having a directory of such prevention resources in your community will be a useful adjunct toother service directories you use in your work.

Screening, brief intervention, and referral to treatment

SAMHSA has endorsed the use of SBIRT, which integrates initial screening with brief interventions or referral to treatment in some settings with people who may have problems with substance use—including clients with substance use disorders and co-occurring mental disorders. SBIRT is particularly useful with individuals who are homeless in that it requires relatively little time (roughly 5 minutes to screen a patient and 10 minutes to provide a brief intervention) and can prevent the need for further, more intensive services later on (Bernstein et al., 2009).

In 2009, the National Institute on Drug Abuse released an Internet-based, interactive tool for screening and brief intervention to address use of illicit substances. Research supports the efficacy of SBIRT in reducing heavy use of alcohol and illicit drug use across arrange of settings and clients. One evaluation of SAMHSA's SBIRT service program found that SBIRT interventions had a positive impact on homelessness as well, with significantly

fewer patients reporting lack of housing 6 months after the intervention than had reported it at baseline (Madras et al., 2009).

SAMHSA's SBIRT model provides for early intervention and treatment services on a continuum of substance use. Beyond providing for substance abuse treatment, SBIRT also targets nondependent substance use problems and provides effective strategies for early intervention before the need develops for more extensive or specialized treatment. See SAMHSA's planned Technical Assistance Publication, *Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment*, for more information (SAMHSA, planned g).

Early Interventions and Stabilization

As behavioral health service providers further develop and maintain trusting relationships, they engage in intensive early intervention and stabilization while addressing urgent environmental needs (such as health or criminal justice issues) and managing acute substance abuse and mental health symptoms. In both treatment and prevention, this activity involves constructing a treatment and/or prevention plan that is person centered, adhering to an individual's goals. Some people who are homeless will need detoxification as part of a stabilization process. Others may need brief hospitalization to stabilize acute symptoms. Stabilizing is a process of beginning to restore physical health and feelings of safety, to relieve emotional turmoil, and to get a sense of future goals and needs.

How Does SBIRT Work?

After Screening: No or Low Risk doesn't lead to an intervention. Moderate risk leads to a brief intervention. Moderate to high risk leads to brief treatment (on site or via referral), and Severe Risk, Dependence leads to a referral to specialty treatment.

Screening (S) is a process of identifying clients with possible substance abuse problems and determining the appropriate course of future action for these individuals. The screening process does not identify exactly what kind of problem the person might have or how serious it might be; it simply determines whether a problem exists and, if so, whether further assessment is needed.

Brief intervention (BI) is appropriate for clients identified through screening to be at moderate risk for substance use problems. BI can be provided through a single session or multiple sessions of motivational interventions. These interventions focus on increasing a client's insight into and awareness about substance use and behavioral change.

Brief treatment (BT), also called brief intensive intervention, is a specialty outpatient treatment modality—a systematic, focused process that relies on assessment, client engagement, and implementation of change strategies. The treatment consists of assessment and a limited number (typically 6 to 20) of evidence-based, highly focused, and structured clinical sessions (e.g., solution-focused therapy, cognitive–behavioral therapy). Clients may receive BT on site but more commonly are referred to an outside program or another component of a medical system.

Clients identified as needing BT or more intensive treatment are referred to specialty substance abuse treatment (referral to treatment [RT]), the primary goals of which are to identify an appropriate treatment program and to facilitate the individual's engagement. RT requires a proactive, collaborative effort between SBIRT providers and those providing specialty treatment to ensure that, once referred, the client accesses and engages in the appropriate level of care.

Behavioral Health Services for People Who Are Homeless—particularly those who have been living in ambiguity, chaos, or from crisis to crisis—stabilization can be uncomfortable. Some might describe their experience as "waiting for the other shoe to drop." Others may have a well-developed ability to "look good" despite physical, emotional, interpersonal, and environmental instability. It is important for you to assess carefully the rate and extent to which a person has actually begun to stabilize; you must resist the temptation to push ahead before stabilization is established. This accentuates how the activities of stabilization may often challenge engagement, in that careful and active worker–client collaboration is required.

Treatment and Prevention Planning

Treatment and prevention planning needs to be person-centered, addressing the client's goals and using agreed-upon strategies. Planning should include decisions about:

- Which services the person needs and wants.
- Where the services will be provided.

- Who will share responsibility with the individual for monitoring progress.
- How services will be coordinated and reimbursed.

Developing treatment and prevention plans for clients with complex needs is, at best, difficult. Services have to be prioritized and plans made based on outcomes that have not yet been achieved. Both treatment and prevention areas likely to involve multiple programs, each with its own goals and priorities, rules, and restrictions, and with different levels of involvement with the client or program participant. For instance, some services require a one-time visit (such as obtaining identification or screening for substance-related and mental health issues), whereas others—such as management of chronic health conditions—may be ongoing. Given this degree of complexity, treatment plans should include:

- Specific biopsychosocial goals relevant to the individual and his or her living situation.
- Projected timeframes for accomplishing these goals.
- Appropriate treatment and prevention approaches.
- Housing and services the client will need during service delivery.
- Follow-up activities during ongoing rehabilitation.

Some services may have priority over others by virtue of immediacy of need or other constraints. For many people who are homeless, life stabilization and safe housing are requisites for approaching and establishing recovery from substance abuse or mental illness. For others, achieving some treatment goals (such as abstinence) may diminish the intensity or importance of other problems. Most important, treatment and prevention planning need to consider the whole person and to prioritize clients' immediate and longer-term goals. Planning should consider the environment in which clients live, differentiate between the problems that can be resolved and those that can only be lessened, and set priorities for services.

Case Management

Case management, which is often assertive in the beginning of care for people in homelessness rehabilitation, is essential in addressing clients' manifold needs and preventing clients from becoming lost in the maze of community services. The job of case management will generally fall to a counselor in a treatment agency, but there is no reason why a properly trained preventionist cannot serve as a case manager. Although most behavioral health counselors are well trained in case management processes and

techniques, clients who are homeless have unique needs and may require assistance with such tasks as arranging transportation, obtaining appropriate clothing for interviews, ensuring follow-through on referrals, understanding the instructions provided by other agencies, and assembling appropriate information and credentials needed by other community programs. Particularly in work with people who are homeless, case management services need to begin when the client enters the service system so that needs are anticipated, clients are not overwhelmed with numerous referrals at once, and you and your clients have time to prepare for upcoming referrals.

Preventive services using case management methods

Although traditionally associated with health, mental health, or substance abuse treatment services, case management extends to preventive services as well. Indeed, the same concerns that motivate case management in treatment services (e.g., matching services to needs, locating appropriate providers, supporting participation in and compliance with collaborative treatment planning, assisting with logistics such as transportation and child care, monitoring attendance and progress) apply as much to preventive services.

The same person may serve as a treatment and prevention case manager, or the prevention case management function may be fulfilled by a prevention professional collaborating with the treatment case manager. In either case, the goal is to integrate treatment and prevention services to meet the unique needs and personal goals of the service recipient.

This TIP emphasizes that people who are homeless or at risk of homelessness can benefit from a variety of preventive services, especially clinical preventive services (i.e., selective and indicated prevention; see Exhibit 1-1).The TIP has discussed a variety of preventive services, including screening and brief or early intervention for emerging substance use or mental disorders, skill building (e.g., parenting skills, coping skills, anger management),strengthening families, relaxation training, exercise, recreation programs, and community involvement. These are illustrated in Vignettes 4 (Troy) and 6 (Mikki) in, .Such services may be offered by local governments, schools and community colleges, freestanding prevention agencies, social service agencies, primary care providers, organizations that serve aging individuals, community clinics, Boys & Girls Clubs, YMCAs, YWCAs, fraternal organizations, congregations, community coalitions, and so on. Not all communities offer all these services. Prevention case managers should

develop a comprehensive prevention directory for use in matching client needs to available services.

The principles and procedures presented in this chapter apply to prevention-related case management as much as to treatment-related case management. The only difference is that the prevention case manager will likely need to access a wider variety of community agencies to meet preventive service needs.

Retaining Clients in Treatment and Maintaining Continuity of Care

For clients who have been living with chronic crises of housing, health care, drug use, criminal justice constraints, financial needs, and perhaps other issues, providing comprehensive, integrated care can seem an impossible task. As a result, it becomes important to keep treatment and prevention goals realistic and achievable, relatively short term (although you and the client may have long-term goals in mind), and measurable. Specific strategies to improve retention may be desirable, such as rewards for achieving and maintaining drug abstinence or consistent participation in treatment or prevention activities.

Defining a process for the setting of goals can be beneficial. You should collaborate with clients to set goals in accordance with their priorities. Targeted goal management will allow you to work with clients to assess current and evolving needs for financial benefits and health insurance; substance abuse, psychological, and medical treatment and prevention services; housing resources; access to transportation; employment and education; social supports; assistance with legal problems; and recreational activities.

As people identify their most important, pressing goals, collaboratively identify one activity related to each goal area that:

- Is specific (e.g., number of weekly negative urine samples screened, groups attended, parenting sessions completed, volunteer opportunities identified, or job applications completed).
- Can be completed successfully in a given timeframe.
- Can be verified objectively via receipts, agency reports, worksheets, or the like.
- Is tailored to the client's individual level of psychosocial functioning and personal and social resources to increase the likelihood of successful completion.

Small successes and progress toward personally meaningful goals while maintaining accountability and autonomy build client self-esteem and confidence. Your relationship with the people you serves is strengthened through collaborative decision-making about activities to be accomplished and reinforcing the individual's completion of activities. In traditional treatment programs, reinforcement for completing activities includes social recognition and sponsor status in mutual support groups, take-home privileges, early dosing windows in methadone maintenance programs, and vouchers for self-care items and food. In prevention programs, reinforcement may take the form of social recognition, opportunities for training, or attendance at conferences.

Relapse Prevention and Recovery Management

Clients with mental illnesses, substance use disorders, cognitive impairment, and/or family histories of substance use and mental disorders are at higher risk for relapse and subsequent loss of housing (see the planned TIP, *Recovery in Behavioral Health Services* [SAMHSA, planned e]). As individuals move into the clinical stage of ongoing rehabilitation, a variety of evidence-based and best practices interventions are available to support personal recovery, including relapse prevention and wellness self-management.

Wellness self-management, also termed illness self-management, is a manualized, evidence-based, time-limited group technique that helps teach skills of maintaining and enhancing health and wellness (Mueser et al., 2006). Interventions are typically delivered through a series of classroom like group sessions that capitalize on cognitive–behavioral techniques, each focusing on a wellness topic, such as medication compliance, diet, or stress management. Simultaneously, mental health and substance use issues undergo continuing treatment, along with housing supports. Supportive housing that accepts and addresses relapse or recurrence of psychiatric symptoms aids this. Coping skills training, employment and educational assistance, and the encouragement of establishing social connectedness through participating in other community institutions (e.g., faith-based organizations, senior centers, community volunteer groups, recreational groups), as well as recovering family ties, help maintain the personal recovery process (Marlatt & Donovan, 2005).

Evidence-Based Practices in Homelessness Rehabilitation

Exhibit 1-6 presents promising and evidence-based practices that support people who are homeless while they move through the stages of rehabilitation and establish stable housing and long-term recovery. You may already use these practices in the behavioral health treatment settings in which you work.

Several evidence-based practices have been evaluated specifically with homeless populations, including ACT, critical time intervention (CTI), motivational interviewing (MI), contingency management, cognitive–behavioral

Treatment Approach
Engagement
Transition
Intensive Care
Transition
Ongoing Rehabilitation
Incentives (food, transportation, benefits)
X
X
X
X
Primary medical care
X
X
X
X
X
Motivational interviewing
X
X
X
X
X
Clinical preventive services
Indicated (e.g., screening, brief intervention)
X
X
X

X

Selective (e.g., skills development, anger management, anticipatory guidance, parenting programs)

X

X

X

X

Universal prevention programs (e.g., workplace programs, recreation programs, volunteerism)

X

X

X

X

X

Integrated treatment for CODs

X

X

X

X

X

Peer support

X

X

X

X

X

Family and social support

X

X

X

X

X

Intensive case management

X

X

X

X

Critical time intervention

X
X
Contingency management
X
X
X
Assertive community treatment
X
X
X
Illness self-management
X
X
Medication
X
X
X
X
Cognitive–behavioral interventions
X
X
X
Relapse prevention
X
X
X
Supportive housing
X
X
X
X
X
Supportive employment (e.g., the International Center for Clubhouse Development model) interventions, supportive housing, and supportive employment. ACT is a widely used treatment method adapted from services for people with chronic mental illness for work with people who are homelessness. Numerous studies (e.g., King et al., 2009; Nelson, Aubry, & Lafrance, 2007) have shown that the intensive services provided by ACT teams increase treatment adherence, reduce days of hospitalization, and increase

housing stability. Teams composed of mental health professionals provide a wide variety of services, including case management, mental health services, crisis intervention, treatment, education, and employment support. ACT services are available around the clock to respond to the client's immediate needs. ACT has been widely implemented in a number of countries, including the United States. For more information on ACT, visit the ACT Association Web site (http://www.actassociation.org).

CTI is a time-limited adaptation of intensive case management to bring problem-solving resources, community advocacy, and motivational enhancement to clients who are homeless. It is particularly useful in work with clients who are in transition, such as those entering homeless shelters from prison, and in the development of continuity of care for people with CODs who are leaving shelters for other community housing resources (Draine & Herman, 2007; Herman, Conover, Felix, Nakagawa, & Mills, 2007; Jones et al., 2003). New York Presbyterian Hospital and Columbia University (2011) developed *The Critical Time Intervention Training Manual,* which describes the phases of the 9-month program of care in CTI as follows:

- Phase One—Transition to Community. A treatment plan is made; clients are linked to appropriate community resources.
- Phase Two—Try Out. Linkages in the system are tested; the treatment plan is formalized, adjusted, and implemented.
- Phase Three—Transfer of Care. Long-term community linkages are monitored and long-term goals are established; work toward them is begun.

Contingency management uses tangible rewards for housing, work training, and work opportunities and can provide direct monetary reinforcement (e.g., gift cards) for accomplishing clearly defined weekly rehabilitation goals. These procedures have been studied intensively in a community setting in Birmingham, AL, in a series of four randomized, controlled trials that showed significant improvement in sustained abstinence, housing stability, and stable employment (Milby et al., 1996, 2000, 2005,2008).

Cognitive–behavioral interventions have shown clear treatment advantages and sustained superior outcomes for abstinence from 6 to 12 months and from 12 to 18 months after follow-up compared with contingency management alone in a delayed treatment effect. Additional cognitive–behavioral interventions were added to and compared with contingency management alone (Milby et al.,2008).

MI is a client engagement, motivational enhancement, and counseling process that has been widely used in mental health and substance abuse treatment settings and has been adapted for the needs of clients in homelessness rehabilitation. It is particularly efficacious in work with clients who are homeless, abuse substances, and are entering sober housing(Fisk, Sells, & Rowe, 2007). Many standard MI techniques and protocols for enhancing commitment to treatment and reducing resistance are applicable to clients experiencing homelessness. For more information on MI protocols, see TIP 35 (CSAT, 1999b).

Supportive housing can improve sustained abstinence, stable housing, and employment (Milby, Schumacher, Wallace, Freedman, & Vuchinich, 2005), and it can greatly improve housing stability for clients with serious mental illness who are homeless (Tsemberis, Gulcur, & Nakae, 2004).

Supportive employment assists clients in accessing, obtaining, and maintaining employment as a primary method to prevent or end homelessness. Recognizing work as a priority in preventing or ending homelessness, Shaheen and Rio (2007) note that early treatment and rehabilitation efforts often focus more on housing and supportive services and highlight the value of assisting clients in obtaining employment and/or education early in rehabilitation. They suggest that employment helps clients who are experiencing homelessness develop trust, motivation, and hope. Supportive employment not only helps people find jobs; it also helps them achieve continued employment by teaching them skills such as problem-solving, managing interpersonal conflicts, developing appropriate work-related behaviors, and managing money wisely.

Your knowledge and skills in working with clients who have mental and substance use disorders may be particularly important in helping them maintain abstinence, regulate symptoms, maintain motivation, and strengthen the interpersonal skills that are necessary to maintain employment and pursue education. Many individuals who have not been employed for months or years—clients who are just leaving prison or are chronically mentally ill—may first need a supervised work environment to develop or improve these skills. The VA hospital system has used a variation of supportive employment called individual placement and support (IPS). IPS focuses on rapid placement in jobs of the clients' choosing, competitive employment, ongoing and time-unlimited support, integrated vocational assistance and clinical care, and openness to all who want to work, regardless of clinical status or work experience (Rosenheck & Mares, 2007).

There are dozens of universal, selective, and indicated evidence-based prevention programs applicable to populations of people who are homeless, but few have been specifically tested with these populations. SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) lists two evidence-based prevention programs for youth that address substance abuse and mental health outcomes.

The Curriculum-Based Support Group(CBSG) Program (Arocena, 2006) is a support group intervention designed to increase resiliency and reduce risk factors among children and youth ages 4 through 15 who are identified by school counselors and faculty as being at elevated risk for early substance use and future delinquency and violence (e.g., they are living in adverse family situations, displaying observable gaps in coping and social skills, or displaying early indicators of antisocial attitudes and behaviors). Based on cognitive–behavioral and competence-enhancement models of prevention, the CBSG Program teaches essential life skills and offers emotional support to help children and youth cope with difficult family situations; resist peer pressure; set and achieve goals; refuse alcohol, tobacco, and drugs; and reduce antisocial attitudes and rebellious behavior.

Lions Quest Skills for Adolescence is a multicomponent, comprehensive life skills education program designed for schoolwide and classroom implementation in grades 6 through (ages 10–14). The goals of the Lions Quest program are to help young people develop positive commitments to their families, schools, peers, and communities and to encourage healthy, drug-free lives. (See SAMHSA's NREPP for further information at http://nrepp.samhsa.gov.)

Say it Straight (Englander-Golden et al., 1996) is a communication training program that helps students and adults develop empowering communication skills and behaviors and increase self-awareness, self-efficacy, and personal and social responsibility. In turn, the program reduces risky or destructive behaviors(e.g., substance use, eating disorders, bullying, violence, precocious sexual behavior, behaviors that can result in HIV infection).

One area of mental health promotion/mental illness prevention that has been addressed income literature is suicide prevention. People who are homeless have high rates of suicidal ideation and suicide attempts. Childhood homelessness, being homeless for 6 months or more, and substance use disorders in adults ages 55 and older are all associated with greater rates of suicidality (Prigerson, Desai, Mares, & Rosenheck, 2003). More information on suicide prevention for clients in substance abuse treatment can be

found in TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a).

Additionally, a variety of evidence-based practices noted in NREPP, although not tested specifically with populations of people who are homeless, have significant implications for The Clubhouse Model of Transitional Employment.

NREPP lists the International Center for Clubhouse Development's (ICCD's) clubhouse model as an evidence-based program. A clubhouse is a day program, often run at a community center, that supports people recovering from mental illness by helping them rejoin the job force and fostering stronger friendships, family relationships, and educational aspirations. Clubhouses are built on:

- *A work-ordered day.* The daily activity of a clubhouse is organized around a structured system known as the work-ordered day. The work-ordered day includes an 8-hour period that parallels typical business hours. During this period, members and staff work together to perform important tasks in their communities. There are no clinical therapies or treatment-oriented programs in the clubhouse; members volunteer to participate as they feel ready and according to their individual interests.
- *Employment programs.* Clubhouses provide members with opportunities to return to paid employment in integrated work settings. These opportunities include transitional employment—a highly structured means for gaining work in local business and industry. Members receive part-time placements (15–20 hours per week) along with onsite and offsite support from clubhouse staff and members. Placements generally last 6 to 9 months, after which members can seek another transitional placement or move on to independent employment. Transitional employment allows mentally ill individuals to gain the skills and confidence necessary for employment while they hold a real-world job.
- *Evening, weekend, and holiday activities.* Clubhouses provide both structured and unstructured social/recreational programming outside the work-ordered day.
- *Community support.* People with mental illness often require a variety of social and medical services. Through the work-ordered day, members receive help accessing the best quality services in their community, acquiring and keeping affordable and dignified housing, receiving psychiatric and medical services, getting government disability benefits, and so forth.
- *Outreach.* Clubhouse staff maintain contact with all active members. If a member is hospitalized or does not attend the clubhouse, a telephone call or visit serves to

remind that member that he or she is missed, welcomed, and needed at the clubhouse.

- *Education.* Clubhouses offer educational opportunities for members to complete or start certificate and degree programs at academic and adult education institutions. Members and staff also provide educational opportunities within the clubhouse, particularly in areas related to literacy.
- *Housing.* A clubhouse helps members access safe, decent, dignified housing. If there is none available, the clubhouse seeks funding and creates its own housing program.
- *Decision-making and governance.* Members and staff meet in open forums to discuss policy issues and future planning. An independent board oversees management, fundraising, public relations, and the development of employment opportunities for members.

The ICCD Web site (http://iccd.org/) offers a directory of clubhouses and more information on this transitional employment model. TIP 38, *Integrating Substance Abuse Treatment and Vocational Services*, covers employment services and can help you select employment support models suitable for clients who are homeless and have behavioral health issues (CSAT, 2000a). SAMHSA's *Supported Employment Evidence-Based Practices (EBP) KIT* (SAMHSA, 2009) provides practice principles for supported employment, an approach to vocational rehabilitation for people with serious mental illness. It promotes the belief that everyone with SMI is capable of working competitively in the community. The KIT is available for free at SAMHSA's Publications Ordering Web page (http://store.samhsa.gov).

Three examples of tested programs for trauma treatment include Seeking Safety, Trauma Recovery and Empowerment Model (TREM), and a modification of TREM, The Boston Consortium Model: Trauma-Informed Substance Abuse Treatment for Women. All of these programs use cognitive–behavioral and psychoeducational methods to teach problem-solving, coping skills, and affect regulation strategies to individuals who have experienced significant trauma. A program that is particularly relevant to people who are homeless and have co-occurring substance use and mental disorders is Modified Therapeutic Community for Persons With Co-Occurring Disorders, a long-term residential program with the structure and processes of a traditional therapeutic community but with adaptations for individuals with co-occurring disorders. The program can be flexibly applied in both correctional and community settings and includes components on mental

health and substance abuse treatment. For more information on these and other evidence-based programs, refer to the NREPP Web site (http://nrepp.samhsa.gov/).

Special Issues in Service Delivery

People with substance use and/or mental disorders who are homeless have a variety of specific needs and considerations in treatment and prevention programs. These needs tend to fall into three major categories:

- Specific client needs
- Family services to reduce the risk of intergenerational problems
- Cultural competence
- Specific Client Needs are not met. It is also much more difficult for individuals with substance use and mental disorders to manage their symptoms when these basic needs are not met. Some of the most pressing issues of people who are homeless include:
- Addressing acute and chronic medical conditions (e.g., diabetes, HIV infection, heart and respiratory conditions, and the like, as well as drug detoxification and medical stabilization of mental illnesses).
- Having untreated or inadequately treated disabilities, such as hearing and/or vision impairment, lack of balance, or mobility impairments.
- Recognizing cognitive problems, such as memory deficits, poor attention, and concentration.
- Making the transition from jail or prison to the “free world,” which includes adapting survival skills that were functional imprison but are counterproductive outside the criminal justice system.
- Making the transition from inpatient hospitalization, where people are free from responsibility for their care, to having to assume full accountability for their care and their behavior.
- Dealing with a history of trauma when sudden or unexpected events may trigger flashbacks or other responses that are perceived as inappropriate and when symptoms of psychological trauma mimic, exaggerate, or obscure the symptoms of other mental and substance use disorders.

F. Family Services to Reduce the Risk of Intergenerational Problems

Integration of prevention and treatment services for families who are homeless is critical.

It is unrealistic to expect that people who are Family programs involving parents and their experiencing homelessness will be able to children have been a mainstay of universal, maintain housing if their social and health selective, and indicated prevention programs for at least 3 decades. Examples include parent participation (e.g., homework assignments) in school-based programs (universal), home-visit programs for high-risk families (selective), and intensive parent–child interventions when one or both parents are undergoing substance abuse treatment (indicated). All of these programs—particularly those categorized as indicated—are appropriate for families who are homeless in which the parents receive substance abuse or mental illness treatment.

NREPP (http://nrepp.samhsa.gov) lists over 50 family programs that may be relevant toworking with families who are homeless. A few examples include:

- The Strengthening Families Program: This is a family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children 3–16 years old.
- The Strengthening Families Program for Parents and Youth 10–14: This family skills training intervention is designed to enhance school success and reduce youth substance use and aggression among 10 to 14-year-olds.
- The Clinician-Based Cognitive Psychoeducational Intervention: Intended for families with parents who have a significant mood disorder, this intervention is designed to provide information about mood disorders to parents, equip them with skills they need to communicate this information to their children, and open a dialog in families about the effects of parental depression.
- DARE To Be You: This multilevel prevention program is intended for high-risk families with children 2–5 years old. Program objectives focus on children's developmental attainments and aspects of parenting that contribute to youth resilience to later substance abuse, including parental self-efficacy, effective child rearing, social support, and problem-solving skills.
- Familias Unidas: A family-based intervention for Hispanic families with children ages 12 to 17. The program is designed to prevent conduct disorders; use of illicit drugs, alcohol, and cigarettes; and risky sexual behaviors by improving family functioning.

Cultural Competence

Race, ethnicity, and culture influence how people express problems, seek help, and accept services. Your cultural background and that of your clients can influence how you present services and how acceptable they are to clients. Staff members should reflect the diversity of the population, work in teams that incorporate diversity, and engage in team discussions about the influence of cultural factors on engagement and retention, risk and protective factors, and resiliency (Rowe, Hoge, & Fisk, 1996). It may be important to include service providers on your team who have experienced homelessness themselves and understand that homelessness itself can be part of a subculture with its own expectations, behaviors, and patterns of communication; understanding this culture is essential to effective work with individuals and families who are homeless.

Culturally competent service providers understand that people sometimes reject services because of cultural norms and/or past negative experiences with the service system. For example, your organization may find that many clients who are at risk of homelessness live with family members who will not come to your organization for services. A culturally responsive service strategy may involve a service provider of the same cultural background providing services where the client lives. You can act as a consultant, offering psychoeducation and skills development to address individuals' issues in a manner that is acceptable to them (Connery & Brekke, 1999).

Culturally competent counselors are also mindful of the client's linguistic requirements and the availability of interpreters. You should be flexible in designing a treatment plan to meet client needs, and, when appropriate, you should draw upon the institutions and resources of your client's cultural community. Treatment providers need to plan for the provision of linguistically appropriate services beginning with actively recruiting bicultural and bilingual clinical staff, establishing translation services and contracts, and developing treatment materials prior to client contact. Even though you cannot anticipate the language needs of all potential clients, you *can* develop a list of available resources and program procedures that can be followed when language needs fall outside the treatment program's typical client demographics.

Women often have unique experiences and challenges different from the male majorities usually found in substance abuse treatment. They often find or take few opportunities to talk in male-dominated groups about physical or sexual abuse perpetrated by the men in their lives, perceived barriers to restoring child custody, and other women's issues.

Absence of opportunities to discuss gender-related problems usually precludes the development of a comprehensive rehabilitation plan to address them (CSAT, 2009d).

People who are lesbian, gay, bisexual, transgender may face different barriers to services. People who are transgendered may need special consideration of options and advocacy prior to placement in shelters, treatment centers, prevention programs, and housing.

For more information on culturally competentbehavioral health treatment, see the planned TIPs, *Improving Cultural Competence*(SAMHSA, planned c) and *Behavioral Health Services for American Indians and Alaska Natives* (SAMHSA, planned a), as well as *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT, 2001).

Community Housing Services for People Who Are Homeless

Earl, A. (August 29, 2019). *Untitled.* [digital image]. Retrieved from https://unsplash.com/photos/VHSDqIKcrKI/info

Unless you work in a setting specifically designed to serve people who are homeless, you are probably not acquainted with the variety of homelessness services available in your community. Services can vary widely from one community to another based on community needs and program goals. You may also not be aware of abstinence or other specific requirements among different program and housing options. Housing services also exist for special populations that might be important in your work, such as veterans or people who live in rural areas. Additionally, the services clients need will vary by the type of homelessness they are experiencing.

In general, housing services can be divided into four main categories.

Emergency shelters provide brief-stay, overnight accommodation to people who have no safe place to stay for a short period of time. Often, people cannot enter the shelter until the late afternoon and must leave by a specific time the next morning. Most allow for storage of personal possessions during the day while the individual has to be out of the shelter; some require that all possessions be taken by the occupant when they leave each day. Most shelters offer assistance with food and other emergency needs, but given their short-term focus, do not provide ongoing services for residents.

Temporary housing can be provided in a variety of settings, including shelter settings (such as a shelter specifically for persons affected by domestic violence), multiple-occupancy dwellings, hotels and single-room occupancy (SRO)settings, small clustered apartments, or apartments in the community. Temporary housing is often a resource for families and individuals in crisis who need immediate housing help and assistance with social service, health, mental health, substance use, financial, legal/criminal justice, and other needs. Temporary housing services typically provide outreach and engagement, case management, referral, and follow-up services to mitigate or resolve crises. Temporary housing services are generally limited to 2- or 3-months' duration. After stabilization, individuals and families may move to either transitional or permanent supportive housing.

Transitional housing is useful for individuals who have no permanent place to live and are making a transition from a location where they have been temporarily housed (temporary housing, a substance abuse or mental health treatment facility, a criminal justice setting, etc.) to housing that supports their transition to a more permanent setting. Transitional housing is normally provided for periods of a few months to 2 or 3 years and is accompanied by a variety of resources (social services, healthcare, employment assistance, mental health and substance abuse treatment, case management, and other services). The use of transitional housing supports for people who have been in substance abuse and/or mental health treatment to smooth reentry into the community is discussed in this TIP (see the vignette about Sammy). Transitional housing and accompanying supportive services are funded by a variety of resources.

Permanent supportive housing combines a long-term commitment to affordable housing with supportive services to allow individuals and families to live more productive and stable lives; it is a primary thrust of SAMHSA's (along with other Federal agencies') efforts to address the needs of people with disabilities. Typically, permanent supportive housing provides homes for individuals and families who otherwise would be living with the constant threat of homelessness and would lack the supportive social and health

services (such as primary health care, mental health treatment, employment, and economic and other resources) necessary to adequately cope in the community. There are no requirements that individuals in permanent supportive housing obtain mental health or substance abuse treatment, and there are no requirements about abstinence from alcohol and/or drugs as a condition for participation in the program. Supportive housing can, however, be coupled with such social services as job training, life skills training, and alcohol, drug abuse, and mental health treatment.

Case management is a key element in helping individuals and families in permanent supportive housing obtain the care they need. Permanent supportive housing can be an apartment or SRO in a building that houses individuals who were formerly homeless, special-needs housing in the same building with generally affordable housing, a rent-subsidized apartment in the open housing market, designated units within privately owned buildings, or individual single-family homes.

Examples of populations served by permanent supportive housing are adolescents, the elderly, persons with serious mental illness, people who are developmentally disabled, and people moving out of transitional or temporary housing who still lack the resources to live in the community without housing assistance. Permanent supportive housing has been shown to be economically viable by creating safe and stable environments in which individuals and families can regain employment, reduce social service and healthcare costs, and reduce costs related to dependence on more expensive housing options. As with transitional housing, permanent supportive housing is supported by HUD, SAMHSA, other Federal resources, State and community resources, and direct payment from those receiving services.

SAMHSA's Homelessness Resource Center (http://homeless.samhsa.gov/) offers resources on community housing services for individuals and families who are homeless or threatened with homelessness. Their efforts include the *Permanent Supportive Housing Evidence-Based Practices (EBP) KIT* (SAMHSA, 2010), a series of eight booklets on developing permanent supportive housing programs using evidence-based practices.

What the Behavioral Health Service Provider Should Know

Your community may offer a variety of housing options to behavioral health clients who are homeless or are at high risk for homelessness. Some of these options are for

emergencies only or are short term, whereas others are ongoing. Some have special restrictions, such as serving only persons with a major mental illness or requiring participation in programs to build employment, money management, and daily living skills. Some programs that primarily serve clients with substance use disorders have rules about drug use either in the residence or while a client is in the program. However, the permanent supportive housing approach, a major focus of Federal housing assistance today, does not mandate mental health, substance abuse, or other care or social services as a condition of participation.

One of your jobs is to become familiar with the resources in your community. You will want to build linkages with these organizations and with their staff members to learn what range of services they provide. This will allow you to recommend particular clients to these organizations in accordance with their specific needs. What are the requirements for accessing their services? What types of reimbursement do they accept? You may be aware of gaps in the services available in your community. Collaborative efforts can, in some cases, help obtain funding, staff, and facilities to fill these gaps. of this TIP discusses “bottom-up planning,” in which treatment staff identify a service need and programs evolve in response to it. Bottom-up planning should always involve program administration, direct service personnel, clients, and other community resources.

Knowing how to assess your clients’ needs is also part of your job. Do they need substance abuse and/or mental health services? Are they ready to accept such services? From what types of medical services and financial help would they benefit? Are they self-sufficient? Do family members need prevention services? Dorthey require special services to address physical or other disabilities? Are their housing needs chronic and long term or transitional and short term?

Along with these questions, you will want to consider the issue of how best to present a program’s goals and rules to clients so as to encourage them to take advantage of community resources. They may need to accept restrictions on their behavior in exchange for shelter. Some negotiation may be necessary to help the client see the advantages of receiving services while consenting to a program’s boundaries.

Housing Services for Individuals with Substance Use and/or Mental Disorders

Housing services for people with a substance use disorder and/or a mental illness can be divided into two broad categories:

(1) housing specifically provided for clients in early and ongoing recovery from substance use and mental disorders, and
(2) housing that offers a safe place to live, a variety of options for homelessness rehabilitation, and other social, health, and behavioral health services. Sometimes, these programs will offer behavioral health treatment and prevention services primarily directed toward the precontemplation and contemplation phases of treatment.

Some communities may offer homelessness and behavioral health treatment services that overlap with these two housing options. Additionally, other shelter or housing options in your community may simply offer temporary housing with no additional social, physical health, or behavioral health services. Because most communities have few, if any, prevention services specifically designed for persons who are homeless, training for prevention workers in the special needs of homeless populations may broaden the range of preventive interventions available to these populations.

Clearly, there is no “one size fits all” accommodation for the diverse population of people with substance use disorders and/or mental illness who are also faced with homelessness. For example, people who are in crisis and transitionally homeless need different services from those who are chronically homeless. Programs for persons with mental or substance use disorders may need to work in close coordination with homelessness programs, especially in early recovery.

Housing services focused on supporting recovery from substance abuse and mental illness

In your work, you will encounter individuals who either are homeless when they enter your program or become homeless during program participation. Some people who are homeless enter programs, especially treatment programs, because they perceive that they have no other place to go. Others—including persons coming from the criminal justice system—may have had stable housing (jail or prison) but have not considered where to live after being released. Some lose their jobs before or during program participation and are left with no housing options. Others may have family members who refuse to allow them to return until they have achieved substantial sobriety, significant stabilization of their psychological symptoms, or significant improvement in interpersonal skills. In any case, homelessness or the threat of it represents a substantial crisis that destabilizes people and challenges their ability to maintain recovery and other gains.

Homelessness also represents a significant case management problem for mental health and substance abuse treatment staff members who are concerned with finding housing resources. Some considerations that have to be addressed include limited resources for housing people in early recovery from substance abuse and/or mental illness in the community, the time required to find and evaluate potential resources, the collaboration efforts involved in working with other community agencies, and the limited funding available for housing services appropriate for people in early recovery. In addition to addressing these considerations, you will need to ensure that individuals who are homeless can continue to participate in services and continuing care. You will need to work with them to manage transportation, mental health, healthcare, financial, criminal justice, and employment issues that are complicated by homelessness. The reality is that an individual who is homeless is in crisis and has housing needs that must be addressed in a very limited period of time.

Some frontline resources often used to help individuals who are homeless make the transition to more stable recovery are residential recovery and other housing options that have a primary focus on recovery from substance abuse and mental illness. Generally, these resources fall into four categories: halfway houses, ¾-way houses, sober living residences for clients with substance use disorders, and supportive housing for clients transitioning out of intensive mental health treatment or treatment for co-occurring disorders. With perhaps a few exceptions for clients from the criminal justice system, all clients in these residences enter and remain voluntarily.

Halfway houses with a primary focus on substance abuse or mental illness recovery generally offer more intensive treatment than other recovery housing options, have the most structured programs, and are the most likely to be professionally staffed. They also generally are the most time-limited service (usually 30–60 days). Persons are likely to enter a halfway house on completion of intensive treatment. Ina halfway house, residents are expected to participate in regularly scheduled (usually daily) individual and group treatment, and regular attendance at 12-Step or other self-help and recovery programs is either mandated or actively encouraged. Program rules often limit the amount of time residents can spend away from the house and the contacts they can have in the community. Programs also specify meal and sleeping times, provide medication management, and usually have an active focus on relapse prevention and recovery maintenance. Case management services, provided by counselors or specialized case management staff, are often available. Frequently, supportive services, such as employment assistance, healthcare, and financial assistance, are available to residents either “in house” or through referral.

Generally, **¾-way houses** have fewer staff persons with professional credentials and may only be staffed by a house manager and assistants. Residents have more autonomy in managing their time and community contacts, and (unless employment is not a consideration for the client) they are usually employed, expected to be seeking employment, or in a job training and support program. Significantly less treatment by professionals is offered in ¾-way houses than in halfway house programs. Residents are expected to maintain abstinence, monitor psychological symptoms, and manage their medication with the support of staff; are often expected to participate in continuing care and 12-Step recovery programs; and may be encouraged (after some time in the house) to seek other residential options. Clients may have the option of staying in a ¾-way house for a longer period than in a halfway house.

In recent years, a variety of **sober living housing** options have emerged for people in recovery from substance use disorders and fill acritical need for housing for people in recovery who do not need more intensive residential services. The best-known sober living facilities today are Oxford Houses(http://www.oxfordhouse.org). The Oxford House movement has residential facilities throughout the United States that are drugfree, self-supporting, and democratically governed by the residents and a board of directors. They normally have 8 to 15 residents. Complete abstinence from alcohol and illegal or illicit drugs is a requisite for residence. Residents can live in the house as long as they desire. There is no professional staff and there are no requirements about attending treatment. Participation in 12-Step programs is strongly encouraged. Other sober living houses that are not affiliated with Oxford Houses may also be available in your community.

Community transitional **supportive housing** can be an intermediate step between leaving an inpatient facility for substance abuse and/or mental health treatment and living independently in the community. Supportive housing programs for people leaving intensive treatment ordinarily provide an affordable place to live; close links to treatment; supporting medication maintenance; services to develop and enhance skills in household, job, and financial management; and day-to-day support from professional and paraprofessional staff. Supportive housing reduces isolation, reduces relapse rates, offers early intervention so that living problems do not escalate, and provides safe housing for people at a very vulnerable point in their lives.

Housing services focused primarily on safe housing and social services

Substance use-related designations for shelter and housing

Housing and shelter programs are sometimes defined by policies related to substance use on and off the premises. Different types of housing are appropriate for clients in different stages of change for substance use behavior and who are, in turn, ready for varying levels of service intensity. In housing, “wet,” “damp,” and “dry” refer to these levels of service intensity and a concomitant demand for abstinence. Exhibit 1-7 describes each program type. Although programs are defined by allowed substance use, their services are not restricted to people with substance use disorders. Sometimes, people are placed in housing when they are in the precontemplation stage of change regarding their substance use or mental health issues. They may show little or no motivation or behavior suggesting that they would even consider addressing their problems. Even so, you may still have several options for working with clients who are in the precontemplation stage, including:

- Providing information about recovery and resources that are available, if and when they do sense a need to do something about their use.
- Building stronger relationships focused on their ability to contact a service provider if they decide to get help for substance use.
- Supporting their efforts to consider or act on changing substance use behavior—for instance, by supporting efforts toward abstinence, even for brief periods.
- Helping individuals develop or improve coping skills for managing life without substances.
- Locating housing in congregate living settings with staff members on site who can provide safety and support.

Concerns, such as drug trafficking on the premises, may be a particular risk factor for some persons attempting to maintain abstinence. Onsite staff persons have a greater opportunity to build relationships by sharing activities and conversation. They can also assess an individual’s functioning and engage them in appropriate services.

Services for veterans who are homeless

In addition to services available in the community and local treatment system, veterans who are homeless may be eligible for VA services. Eligibility varies for each of these services. In general, eligibility is least restrictive for entry to VA homelessness programs. Those who have a service-connected disability or VA pension are most likely to access VA services. Nearly every VA hospital has a Health Care for Homeless Veterans (HCHV) Program caseworker who can inform you about local services and eligibility criteria. VA services for veterans who are homeless vary geographically and include the following:

- HCHV: VA outreach workers and case managers help establish eligibility for VA medical services, develop appropriate treatment plans, and screen for community placement.
- Stand Downs: These give veterans who are homeless 1–3 days of safety and security where they can obtain food, shelter, clothing, and other types of assistance, including VA-provided health care, benefits certification, and linkages with other programs.
- Drop-In Centers: These programs are a daytime sanctuary where veterans who are homeless can clean up, wash their clothes, and participate in therapeutic and rehabilitative activities.

Recovery-oriented and rehabilitative treatment programs for veterans who are homeless include:

- Domiciliary Care for Homeless Veterans (DCHV): DCHV provides residential treatment and rehabilitation to veterans who are homeless.
- VA Grant & Per Diem Program: This program subsidizes residential treatment and transitional housing.

VA-based substance abuse treatment programs:

- These can be found using the
- SAMHSA Treatment Locator (http://findtreatment.samhsa.gov/).
- Supportive Housing: This program provides ongoing case management services to veterans who are homeless. The emphasis is on helping veterans find permanent housing and providing clinical support to keep veterans in permanent housing.
- Veterans Affairs Supportive Housing Program with HUD: This program provides Section 8 voucher program and permanent housing and treatment for veterans who are homeless and have mental and substance use disorders through VA outreach, clinical care, and ongoing case management services.

Homelessness services in rural areas

People who are homeless in rural and remote areas typically live temporarily in campers, cars, abandoned buildings, tent encampments, or with a succession of friends or family in overcrowded, substandard housing (Dempster& Gillig, 2006). As a result, people who are homeless in rural areas are often less visible than those in more urban settings and may not be counted in census or other surveys. Outreach and engagement are different

in rural areas than in urban centers, because people who are homeless in rural areas are more difficult to identify. In addition, outreach and engagement activities are successful only if you can refer individuals to services relevant to rehabilitation from homelessness.

Job opportunities, transportation, health and social services, and shelter options tend to be more limited in rural areas. Individuals with mental illness who are homeless and unable to live with family in rural areas may be particularly vulnerable and may migrate to larger population areas to obtain housing and services. In rural areas where the predominant employment is agriculture, migrant workers who are homeless and depend on employer-supplied housing can be particularly vulnerable. Often, the housing offered for temporarily employed migrant workers is substandard and inadequate, creating a unique situation of homelessness or near homelessness.

To create temporary shelter, some providers develop contracts with local property owners in which an agency pays a monthly rate for sleeping rooms used as temporary housing until other arrangements are made. This may be more cost-effective when actual numbers of clients do not warrant larger shelter programs; it gives the individual and the agency flexibility to better prepare for more adequate housing. In some locations, faith-based communities can temporarily house people for brief periods in members' homes, church buildings, or in low-cost motels paid for with money set aside to help those in need.

SAMHSA's PATH program provides formula grants to States, which they can then use for homelessness services in rural areas. The grants can be used for outreach, screening, behavioral health services, case management, and other supports for housing assistance. A primary problem is that, given the actual number of individuals and families needing a specific form of housing among a dispersed, rural population, costs for the construction of congregate housing or shelters can be prohibitive. As a result, developing an adequate supply of rental stock and providing rental subsidies may take on particular importance. There is often a waiting list in rural areas for housing that is available through programs serving people who are homeless.

Where adequate services do not exist, workers in PATH-supported outreach and engagement programs in rural areas often carry sleeping bags, camping gear, and food. Some programs employ former consumers who can establish good rapport with individuals who are homeless. The programs work to create linkages and good

relationships with nearby communities and agencies (Robertson & Myers, 2005). The National Alliance to End Homelessness (2010) emphasizes using naturally occurring support networks in rural areas to provide support to people who are homeless. Involvement of local area leaders and stakeholders promotes an inclusive, collaborative system.

You Can Do It

Working with clients who are homeless or at risk of homelessness certainly increases the complexity of your job. Clients who are facing homelessness have unique personal and environmental dilemmas that require special care and attention. Nevertheless, with some additional knowledge, enhanced skills, and an examination of your own attitudes toward homelessness, ***you can do this work*** effectively. The skills required will simply complement the skills you already have as a treatment or prevention professional. The additional knowledge you need will benefit not only your work with people who are homeless, but also your work with any person who has layered problems. A significant milestone in professional growth is expanding your horizons and capabilities to work with different types of people, some of whom have more complex needs than others.

In the next chapter, you will meet several people who are homeless and in various stages of need, and you will examine how your new and expanded knowledge, skills, and attitudes can be applied in realistic treatment and prevention service situations.

Chapter 5: Vignettes of Homelessness Intervention (Page 55)

In this chapter, you will meet several people with behavioral health disorders who are homeless or at risk of homelessness. Each person is introduced in a vignette that demonstrates effective approaches to treatment for people who are in different phases of homelessness rehabilitation (described in Chapter 1) and who have a substance use and/or mental disorder. Prevention techniques and methods to reduce the incidence or manifestations of mental illness or substance abuse are also demonstrated.

Skills introduced in the seven vignettes include:

- Building rapport.

- Identifying client strengths, needs, preferences, and resources in housing and other life issues.
- Managing inappropriate behavior, requests, and expectations.
- Providing case management to access and coordinate housing and other services.
- Developing and monitoring treatment and housing goals.
- Assisting clients in improving coping skills.
- Adapting services for people who have cognitive problems.
- Adopting a trauma-informed approach to working with all clients who are homeless.
- Helping clients stay engaged in recovery despite ongoing mental illness/substance abuse symptoms.
- Recognizing the impact of co-occurring disorders (CODs) on recovery from homelessness.
- Helping clients find appropriate housing among the variety of options that may be available.
- Preparing clients to accept the terms of rental agreements and other housing constraints.

Each vignette begins by describing the setting, learning objectives, strategies and techniques, and counselor skills and attitudes specific to that vignette. A description is given of a client's situation and current symptoms. Counselor–client dialog is provided to facilitate learning, along with a selection of aids that may include:

- **Master clinician notes:** comments from an experienced clinician about the strategies used, possible alternative techniques, and insights into what the client or prospective client may be thinking.

- **How-to notes:** step-by-step information on how to implement a specific intervention.

- **Decision trees:** aids to help you sort options and arrive at the best possible outcome.

The master clinician represents the combined experience of the contributors to this Treatment Improvement Protocol (TIP). Master clinician notes assist behavioral health counselors at all levels: beginners, those with some experience, and master clinicians.

Before using the described techniques, it is your responsibility to determine whether you have sufficient training in the skill set and to ensure that you are practicing within the legal and ethical bounds of your training, certifications, and licenses. It is always helpful to obtain clinical supervision in developing or enhancing clinical skills. For additional information on clinical supervision, see TIP 52*, Clinical Supervision and the Professional Development of the Substance Abuse Counselor*(Center for Substance Abuse Treatment [CSAT], 2009b).

For the convenience of the reader, the TIP refers in the vignettes to “counselor” generally rather than specifically by name. This will make it easier for the reader to track who is speaking at any given point in the vignette. As you are reading, try to imagine yourself through the course of the vignette in the role of the counselor. The seven vignettes are as follows

- **Vignette 1:** Juan is in the outreach and engagement (O&E) phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for responding to his chronic homelessness.

- **Vignette 2:** Francis is in the outreach and engagement phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for responding to his health and safety concerns.

- **Vignette 3:** Roxanne is in the intensive care phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for preventing homelessness and stabilizing a client who is in the precontemplation stage of substance abuse treatment.

- **Vignette 4:** Troy is in the intensive care phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for preventing homelessness and engaging the client in substance abuse treatment.

- **Vignette 5:** René is in the transition planning/ongoing homelessness rehabilitation phase. This vignette demonstrates approaches and techniques for substance abuse relapse prevention.

- **Vignette 6:** Mikki is in the early intervention stage of homelessness prevention. This vignette demonstrates approaches and techniques for preventing additional trauma to her family because of temporary homelessness.

- **Vignette 7:** Sammy is in the permanent supportive stage of homelessness rehabilitation. This vignette demonstrates approaches and techniques for supporting access to housing for a client with serious mental illness (SMI) through programs partially funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Projects for Assistance in Transition from Homelessness (PATH) program.

A. Vignette 1-Juan
Overview
Juan is in the outreach and engagement phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for responding to his chronic homelessness. Juan is in his mid-thirties and is chronically homeless. He is dependent on crack cocaine, drinks alcohol, and occasionally smokes marijuana. He typically sits alone at a soup kitchen table. He knows who the outreach team members are and has walked away in the past when approached. The outreach team has information about Juan from shelter staff members and other people who are homeless. He is unemployed but has worked in the past. Juan is hypersensitive to being "putdown" by others. He is easy to anger, and his anger is often out of proportion to the stimulus. If he feels criticized, he will become sarcastic and will withdraw from interaction with others. He is very suspicious of the motives of others, often expecting that people have an agenda to disrespect him. These limitations have resulted in many losses: jobs, family relationships, apartments, and social supports. He has a history of being banned from shelters as a result of outbursts and fighting. The outreach team members believe that if they form a relationship with Juan and offer him a place to live, they will be able to engage him in treatment.

Substance use is believed to play a significant role in Juan's homelessness, so the member of the team who provides substance abuse counseling will take the lead in engaging him. The counselor's goals for the first visit are to:

- Meet Juan and begin to establish a relationship with him.
- Determine whether or not Juan will engage in a conversation about housing and other services.

Setting

The behavioral health counselor is a member of a community-based, interagency O&E team and works for a mental health and substance abuse treatment organization providing O&E services in collaboration with counselors, case managers, and outreach workers from other organizations. A Housing First program is available to clients through this interagency partnership.

Learning Objectives

- Use rapport-building outreach methods: Accurately identify the client's beliefs and frame of reference.
- Reflect the client's feelings and message.
- Demonstrate empathy, respect, and genuineness.
- Offer concrete assistance.
- Establish an initial plan based on the client's needs and preferences, community resources, and the intervention plan.
- Determine the client's stage of change; respond appropriately to changes in client behavior.

Strategies and Techniques

- **Rapport and relationship building with a client who is difficult to reach**
- Housing First as an approach to provide safe and stable housing
- Motivational interviewing (MI)

Counselor Skills and Attitudes

- Recognize and address ambivalence and resistance.
- Work as a member of a team to remove barriers to services.
- Emphasize client autonomy and development of skills.

- Show respect for both the client's needs and the organization's services.
- Help the client explore resources and determine which ones he would like to use.

Vignette

Visit 1 (soup kitchen)

The counselor walks to a seat near Juan at the soup kitchen, noticing that Juan watches her from the corner of his eye and appears tense. He sits alone and appears disinterested in the goings-on around him.

COUNSELOR: How's it going?

JUAN: Do you work here?

COUNSELOR: I work for the local outreach and engagement team.

JUAN: You're treating people?

[He talks to her, but his demeanor is aloof and suspicious, and he maintains his distance.]

COUNSELOR: No. I get to go out and spend time with people out here. Do you mind if I sit-down? [*Juan nods.*] What do you think of the coffee here?
JUAN: Not too good. Better than nothing'.
COUNSELOR: Better than nothing', that's for sure. The food's okay?
JUAN: Yeah. This is a good place to eat, you know, a meal. What's *your* name?
COUNSELOR: It's Megan. How about yours?
JUAN: I'm Juan.
COUNSELOR: It's nice to meet you. So, you've been in the area long?

Master Clinician Note

Building relationships with people who are homeless proceeds at their pace. You can give people opportunities to accept assistance, but it is important that you consistently respect their choices. If someone refuses to talk to you, respectfully leave and plan to show up again with something the client might accept (e.g., coffee, socks, a chance

to talk). Building relationships with soup kitchen workers who know the client can help you gather more information and facilitate a meeting.

Housing First Models

Housing First approaches have been used to engage people who are chronically homeless and have severe and chronic mental illnesses. The goals of Housing First are to end homelessness and promote client choice, recovery, and community integration. Housing First engages people whom traditional supportive housing providers have been unable to engage by offering immediate access to permanent scatter-site independent apartments in buildings rented from private landlords. Clients have their own lease or sublease and only risk eviction from their apartments for nonpayment of rent, creating unacceptable disturbances to neighbors, or other violations of a standard lease. To prevent evictions, teams work closely with clients and landlords to address potential problems. Refusal to engage in treatment does not precipitate a loss of housing. Relapses to substance abuse or mental health crises are addressed by providing intensive treatment or facilitating admission to detoxification or the hospital to address the clinical crisis. Afterward, clients return to their apartments. Support services are often offered through multidisciplinary assertive community treatment (ACT) teams, with slight modifications.

Source: Stein & Santos, 1998.

[Juan says that he's been in town for a while and knows his way around. He's currently staying at a shelter that he doesn't like. The noise keeps him up at night, his things get stolen, and there are too many rules. He says he'd rather camp out, except for the police. The counselor mentions the possibility of housing.]

Master Clinician Note

Nonclinical conversation is an important outreach tool. Social conversation is an icebreaker and helps identify a person's interests and needs. While the counselor talks with Juan, she listens for information that will help her guide him in creating a recovery plan—that is, information that may indicate some of Juan's strengths and limitations,

problems related to substance use and homelessness, housing history, goals, values, and so forth.

COUNSELOR: If you were to have your own place, what would that be like for you?

JUAN: Well, that's what I do if I find a building where I can camp out. I make it my own place.

Master Clinician Note

Having clients imagine themselves in a desired situation can help you identify what matters to them and the barriers to their goals. Open questions and reflection encourage Juan to elaborate.

COUNSELOR: You set up house.

JUAN: Right. Right now, I don't have an income, so there's no way I can pay the rent or get a place, so I'm just making the best of what I got.

COUNSELOR: It's hard to imagine what it'd be like to move into your own place right now because it's hard to imagine how you'd get it. You don't have any income, and that's a problem.

JUAN: Right.

COUNSELOR: One of the things I do is help people find places to live that they can afford.

JUAN: Are you playing a game? You want me to go to treatment or something like that?

COUNSELOR: No, you don't have to go to treatment to get into housing. We have a program called "Housing First" that might really be something you could look into.

JUAN: Well, I don't understand. Why would you do that for me?

COUNSELOR: I think somebody would do that for you if they thought you could do it successfully.

JUAN: My own place—somebody's gonna give me my own place?

COUNSELOR: Doesn't make a lot of sense to you, does it?

JUAN: No; what's the catch?

COUNSELOR: You and I would have to have a plan for how you would hang onto that place.

Master Clinician Note

The counselor demonstrates that the client can expect her to be honest about what to expect. As he considers making a change, it's natural for him to feel ambivalent about it and back off. This is part of the process of engagement, and the counselor doesn't want to prevent his ambivalence from arising. In the following exchange, she'll reflect both sides of his ambivalence so he can see the discrepancy between where he is now and where he wants to be. This is a technique from MI. Additional information on MI can be found in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT, 1999b).

JUAN: Make a plan for how somebody wouldn't take it away from me.

COUNSELOR: How you'd be able to hang onto it, yeah. So that would mean income. Let me ask you this: When you got your last place, how did you do that?

JUAN: Uh, I got on assistance and they just took the rent out of that, so I never saw the rent check. But I got kicked out 'cause I had friends over, and we were partying. It got loud and somebody got into a fight, and then somebody else called the police. The next week I was out. I still get my disability assistance from the government.

COUNSELOR: So, a couple of things happened there. You got on assistance that paid the rent, you got your place, and then your friends came over and had a party. Things got loud and people started fighting, and that caused a problem.

Master Clinician Note

The counselor gathers housing history information and summarizes what Juan says to reinforce her understanding of how he lost his housing. Reflecting Juan's response empathically helps him feel heard and accepted and builds a mutual understanding of

the issues they will need to address to make his plan for housing work. The counselor carefully avoids blaming Juan for losing his housing.

JUAN: Yeah. It's not like other people weren't having parties. They were having them every weekend, so I had a party, and the next week, I'm out of there.

COUNSELOR: It didn't make any sense to you that you were bounced out and other people got to stay, even though they were having the same kind of parties.

JUAN: Yeah. I don't want rules for when I can come and go or who I can have visit and stay over.

COUNSELOR: You want to be able to come and go as you please.

JUAN: Yeah. Just like anybody else paying rent for an apartment.

COUNSELOR: What other sorts of things do you think would be reasonable for a landlord to ask from you? Paying rent, that's one.

Master Clinician Note

Given Juan's history of homelessness and tendency to be irritable, the issue of reasonable expectations of a landlord is a touchy one. To avoid provoking Juan, the counselor is eliciting and reinforcing his understanding of reasonable expectations from a landlord.

JUAN: Pay for your rent. Take care of the place. Don't smash in the walls. Stuff like that.

COUNSELOR: Okay. So, you wouldn't tear the place up and you'd pay the rent. The only other thing from the last story is that it sounds like maybe your guests might get a little loud.

JUAN: Yeah. I mean, what can you do in that situation? You ask the guys to keep quiet. If you try to throw them out, you may get hurt yourself.

COUNSELOR: You're not real sure what to do if they start being that way.

JUAN: Right.

COUNSELOR: So, if we're going to make a plan, we might need to include some ideas about that for you.

JUAN: Like, no parties?

COUNSELOR: Well, how to deal with that kind of situation. We could look at your options and see what you'd like to do. How does that sound to you?

JUAN: You mean you're offering me a place now?

COUNSELOR: I'm offering to work with you to help you see if it's something you want.

Master Clinician Note

If the counselor agrees with Juan's understanding of her offer, then she's agreeing to help him find a home before they have agreed on how they'll work together to help him keep it. She's balancing good judgment with moving at his pace. From his history, she knows that if he's housed without being confident that he can adhere to the terms of a standard lease, he'll be at high risk for a return to homelessness.

JUAN: Yeah, I mean, I'd like that.

COUNSELOR: Well, there are a couple of things that you and I need to do. The first step is to begin to fill out an application where I'm going to ask you for—

JUAN: [*interrupts*] Filling out lots of papers?

As they move toward the beginning of the process, Juan experiences more intense ambivalence. The counselor expected this and responds to it with acceptance.

COUNSELOR: It's not pleasant, is it. How do you feel about that?

JUAN: [*irritably*] Eh, I don't need to get into that stuff. If that is where this is going, I don't want to go there. I don't need that stuff.

COUNSELOR: Okay. I can appreciate that.

[Juan's ambivalence intensifies. He backs his chair away and leaves, ignoring the counselor's request for him to wait. The next time she sees Juan, she tries to approach him, but he walks away.]

Visit 2 (shelter)

A few days after the first visit, the counselor finds out that Juan is at the shelter and stops by in hopes of bumping into him. Her goals for this meeting are:

- To reengage him.
- To offer him the opportunity to look at an apartment that has become available.

- If he wants the apartment, to see whether he can create a plan that will help him keep it.

Juan is cranky but agrees to talk to the counselor. He says he's been in the shelter for 4 days, that a staff member is badgering him into substance abuse treatment, and that he's getting ready to leave. Noting the opportunity, she reflects his wish for new accommodations and offers to take him to see an apartment.

COUNSELOR: So, you could use some options like maybe having a place to stay. We have an apartment that's become available, and the last time we talked, you sounded like you might be interested in something like that if it could be worked out to your satisfaction. I wonder if you'd be interested in taking a look.

JUAN: [*suspiciously*] Now?

COUNSELOR: Yes, I have a van here and a coworker from my outreach team. We can take you.

JUAN: All right, where is it? Not around here?

COUNSELOR: Well, it's not immediately around here. It's a few miles away.

JUAN: Well, I kinda like *this* part of town.

COUNSELOR: So that would be a big change for you, being way over there. Tough decision whether to go see a place that far out of your usual space. But, it's near a bus stop.

JUAN: Sure. Well, I'll go take a look at it.

[The counselor and her colleague drive Juan to the apartment. As she shows him the building, he mentions a landscaping job he had. He's proud of his landscaping abilities and describes being fired.]

JUAN: Yeah, I changed the garden around to make it better, and they told me I was doing stuff I wasn't supposed to do. They just didn't know what they were doing. I said, "I'm outta here."

COUNSELOR: I see. So far as you're concerned, they didn't appreciate that you were taking initiative to try to make things better.

JUAN: Oh, yeah! Right on.

[They look around, and the counselor tells Juan he can move in when the paperwork is approved and they are able to reach an agreement to help him keep this apartment.]

COUNSELOR: We have to do the paperwork and work out a plan that makes you and everyone else feel confident that you would be able to keep this place.

JUAN: Like whether you're bringing in bags with bottles in them, or… ?

COUNSELOR: No, they don't complain about people bringing in bags with bottles in them. Remember that party you were talking about where things got heavy and the cops came? That's the sort of thing that would cause concern. You and I are going to have to figure out what the program guidelines are and what that means for you.

Master Clinician Note

Juan is in the precontemplation stage of change for substance abuse and the contemplation stage of change for housing (see , Chapter 1, of this TIP). The counselor is seeking to enhance the relationship with him to support his engagement—first to obtain housing and then to help him move toward acting on other issues in his life, particularly his substance abuse.

[Juan agrees to go back to the shelter to start the paperwork despite his ambivalence. At the shelter, the counselor begins to collect information about Juan's housing history for the application. She mentions the party that led to his most recent eviction.]

COUNSELOR: We started talking about the parties and how those can disturb other people.

JUAN: Well, it's not like other people didn't have parties. I didn't complain about that.

COUNSELOR: So, this is one of those areas where it may feel like you're being treated unfairly.

Master Clinician Note

Again, the counselor is careful to reframe this issue to be about Juan's experience of what happened and avoid making him feel blamed, judged, or disrespected by the counselor. This is especially important given his sensitivity to feeling criticized.

JUAN: [*irritably*] I can tell you, I'm not gonna stop having my friends over.

COUNSELOR: Okay.

JUAN: [*still irritably*] What's the point of having your own place if you can't do what you want? I'm not saying they're gonna come over and bust the place up. I don't want that, either. But…

COUNSELOR: Well, you don't want people to come over and bust the place up and neither would any landlord. That makes sense to you. That seems reasonable.

JUAN: Yeah, sure, yeah. But these guys weren't fighting, nothing got broken, and they weren't any louder than the couple next door hollering at each other all the time.

COUNSELOR: Right. So, you feel like the thing that happened last time, the thing that caused the problem, you didn't feel it was as big deal as they made it out to be.

JUAN: No. No way!

COUNSELOR: There really wasn't anything there for them to be concerned about at all.

Master Clinician Note
The counselor is using a technique known as "over reflecting." This deliberate emphasis on Juan's initial opinion concerning the episode invites him to think more deeply about the episode and his feelings, evoking self-reflection, especially because he is a person who may not spontaneously self-reflect. There are risks with this approach—such as provoking defensive anger—but if presented with a nonconfrontational and supportive tone, even the most sensitive people will not respond negatively.

JUAN: No. They just didn't treat me right—with respect.

COUNSELOR: That was the problem; it felt like they were kind of singling you out.

JUAN: Yeah. And then that guy upstairs was always playing that #*%! speaker—I could feel the #*%!ing thing in my ceiling. Nobody else complained about that! They didn't kick him out.

COUNSELOR: Uh-huh. So, part of what made you so angry the last time was that it seemed like everybody else was doing this stuff and not getting into trouble for it. You were the only one.

JUAN: Right!

COUNSELOR: It's hard for you to see what was different about your situation that got you kicked out.

JUAN: There wasn't anything different about this! They just need the excuse of their #*%!ing rules! I think it's better sometimes just to camp out. Nobody tells you what to do.

COUNSELOR: One of the things that's easier about camping out is that you don't have to deal with other people's ideas about the things you're doing.

JUAN: Right. If things get bad there, you just move off to another place, and that's cool.

COUNSELOR: That's right. You just keep moving around when it starts to get bad. So that's some of the good stuff about camping out; you don't have to put up with other people's complaints. If we're going to make this apartment work for you, we need to figure out how to help you manage those situations. I can't guarantee that the housing manager won't have some opinions about any parties you might throw.

Master Clinician Note

The counselor identifies a potential challenge for Juan in maintaining stable housing. The counselor avoids an adversarial stance by also commenting on the client's coping mechanisms in an accepting manner. Thus, the counselor attempts to begin to frame the issue of housing stability as an objective "problem" that would need to be "solved" by Juan with the counselor's support.

JUAN: Those guys, they weren't fighting, they were arguing with me. Maybe they got a little bit loud, but they didn't bust up the place.

COUNSELOR: That's another thing that might happen, right? You might have some friends over and they might just be hanging out, and somebody else might complain. That'd be tough for you to deal with.

JUAN: Yeah. What's the use of moving into a place and you have some friends over and somebody complains and they kick you out in a week? [*angry, dejected, and disgusted*] Hell, let's just give it up. I don't want to mess with this anymore.

COUNSELOR: Okay, I appreciate that.

[Juan abruptly leaves.]

Master Clinician Note

The counselor knows that a lot is at stake for Juan; if he tries and fails, he might feel humiliated, so he's avoiding the risk of failure. This is a common response for people experiencing homelessness who are considering making a change. Some clients may experience ambivalence about change more intensely because failure causes them intense humiliation. Understanding this makes it easier for the counselor to accept Juan's ambivalence.

Visit 3 (soup kitchen)

Juan disappears for a few days. When he shows up at the soup kitchen, he looks like he hasn't slept for several days, seems to have been using, appears especially unkempt, and has a black eye and other bruises. The counselor asks if she can sit down. He shrugs with a disgusted look but says okay. She takes a seat.

The counselor says that Juan doesn't really look like himself today. Juan explains that he was attacked by someone outside the shelter. She asks whether he's had any medical attention. Juan says no and that he's not interested in getting any. He's not seriously injured, though his bruise looks ugly; the counselor's anxiety increases on seeing Juan's condition. She notices her anxiety and consciously relaxes so she can honor his freedom of choice instead of trying to push him to accept health care. She also notes that Juan gets into pretty serious fights despite portraying himself as someone who stays out of them. Juan agrees to have the counselor check in with him later.

The counselor discusses Juan's condition with her supervisor, and they decide that she should continue to check on him over the next couple of days and watch for any changes in his functioning. If she notices a decrease in his ability to function, she will address this again with him and with her supervisor.

Visit 4 (soup kitchen)

When the counselor finds Juan in the soup kitchen several days later, he looks better. His eye is healing, he's sleeping and eating better, and he has a decent spot on the

street where he can get out of the weather. Her goal is to engage him into housing and other services.

COUNSELOR: So, you're feeling like staying at this construction site is working for you?
JUAN: Just a little while. I mean, when they start opening up the fence and bringing in the big equipment and stuff, I won't be able to stay there. Are you still putting people in those apartments?
COUNSELOR: I certainly am. You think you might be interested in that?

JUAN: I don't know. There's all that rules stuff, people telling you what to do.
COUNSELOR: Well, it's a tough decision.
JUAN: On the other hand, I might only be able to stay at this construction site for another week.
COUNSELOR: You're getting to the point where you need a more permanent plan for where you stay.
JUAN: Yeah, it would be nice.
COUNSELOR: Yeah. You want to talk about it some more?
JUAN: Yeah.
COUNSELOR: One thing we ask is that you stay in the shelter a few nights before going into an apartment so we can get to know you a bit. We want to ensure that the housing fits your style and priorities.

Master Clinician Note

The counselor avoids confrontation and allows Juan to save face while also emphasizing his need for success. *Note:* Housing First models generally don't require potential clients to spend any amount of time in a shelter prior to entering housing. Getting to know or assessing the client can occur on the street, in the Housing First program offices, or at sites in the community.

[Juan is concerned about returning to the shelter where he had the fight, because they made him leave. The counselor says some of the shelter staff members are familiar with Juan and his situation, and she'll talk to them about helping him possibly get his shelter housing back. Several days later, when they discuss Juan's situation with the shelter staff,

Juan agrees to the shelter's rules and says he'd like to stay there until the apartment paperwork is complete and approved.]

Visit 5 (shelter)

Megan talks with shelter staff the next day and checks in with Juan. Her goals for the visit are to:

- Collect information for the housing application.
- Create a plan to address the issues that have caused Juan to lose housing in the past.

The counselor tells Juan that he has impressed the staff by staying out of arguments and not causing problems. She emphasizes this as Juan's accomplishment to reinforce his sense of pride in adaptive behavior. As we pick up the session, the counselor is collecting information about Juan's housing history.

COUNSELOR: So far, there are a couple of things I know. I know you've had an apartment before. And we've talked about what happened with that apartment. I'm wondering about other places you've lived.
JUAN: Actually, a couple different places. I had a friend, Tom. We shared a place for a while.
COUNSELOR: And how did you get that place?

JUAN: He got it. I don't know. He just asked me if I wanted to move in and split the rent.
COUNSELOR: Okay. And how were you affording your rent at that time?
JUAN: I was hustling, moving product—drugs and stuff. I didn't have a regular type job.
COUNSELOR: That's how you were getting the money to pay the rent and to use?
JUAN: Right.
COUNSELOR: So, that was one apartment you had with Tom. How long did that last?
JUAN: I guess about 2 months.
COUNSELOR: What other places?
JUAN: Well, when I was working for that landscaper, I had my own place for more than a year.
COUNSELOR: Oh, so that worked out well. That's a long time to hold on to a place.
JUAN: Yeah.
COUNSELOR: So, you had the job first, and then got the apartment on your own.
JUAN: Yeah, those were some good times!

COUNSELOR: You liked that work, and you were good at it.
JUAN: Yeah. I liked being outside, working with the plants, seeing stuff grow and look nice.

[The counselor gathers the rest of Juan's housing, substance abuse, family, financial, and health history. The longest he's been housed is a year. He loses housing because of drug use and fighting. It's important to him to spend time with friends. The counselor notes that he will need positive social supports to maintain his housing. He reveals that he's on parole but hasn't seen his parole officer (PO) in 10 months. He's worried about an outstanding warrant. They discuss the need to address his legal issues, and the counselor offers her support through the process. Juan expresses some discomfort talking about his parole issues. Agreeing to set this aside for now, the counselor shifts the focus to Juan's relationship with his family.

Juan's brother lives upstate, and his parents live in town; he hasn't had contact with them for 3 years. He doesn't make contact with them because he believes that they're going to worry about him. The counselor believes his family could help support Juan's recovery. Once he's settled, he may be interested in inviting his family to his apartment, which could open a discussion about how his having an apartment is great but may also prompt conversation about his drug use. When the time comes to create a plan with Juan for substance abuse treatment, the counselor will ask about his interest in including his family in that plan.

The counselor assesses Juan's substance use and other likely problems based on what she already knows. They will use the information to create a plan to support housing stability and recovery. The counselor continues to gather information on Juan's substance abuse.]

COUNSELOR: We talked already about your use of crack. I wonder what other drugs you might use.
JUAN: I smoke a little grass every once in a while. Not on a regular basis.
COUNSELOR: So, every so often, some pot. What else?
JUAN: I drink to come down. Wine helps me get to sleep.
COUNSELOR: Wine. What else?
JUAN: That's pretty much it, and all that other stuff I mentioned.
COUNSELOR: So, you use some grass and some wine to come down. But the one you use most is crack.
JUAN: Yes.

Master Clinician Note

Asking “what else?” and reflecting the client’s response invites the client to elaborate. This lets the counselor explore client motivation for substance use without evoking resistance. Similarly, in the next exchange, she uses “tell me more” to gather details about psychiatric symptoms.

COUNSELOR: Okay. I’d like to ask you a couple of questions about just how you have been feeling. Have you been feeling depressed, sad, like you are not enjoying things that you might usually enjoy?

JUAN: I haven’t been too good up here [*points to his head*] the past few weeks, so—

COUNSELOR: Well, tell me more about the past couple of weeks.

JUAN: I always wake up in the middle of the night and can’t get back to sleep with guys playing music at the shelter and stuff, and that pisses me off.

Master Clinician Note

The counselor is attempting to maintain and build the relationship with Juan through reflection, restating, and paraphrasing his comments. This is an effective technique from MI, although the counselor needs to be aware that the technique can be overused. If overused, rapport with the client will suffer.

COUNSELOR: So, you are having some trouble sleeping. What else is going on?
JUAN: That’s pretty much it.
COUNSELOR: That’s pretty much it. What about feeling anxious or irritable and angry?
JUAN: Well, yeah. All those things.
COUNSELOR: All those things from time to time. Is there ever a point where they are really causing big problems for you or getting in the way of other things you want to do?
JUAN: Yeah. I walked off that job. That was a dumb thing to do.

COUNSELOR: So that’s one case of feeling angry and making a choice you didn’t really want to make.
JUAN: Yeah, that wasn’t a good thing to do. It happens.

COUNSELOR: I hope that when you get settled in your apartment and when things are going better, we can talk about what happens when you get angry and get yourself in trouble.

JUAN: Yeah.
COUNSELOR: Juan, tell me some more about your sleep problem.
JUAN: Well, the wine just levels me off, helps me get to sleep. But then, when I drink a lot of wine, I wake up in the middle of the night and I can't go back to sleep.
COUNSELOR: Yeah, so that's sort of interfering with your sleep, too, you've noticed.
JUAN: I can't get to sleep without it, but then I wake up in the middle of the night.

[The counselor is supporting the client's growing awareness of the relationship between sleeping problems and substance use patterns.]

COUNSELOR: You drink wine to come down and fall asleep, but you've noticed that when you drink, you wake up in the middle of the night.
JUAN: Yeah, but it's better than going for a couple more days without getting any sleep.
COUNSELOR: How much sleep do you usually get?
JUAN: Don't know… 4 or 5 hours, maybe.
COUNSELOR: How much do you think you need?
JUAN: Maybe 6 or 7, 6 and a half hours.

How To Summarize for Your Client

Be concise. This makes for clarity and easier processing for the client. When summarizing:

- If possible, use the words and phrases the client has used.
- Be as accurate as possible in restating what the client seems to be trying to say. Try to not exaggerate or minimize what the client has said.
- Use phrases such as "What I am understanding is…" or "It seems that you're saying…" and check with the client to see if your understanding is correct.
- If the client says you are not understanding, ask him or her to tell you again and use the client's words in your feedback.
- Sometimes, it may be important to let the client know that understanding what he or she is saying does not imply approval of potential actions. For instance, if a client says they want to hurt someone else, be sure your feedback does not imply that you agree with their intent.

COUNSELOR: How often do you usually get that?

JUAN: Huh! Almost never.

COUNSELOR: Not very often. So, you walk around sleep deprived most of the time.

JUAN: Well, I never really thought about it that way. I'd like to sleep longer.

COUNSELOR: Yeah. You and I could work on ways to get a good night's sleep, and you've already connected wine with trouble staying asleep, and you have trouble falling asleep.

JUAN: Yeah. Without the wine, I lie in bed a long time before I drop off.

COUNSELOR: We could see what we can do to help you, if you would like us to do that.

JUAN: I don't know what, but yeah, if something can be done, I'm all for it. Maybe later.

Master Clinician Note

The counselor suspects, from the symptoms Juan has described, such as depression, anger, and anxiety reactions, that he might have a trauma disorder, but she avoids probing his trauma experience, which might, given his situation now, destabilize him and/or disrupt their developing rapport. Instead, she focuses on Juan's main related concern: sleep. She helps him see how these symptoms may be related to substance use. Once Juan has stabilized in housing and is possibly more receptive to engaging in counseling, she will help him access care for both his substance use disorder and, if necessary, his trauma disorder. For more information on working with clients who have trauma symptoms, see the planned TIP, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, planned h).

COUNSELOR: Okay. Do you ever have any beliefs that other people don't have, or do you see things other people don't see or hear things other people don't hear?

JUAN: No. I'm not crazy, man.

COUNSELOR: That's not you. Are there other problems you want me to be aware of at this point? Anything else that you would like us to work on?

JUAN: Just the apartment.

COUNSELOR: The apartment. So, at this point, we've completed this paperwork. The housing program will discuss this application, and we will get an arrangement that we can all agree to.

JUAN: Okay.

COUNSELOR: So, some of the things we've talked about working on are sleep, legal issues, anger, and how to manage things when situations aren't fair. Is that about right?
JUAN: So, when can I move in?

Master Clinician Note

Juan doesn't respond with "yes," which shows that he's not yet committed to working on these issues. The counselor must reexplore the issues with Juan to identify which ones he's ambivalent about.

How To Prepare a Client for a Conversation With a Parole Officer

When your client agrees to contact his or her PO to explore options, help prepare as follows:

- If your client isn't ready for treatment yet, it's reasonable to expect him or her to leave if the PO says going back either to jail or to treatment is necessary. Discuss the consequences of leaving (e.g., the possibility of being remanded to jail) and tell your client that, no matter the outcome, he or she is welcome to come back for help in the future.
- If your client is ready for substance abuse treatment, you can indicate that sometimes, when people agree to accept treatment and stay in it for a while, POs agree to remove the warrant.
- If parole concerns are a significant burden to your client, help him or her envision what it will be like to be rid of them. The PO might require substance abuse treatment or enforce jail time, but after, it will no longer be a concern. If needed, the two of you can work together on a plan for making it through treatment or jail time.

COUNSELOR: Well, we went over a lot just now. We want to make the housing plan really work for you. Next, we'll review your application and get our agreement in place. You can have a little more time to think about what I just summarized as part of your plan. Tomorrow, let's review the whole thing and make a housing plan we feel really good about—one that will give you the best shot at making it stick with the landlord. Now, let's talk about contacting your parole officer and get that sorted out.

JUAN: Yeah, well, I'm outta here if the PO's got a warrant on me.

[The counselor and Juan proceed to discuss what is going on between Juan and the PO. Juan and the counselor briefly role-play Juan talking to the PO.]

COUNSELOR: Do you want to call him now, while I'm here?
JUAN: That sound okay. If he doesn't go along with this, then everything else is out.
COUNSELOR: Right. We should talk with the PO first. We can use the speaker phone to hear both sides of the conversation. We'll see how that goes, then decide about talking to the team about your plan.

JUAN: Yeah, let's do that.

COUNSELOR: Juan, I'll need you to sign this "release of information" form that authorizes me to talk with your PO and provide him with information about our work so far. Is that okay?

JUAN: Okay, where do I sign?

[The counselor helped Juan prepare for his meeting with the PO by using some of the guidelines noted in the how-to box above. Juan's PO determined that he could avoid incarceration if he stayed in the shelter for homeless services. Juan did move into the Housing First program, and he and the counselor continue to work on his multiple problems. Likewise, the counselor continues to work on engagement, helping Juan move from precontemplation to the contemplation stage with his substance abuse. The counselor, using MI methods, has helped Juan examine how his ambivalence and sensitivity often prevent him from initiating actions that could be helpful to him.]

Summary

Juan's story took place in the O&E phase. The work focused on:

- Establishing a trusting relationship through nonintrusive persistence.
- Identifying acceptable goals to work on.

Maintaining teamwork among the counselor, Juan, and the interagency O&E team.

Teamwork was central to Juan's willingness to talk to the counselor, see the apartment, regain access to the shelter (and thereby move toward housing), begin the application process, and explore his legal status.

The counselor helped Juan move through the stages of change by prioritizing Juan's most important goals. Juan began in precontemplation for substance use and mental disorders

and the contemplation stage for housing. Housing became the highest priority goal; this let the counselor and Juan identify barriers to maintaining stable housing and reasons to engage in other services. Juan is now in the action stage for obtaining housing and the contemplation stage for substance abuse, mental illness, and legal issues.

Juan's personality problems, such as his hypersensitivity to criticism, his feelings that people are against him, and his sudden anger, may be his most challenging issues. They will be identified as concerns in his treatment after he becomes abstinent, manages trauma disorder symptoms, and develops a resilient, trusting relationship with his treatment team. At this phase of homelessness rehabilitation, the clinician can address behavioral issues by:

- Demonstrating respect for and acceptance of his feelings (e.g., anger, sense of unfairness).
- Helping him see how his behavior (e.g., hosting loud parties, leaving his job) contributes tohis homelessness.
- Setting a goal of working on alternative responses to problem situations.

Longer-term goals for this client will include:

- Creating a plan that Juan is confident he can accept and comply with for housing.
- Reconnecting him with family and other natural recovery supports.
- Working with treatment providers to engage him in substance abuse treatment.
- Reconnecting him with employment and other meaningful roles in the community.
- Addressing his parole obligations.
- Evaluating him for mental disorders

B. Vignette 2—Francis
Overview
Francis is in the outreach and engagement phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for responding to his health and safety concerns. Francis is a 54-year-old man who is chronically homeless and has limited interpersonal and intellectual resources. He is now a loner and has had difficulty in the past maintaining a place to live. He currently lives in a subway tunnel, is suspicious of anyone who approaches him, and worries that the transit authority will put him out. He can be personable, and he often spends his day at the entrance to the subway. The

outreach team has learned that Francis has occasionally gone to the local community health center, which is a Federally Qualified Health Center (FQHC; see the text box on p. 81), during the past 4 years. According to his clinic records, he has mild intellectual disabilities (intelligence quotient [IQ] near 70) and may have cognitive impairments as a result of a head injury incurred many years ago. He receives a small disability check monthly. The money is managed by a designated payee, a person who is authorized to help Francis manage his money. He also receives Medicaid as a result of his disability.

The program has been in contact with Francis for some time. He has always walked away after insisting that he is fine and doesn't need anything. The O&E team has new information from area shelters that he's building cooking fires in inappropriate places. In addition to his cognitive impairment, he has significant health problems, including diabetes and nutritional deficiencies. This information, along with an impending severe cold spell, mobilizes the O&E team to persist in trying to engage Francis in services.

A team of two counselors plans to meet him, briefly assess his situation, offer material goods, and establish a relationship. Getting him to accept shelter, health care, and ongoing support are long-term goals. The present goals are to engage him in any possible way to improve his safety and to find opportunities to offer other services.

Maintaining the safety of O&E team members is a critical element of this type of work. Francis's location has been reviewed and approved as safe by the team. (Sample safety policies and procedures are located in.)

Setting

The counselor team is part of a multiservice organization serving homeless populations; its street outreach component is staffed by peer counselors, substance abuse specialists, psychiatric social workers, and consultant psychiatrists. It has a drop-in center, housing resources, a working agreement with a local FQHC, and ties to community homelessness programs.

(Note: The designation of FQHC is based on specific funding and reimbursement criteria. There are a number of community health centers that may have an FQHC designation; however, there are other community health clinics and health centers that may not.)

Learning Objectives

- Build rapport (offer material goods; engage in casual conversation; work at the client's pace; show empathy, respect, and genuineness).
- Assess the severity of the client's problems (e.g., safety, health) and develop responses.
- Work with others as part of a team.

Strategies and Techniques

- Outreach
- Match client and counselor
- Service coordination with a local health clinic, a Federally Qualified Health Center

Counselor Skills and Attitudes

- Build rapport.
-

How To Engage People Who Are Living on the Street

Several tools can help outreach workers engage a person who is living on the street: • Observe from a distance to get a sense of what the person may need and how he or she is doing.

- Approach respectfully. Ask to join the person at his/her bench, campsite, or other personal area.
- Offer safety-related items that h e or she appears to need (e.g., food, shelter, blankets, water).
- Resist the temptation to offer items solely for comfort rather than safety, as this may support the client in refusing services. The goal is to develop an empathic

relationship that respects the client's wishes and creates opportunities to help the person become housed and enter treatment.

- Unless the individual indicates a willingness to have a longer conversation, keep your interactions brief (about 2 minutes) to avoid wearing out your welcome. Work collaboratively with the client and others.
- Recognize and accept the client as an active participant in prioritizing needs.

Vignette
Visit 1 (Francis's camp)
During this visit, the team will: • Initiate a relationship, begin to build trust, and establish rapport. • Offer Francis food and a blanket. • Tell Francis the weather is turning cold and offer to take him to a shelter. • Assess Francis's condition.

The two counselors slowly but casually approach Francis, who is seen lying down and snoozing among some of his belongings. He's bearded, disheveled, dressed in dirty clothing, mildly malodorous, and grimy. He is a large man, but he seems physically weak and malnourished. He awakens spontaneously as they approach but is unfocused and seems confused. Team members introduce themselves and shake Francis's hand. He doesn't know who they are and, fearing police or transit officials, he gets up, covers some items, picks up others, and begins moving away.

COUNSELOR 1: Hey.

FRANCIS: Hi.

COUNSELOR 1: How are you doing?

FRANCIS: I'm good.

COUNSELOR 1: Good. My name is Alex, by the way. [*gestures to colleague*] This is Tommy. [*Francis acknowledges them minimally.*] We were just coming by here and noticed that you looked kind of down in the dumps a little bit. How are you doing?

FRANCIS: I'm fine.

COUNSELOR 1: Good. Did we startle you?

FRANCIS: Are you the police?

COUNSELOR 1: Oh, no. We work down here in the tunnels and meet people who may be living down here or staying down here. Have you been down here for a while?

FRANCIS: Yeah.

COUNSELOR 1: What's your name, sir?
FRANCIS: Francis.
COUNSELOR 1: Hi, Francis.
FRANCIS: Hi.
COUNSELOR 1: It's getting kind of cold. Can I help you somehow?
FRANCIS: No.
COUNSELOR 1: Okay. Can we sit down?
FRANCIS: Yeah

[After receiving permission to do so (it is Francis's "home"), the outreach workers sit down. This encourages Francis to stay and talk with them. He makes eye contact and starts to pay attention.]

COUNSELOR 1: So, how long have you been here?
FRANCIS: Not long.
COUNSELOR 1: Um, I was thinking that it's getting kind of cold out. You said that you were okay. I just wanted to check and see if we could offer you a place to stay indoors.
FRANCIS: No, I'm fine. I went to the health clinic.

COUNSELOR 1: You did? Is that the one over on Second Avenue?
FRANCIS: Yeah.
COUNSELOR 1: I notice that your ankles look pretty swollen and red. Does that hurt?
FRANCIS: A little, but not all the time.
COUNSELOR 1: Is that what you went to the health clinic for?

How To Work as a Team Member on an Outreach and Engagement Team
Agencies often have policies supporting teamwork during outreach. Successful O&E teams collaborate on plans for outreach visits and respect each other's opinions. In Francis's case, the team agreed on the following:

1. O&E will proceed at the client's pace unless there is reason to fear that this will endanger the client (see the decision tree on p. 77).
2. Specific problems will be addressed as the client is willing. Team members work together to create opportunities to offer assistance in resolving these problems.
3. Team members should define roles in advance, especially in terms of who will take primary responsibility for the interaction.

Team members should observe which worker the client prefers to speak with and respect that choice. Workers not speaking directly with the client will help in other ways by remaining alert to the needs of both the client and their colleagues.

[Counselor 2 suddenly notes that Francis is becoming uncomfortable, looking away and beginning to pick at his clothes. The counselor assumes that his partner is being too directive with questions and, glancing at his partner, decides to take another approach]

COUNSELOR 2: How are you doing in the food department? Can I offer you a sandwich?

FRANCIS: Yeah.

COUNSELOR 2: [*handing him a sandwich*] Here you go.

FRANCIS: Thanks.

COUNSELOR 2: Sure. One of the reasons we are down here is that we're moving into a real cold spell over the next couple of days and, you know, when it gets cold, how do you usually manage yourself?

FRANCIS: [*making eye contact*] I'm fine. I have a bag.

COUNSELOR 1: A sleeping bag, you mean?

FRANCIS: Yeah
[Francis shows the counselor a warm sleeping bag in good condition.]

COUNSELOR 2: Do you need anything else from us? Like a blanket, maybe?

FRANCIS: Um… sure.

COUNSELOR 2: [*handing him a blanket*] Here you go.

FRANCIS: I'm through talking with you now.

COUNSELOR 1: Okay, I'll tell you what—we'll come back and see you another time. Can we do that?

[Francis agrees, and the outreach team says goodbye and walks away. After the visit, the two counselors report to the rest of the O&E team (consisting of a psychiatrist, a social worker, peer counselors, and a substance abuse treatment provider) and discuss the temperature and whether to do something to ensure Francis's safety. They decide that his situation isn't that bad; he responded appropriately to all questions, is sheltered from the weather, and has a good sleeping bag. They're concerned that he'll move now that he's been approached but decide that his camp looked well set up. That, coupled with his making eye contact and accepting food and a blanket, suggests that Francis will be in his camp the next day. They're concerned about his health and make a plan for the counselors to visit him frequently to monitor his general condition and the condition of his ankles, along with his ability to take care of himself in the cold. If the opportunity arises, they'll try to look at his feet. They plan to engage him in medical and other services at his pace and to take him some socks.

The decision tree on the following page indicates how providers might decide whether and how to intervene when a person who is homeless declines services.]

The next day, the O&E team members visit Francis again. Their goals are to:

- Offer him their business cards so he has a way to contact them.
- Offer him information about a new, smaller shelter that has opened up nearby.
- Make sure he knows that the weather is going to get even colder tonight.
- Observe his overall condition, the status of his feet, and his ability to take care of himself.
- Give him some socks.

COUNSELOR 1: Francis? It's Alex and Tommy. Remember us from yesterday?
FRANCIS: Yeah.
COUNSELOR 1: Good. Man, it was cold last night! How did you do?
FRANCIS: I did fine.
COUNSELOR 1: I see you're fixing up a little bit more space for yourself here.
FRANCIS: Yeah

[Francis attempts to stand and stumbles. He appears to be physically uncomfortable.]
COUNSELOR 1: Can we give you a hand?
FRANCIS: No, I'm fine.
COUNSELOR 1: Okay. Hey listen, you know—that shelter up on Avenue A has opened up and there's a spot in case you need it, because it's getting really, really cold. Is that something we can help you with?
FRANCIS: No. I'm fine

COUNSELOR 1: Okay. Well, we brought some socks for you; would you like some socks?

Master Clinician Note

Giving Francis socks is a nonverbal intervention that shows concern for his health and safety. It shows Francis that the team is connecting with his needs and is interested in building an alliance.

FRANCIS: Yeah. Thanks.

[Tommy hands Francis the socks.]

COUNSELOR 1: We'd also like to give you our cards in case you need to go to the shelter. We'll be around. Is it okay if we come back and see you again?

FRANCIS: Thanks. Yeah, you can come back.

COUNSELOR 1: Okay. Good. Give us a call if you need to. There's an 800 number there. Feel free to just call that number if you need us. We'll come back and see how you're doing in a while, okay?

FRANCIS: Okay.

COUNSELOR 1: There is a telephone right up at the top of the subway entrance, and this is an 800 number, so you don't need to use coins. You just dial this number. Is that okay with you?

FRANCIS: Okay.

Visit 3 (Francis's camp)

On their third visit to Francis's camp several days later, the O&E team has the following goals in mind:

- Continue to develop a relationship with Francis.
- Introduce Francis to the idea of getting follow-up medical care.
- Look for ways to connect him to housing opportunities.

COUNSELOR 1: Hey, Francis.

FRANCIS: Hey, how you doin'?

COUNSELOR 2: Hey, how you doing, Francis?

FRANCIS: Good.

COUNSELOR 1: I heard that you were in the shelter the other day.

FRANCIS: Yeah. I was there for a couple of days.

[Francis struggles to stand up—even though he is obviously in some pain—and he stumbles. The counselor reaches out his hand to help Francis stand and steady himself.]

COUNSELOR 1: Let me give you a hand there.

FRANCIS: Ow! I went to the clinic ’cause my foot was hurting a little bit, and they said I should go to the shelter.

Master Clinician Note
Francis has shown that if he really needs medical care and shelter, he can get them. This indicates that, despite some cognitive impairment, he uses good judgment in at least some situations. Cognitive impairment has a broad range of severity, from mild forgetfulness to full disorientation as to time, place, and person. Cognitive impairment may also be temporary or chronic. Because thinking can become disordered or inefficient, cognitive difficulties can impair judgment by compromising a person’s ability to evaluate the risks and benefits of any choice. The causes of cognitive impairment are many, but it may result from a head injury, malnutrition, alcoholism, or acute physical illness. The presence of clear cognitive impairment signals the need for a prompt medical evaluation.

COUNSELOR 1: Yeah, it looks pretty raw right down there. Looks really painful.

FRANCIS: No, it really don’t hurt that much.

COUNSELOR 1: Really? I see that your shoes are in kinda bad shape too. So, you’ve been walking around in shoes with holes in them, and it snowed the night before last, too, didn’t it?

FRANCIS: Yeah.

COUNSELOR 1: The weather must’ve been pretty bad on your foot. That’s why you went to the clinic?

FRANCIS: Yeah.

COUNSELOR 1: Well, you know, Tommy and I were talking, and we were thinking you could probably use a better place to sleep at a certain point; you know, indoors, in an apartment. Is that something you might be interested in at some point in time?

FRANCIS: Nah. I'm pretty fine out here. I mean, it's not too bad.
COUNSELOR 1: But when it gets cold, it gets a bit rough, and right now it's kinda tough.
FRANCIS: I'm pretty much a tough guy.
COUNSELOR 1: Yeah. I know. How long have you been staying outside? When was the last time you had your own place?

FRANCIS: Oh, about 3 years ago. Yeah, me and my buddy got a place. I moved in. It was pretty nice and everything. He kinda got sick a little bit. My friend passed away.
COUNSELOR 1: Oh, he did? I'm sorry.

FRANCIS: Yeah, it kinda was his place, so I couldn't stay there any longer.
COUNSELOR 1: Got it. You had trouble making ends meet and stuff like that after he passed.
FRANCIS: Well, yeah. It was hard.
COUNSELOR 1: Well, Francis, we'd like to help you find some better housing if you are interested.
FRANCIS: I'm fine.

COUNSELOR 1: Okay. Well, it's something to think about, and we would be glad to talk more about it.
FRANCIS: Okay.

COUNSELOR 1: I'm a little concerned about your foot, though, especially the pain you're going through.
FRANCIS: It's not much pain. I've seen worse. [*rubs his shoulder*] I was shot a long time ago.

COUNSELOR 1: Oh really? Can you use that shoulder pretty good?
FRANCIS: It's fine. Sometimes it hurts a little bit.
COUNSELOR 1: Just so you know, at the clinic there's a nurse in charge of foot problems, and if you'd like, we could take you down there to have her take a look at it if you want.
FRANCIS: You mean Miss Kate. I know her. She's nice. But I don't know. Like I said, it don't hurt that much.
COUNSELOR 1: Okay. It's a little raw. I'm concerned about you with your shoes in bad shape and stuff. You know, at the clinic, they might be able to set you up with a new pair of shoes.
FRANCIS: Can *you* get me some shoes?

Master Clinician Note

This is the first request Francis has made of the O&E team, and they take this window of opportunity to let him know that they want to help him get what he needs. Offering concrete aid like this fosters engagement because it shows Francis that the team will respond to his manifest needs. Counselors will want to be sensitive to clients making a request as a test of whether the counselor and other members of the staff will really respond to the client's expressed needs.

What Is a Federally Qualified Health Center?

A Federally Qualified Health Center is one that is qualified to receive Federal Medicare and Medicaid funds for delivering services to persons enrolled in those programs. In addition, an FQHC program may be eligible for grants to provide services to special target populations, such as individuals and families experiencing homelessness. Typically, FQHCs are found in areas that have large populations of medically underserved individuals and/or in areas with high concentrations of migrant and seasonal agricultural workers, significant numbers of people in public housing, or high rates of homelessness. FQHCs are located in every State.

FQHCs are directed by a community-based board of directors and provide comprehensive primary health care regardless of a person's ability to pay. Fees are based on the individual's ability to pay. Additionally, many preventive services are offered, including screening, brief intervention, and referral to treatment (SBIRT) for individuals at risk of substance abuse and substance use disorders. For more information, see https://www.cms.gov/MLNProducts/downloads/fqhcfactsheet.pdf.

COUNSELOR 1: Yeah, we can bring you some shoes the next time we come. Would it be all right with you if I bring a worker from the clinic? They can help you get medical care for your feet.

FRANCIS: Yeah.

COUNSELOR 1: Okay, great. Take it easy, all right? By the way, what size shoes do you wear?

FRANCIS: I don't know. Size 10, I think. Okay, see you later.

[The team will ask the FQHC clinic's homeless program case manager to join them on their next visit with Francis. They intend for the clinic staff person to become Francis's case manager and help him access medical care, possibly obtain permanent supportive housing, and access other services. During the visit, the clinic case manager will take engagement and intervention cues from the O&E team.

The team feels hopeful that they will get medical attention for Francis's feet on their next visit. Francis has demonstrated that he'll go to the clinic when the pain becomes limiting, but the immediate risk to Francis is that his feet are probably numb as a consequence of his diabetes. This creates a risk of injury and infection, which can lead to serious complications.]

Visit 4 (Francis's camp)

The team approaches this visit with the following goals and strategies in mind:

- The clinic case manager will accompany them and begin to establish a relationship with Francis.
- The team will offer Francis food, shoes, and a ride to the clinic, where he can have his foot examined.
- If Francis fears being coerced into unwanted services, they'll promise to return him to his camp.

Francis is at his camp and is irritable. He didn't go to the shelter and is cold and obviously unhappy. The two counselors introduce the clinic case manager to him.

COUNSELOR 1: Hey, Francis.

FRANCIS: Hey.

COUNSELOR 1: You know, I said we'd be back in a day or two, but we've been thinking about your situation with your foot. We called up the clinic, and they were concerned. Let me introduce Jesse to you.

CLINIC OUTREACH WORKER: Hi, Francis. Yeah, I've seen you come by the clinic a couple of times. I think we spoke once. My office is just as you enter the clinic out of the waiting room, on the right. You know, we can help you with that foot, man.

COUNSELOR 1: Yeah. We can take you to the clinic and then bring you back here if you want.

CLINIC OUTREACH WORKER: Yeah, we can do that. You don't need to stay here.

FRANCIS: I don't need no help.

COUNSELOR 1: A nurse can look at that foot.
FRANCIS: Didn't I just tell you I don't need no help

Master Clinician Note

The counselor appraises the situation and realizes that the introduction of another person with whom Francis has not had a chance to develop rapport and, possibly, the pressure Francis perceives about getting help are causing Francis to resist. Rather than provoke the resistance, the counselor takes the opportunity to change the topic and talk about the weather for a few minutes. He then returns to the discussion of Francis going to the clinic for health care.

COUNSELOR 1: Well, man, I hope you are going to be willing to let Jesse help you get over to the clinic and get that foot taken care of.

FRANCIS: That's all we're gonna do, right?
CLINIC OUTREACH WORKER: Yeah. It's your call. Can we take your stuff with us?
FRANCIS: Yeah. If you don't take things around here, they…
CLINIC OUTREACH WORKER: Yeah, I know. They get taken by somebody else.
FRANCIS: So, are we going to the clinic that I go to?

COUNSELOR 1: Yeah, that's where the nurse is. She'll look at your foot and we'll get some food for you—a sandwich and some hot coffee. How do you like your coffee?
FRANCIS: All black

[Once the team has promised not to leave him at the clinic, Francis agrees to go with the outreach worker. He's now in the preparation stage for medical care and the precontemplation stage for assistance with housing.]

Summary

This vignette demonstrates counselor skills and attitudes involved in outreach work, including:

- Patience, respect for client autonomy, and trustworthiness
- Relationship-building skills.
- Ability to respond appropriately to changes in the client's behavior.

- Ability to work as a member of a team and respond appropriately to safety and medical needs.

In the O&E phase, the team's interventions suited Francis's stages of change: contemplation and preparation for medical treatment, and precontemplation for housing. They prioritized the goal most pressing to Francis and his well-being: addressing his medical problems. Interventions to build a relationship and increase readiness for services included:

- Asking for permission and respecting his decisions and personal space.
- Offering incentives (e.g., socks, blanket, shoes, food).
- Increasing access to services (e.g., bringing workers to him, helping with transportation, helping him take his things with him).

Given Francis's willingness to engage *on his terms*, agreement to engage in additional services will also be on his terms. As shown in this vignette, Francis moves forward assisted by the creativity, care, respect, and persistence of the counselors who work with him. The challenge for the counselors is to continuously balance Francis's freedom of choice with the severity of his condition.

Long-term goals for working with Francis include:

- Help him engage in medical treatment at the clinic to stabilize his current medical conditions.
- Evaluate his mental health, particularly in light of his cognitive impairments.
- Make a plan that he's confident he can adhere to for housing.
- Reconnect him with his family and other recovery supports.
- Connect him with other peer-led community recovery supports.

C. Vignette 3—Roxanne

Overview

Roxanne is in the intensive care phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for preventing homelessness and stabilizing a client who is in the precontemplation stage of substance abuse treatment.

Roxanne is 32 years old, has been diagnosed with antisocial personality disorder, and is possibly dependent on oxycodone and other opioids. She occasionally has sex in exchange for money and sells pain pills for income. Roxanne lives in a supportive housing program, but her behavior has put her housing at risk. Her hostility, impaired ability to regulate her emotions, physical complaints, self-destructive and impulsive behavior, and impaired relationships may be indicative of a trauma-related disorder as well as a personality disorder.

These behaviors may evoke an emotional reaction (countertransference) in the counselor, evidenced in this case by the counselor's anger, frustration, and helplessness. This makes it hard for the counselor to respond effectively to Roxanne's needs. Supervision in such a situation is quite important and can help the counselor clarify boundaries, responsibilities, and strategies for holding Roxanne responsible for her behavior while providing support to facilitate behavior change.

Roxanne's behavioral health counselor has talked to her many times about using drugs, bringing men paying for sex to her single room occupancy (SRO), and "shopping for pills." Even so, Roxanne continues to have her clients "visit" her in her room. She also continues to seek drugs for severe chronic back pain—particularly oxycodone—in local emergency departments (EDs).She has been evaluated on several occasions for pain (including comprehensive studies of her back and spine in the hospital pain clinic), but no evidence of a physical disorder has been found. About 2 years ago, she was referred to the hospital pain management program but did not follow through with their recommendations. She has had two admissions to a local mental health treatment center, both times following arrests for disorderly conduct and resisting arrest.

The clinic suggested that she might have posttraumatic stress disorder (PTSD) and/or a substance use disorder in addition to her personality disorder, but these diagnoses were not confirmed, and Roxanne refused to continue to be seen at the clinic. She did agree to enroll in a hospital case management program for ED users that includes consent to share information with the behavioral health counselor in her SRO. The ED has called the counselor to report that Roxanne is now there and is refusing to leave without medication, even though she has been examined and released with a clean bill of health.

Setting

The behavioral health counselor provides case management services for a community program offering a variety of housing options to clients with a history of substance use

disorders or SMI. All of the clients have had mental health and/or substance abuse treatment. The level of recovery varies from very stable to active symptoms that interfere with daily functioning. In most cases, a client's level of recovery determines the housing options available to him or her. In this case, the counselor provides services to clients housed in an SRO supportive housing program funded through the U.S. Department of Housing and Urban Development (HUD). The housing consists of units with a kitchen and bath for occupancy by one person

Learning Objectives

- Tailor treatment strategies, including the use of incentives, to match the client's motivational level.
- Work with others as part of a team.
- Recognize situations in which supervision is appropriate.
- Work with clients experiencing homelessness who are in the precontemplation stage of change for their substance abuse.

Strategies and Techniques

- Behavioral interventions, including contingency management
- **Structuring sessions**
- Managing and setting limits on inappropriate behavior

Counselor Skills and Attitudes

- Work collaboratively with the client and others.
- Recognize and accept behavioral change as a multistep process.
- Take responsibility for personal and professional growth (e.g., address countertransference).
- Adjust strategies to suit client characteristics (e.g., using a calm tone to convey safety and control when clients feel out of control, making lists of priorities to structure sessions).

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Vignette

Visit 1 (hospital emergency department)

Because Roxanne's behavior is sometimes inappropriate, two counselors go to the ED. Counselor 1 is Roxanne's assigned counselor. The counselors' goals for this meeting are to:

- Help Roxanne leave the ED before she is arrested.
- Set up an appointment for the next day to discuss her concerns.
- Transport her back to her SRO.
- Preserve their organization's relationship with the ED.

They find Roxanne in the waiting area. When she sees the team arrive, she immediately begins insulting the ED staff, loudly complaining that no one is paying attention to her pain.

ROXANNE: That b#*%! is ignoring me! Can't you see I'm in pain? My *God!* No one here cares about anybody but themselves, God #*%! it! Maybe you can help me. Tell them I'm in pain! I'm in pain!!!

COUNSELOR 1: Roxanne…

ROXANNE: Thank *God* you're here! Oh my God, thank you. You gotta tell them I hurt! I'm hurting! My back hurts so much! They don't know what the #*%! they're doing here!

[Roxanne grabs Counselor 1's shirt. Caught off guard by this, the counselor turns his head away.]

ROXANNE: Make them pay attention to me!

Master Clinician Note

Given Roxanne's history and current behavior, it may be that she was not examined carefully. Barring any clear danger to the client, it is important to avoid confronting the ED staff with this possibility at this time. Issues about Roxanne's treatment in the ED

can be carefully examined away from the urgency of the moment. Moreover, Roxanne may further escalate her behavior if she senses disunity between the ED staff and her counselor. The team will address Roxanne's own behavior and desire for medication after leaving the ED, minimizing disruption and breach of privacy in the public waiting area

COUNSELOR 2: Roxanne, listen…

[Counselor 2's calm tone and kind manner catch Roxanne's attention.]

ROXANNE: No, I'm really hurting! You gotta get me some medication, pleeeease! *You* understand. I'm a woman. I have problems. You understand. Can you help me, *please!!* Please! My back really hurts!!

COUNSELOR 2: Roxanne. Can you—

ROXANNE: [*shouting*] Let's go to another hospital! I gotta do something!

COUNSELOR 2: [*calmly but firmly*] Can you go back to the chair, please? Listen, they called us and said they can't give you medication. We'd like to get you in the van and take you home.

Master Clinician Note

Counselor 2's calm, firm tone communicates safety and control, and the simple instructions help Roxanne, who feels out of control, focus and calm down. There are no easy solutions to this situation. If Roxanne had *not* deescalated, the counselor might next have opted to give her the choice of leaving the ED to discuss further options. She may have said, for example: "You say you want to go to another hospital. Let's go outside, where we can speak more privately and discuss the options." The short walk may have allowed Roxanne to collect her thoughts away from an audience in the ED. The counselor's second option might have been to call security. Although always a potential tool for safety, using this option too hastily may have resulted in a power struggle and led to Roxanne's physical restraint and sedation, the former being highly traumatizing and the latter unintentionally colluding with her demand for medication. This would have reinforced her repeated inappropriate demands. As Roxanne engages in treatment, her providers will assess her trauma symptoms, develop an understanding of how her behavior helps her cope with these symptoms, and integrate this conceptualization into her treatment plan.

[In a quick, nonverbal exchange, the two counselors agree that Counselor 2 will take the lead in interacting with Roxanne. Their training has prepared them for just such situations. They know that if both try to interact with Roxanne, it is likely to create an environment in which Roxanne can play one counselor against the other.]

ROXANNE: What are we gonna do about this God #*%! pain?! That b#*%! isn't helping me.

COUNSELOR 2: We'll set up an appointment. Do you think you'll be ready for one tomorrow?
ROXANNE: I want some meds.
COUNSELOR 2: They aren't going to give you meds here. We already know they've made that decision.
ROXANNE: I hurt. I'm hurting. I'm *really hurting!* Please! Somebody *help* me, please!

COUNSELOR 2: Tomorrow we're going to try and take care of it. Just let me—
ROXANNE: Well, you *better*. I'm gonna sue somebody. I'm gonna sue that b#*%! over there!
COUNSELOR 2: Forget them for now. You know the last couple of times we talked to you about some options, and we can do that again tomorrow.
ROXANNE: I need something for this pain. Can you get me something tonight?

COUNSELOR 2: I can't get you something tonight.
ROXANNE: What am I gonna do, then?
COUNSELOR 2: We're going to get in the van, we'll take you home, and you can get some rest, try to sleep, and get a fresh start in the morning. All right?
ROXANNE: What time?

How To Intervene With a Client Who Is Being Disruptive in a Public Place

1. Compassionate direction can help the client disengage from the situation and calm down. Speak calmly and firmly; give simple instructions (e.g., "look at me," "please sit down").
2. Get the client out of the public place. One way to shift the client's focus is to say, "Your pain is important to us—let's go somewhere where we can talk and make a plan to deal with it the best way we can."

3. You may be tempted to agree to unrealistic requests, like a meeting at 7 a.m. It's okay to set limits by saying, "I'm not able to meet with you at 7, but I can meet with you at 8:30."
4. If you give in, one way to rectify it is to say, "Look, I know we said 7. I was feeling your pain and lost my sense of what I'm really able to do tomorrow. I can't come any earlier than 8:30." Your client may not be pleased with waiting until 8:30, but you're modeling how to handle inappropriate requests, and the client will appreciate that you are being clear about what you're able to do.

COUNSELOR 2: You name it.

ROXANNE: Seven o'clock.

[During the van ride back to her home, Roxanne tests more limits by insisting that she needs pain medication and taking off her seatbelt. The counselors stay composed, calmly telling Roxanne that they'll pull over if she won't put on her seatbelt. They give her the option of getting aspirin at a drug store, which she accepts. As Roxanne begins to calm down, she throws a cup at a counselor. Both counselors stay calm, explaining that her safety is important to them, so they can only transport her if she stops doing things like throwing cups. They say that they want to take her back home as long as she's willing to use her seatbelt and refrain from unsafe behavior. Roxanne agrees to accept the ride on those conditions.]

Master Clinician Note

Reacting with harsh confrontation or a punishing tone to provocative behavior like Roxanne's is tempting. However, the counselors understand that her personality disorder along with possible PTSD make it very difficult for her to regulate her emotions and that it is important to reinforce her sense of safety, control, and empowerment. Additionally, Roxanne has, in the past, often been successful in getting what she wants by escalating her disruptive behavior and becoming provocative. It is important that the counselors recognize the provocation as an attempt to get her needs met and refuse to be manipulated by it. The counselors believe that when Roxanne returns home, she'll buy pills on the street. They could say, "I can see that you're really hurting and I'm worried that you'll do something that may put you at risk between now and tomorrow morning. Let's talk about options." The counselors know that this suggestion is unlikely to influence her immediate choices, but planting the seed helps her develop alternative coping skills to manage her discomfort, and they convey their concern that she might

use a maladaptive coping behavior. The counselors also recognize that some of the irritation, agitation, and pain that Roxanne is experiencing may be residual withdrawal symptoms. In subsequent visits, the counselors will focus on helping Roxanne increase her motivation to obtain substance abuse treatment, return to the pain management clinic, and develop coping options when her subjective experience of pain feels like it is becoming unmanageable.

Visit 2 (Counselor's Office)

Roxanne sleeps past her appointment, although the counselor has telephoned to wake her. When she finally arrives in the afternoon, she doesn't want to discuss her behavior at the ED, preferring instead to make demands on the counselor. The counselor's goals for this meeting are to:

- Reinforce the therapeutic relationship with Roxanne, particularly in light of their encounter in the ED the previous evening.
- Discuss her behavior at the clinic and her other options for pain management.
- Engage Roxanne in a screening process to assess for a possible substance use disorder.

Help Roxanne understand the requirements of the SRO regarding drug use and visitors.

Roxanne arrives with a list of complaints, including not having water last night and feeling back pain. In response to the counselor's attempt to focus on her behavior at the ED, she becomes even more upset.

Master Clinician Note

The counselor agreed to meet Roxanne at an early hour. When she doesn't appear, he's angry. He also expects Roxanne to be erratic and provocative in today's session, possibly leading to a nonproductive or even contentious session. He needs to prepare for the session, first, by accepting his angry feelings and, second, by carefully preparing constructive responses (e.g., supportive limit setting, keeping goal expectations modest and prioritized) before the meeting.

ROXANNE: I go ’cause I hurt and they ignored me last night! What are we gonna do about this water situation? I had to go out last night to get water, to take some more pills. There was no water. By the way, I got a letter today from public assistance telling me they’re cutting off my benefits. Nothing’s happening! I don’t understand. Somebody here did something. Somebody’s got it in for me, I just *know*.

Master Clinician Note

In almost every session, Roxanne has a pattern of raising multiple issues that seem unrelated. If the counselor begins to address one of these issues, Roxanne is likely to change the subject and move to another perceived problem. It is important for the counselor to identify the most pressing issues and help Roxanne stay focused on those issues. Some strategies the counselor could use include:

1. Assessing and prioritizing problems to address.
2. Considering which problems, if effectively addressed, will ease the pressure of or resolve other problems.
3. Evaluating which problems Roxanne and the counselor can effectively address and which they cannot.
4. Deciding how complex problems can be broken down into several less complicated problems that can be addressed.

COUNSELOR 2: They’re concerned about your behavior at your building. The housing manager called and said you’re violating the visitor policy and getting into fights with your neighbor. I’m worried about your being able to stay there. If things keep going like this, I’m afraid you’re going to lose your apartment.

How To Keep a Client Focused

When treating clients with many demands or problems, the following strategies may help:

- Limit session length at the outset (e.g., “we have only half an hour today”).
- Create a list of the client’s priorities to help you both maintain focus on treatment goals.
- Stay consistent from session to session. Stick with the treatment plan.

- Be firm but not rigid. Things will occur that dictate a need to change the treatment plan.
- Set goals that are realistic and can be accomplished in a timely manner. Identify realistic expectations for client behavior; recognize small successes as progress.

[The counselor decides to focus on the housing issue with Roxanne because if she does lose her housing, it will be very difficult for her to maintain the gains she has made in other areas of functioning.]

ROXANNE: I'm gonna lose my apartment if I don't get my #*%!ing benefits turned back on.

COUNSELOR 2: Well, we don't want you to lose your apartment. So, the next time or maybe the time after when you come in, bring that paperwork for your benefits, and we'll see what you and I can do about you keeping your benefits. But Roxanne, we have to look at what is going on in your apartment. Maybe we can meet—you, me, and the housing manager of your apartment—and see how we can resolve some of these problems. Do you think we could do that?

ROXANNE: That's really not gonna do anything for my pain. My back hurts, and it hurts *all the time!*

COUNSELOR 2: I agree; your pain is difficult. I hope you can get back to the pain clinic at the hospital, but right now, let's see what we can work out about keeping your housing.

ROXANNE: The only thing that helps is oxycodone. It *really* helps

Master Clinician Note

The counselor realizes that Roxanne is not prepared to focus on any one issue except getting her drugs and that continuing to pursue issues about housing or obtaining substance abuse assessment is going to be futile. He anticipates that continuing to press Roxanne at this time will only increase her alienation and escalate her complaints. He decides to forgo more discussion at this time and wraps up the session with a summary of their visit, reminding Roxanne to bring her benefits papers when she returns for the next visit.

[This was a particularly challenging session for the counselor. Feeling overwhelmed by Roxanne's demands, the counselor knows he should seek supervision. The supervisor

affirms the counselor's choice to seek assistance. His supervisor helps him assess Roxanne's problems and then structure sessions, assess Roxanne's readiness for change regarding her possible substance abuse, and identify appropriate interventions while also providing support for the counselor. The supervisor encourages the counselor to continue to address the challenges of working with Roxanne in supervision. Some of the supervisor's suggestions and insights include:

- Support Roxanne's goal to keep her housing; this keeps the door open for her to accept indicated treatment later. Offer options, but don't take responsibility for her choices. She will make her own.
- Help Roxanne increase her motivation to obtain an evaluation for substance abuse treatment.
- Use contingency management (described later in this vignette) to help her engage and stay in treatment if it is indicated. Offer incentives she relates to (e.g., clothing vouchers) for meeting objectively measurable goals that are important to her (e.g., keeping her housing by behaving appropriately in response to complaints, attending pain management for treatment of her back pain). This will help her develop internal motivation.
- Encourage Roxanne to develop coping skills for managing anger. If she becomes hostile, end the session in a compassionate, noncombative way and see her again when she's able to speak calmly.
- Help Roxanne focus during sessions by making a list with her that includes her goals, such as getting help for her pain and addressing concerns about her apartment.
- Spend the last 15 minutes of every session reviewing the items covered during the session, keeping Roxanne focused on her list of goals and ways she can demonstrate that she has reached these goals.
- Reframe her behaviors as strengths. She is skilled at reading people, focused on her own agenda, actively engaged in getting what she wants, and persistent. This will increase her sense of self-efficacy and help her see ways of shifting her behavior toward more adaptive outcomes.

Continue noting counter transferential feelings in response to Roxanne's behaviors; seek supervision.]

Visit 3 (housing manager's office)

After meeting with his supervisor, the counselor, with the cooperation of the housing manager of Roxanne's apartment building, schedules a meeting with Roxanne, the housing manager, and himself. The manager has been confronted by other tenants who complain that Roxanne is loud and argumentative and may be using her apartment for prostitution. The housing manager notes that if Roxanne cannot be more cooperative, she is going to lose her apartment.

The counselor wants to foster a spirit of teamwork, hear firsthand about the problems Roxanne is creating, and support the housing manager in working with Roxanne to reduce the risk of losing her apartment. The counselor's goals for this meeting are to:

- Assist Roxanne in keeping her apartment; the counselor sees Roxanne's maintaining stable housing as a precondition to addressing other issues, such as pain management, substance use, and management of trauma symptoms.
- Show Roxanne that her concerns are taken seriously.

Trauma-Informed Care

Trauma-informed care is an approach to working with clients who have histories of trauma that recognizes trauma symptoms and integrates this information into treatment planning and delivery. Roxanne's counselors recognize that many of her behavioral symptoms may be a result of significant trauma in her history, and they use that recognition in helping Roxanne develop a treatment and recovery plan that incorporates mental health, substance abuse, and trauma care along with housing. One key strategy of trauma-informed care is empowerment: helping the client take responsibility for his or her own recovery and life. Observe how the clinicians, in cooperation with the housing manager, seek to empower Roxanne. For more information on trauma-informed care, see the SAMHSA-sponsored National Center for Trauma-Informed Care Web site (http://samhsa.gov/nctic/) or consult the planned TIP, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, planned h).

- Create an environment that reinforces adaptive behavior.
- Show that the service team is unified in its approach to her problems.
- Address specific issues raised by a neighbor who has complained about Roxanne's behavior.

The counselor and the housing manager agree that the housing manager will take the lead in the meeting. The counselor will step in to support Roxanne when she identifies positive changes, she is willing to make regarding her housing situation.

ROXANNE: Someone stole my public assistance stuff, and I'm sure it was her, because that b#*%! is just out to get me. She has nothing good to say about me. You've gotta take care of that! She slips nasty notes under my door and threatens me for some reason. She's just got it in for me, and I've just *had it* with her!
HOUSING MANAGER: Well, she has some complaints about you too, Roxanne.

ROXANNE: What have *I* done?
HOUSING MANAGER: She says you're always having a lot of men over at your place.
ROXANNE: [*sounding superior*] I'm allowed to entertain anybody I want.
HOUSING MANAGER: Well, I need you to do some things for me; I have a job to do, Roxanne.
ROXANNE: You just do your job.

HOUSING MANAGER: Well, you're going to have to help me do my job.
ROXANNE: How? You're gonna pay me to do your job?
HOUSING MANAGER: No, this is what I want you to do: Cut down on the traffic to your room.

ROXANNE: There's nothing in the rules that says I can't have people there. I've read the rules. I know what they say. They don't say that I can't have people there.
HOUSING MANAGER: I have just told you I've had complaints from your neighbors, so I'd be willing to work with you if you're not going to—
ROXANNE: She's just got it in for me. I'm not going to say one word to that b#!*%! But I tellya, when I catch her stealing my mail, she's gone!

How To Prepare for Joint Sessions

1. Support a spirit of teamwork among the staff members who are present: Create a tone that emphasizes that everyone is working toward the same goal.
2. Use the first minutes of the session to set boundaries for the focus of the session, being clear about the issues that will be discussed. Everyone comes to the session with a separate agenda, and things can get out of hand without clear agreement on session goals. Be sure all participants have an opportunity to state their goals.

3. Prepare all participants for the client's likely responses (e.g., coping styles): review the client's history, current issues and goals, and past behaviors in similar circumstances.

How To Manage Inappropriate Behavior

When your client becomes inappropriately seductive and oversexualized with the staff:

1. Pause and identify for yourself what he or she is doing.
2. Consider how this behavior fits with your conceptualization of the client. Inappropriate behavior is part of chaotic relationships.
3. By stepping outside the chaos and observing what is going on, you can identify the seductiveness and label it as an issue to work on in treatment.
4. It is also important to kindly and firmly limit the inappropriate behavior.
5. Use structure (e.g., a list of priorities) to help the client focus.

HOUSING MANAGER: Well, if you catch her stealing your mail, you should come tell me and I'll make a police report. What's going on with your apartment?

[Roxanne continues by listing a variety of problems with her apartment: a leaky bathtub, peeling paint, a problem with her refrigerator, a wall switch that isn't working, and a request for a new mailbox lock because she thinks her neighbor is stealing her mail. The housing manager listens carefully and takes notes of the items that need correcting. Although the housing manager does not commit to making all of the repairs immediately, he does seem to be listening carefully and taking her concerns seriously.]

HOUSING MANAGER: Anything else?

ROXANNE: Well, that's it for now. There's always something. But those are the worst now.

HOUSING MANAGER: So, you need a mailbox key, a refrigerator, a new paint job, and the tub fixed.

ROXANNE: When are you gonna do it?

HOUSING MANAGER: What are you going to do for *me?*

ROXANNE: What do you mean, what am I gonna do for *you*? I don't *work* for you!

HOUSING MANAGER: What are you going to give me when I fix these things?

ROXANNE: [*a bit sarcastically*] A "Thank you very much."

HOUSING MANAGER: Now, can I tell you what I want from you?

ROXANNE: Something from me? *I've* got something. [*seductively*] You'll really enjoy it.

HOUSING MANAGER: This is exactly what I'm talking about, Roxanne. This is not appropriate. Let's talk about what we can do with the apartment.

ROXANNE: But you said I was going to have to give you something, so you set me up.

Master Clinician Note
The counselor steps in to interrupt the conflict and redirect the conversation and then steps back to let the housing manager take the lead once again.

COUNSELOR 2: Let's listen to what he would like to have you do. [*addressing the housing manager*] What is it that Roxanne can do to help with this?

HOUSING MANAGER: The main thing that will help me speed up making the repairs is if you're willing to consider not having as many people over in one evening.

ROXANNE: What do you mean, not as many people?

COUNSELOR 2: Limit her guests to just one or two in an evening?

HOUSING MANAGER: Yeah.

COUNSELOR 2: Can you do that?

ROXANNE: Yeah, I can do that.

HOUSING MANAGER: Which of your apartment problems would you like me to address first?

ROXANNE: Uh, my refrigerator.

HOUSING MANAGER: Yeah, I'm not saying I'm going to replace it. I'll replace it if it's not repairable.

ROXANNE: Okay.

HOUSING MANAGER: And we'll take care of the tub.

ROXANNE: Okay. What are you going to do about my neighbor, though?

HOUSING MANAGER: I'm going to talk to her, and I'm going to ask her not to bother you.

ROXANNE: You do that. I won't bother her, believe me. She's gotta stay away from my mail!

COUNSELOR 2: If you think that she's in your mail, will you come to me and let me handle it?

ROXANNE: Yes.

COUNSELOR 2: Okay. So, can we go look at her refrigerator now?

HOUSING MANAGER: Yeah, sure.

[The housing manager leaves the meeting to get the repairman to work on Roxanne's refrigerator. After his departure, the counselor spends a few minutes with Roxanne, supporting her for working toward resolving the problems. He also reinforces the need for Roxanne to limit visitors to her apartment and to bring complaints to the manager rather than confronting other residents directly. The counselor notes that during the entire meeting, Roxanne did not complain of pain or the need for pain pills. He does not mention this to Roxanne, but decides to wait for Roxanne to raise the issue again. He schedules the next appointment with Roxanne for later in the week at his office.

After returning to his office, the counselor calls the housing manager to express appreciation for his skillful work in the meeting, thus building teamwork.]

Visit 3 (Counselor's office)

After another meeting with his supervisor, the counselor sets these goals for his next visit with Roxanne:

- Use a list to structure and prioritize the conversation.
- Help Roxanne accept medical treatment with Dr. Thomas, the program physician, who is associated with a local community health clinic. The counselor would like to use the visits with Dr. Thomas as an entry point for getting Roxanne to return to the pain clinic at the hospital, hoping that pain management may be a way to engage her into addressing her substance use.
- Identify some strategies to help Roxanne move from the precontemplation stage to the contemplation stage for addressing her substance use.

Roxanne arrives late, looking exasperated and preoccupied. She apologizes for being late and begins a rapid-fire complaint about her neighbor. The counselor helps her focus on making a list of priorities for them to work on.

COUNSELOR 2: What I'd like to do is talk about the most important things for you *right now*. There are so many things going on. What's the most important thing for us to try to help you with right now?

ROXANNE: What do you mean, "help?" I mean, there's all kinds of things going on.

COUNSELOR 2: Yes, there are a lot of things. Let's see if we can decide which are most important to focus on right now.

ROXANNE: So, you want me to choose which is the most important thing?

COUNSELOR 2: Yeah.

ROXANNE: My back.

COUNSELOR 2: Okay, so we want to concentrate on…

ROXANNE: Then my neighbor.

COUNSELOR 2: Your neighbor?

ROXANNE: My public assistance is still cut off. I got this leaky faucet.

How To Use Lists To Keep Clients Focused

1. Ask, "What are the three most important things for you? It helps me to make a list of what's important." Lists create structure and help the counselor and client stay on the same page.
2. Help the client prioritize his or her most important concerns.
3. When the client veers off, the counselor can say, "Well that's not on the list. Let's talk about your list because those are the most important things. If they aren't the most important, we can change the list."
4. Agree on the time needed for each item to increase structure. "How long do you think we need to handle this item? Also, I need to speak with you about a few things, so I'll need 15 minutes at the end to talk about… "

COUNSELOR 2: So, there are four things.

ROXANNE: I've got this guy after me—I'm real worried about that. And my back.

[The counselor and Roxanne settle on three issues to focus on today: her pain, the man who is after her, and relationships with other tenants at the SRO housing facility.]

COUNSELOR 2: All right, so let's talk first about getting you an appointment with Dr. Thomas about your pain.

ROXANNE: I don't like him.

COUNSELOR 2: He's the physician we can use in this program.

ROXANNE: Can't you find me somebody else? Can't you find me a woman doctor?

COUNSELOR 2: Sorry, we don't have a woman doctor. I understand that you would rather see a woman doctor, but Dr. Thomas is the only doctor assigned to this program. If you see Dr. Thomas and then still want to see another doctor who is female, I can see if we can arrange a referral.

Master Clinician Note

The counselor thinks that Roxanne wants another physician because Dr. Thomas has not given her pain pills on past visits, but he is sensitive to the possibility that Roxanne may want to see a female physician because of a history of sexual traumatization. He doesn't explore that issue right now with Roxanne, but he makes a note to explore it in the future with her.

ROXANNE: [*sighing*] Oh, all right. But he doesn't give me pills for my pain.

COUNSELOR 2: Roxanne, I understand that your pain is a real difficulty for you. But the drugs you want are very addictive, and I don't think you are going to find doctors who will consistently give you the drugs you want.

ROXANNE: No, I need it. It takes away the *pain*. I'm not addicted to it.

COUNSELOR 2: I know you don't think you are addicted. But we need to find some other ways to manage your pain and your drug use.

ROXANNE: Yes. I'm not addicted to it, I mean… I just need something for the pain. I mean, look, if I can't get oxies, I'll buy something else off the street.

COUNSELOR 2: They help?

ROXANNE: Yeah, because the pills take away the *pain.*

Master Clinician Note

The counselor is preparing Roxanne to have modest but substantive expectations of the consultation with Dr. Thomas. By acknowledging Roxanne's pain and eliciting the relationship between Roxanne's pain and her drug-seeking behavior, the counselor enhances rapport and identifies one of Roxanne's needs. The counselor also demonstrates acceptance that Roxanne is in the precontemplation stage of change for addressing her drug-seeking behavior and the contemplation stage for exploring alternatives to oxycodone for managing her pain.

COUNSELOR 2: You can talk to Dr. Thomas about what you might do to manage the pain. You and he can make a plan for what you can do about the pain.

[The counselor raises the issues of the man who is “after” Roxanne and her relationship with the other tenants in her housing, but Roxanne shows little interest in addressing either issue now.]

Master Clinician Note

The counselor suspects that Roxanne’s complaints have diminished as a result of her feeling understood and having her needs recognized. With another client at a more advanced stage of change, the counselor might ask if the client feels more comfortable or less distressed than when she came in, and then proceed to explore what happened to initiate the change. But with Roxanne, the counselor suspects this intervention might just invite Roxanne to begin focusing on all that is going wrong in her life and lead her to feel more agitated.

Roxanne lets the counselor schedule the appointment, and the counselor agrees to talk to Dr. Thomas about attending to Roxanne’s concerns. He will also ask Dr. Thomas to consider talking with Roxanne about the pain management clinic and encourage her to accept a referral.

Besides the meeting with Dr. Thomas, Roxanne agrees to continue to bring her concerns about the apartment to the housing manager and not the other residents. Roxanne has a letter from public assistance that she doesn’t understand, so she will bring it with her when she goes to see Dr. Thomas, and the counselor can help her with it. This contingency makes it more likely that Roxanne will show up for her appointment.]

Visit 5 (counselor’s office)

The counselor speaks with his supervisor about his countertransference with Roxanne and his concerns about forming a treatment contract. They agree on specific goals for the counselor’s next visit with Roxanne, which include:

- Remaining consistent with the list of priorities.
- Following up on Roxanne’s visit to Dr. Thomas.
- Developing a contingency management program for Roxanne that will support her continuing in treatment and reinforcing changes she has made in pain reduction, drug use, interpersonal relationships, and continuing in treatment.
- Expecting Roxanne to present urgent issues and responding by maintaining a firm but flexible focus on treatment goals.

- Helping her form reasonable expectations of what can be accomplished; keeping the list manageable.

Roxanne reports that, as a result of seeing Dr. Thomas, she's scheduled for a magnetic resonance imaging scan (MRI) of her back and asks what an MRI is. The counselor explains, and Roxanne expresses disappointment that the doctor gave her no medication. She also agreed to schedule a visit to the pain clinic to reenter the pain management program, part of which is a comprehensive evaluation for substance abuse, brief intervention, and referral for treatment, if needed.

ROXANNE: I'm really pissed off 'cause I'm still hurting, and he didn't give me anything.

COUNSELOR 2: Well, I'm really impressed by the fact that you're hurting and yet you came to meet with me, and you worked to get some things done in the apartment.
ROXANNE: My bathtub still isn't fixed.
COUNSELOR 2: Some things are taken care of.
ROXANNE: Yeah, he gave me a new key. I got that.
COUNSELOR 2: Good. I think when you focus, you get things done and people respond to you. That is a real strength that you have.

Master Clinician Note

This intervention identifies and positively reinforces Roxanne's adaptive behavior, thus building her self-confidence and esteem.

ROXANNE: I guess… people just keep bothering me.

COUNSELOR 2: Well, look. I read over your letter from public assistance. It's just a confirmation of your status. Your status hasn't changed. I can be a witness to that.

ROXANNE: What happened?
COUNSELOR 2: It's just a routine evaluation to see whether you're eligible to have continued assistance. You have to sign this to confirm it and I can sign off on it.
ROXANNE: [*after reading the document*] Where do I sign?

COUNSELOR 2: Right here. [*Roxanne signs the document.*] Good. I'll sign as a witness.
ROXANNE: Can I get a copy of that?

COUNSELOR 2: Absolutely. So, you've shown up for the appointments with the housing manager and Dr. Thomas, and you brought your letter as I asked, so I think you're really making some progress here.

ROXANNE: My *pain* is still there, though.

Master Clinician Note

The counselor is participating in a pilot program in the agency to use a newly developed cognitive–behavioral strategy, contingency management, with a few selected clients. Contingency management reinforces positive behaviors toward treatment goals by rewarding the client with vouchers for items that most people would like. Rewards might include special recognitions or program benefits, such as additional hours away from the treatment program. The rewards need to be tied to specific, identifiable, clearly measurable goals, such as clean drug screens, attendance at self-help meetings, and consistent treatment program attendance. Contingency management is generally implemented in settings with a number of clients participating. In this vignette, contingency management is used with just one client. Contingency management is often used in concert with cognitive–behavioral therapy. For more information on contingency management, refer to SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP). Contingency management is also a term sometimes used in housing services, where contingencies, such as staying abstinent, are a condition for housing.

[The counselor briefly explains the contingency management program to Roxanne in terms of rewarding positive, objectively measurable steps toward treatment goals. Roxanne seems quite interested in obtaining vouchers or coupons for products that she might not otherwise be able to purchase.]

COUNSELOR 2: I want to give you a coupon because you kept your appointments with the doctor and the housing manager. I've got a voucher that will get you a free hair appointment. How would you like that?

ROXANNE: I'd like that. Thank you.

COUNSELOR 2: Okay. Next week, if you keep doing well and I get no calls from the housing manager or from the ED, you'll get a voucher for Interfaith Clothing Closet to get some outfits. How's that sound?

R**OXANNE:** *Now* what do I have to do?

COUNSELOR 2: I don't get any calls that you've been into the ED.

ROXANNE: What if I'm *sick*?

COUNSELOR 2: Well, you're working with Dr. Thomas. You're having an MRI next week, so we have a plan that you're working on. If you get sick in the meantime, call Dr. Thomas.

ROXANNE: What if I have a pain in my back again, like a stabbing pain, and I can't stand it anymore and it's, like, in the middle of the night, and Dr. Thomas is not available?

COUNSELOR 2: If something happens and you have an emergency, then you can go to the emergency room. But if you're going to ask for oxycodone, that wouldn't be following our agreement.

ROXANNE: So, I can go to the emergency room, but I can't ask for any pills?

COUNSELOR 2: Right.

ROXANNE: Okay.

[The counselor educates Roxanne about how stress and pain are related, and how there may be other ways to address the pain that may be more helpful than pills. Roxanne refuses to consider going to the pain clinic and steers the conversation back to the emergency department.]

ROXANNE: [*dismissive*] Well, I just know what's gonna happen. I'm gonna wake up in the middle of the night, and I'm gonna be in pain, and I'm not gonna be able to go back

to sleep, and I'm not gonna be able to get help because you're telling me I can't go to the emergency room and get some oxies.

COUNSELOR 2: I didn't say you couldn't go to the ED. I said it's not consistent with our agreement if you go to the ED and try to get oxycodone.

ROXANNE: I'm gonna go to the emergency room to get some relief or something
COUNSELOR 2: So that will be our understanding. If the ED tells me you were requesting oxycodone again, I won't give you the voucher for the Clothing Closet. Do we agree about the voucher and the ED?
ROXANNE: [*tolerant*] I suppose.

COUNSELOR 2: Okay. Well, I think we have everything set up. Now, I'd like for us to put our agreement in writing. Would you like to have that? I promised you a voucher for the Clothing Closet. You could go there and pick two outfits, but in return, the understanding is that you won't go to the ED and ask for oxycodone, and you'll follow through with your appointment with Dr. Thomas next week.

ROXANNE: [*a little confrontational*] And if I don't sign?

COUNSELOR 2: We won't have an agreement, and you won't get a chance to get a couple of new outfits. This is how we both understand what we're agreeing to. What have you got to lose?

[Roxanne challenges the counselor; his calm response enables her to go along with the plan.]

ROXANNE: Can I get some shoes with that?

COUNSELOR 2: I don't know whether they have shoes, but the voucher gets you a couple of outfits. If the outfits include shoes, you could look at shoes.

ROXANNE: Okay.

Master Clinician Note

Committing the plan to paper is a good idea for Roxanne; she'll have it to help her remember what she is supposed to do in order to get the clothing voucher. It also assures her that as long as she follows through, the counselor will, too. Some clients may not need written cues, but when structure and/or ability to remember details are issues for clients, it is a good idea to put agreements in writing.

Summary

The counselor now has the tools to respond effectively when Roxanne is demanding and chaotic. He understands that he can't realistically meet all her needs and doesn't have to. Clinical supervision helped him become aware of his countertransference (i.e., feeling angry, weary, manipulated, challenged, and provoked) and develop ways to manage it so he can respond to Roxanne calmly yet firmly. This approach helps her form a plan to keep her housing, address her back pain, and consider alternatives to oxycodone.

When Roxanne was in the ED, she was in the precontemplation stage of change for finding alternative ways to manage pain, substance use, high-risk behavior, provocative behavior, and housing problems. The counselor's respectful and empowering intensive-care approach (goal setting and reinforcement of appropriate behaviors) has moved Roxanne into the preparation stage for alternatives to managing pain and the action stage for keeping her home and changing problem behaviors. As she succeeds in managing pain and maintaining housing, she may be more motivated to engage in substance abuse treatment.

Long-term goals for working with Roxanne include:

- Continuing to support and reinforce behavior that allows her to maintain her housing.
- Continuing to pursue pain management.
- Obtaining treatment for her substance use, if warranted.
- Increasing motivation to engage in services by exploring and resolving ambivalence; creating plan that she is confident she can make work.
- Connecting her with acceptable recovery supports (e.g., mutual support groups, faith-based supports).

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End of the Course!!