

Services for People with Special Needs

participant materials
supportive housing training series



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PSYCHOTIC REACTIONS

I. DEFINITION

Psychosis means the person has had an extreme break with reality. There is severely maladaptive behavior and subjective disturbance.

II. CHARACTERISTICS OF PSYCHOSIS

1. DISTURBANCES IN THINKING. This may be in the area of:
 - a. Thought content — this means the person is delusional. A delusion is a fixed and false belief system.

OR

 - b. Thought process — the person cannot organize his/her thoughts in a way where one statement coherently follows the next. What is being said makes no sense to the listener.
2. PERCEPTION — The person will perceive things that are not actually present (hallucinations).
3. AFFECT — The person may not be able to express emotion that is appropriate to the situation at hand.
4. BEHAVIOR — The person's behavior may be disorganized, confused or bizarre. This is usually in response to internal stimuli (hallucinations and delusions).

III. WORKER'S ROLE IN MANAGEMENT OF PSYCHOSIS

1. Provide support and empathy.
2. Do not agree or disagree with psychotic beliefs. Try to focus on what is based in reality or on the person's feelings.
3. Document behavior and alert appropriate staff.
4. Be familiar with program rules about emergencies.
5. Medication is crucial to controlling severe symptoms in some types of psychotic disorders. Social service staff may monitor person's medication.
6. Symptoms escalate if the person is under stress. Person needs help to avoid and manage stress.
7. Person may need help with basic independent living skills.

IV. CAUSES OF PSYCHOSIS

There are many reasons why someone may show symptoms of psychosis. Some possible reasons are:

1. The person has a serious mental illness such as schizophrenia.
2. The person is using psychoactive substances.
3. The person is under a lot of stress.
4. The person has a personality disorder.
5. The person has an organic mental disorder.

MOOD DISORDERS

DEFINITION: A disturbance in mood or emotions (usually depression or elation) that is prolonged and affects the individual's functioning. Stressors (e.g., loss) can bring on these disorders in those who are vulnerable to them.

I. MAJOR DEPRESSION

Overall Mood and Related Symptoms:

- Loss of pleasure or interest in activities
- Feelings of hopelessness, worthlessness, guilt
- Difficulty concentrating
- Recurrent thoughts of death
- Lethargy
- Agitation
- Sleep and eating disturbance
- Possible hallucinations and/or delusions

II. MANIA

Overall Mood and Related Symptoms:

- Extremely elevated mood
- Grandiosity
- Euphoria
- Pressured speech
- Extreme excess of energy
- Person may not eat or sleep
- Possible delusions

III. BI-POLAR DISORDER

Person fluctuates between mania and depression

IV. WORKER'S ROLE

1. Document and alert appropriate staff of any concerns about person's behavior.
2. Be empathic and supportive without agreeing with hopelessness.
3. Do not try to cheer up a depressed person. It may make them feel worse about themselves.
4. Remind depressed person that there is treatment that is usually effective.
5. Be familiar with procedures for suicidal emergencies.
6. Medication is usually necessary to treat these mood disorders. Social service staff may monitor medication.
7. Person may need help with daily tasks.
8. Try to direct the manic person into "safe" activities.

PERSONALITY DISORDERS

A personality disorder is a cluster of specific traits that are inflexible and maladaptive and cause significant impairment in social and occupational functioning or cause significant subjective distress. The impairment generally persists throughout the person's life. Personality Disorders result from arrested or impaired development stemming from childhood experiences. It is also possible that biochemical factors play a role in the development of these disorders.

TYPES

PARANOID PERSONALITY DISORDER is a pattern of pervasive distrust and suspiciousness such that others' motives are interpreted as malevolent.

SCHIZOID PERSONALITY DISORDER is a pattern of detachment from social relationships and a restricted range of emotional expression in interpersonal settings.

SCHIZOTYPAL PERSONALITY DISORDER is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior.

ANTISOCIAL PERSONALITY DISORDER is a long-standing pattern of disregard for other people's rights, often crossing the line and violating those rights. The hallmark of this disorder is that the person does not feel regret or remorse.

BORDERLINE PERSONALITY DISORDER is a pattern of instability in interpersonal relationships, self-image, affect and marked impulsivity in a variety of settings. There may also be a history of self-abuse and/or suicidal behavior.

HISTRIONIC PERSONALITY DISORDER is a pattern of excessive emotionality and attention-seeking behavior.

NARCISSISTIC PERSONALITY DISORDER is a pattern of grandiosity, need for admiration and lack of empathy.

AVOIDANT PERSONALITY DISORDER is a pattern of social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation.

DEPENDENT PERSONALITY DISORDER is a pattern of submissive and clinging behavior related to an excessive need to be taken care of and fear of abandonment.

OBSESSIVE COMPULSIVE PERSONALITY DISORDER is a pattern of preoccupation with orderliness, perfectionism and control at the expense of flexibility and efficiency.

NOT OTHERWISE SPECIFIED (NOS) is a pattern of functioning that does not meet criteria for any specific disorder.

Criteria summarized from *American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders, fourth edition.*

PERSONALITY DISORDERS

STAFF'S ROLE IN MANAGEMENT OF BEHAVIORS ASSOCIATED WITH PERSONALITY DISORDERS (particularly those associated with Borderline Personality Disorder)

MEDICATION

For periods of psychosis, depression or anxiety, medication may be useful. Social service staff would work on this issue.

TEAMWORK

To avoid division among staff, it is important that all staff give the person the same message. Set clear limits and boundaries. This means staff communication is essential. Do not talk with the tenant about other staff.

MANAGE OUR OWN ANGER

In order to maintain a sense of safety, some individuals with Personality Disorders may challenge others by targeting their insecurities. Do not take what is said personally. When staff feel anger toward a tenant who is doing this, we accept the feeling because it is only natural, but we avoid acting on it. We maintain a professional stance. Get support and vent feelings with other staff/supervisors.

PROVIDE STRUCTURE AND LIMITS

Be clear, consistent and non-punitive. All staff sets the same limits. Do not get personally involved with the individual's problems.

TEACH PROBLEM-SOLVING SKILLS

People with Personality Disorders have a hard time making decisions. Social service staff may assist individuals to make their own decisions. It may be tempting to make the decision for the person, but this does not allow them to learn new skills and they will likely blame you if things go wrong.

PRESENT OBJECTIVITY DESPITE STRONG FEELINGS

People with Personality Disorders often attempt to recreate their chaotic childhood environment because it feels familiar and is all they know. The emotions of such individuals are very intense, whether it be sadness, rage or anxiety. We try not to react to or get "caught up" in the intensity of such feelings because it limits our ability to be helpful and professional.

SIGNS AND INDICATORS OF SUBSTANCE USE

BACKGROUND:

People use substances (alcohol and other drugs) and become dependent upon them for a variety of reasons. Some of these reasons include a genetic or hereditary predisposition, childhood exposure, a way to reduce depression, anxiety, stress or other psychological distress. Oftentimes, this use of substances causes impairments in an individual's functioning, including an inability to work, budget and socialize, and an increase in depression, psychotic symptoms and disruptive behavior.

SIGNS AND INDICATORS OF SUBSTANCE USE

<u>PHYSICAL SIGNS</u>	<u>BEHAVIORAL/MOOD INDICATORS</u>
blood-shot eyes alcohol on breath smell of marijuana sweating staggering slurring of speech lack of coordination laughing uncontrollably bizarre, inappropriate behavior drowsiness poor concentration watery eyes, runny nose insensitivity to pain nausea and vomiting nodding, itching	change in mood change in mental status chronic irritability secretiveness friends who use substances borrowing, stealing money or valuables out late lack of accountability to community norms/rules increased aggression/hostility depression paranoia prolonged sleep fatigue poor money management unexplained injuries unwillingness to allow worker to contact family/friends poor personal hygiene arguments or fights inexplicable protracted homelessness poor management of time inability to keep appointments

Guidelines for Staff:

- It is helpful to remember that people are often motivated to stop using substances when it becomes an obstacle to achieving some goal that they have, rather than because it is a problem for others. This is an area for social service staff to work on with the person.
- Workers should be aware of own judgmental attitudes regarding substance use and avoid conveying them to the tenant.
- Set clear limits especially around disruptive behavior. Staff should share information about tenant substance use.
- People who are addicted are focused on obtaining drugs and alcohol. Do not lend money or otherwise contribute to the person's ability to obtain substances.
- Maintain realistic expectations. Recovery is an ongoing process often involving some "slips" or relapses. Support the relapse-prevention plan for tenants.
- We often feel angry about this problem. However, it is not helpful to express this to the substance user. Express your anger, frustration and other negative feelings to your supervisor and colleagues.
- It is generally ineffective to talk to a person about his or her substance use when he or she is high. The priority at that time is to provide support by keeping things safe and calm for the tenant.
- Document all incidents and alert social service staff. Social service staff will do outreach and offer individual support.

MODELS OF ADDICTION AND RECOVERY

MORAL MODEL: Drug and alcohol use is considered a matter of choice and addiction is caused by a lack of will or poor character.

TREATMENT GOAL: To deter addiction through laws that punish use.

TREATMENT STRATEGIES: Usually interventions of choice are seen in terms of punishment or repentance.

GENETIC/DISEASE MODEL: Addictions are caused by pre-existing, perhaps genetic, physiological conditions that result in a "loss of control" over drug use. Loss of control means the addict cannot control the amount they will consume during an episode of drinking, nor predict when it will stop.

TREATMENT GOAL: Life-long abstinence from all drug use.

TREATMENT STRATEGIES: Detoxification or maintenance on substitute drugs such as methadone. Addicts are educated about the adverse consequences of addiction and helped in overcoming psychological defenses, such as denial, that prevent abstinence.

SELF-MEDICATION MODEL: Individuals use/abuse substances in order to self-soothe unpleasant mood states, feelings and emotions such, as anxiety, emptiness, hyperactivity, depression, etc., in an attempt to gain emotional equilibrium. This is particularly relevant to mentally ill people who may use illicit substances for years in an effort to control their thoughts and behaviors.

TREATMENT GOAL: To treat the underlying problems.

TREATMENT STRATEGIES: Use of biofeedback, acupuncture, stress reductions, various medications, including methadone, psychotropics, antidepressants and anti-anxiety.

SYMPTOM MODEL: Addiction is a result of underlying emotional disturbance. Psychodynamic theorists see addiction as a symptom that is shaped by underlying emotional conflicts, such as fixation at early stage of psychosexual development or other intrapsychic events.

TREATMENT GOAL: Resolution of the underlying conflict that gives rise to drug use.

TREATMENT STRATEGIES: Psychotherapy that is aimed at gaining insight into the antecedents of addict's behavior and restructuring their personality.

LEARNING MODEL: Addiction is learned behavior acquired by positive and negative reinforcements. This learned behavior is a result of one's environment, including family, friends and community. For instance, one may learn to reduce tension by taking drugs.

TREATMENT GOAL: To interrupt drug use behavior patterns and develop alternative behaviors.

TREATMENT STRATEGY: To discover the stimuli that elicit drug use, the events that shape the stimuli and the effects that maintain it. Help develop alternative behaviors.

SOCIAL MODEL: Addiction is caused by social arrangements in which an addict is embedded. It is thought that social conditions that produce alienation, frustration and despair lead to drug use. Addictive behavior is seen as being supported by subcultures where drug use is seen as normative.

TREATMENT GOAL: Change society so that conditions favoring drug use do not exist.

TREATMENT STRATEGIES: Vocational training and job development programs designed to give addicts access to mainstream opportunities and culture. Remove addicts from subcultures that are seen as supporting/legitimizing use. Work-site prevention programs are aimed at organizational factors that normalize drug use.

BIOPSYCHOSOCIAL MODEL:

The biopsychosocial model incorporates all aspects of a person's life and is a holistic approach to viewing addiction. Addiction is influenced by a myriad of conditions and factors. As the addiction process unfolds the psychological, physiological and sociocultural factors interact to influence not only the emergence of addiction but also its maintenance and interruption.

TREATMENT GOAL: To help the person gain insight into factors that affect their particular addiction and its maintenance.

TREATMENT STRATEGIES: To understand the unique factors in a person's life that have contributed to drug use and to understand what their current needs are.

STAGES OF CHANGE — HIGHLIGHTS

*Modification of problem behavior involves progression through five identifiable **stages**:*

• **precontemplation** • **contemplation** • **preparation** • **action** • **maintenance**

Individuals typically recycle through these stages several times before termination of the problem behavior, especially if the problem behavior is addiction.

Precontemplation is the stage of unawareness or under-awareness of any problem related to either drinking or other drug use. There is no intention to change behavior in the foreseeable future. A lot of defensive behaviors are evidenced, including denial, externalization and minimizing. It is the rationalization stage where it is commonly heard, *"I don't have a problem...it's your problem."*

Contemplation is the stage in which the person is aware that a problem exists and begins to think seriously about overcoming it. However, a commitment to take action has not yet been made. An important aspect of this stage is weighing the pros and cons of the problem behavior. It is sometimes called the *"Yes, but..."*, or mobilization stage. Helping people to examine their drug using behaviors in the context of their life goals, while eliciting negative consequences of use, is critical. Abusers struggle with giving up the positive effects of their substance use as they consider the amount of effort, energy, and loss it will cost to stop using.

Preparation is a decision-making stage and combines intent with behavioral criteria, i.e., *"what I will do, what I will not do."* Some reductions in problem behaviors may have been made — for example, no longer drinking in the residence, but standing outside on the corner — so that specific criteria for effective action, such as abstinence, have not yet been reached. Nonetheless, in talking with workers, residents may say they are not drinking at all, *"...after next weekend."*

Action is the stage in which individuals modify their behavior, experiences or environment in order to overcome their problems, and can range from a period of one day to six months. For dually diagnosed people, this abstinence follows considerable commitment of time and energy. Most supported housing programs have strict (sometimes rigid) requirements regarding sobriety before applicants are accepted, so that most residents have reached this stage in the past. Cycling toward action again, following relapse, is difficult, but the reminder that it has been accomplished in the past is somehow encouraging, to both resident and worker. In this way, relapse is viewed as an opportunity for learning and not as a failure.

Maintenance is the stage in which people work to prevent relapse and consolidate the gains attained during action. This stage extends from six months and onward from the initial action. For mentally ill, chemically abusing people, maintenance, in essence, lasts a lifetime. Since relapse is the rule rather than the exception with addictions, relapse prevention is critical.

* Source: *In Search of How People Change* by Prochaska, DiClemente and Norcross, *American Psychologist*, September 1992.

HARM REDUCTION

Harm Reduction is a model of intervention developed in Europe during the 1980s as a public health response to the spreading HIV disease epidemic. Given that there will always be a portion of the population that becomes dependent on chemicals, harm reduction stresses that morality should be removed from the solution. This model aims to reduce the negative consequences of use, including reducing the public health threat of HIV transmission and contact with the criminal justice system. It also strives to minimize physical and psychological deterioration, while helping a person maintain some level of functioning.

Harm Reduction may include:

- ❁ Offering services to active users (i.e., clean needles, safe havens, wet housing, big breakfasts for drinkers and supportive counseling).
- ❁ Recognizing abstinence as an ideal outcome but accepting alternatives that reduce harm.
- ❁ Providing user-friendly services, including low barriers for participation, informal atmospheres, consumer-appropriate hours and location considerations.

COMPONENTS OF RELAPSE PREVENTION

- **IDENTIFY TRIGGERS:** Looking at people, places and things associated with addictive behavior. Fun group activities can include “the clock”: identifying times of the day associated with positive experiences and then looking at the times most associated with use. “Trigger hunt”: combing the neighborhood for triggers and writing up a list.
- **PSYCHO-EDUCATION:** Teaching about the withdrawal process, principals of addiction and recovery through worksheets, presentations, videos, etc.
- **DEVELOPING COPING STRATEGIES** for high-risk situations: Using behavioral rehearsals, role plays and discussion to prepare for difficult encounters (i.e., meeting the “active” friend, telling family about recovery needs, attending a social function, etc.)
- **EXPLORING POSITIVE ALTERNATIVES AND USE OF LEISURE TIME:** Looking at how to manage one’s time now that substance use is not the organizing force. Suggesting or learning about new activities, hobbies and interests. Discussing how change and growth is often accompanied by fear.
- **LEARNING FROM PRIOR RELAPSES:** Listing the circumstances that preceded the last relapse: teasing out the changes in thinking, behavior and emotion that precipitated the act of “picking up.” Helping the person to recognize their own particular warning signs.
- **JOURNALING THOUGHTS, EMOTIONS AND BEHAVIORS:** Using a personal journal to record situations that provoke thoughts and emotions and how these can lead to picking up or abstaining. Incorporating cognitive-behavioral tools such as the “Action Connection”.
- **PLANNING AND DOCUMENTING SOLUTIONS:** Identifying high-risk situations and formulating a list of possible coping strategies. After the situation, reviewing what worked and what did not. Incorporating cognitive-behavioral tools such as “SODAS”.

HIV/AIDS FACT SHEET**I. DEFINITION:**

AIDS (Acquired Immunodeficiency Syndrome) is a condition caused by one of the many strains of the human immunodeficiency virus (HIV). The HIV virus debilitates the body's immune system — its armor, or defense system, against illness — and the person is easily susceptible to a range of illnesses, infections and cancers. Ultimately, it is one or more of these "opportunistic infections" that results in death for the individual. A person can be infected with the HIV virus and not have AIDS.

II. TRANSMISSION:

HIV is transmitted through INTIMATE PHYSICAL CONTACT. To date, there has been NO EVIDENCE that the virus can spread by:

- The air
- Toilet seats
- Holding hands or hugging a person with AIDS
- Eating food prepared by a person with AIDS
- Through tears or sweat

HIV IS SPREAD BY:

- Blood to blood contact — i.e., sharing needles
- Blood to semen contact — i.e., oral, anal and vaginal sex
- Through breast milk and amniotic fluid from mothers to children
- Receiving contaminated blood products [risk of contracting the virus this way is 1 in 60,000 and cannot be contracted by giving blood].

III. SIGNS, SYMPTOMS AND OPPORTUNISTIC INFECTIONS:

There is variation in which illnesses people will contract. Common illnesses include bacterial infections, funguses and certain cancers.

- Excessive fatigue
- Weight loss and "wasting syndrome"
- Persistent fever/night sweats
- Persistent diarrhea
- Enlarged lymph nodes
- Discolored nodules, lumps, boils or sores on the skin
- Thrush — white coating on the tongue
- Shingles — blisters caused by a herpes virus
- Pneumonia/tb
- Karposi's sarcoma — skin cancer
- Encephalitis, meningitis

- Cervical cancer
- AIDS Dementia — can include psychotic symptoms, personality dysfunction, memory and judgement impairment
- CD4 cell (also called T-helper or T-cell) count below 200/cubic mm of blood. These cells are important to the body's ability to fight infection.

IV. TREATMENT:

At this time, there is no cure for AIDS. The person is treated for the opportunistic infections he or she develops. Medication seems to delay or eliminate the onset of symptoms. There are a number of other experimental drugs undergoing trials.

To reduce the likelihood of developing opportunistic infections:

- Avoid high-risk behavior — i.e., unprotected sex, sharing needles
- Avoid cuts and scrapes
- Avoid travel to areas with poor hygiene/sanitation
- Eat a good diet
- Avoid drugs, including nicotine, caffeine, ETOH, narcotics, as these substances are immune-suppressing
- Reduce stress and depression

V. COMMON RESPONSES TO BEING HIV+ OR TO HAVING AIDS

- Denial
- Grief, mourning, sadness, depression
- Withdrawal, isolation
- Anger — why me?
- Shame

VI. STAFF'S ROLE IN MANAGEMENT OF ILLNESS:

- Be supportive
- Don't withdraw — if you feel like withdrawing, get support from your colleagues/supervisor
- Try to accept bad/sad feelings
- Be watchful for depression/suicidal thoughts and report to colleagues
- AIDS and HIV-related information is protected by strict confidentiality laws. You may not always know if a person is HIV+ or has AIDS. Since we don't always know who is/isn't infected, we should always use **universal** blood and body **precautions**.

HIV/AIDS TRANSMISSION QUESTIONNAIRE

Most of us have contact with HIV-positive persons regularly. It may be riding on public transportation, going to a sports event or concert, it can be family members, friends, neighbors, co-workers and tenants. Fill out the following questionnaire about the transmission of HIV/AIDS.

CAN YOU GET HIV FROM:

	YES	NO
• THE AIR	[]	[]
• TOILET SEATS	[]	[]
• ORAL SEX	[]	[]
• EATING FOOD MADE BY SOMEONE w/AIDS	[]	[]
• ANAL SEX	[]	[]
• BREAST MILK	[]	[]
• TEARS	[]	[]
• VAGINAL SEX	[]	[]
• SWEAT	[]	[]
• SHARING NEEDLES	[]	[]
• HOLDING HANDS	[]	[]
• HUGGING	[]	[]

UNIVERSAL PRECAUTIONS GUIDELINES

Universal Precautions are a set of risk-reduction measures, outlined by the Centers for Disease Control, to be used for anyone coming into contact with the blood or body fluid of another person. These precautions can help reduce the risk of infection with blood-borne viruses such as HIV, hepatitis B, herpes viruses and other retroviruses.

BODY FLUIDS TO WHICH UNIVERSAL PRECAUTIONS APPLY

- Blood
- Semen & Vaginal Fluids

BODY FLUIDS TO WHICH UNIVERSAL PRECAUTIONS DO NOT APPLY

- | | | |
|---------|--------|------------------|
| • Feces | Sputum | Nasal Secretions |
| • Sweat | Saliva | Tears |
| • Urine | Vomit | |

The exception would be if any of the above fluids contained *visible* blood. Of course, good infection-control practices should still be used when handling these fluids, such as wearing gloves and washing hands after contact.

TREAT EVERYONE WITH THE SAME DEGREE OF CAUTION

There is no way to know who is infected with a blood-borne infectious disease, so when handling body fluids, assume everyone might potentially be infected.

BARRIER PROTECTION

Barriers keep a potentially infectious substance from contacting your blood stream. There is no current evidence to suggest that hepatitis B or HIV can penetrate intact skin.

- PROPER HAND WASHING — after handling any body fluids and removing gloves.
- INSPECT HANDS — before coming in contact with any body fluids, check your hands for openings in the skin barrier (rashes, cuts).
- PROPER USE OF GLOVES — latex or vinyl gloves should be checked for holes before wearing. They should be thrown away immediately after use.

ANTIVIRAL CLEANERS

- Bleach
- Peroxide
- Isopropyl Alcohol

Wearing gloves, pour cleanser on spill, cover with paper towel and mop up.

HANDLING SHARPS

- Never Attempt to Recap a Used Needle
- Dispose of Used Needles in a Sharps Container Immediately After Use
- Keep Sharps Containers Readily Available and Do Not Overfill

SUPPORTS NEEDED IN HOUSING

The primary goals of most supportive programs are to help tenants maintain their housing and maximize their capacity for independent living. Supportive services focus on helping tenants meet the obligation of their lease and develop the skills to live stably in the community. Services in supportive housing are meant to be flexible, and adjust to the changing needs of tenants rather than tenants adjusting to fit into the supportive service program and may include:

- Assistance with Budgeting and Paying Rent
- Access to Employment
- Tenant Involvement in the Ongoing Development of Community, Including House Rules and Services Offered
- Medication Monitoring and Management
- Daily Living Skills Training or Assistance
- Medical and Health Services
- Counseling and Support in Achieving Self-Identified Goals
- Assistance in Meeting Lease Obligations and Complying with House Rules
- Referrals to Other Services or Programs
- Conflict-Resolution Training
- Substance Abuse Counseling
- Entitlement Advocacy
- Community Building

Many programs have integrated communities, meaning that some tenants may be designated as having special needs while others are not. The on-site supportive services are usually available to all tenants regardless of whether they have been designated as having special needs.

STAFF ROLES AND BOUNDARIES

It is important to know your role in the supportive housing project. It is helpful to be friendly with tenants, but professional boundaries must be maintained. All people need clear boundaries in order to feel safe. The following are some standard issues that define professional boundaries.

COMMON GOAL

In the many roles and different tasks we perform at work, there is a common goal — to help the tenants maintain themselves in supportive housing. This is part of what makes the relationship professional vs. personal.

DEALING WITH DIFFICULT BEHAVIOR

This is supportive housing. By working in this setting, we are required to be supportive and to sometimes deal with behavior we would not have to deal with at a different type of job setting or off-the-job site.

NOT TAKING THINGS PERSONALLY

As workers in supportive housing projects, we cannot personalize the behavior of the tenants. We can set limits.

ENFORCING RULES

Setting limits is based on project norms, not on our personal feelings. The aim is to enforce project rules, not punish people.

TERMINATION OF THE RELATIONSHIP

Unlike with a friend, we cannot decide to stop talking to a tenant or choose to never see them again.

SELF-DISCLOSURE OF PERSONAL INFORMATION

If we share personal information about ourselves, tenants may perceive us as friends. This can undermine our ability to function in our roles.

PROFESSIONAL DON'TS

- Never date, socialize or have sex with a tenant
- Do not ask for help with personal problems
- Do not loan or borrow money
- Do not give your home number or address

BUILDING A PROFESSIONAL RELATIONSHIP

USING EMPATHY

Empathy is an important part of a professional relationship, particularly in a human service setting. When we are listening with empathy, it is important not to assume that the person feels what we think we would feel in that situation. Let them tell us or show us by their behavior or body language how it is for them. A word of caution: it is not helpful to say, "I know how you feel." This can often make someone feel angry or misunderstood, because even though we can empathize, we never know exactly how another person feels.

BEING TRUSTWORTHY

People's behavior will tend to be more problematic if they do not trust us. Building trust takes time. Some people will never trust us, but we must still be trustworthy. It is part of behaving professionally and includes following through on what we say we'll do, being predictable, consistent and respectful.

CONVEYING RESPECT

A critical element in the development of a helping professional relationship is the ability to treat tenants respectfully. When someone feels disrespected, they will be more difficult. In order to convey respect to another person, we must be willing to keep our values to ourselves. We may not like a behavior, but we avoid judging the person. We may see the behavior as bad but we avoid labeling the person as "bad."

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This booklet published by NAMI-NYS [1-800-950-FACT] offers a layman's guide to bi-polar disorder. It details the causes, symptoms, types, treatment and recommendations for help regarding this diagnosis.

National Alliance for the Mentally Ill of New York State: "About Borderline Personality Disorder." NAMI, 1999

This booklet published by NAMI-NYS [1-800-950-FACT] offers a layman's guide to borderline personality disorder. It details the causes, symptoms, types, treatment and recommendations for help regarding this diagnosis.

National Alliance for the Mentally Ill of New York State: "About Addictions." NAMI, 1999

This booklet published by NAMI-NYS [1-800-950-FACT] offers a layman's guide to addiction. It details the symptoms, treatment and recommendations for help regarding addiction.

"New York City Voices: Surgeon General Issues Mental Health Report." *New York City Voices*, Vol. V, No. 1, January/February 2000

This article reprinted with permission from the National Mental Health Association's *The Bell* briefly overviews the new report on mental health the Surgeon General issued in 2000.

Prochaska, J; DiClemente, C; Norcross, J.: "In Search of How People Change." *American Psychologist*, September 1992

This article focuses on the "Stages of Change" model and explores addictive behavior. The authors offer an overview of each stage of change and the intervention tools necessary to motivate a person into the subsequent stage.

Springer, E: "Effective AIDS Prevention with Active Drug Users: The Harm Reduction Model." *Counseling Chemically Dependent People with HIV Illness*. The Haworth Press, Inc., 1991

This chapter reviews the basic premise of Harm Reduction. Ms. Springer explores new philosophies regarding services for persons with addiction and investigates the successful model of Harm Reduction started in the mid 1980s in Mersey, England. It gives the readers an understanding of how to work more effectively with chemically dependent persons with HIV.

Steele, K: "Homeless and Mentally Ill in NYC." *New York City Voices*, Vol. IV, No. 6., Nov/Dec 1999

This article subjects the high correlation of homelessness and mental illness in New York City and advocates consumer empowerment and advocacy.

Torrey, E: *Surviving Schizophrenia, a Manual for Families, Consumers and Providers*. HarperCollins, 1995

Completely updated and revised, the third edition of this indispensable manual thoroughly details everything patients, families, and mental health professionals need to know about one of the most widespread and misunderstood illnesses. Includes detailed information regarding symptoms, medications, treatment and prognosis of schizophrenia.

Upadhyia, G: "MICA Populations and HIV." *The Body: An AIDS and HIV Information Resource*, Vol. 9, No. 3, Summer 2000

This article looks at the connections and impact of dual diagnosis and HIV disease. It investigates the components of effective integrated treatment delivery for this multi-service need population.

Wheeler Communication Group, Inc.: *I'm Still Here: The Truth About Schizophrenia* (Video 1996)

This 1996 hour-long documentary video focuses on the issue of Schizophrenia. People with schizophrenia describe their lives and researchers describe their challenges in this film. Wheeler Communications Group has an entire series of non-fiction film productions on the topic of Schizophrenia.

Internet Sites:

Center for Urban Community Services

<http://www.cucs.org>

Center for Urban Community Services (CUCS) provides a continuum of supportive services for homeless and formerly homeless people, including street outreach, a drop-in center, transitional and permanent housing programs, and vocational and educational programs. Particular emphasis is placed on specialized services for people with mental illness, HIV/AIDS and chemical dependency. This web-site provides information and links to a variety of resources regarding transitional and permanent housing.

Corporation for Supportive Housing

<http://www.csh.org>

CSH's mission is to help communities create permanent housing with services to prevent and end homelessness. CSH works through collaborations with private, nonprofit and government partners, and strives to address the needs of tenants of supportive housing. CSH's website includes a Resource Library with downloadable reports, studies, guides and manuals aimed at developing new and better supportive housing; policy and advocacy updates; and a calendar of events.

Internet Mental Health

<http://www.mentalhealth.com>

This site is a free encyclopedia of mental health information promoting improved understanding, diagnosis and treatment of mental illness. Information available includes descriptions of the 50 most common psychiatric disorders, information on psychiatric medications and side effects, research information on diagnoses and links to related sites.

National Alliance for the Mentally Ill (NAMI)

<http://www.nami.org>

This website is dedicated to improving the lives of people with severe mental illness, family and friends. NAMI provides up-to-date information on a variety of mental illnesses including schizophrenia, mood disorders and personality disorders. Information includes recommended books and readings, a help line, information on membership, statistics and links to other relevant Internet resources.

National Alliance to End Homelessness (NAEH)

<http://www.naeh.org>

The National Alliance to End Homelessness (NAEH), a nationwide federation of public, private and nonprofit organizations, demonstrates that homelessness can be ended. NAEH offers key facts on homelessness, affordable housing, roots of homelessness, best practice and profiles, publications and resources, fact sheets and comprehensive links to national organizations and government agencies that address homelessness.

National Clearinghouse on Alcohol and Drug Information (NCADI)

<http://www.health.org>

This site provides up-to-date information about new NCADI publications and campaigns. It also lists resources and referrals for those overcoming substance abuse problems. Research, surveys, and statistical data, as well as forums, databases and an online calendar are available.

National Resource Center on Homelessness and Mental Illness

<http://www.prainc.com/nrc/>

The National Resource Center on Homelessness and Mental Illness provides technical assistance, identifies and synthesizes knowledge, and disseminates information. Users can be linked to findings from Federal demonstration and Knowledge Development and Application (KDA) projects, research on homelessness and mental illness, and information on federal projects.

Substance Abuse and Mental Health Service Administration (SAMHSA)

<http://www.samhsa.gov/>

This site offers information on drug abuse and mental health, and provides links to other relevant Internet resources. A general profile of SAMHSA programs and services, as well as weekly report, is provided. Also listed is a schedule of upcoming events and conferences.