Shelter Training Manual

for

San Francisco Single-Adult Shelters

Created by the Department of Human Services
City and County of San Francisco
Laura Gerard, Contract Manager
Dorian Kittrell / Jason Albertson
February, 2004

To Arnett Watson and Carolyn Plybon

Without whose shared efforts this would never have been possible

Some of the people who helped produce this training manual include the following:

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City and County of San Francisco

Department of Human Services
Housing and Homeless Programs

February 28, 2004

Dear Shelter Directors:

On behalf of the Department of Human Services, I am pleased to introduce this comprehensive training manual to be used by all single-adult shelters. I would like to extend my appreciation to you and your staff for taking the time to provide valuable input in the development of this manual.

Our goal is to provide a uniform training process for all the shelters that will help to support staff in providing an engaging and healthy environment for homeless clients. I strongly encourage you to take advantage of the great resources included in this manual by using it as a tool to train all new staff of your shelter.

Sincerely,

Dariush Kayhan
Director, Housing and Homeless Programs
San Francisco Department of Human Services

Introduction

This Shelter Training Manual provides a basic, universal training standard for all shelter staff working in San Francisco single adult shelters. It ensures that the quality of care provided to shelter guests is the same, regardless of which shelter provides them with residence or services.

History:

In fiscal year 2000–2001, the Department of Human Services set aside funding to implement a local homeless advisory board called the Strengthening Single Adult Shelter Subcommittee (SSASS). Its recommendations focused on strengthening services in city funded single adult homeless shelters. In May of 2001, the local homeless advisory board began considering the priorities recommended by SSASS. Meetings were held in July and August 2001 with shelter providers, homeless people and advocates to develop a plan for the funding. These meetings, called Strengthening Shelter, identified a critical need for investment in staff training and development. Specific areas of training and development were identified and are addressed in this manual.

Impact of CHANGES:

Since Strengthening Shelter ended its review of the shelter system, there have been changes to the ways San Francisco's shelter services are delivered. This includes the redevelopment of Multi-Service Center North to a case-management, intermediate-to-long-term-stay model (now called Next Door) and the development of Central Access and the CHANGES (Coordinated Homeless Assessment of Needs and Guidance thru Effective Services) bed reservation system. Since all homeless people may receive services at any San Francisco adult shelter, they must receive similar services. There are three reasons why:

Fairness: All shelter seekers have the right to similar services. Because CHANGES determines a shelter guest's placement, no shelter should provide better, more complete, or less adequate services than any other. Customer service should not be better at one shelter than another. All guests should have access to equally-trained staff that can provide services of similar quality.

Accountability: The Department of Human Services (DHS) needs shelter providers to focus on providing culturally competent services to homeless peo-

ple in San Francisco that help them exit homelessness. This Shelter Training Manual ensures a similar level of training, knowledge, and practice so that shelter staff can be held accountable for the delivery of quality services.

Increased professionalism: Individuals who work in shelters come from many walks of life. They have diverse life experiences, cultural backgrounds, and individual perspectives. This presents a challenge to supervisors, who need to provide effective supervision to their employees. A single training standard ensures that all supervisors know about the growth areas and challenges that shelter staff face, and assist staff to gain the tools to become increasingly responsible and enter management. A single standard of training ensures that shelter staff who complete the training cycle will be able to work in other shelters after learning each shelter's unique policies and procedures.

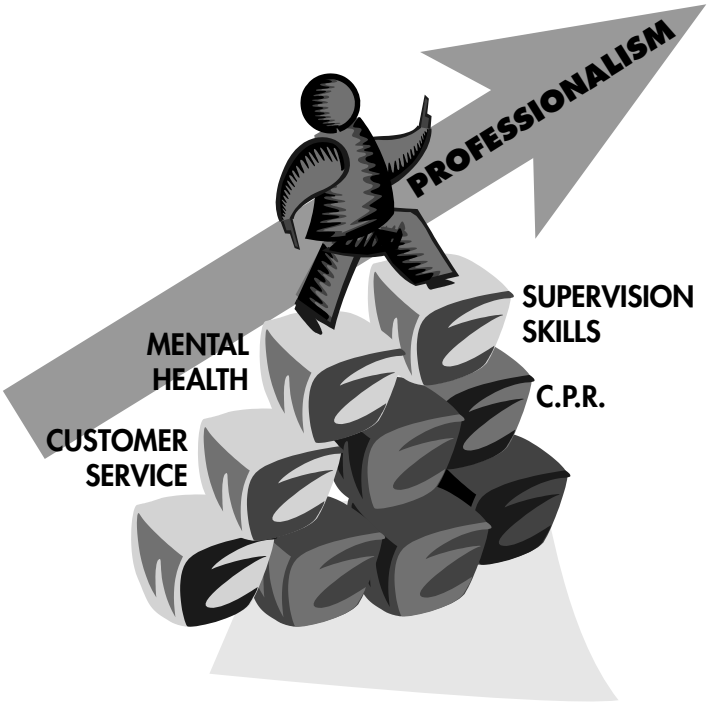
Purpose of this Manual:

This Shelter Training Manual provides the San Francisco single adult shelter system with the training materials necessary to create a group of professional frontline shelter staff that can effectively and respectfully deliver services in one of the toughest service environments. Its purposes are:

- To provide shelter staff with a uniform standard of training.
- To help supervisors support an employee's professional development by providing basic skills training in a systematic and effective way.
- To help shelter staff improve customer service skills, so that shelter clients may have the best shelter experience possible. This increases the chance that homeless people will access services and housing, and then exit the shelter system.
- To ensure that shelter staff treat clients at a high standard of dignity, safety, service quality, and respect.
- To provide shelter management with training and information resources within the community.

How to use this manual:

This manual contains 10 training areas. It is not intended to replace the personnel policy or procedure manual of a specific shelter or organization. Each training area is designed to be used at different points in an employee's career. The training materials form a skills ladder. The most important information for a new employee is delivered first. The training topics become more challenging as the employee gains more professional experience. They should not skip steps on the ladder.



These training chapters are:

1. Ethics and Boundaries
2. Customer Service and Professionalism
3. Effective Communication
4. Mental Health:
    a) Mental Health Issues in the Homeless Population
    b) 5150: Emergency Mental Health Treatment
    c) Suicide Prevention: Assessment and Intervention

5. Substance Abuse:
    a) Addiction Basics
    b) Overdose Detection and Response
    c) Harm Reduction
6. Intervention with Escalating Clients
7. Working with Homeless Seniors
8. Cultural Competency and Diversity in the Shelter Setting
9. Supervision for Supervisors and Trainees
10. Cardio-Pulmonary Resuscitation (List of provider resources).

CD ROM:

Enclosed with this manual you will find a CD-ROM. This contains two directories. One of them is the supervisor's version. It contains the full text manual and includes supervisors TIPs, (an example of a TIP can be seen below), as well as answers to the self-tests to assist in training employees. The second directory has each chapter of the manual without the TIPs, which can be printed for employees, complete with a self-test. These sections are ideal for self-study. We suggest not copying pages from your hard copy, which may be updated by DHS from time to time. We suggest printing out sections as needed from the CD ROM, which will reduce page wear due to excessive handling and copying.

SUPERVISOR'S TIP

Throughout this manual you will find TIPs (Training Improvement Points).

TIPs highlight important information, provide questions to help with the scenario discussions, and present information asked on the self-tests. These TIPs are not included in the employee version. They are intended to support supervisors when reviewing the training materials with their staff.

Training Protocol and Timelines

Supervisors should review the training areas in this manual with their staff. You can do this in staff meetings or one-on-one during individual supervision. Shelter directors consulted for this manual said that time management was extremely difficult. The self-tests at the end of each training area provide a way to monitor an employee's progress throughout the manual. If the manual is used primarily as a self-study guide, review the employee's completed self-test material. The questions check the employee's understanding of the material. They require the employee to read the materials closely. These self-tests may be

placed in an employee's human resource file as a training record. For this reason, self-tests include a signature sign-off line for supervisor and employee.

A general timeline of these training areas is presented below. Training should begin as soon as possible after the employee begins working at the shelter. This is useful for the Human Resources, Management Team, and supervisory personnel in charge of promoting and retaining staff members.

Training Timeline

Chapters 1–3 First 3 months of employment

Chapters 4–6 Next 6 months of employment

Chapters 7–9 Last 3 months of first year of employment

Resources

Each Training chapter concludes with a list of training materials relevant to the section, such as web sites and library resources, and available community training providers who deliver trainings in the subject area. Supervisors should review this information. Make time for staff members to review the web sites. Individuals who provide training in these areas have also been listed. This is not an endorsement of their training or a suggestion that it is appropriate for your organization. You will need to contact them and discuss your specific training needs.

We believe that this manual is an effective aid to shelter supervisors, workers, and ultimately clients. However, it won't help if no one uses it. Implementing the training series, with all frontline shelter staff will require both resources and commitment on the part of shelter management, Department of Human Services, and shelter line staff.

People who have worked in San Francisco shelters and provided services to homeless people developed this manual. It came about because of the community process, Strengthening Shelter, which incorporated shelter providers, homeless people, and advocates. It is grounded in the reality confronting shelter providers, clients, and staff in San Francisco today. This manual is the first step in creating a trained, professional group of shelter service providers and a shelter experience for homeless people that truly assists them to exit homelessness.

C.P.R. can only be taught by a certified trainer, in person. This manual does not contain training materials in this content area. Instead, it provides referral to individuals and organizations providing this training in our community.

Table of Contents

Ethics and Boundaries

Chapter

1

Goals of this Training:

1. Define the concepts of professional ethics and boundaries
2. Provide a basic "Code of Ethical Conduct" for all shelter workers.
3. Provide guidelines on how to maintain professional boundaries with all clients.
4. Provide a Code of Ethics and Code of Conduct templates to use in the shelter.

Ethics

Ethics are a system of moral principles shared by a group. These principles define fair treatment and good behavior. Within the shelter system these principles provide standards for workers serving homeless people. These standards define a code of conduct that is **humane, fair, and caring**. Let's look at these principles, that all homeless service providers share:

- Individuals have the right to safe shelter, adequate food, and sanitary conditions.
- All residents should be treated with dignity and respect.
- Shelter guests should not be blamed for their situation or for attempting to meet their needs.
- Residents have the right to privacy and confidentiality.
- Residents have the right to make their own choices, and those choices should be respected. However, shelter workers must try to let guests know the consequences of those choices.
- Residents deserve to have services provided competently and fairly.

- All residents of shelters deserve the same quality service and not get special treatment because they are liked or disliked.
- Shelter residents should be treated with warmth and friendliness to decrease alienation and despair, and to increase their chances of obtaining the services they need.

Boundaries

Boundaries are the limitations staff place on their relationships with clients to practice the ethical standards outlined above. These limitations don't mean staff can't be friendly with clients in the course of their work. However, staff must maintain boundaries with a client—even when the client tries to test those boundaries. This is not an easy task as clients can sometimes feel appreciation, indebtedness, or even affection for workers who help them. While the client's appreciation is not a problem, the expression of it can lead to difficulty in the professional relationship.

Boundary problems can range from mild to severe, but they are potentially harmful to the client and affect the quality of care that a resident receives. There are four major areas where shelter staff can run into problems:

1. Special Favors
2. Gifts
3. Personal or Financial Gain
4. Sexual Relationships

1. Special Favors

Crossing some boundaries with shelter guests may appear to be harmless. However, once staff have started down this path it is difficult to return the relationship to a professional level. Many lines, once crossed, are difficult to "uncross." For instance, if you ask a client to buy you a pack of cigarettes while they are out of the shelter, the client may then expect that you will do them a favor. Perhaps they might ask you to let them stay out after curfew. Once this type of relationship, where special favors become the norm, is established it can become difficult for either party to refuse future requests. Giving special favors to a client may result in them becoming demanding, or resentful if staff don't

continue with the favors. What would other clients expect when they see staff performing favors for another resident?

2. Gifts

It is not uncommon for a client to give a small gift of appreciation to a staff member. Small gifts, such as a card or small plant seem a harmless gesture, to be welcomed and not viewed as a boundary problem. However, remember that for a resident who has little or no money even this type of gift may represent a large amount of their income. It is not OK to accept any gift from a shelter resident without clearing it with your supervisor. Thank them for the thought.

Repeated attempts at gift giving may be a sincere expression of gratitude. Or the shelter guest can be attempting to control the staff/guest relationship. Meaning they may try to get special treatment later. In either case, **don't accept gifts.** Discuss the gift giving behavior with your supervisor. Staff who receive gifts may feel an obligation that influences their professional judgment and behavior.

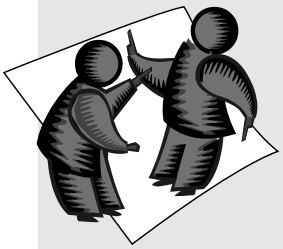
The same can apply when staff give clients gifts. The client may feel burdened by a sense of obligation that can never be discussed with the staff person. When shelter workers see such tremendous need, it is natural to want to assist their clients. But remember, shelter workers are assisting clients by the commitment to their work. If a staff person wants to contribute something more than their work, for instance books or clothing, they can discuss this with their supervisor so that the donation goes to the facility and therefore all clients. Whenever there is a question as to giving or receiving a gift, staff should consult their supervisor.

A good guide to help you know if something is ethical or if it is a violation of boundaries is to ask yourself the following questions:

1. Would you want to see your action written up on the front page of the Chronicle?
2. Would you want to discuss this with your supervisor?
3. How would you feel if your coworkers knew about this?

Scenario for Discussion:

A female client becomes friendly with a male staff member she knew before she entered the shelter. She lets the staff member know that she appreciates his treatment and friendliness at the shelter and would like to take him to dinner when her GA check arrives.



What might happen if the staff person agreed to this offer? What might be the possible perceptions of the client, residents, or other staff?

If the client is attracted to the staff person, he might be giving her the impression that a romantic relationship is desired and possible. If the client had no romantic intentions, but simply wanted to buy dinner as a gift of appreciation, the cost may be a hardship for her. It might also signal to other clients or staff that some other type of a relationship is taking place.

How could staff politely turn down this request and maintain a helping relationship with the client?

First, acknowledge the dinner offer as an expression of thanks on the part of the client: "Sarah, that is a nice gesture. I can see that you feel like I've been helpful to you since you've been here."

Second, turn down the request with an honest explanation of why it would not be appropriate to accept. Express gratitude for her generosity: "I appreciate you offering to take me to dinner. But it wouldn't be right for me to have dinner with you because you are a resident here and our relationship has to stay professional. If we had dinner together it might send a message that I was treating you differently than other residents. Also I wouldn't want you to spend so much of your income on dinner for me. You should use that money for yourself. The offer itself is thanks enough. I really appreciate it."

3. Personal Gain and Other Conflicts of Interest

Under no circumstances should staff engage in financial transactions with clients. Any behavior on the part of staff that seeks to use their relationships with a client to make money is unethical. Having any type of business relationship with a client—such as buying merchandise, drugs, gambling, or selling a client cigarettes or other goods—takes the staff member's focus off the care and well being of the client.

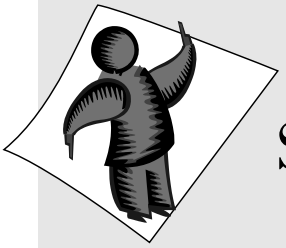
Do not transact business or have any financial relationship with residents. Your main relationship with shelter guests is to support and care for them so they can get the benefit from the shelter. Having more than one kind of relationship with shelter guests complicates your relationship with that person and is not fair to the other shelter guests.

There are other types of staff/client relationships that are inappropriate. These are known as "dual relationships." A dual relationship is an additional relationship between staff and client that is outside the professional. A dual relationship does not necessarily mean that a staff person is trying to take advantage of a client. It means that, no matter what the reason, the professional judgment of the staff person may be compromised by the different roles they have with the client.

4. Sexual Relationships

Staff should never have sex with a client. This is unprofessional and damaging to the client. It may cause the client to suffer psychological problems. As shelter employees, staff have authority over clients. A sexual relationship, where one person holds power and status over the other, is abusive. This is particularly true for a resident who may have a pattern of entering into abusive relationships. They may have had to survive by exchanging sex for money or services in the past. They may not know any other way to relate to people. Shelter workers who have sex with a client perpetuate harmful behaviors. Staff who have sex with clients demonstrate poor judgment that impairs their ability to provide services.

Boundary violations usually occur one small step at a time. What appears to be innocent and small can lead to an unprofessional relationship with a client. Shelter staff need to be aware of clues that show they are crossing professional boundaries. On the next page there is a list of warning signs that indicate this may be happening to you.



Warning Signs that Staff May Be Crossing Boundaries

1. You spend much more time with one client than the others.
2. You spend time with a client when you are "off duty," such as lunch, dinner breaks, or after work.
3. A client stays up late or makes special arrangements to their schedule in order to be around you when you are working.
4. You feel you are the only one who really understands the client. You feel the other staff members are just critical or jealous of your relationship with the client.
5. You keep secrets with the client, and do not report or document certain information.
6. You become defensive if someone questions your interaction or relationship with a client.
7. You discover that communication between you and a client has become overly familiar or flirtatious, perhaps joking with some sexual overtones.
8. A client does not want to interact with other staff, but waits for you to get what they need.
9. You think a lot about the client when you are not at work.
10. You begin to view the client as your client. Other staff members call you for help when working with this client.

Code of Ethics

The following ethical standards provide a consistent standard of care. All shelter staff are responsible for upholding these standards in their daily work of providing quality service to shelter guests.

- The welfare of shelter residents is the guiding principle for all shelter staff in performance of their duties.
- Residents have the right to shelter that is safe and sanitary.
- Residents deserve to be treated with basic human dignity and respect.
- Residents have an expectation of privacy and confidentiality. Information about a shelter resident shall not be given out without their permission.
- Residents have the right to make their own decisions. They should expect the staff to respect those choices, and to have the consequences of those choices clearly explained.
- Residents deserve to be treated courteously, fairly, and equitably.
- No client should face discrimination based on race, religion, ethnicity, national origin, sexual orientation, gender identity, age, political beliefs, or disability.

I, _____, have read and understood the Code of Ethics listed above. I agree to abide by these ethical standards in my work as part of the shelter staff team.

_____

Name Date

Code of Conduct

This Code of Conduct is a set of behaviors to establish and specify relations between staff and shelter residents. Not all behaviors and circumstances can be foreseen. This Code is meant to give staff knowledge of appropriate behavior between residents and staff. Any questionable situations that arise between staff and residents that do not seem to be covered in this code of conduct should be addressed with a supervisor to obtain clarification and guidance.

1. Staff will always treat residents with respect and dignity. No guest should be a victim of verbal, emotional, or physical abuse by staff.
2. Staff will behave in accordance with all applicable safety policies and procedures. The safety of all residents and staff shall be held as the highest value.
3. Staff must refrain from alcohol or drug use while on duty. They should never come to work under the influence of alcohol or drugs.
4. Staff must refrain from any relationship with a client that could be viewed as unprofessional. Inappropriate types of relationships include, but are not limited to:
    - Sexual relationships
    - Business relationships
    - Sale or use of drugs and alcohol
    - Gambling
    - Financial Assistance (acting as a payee or conservator)
    - Personal relationships outside of the work environment
5. Staff will always apply rules and regulations fairly and equitably to all residents.
6. Staff will not provide favors for, or accept favors from, residents.
7. Staff will never give or take money from a resident.
8. Staff will not use any language that is offensive or discriminatory.
9. Staff will dress in a way that reflects positively upon their role as professionals working in shelter or social services.
10. Staff will refrain from any communication with clients that may be interpreted as sexual or flirtatious, including inappropriate jokes, self-disclosure, or touching.
11. When in doubt about any course of action or behavior with residents, staff should consult their supervisor.

I, _____, have read and understood the Code of Conduct that is to be followed by all staff working in the shelter. I further understand that this code does not include all foreseeable circumstances that I may face in working with shelter clients, and that I will seek supervision anytime I have questions about appropriate or professional behavior.

_____

Name Date

Ethics and Boundaries
Self-Test

1) The Ethical Code of Conduct results in shelter standards that are (three things.)

_____

_____

_____

2) Ethical standards are made up of guiding principles. Name two guiding principles that are outlined in this training for providing services to the homeless.

_____

_____

_____

3) What is meant by the term "dual-relationship?"

_____

_____

_____

4) Name three major areas where boundaries can run into problems.

_____

_____

_____

5) Give an example of a warning sign that might indicate a staff person is crossing boundaries with a client.

_____

_____

_____

6) What is the most important behavior outlined in the Code of Conduct? Why is it important to you?

_____

_____

_____

7) What should staff do if they ever question the appropriate way to act in a situation with a client?

_____

_____

_____

Name: _____ Date Completed: _____

Supervisor's Name: _____ Date Reviewed: _____

Ethics and Boundaries Resources

The Harm Reduction Coalition and Training Institute, Oakland

www.harmreduction.org
HRC Oakland Office
1440 Broadway, Suite 510
Oakland, CA 94612
Telephone: (510) 444-6969 ext. 10

The Harm Reduction Training Institute has a series of trainings, which include topics on Ethics and Boundaries. Their trainers come from a variety of settings. Visit the website for the most current training topics.

Larry Picard

Social Work Supervisor
Telephone: (415)-355-6735

Department of Aging and Adult Services, City and County of San Francisco
Provides trainings on legal and ethical issues affecting the elderly population.

The Center for Human Services

http://humanservices.ucdavis.edu/about/index.asp
UC Davis Extension
University of California
1632 Da Vinci Ct.
Davis, CA 95616-4860
Telephone: (530) 757-8643
Fax: (530) 754-5104
human@unexmail.ucdavis.edu

The Center for Human Services is a national leader in disseminating knowledge and skills in the human services. It provides trainings in ethics and boundaries, customer service, and supervision. Through professional services and training, The Center translates research and theory into practice, fosters partnerships that create opportunities for individuals, agencies and communities, and improves the quality of life for vulnerable children, adults and families.

State of Utah, Draft Ethics for Homeless Shelters

http://dced.utah.gov/cdbg/IIIEthics.PDF

Excellent example of ethical standards established for homeless shelter systems.

Customer Service and Professionalism

Chapter

2

Why this Training:

Shelter residents are customers—a simple but essential concept. Using basic customer service skills, shelter staff can create a welcoming environment that is safe and comfortable for shelter residents. By feeling welcome, safe, and comfortable clients can begin to accomplish their own goals.

Goals of this Training:

1. Help staff understand the reasons for using good customer service when working with shelter clients.
2. Teach staff the three fundamental areas of customer service.
3. Give staff specific skills to providing good customer service.
4. Assist staff in recognizing and reducing stress-related burnout that affects customer service and hinders job satisfaction.

Supporting Clients

The frontline shelter staff's job is to support shelter residents. Depending on the shelter, these job responsibilities can be helping clients understand shelter rules, providing information and referrals, counseling or emotional support, and crisis intervention. No matter what kind of support staff are providing, it should be provided within the model of customer service and professionalism.

This customer service training focuses on three areas of professionalism that will help shelter staff meet their goals:

- Respect
- Responsibility
- Staff Self-Care

To understand these areas of professionalism, it is helpful to examine some of the reasons why customer service and professionalism are so important within the shelter system.

Why Customer Service and Professionalism are Important:

1. Good customer service skills are the foundation for all professional skills.

Good customer service is the first step in developing more advanced professional skills such as assessment, referral, and basic counseling techniques. Before a staff member can help a client address critical issues, such as permanent housing, mental health, or substance abuse, the client must trust that the staff can provide that assistance. **By using good customer service techniques staff can create a positive relationship with the client.**

2. Good customer service makes your job easier.

When a customer feels they are being treated well, they are more willing to accept staff guidance and direction. This makes the staff's job easier as they work to maintain orderly behavior and a safe environment. Remember, **staff behavior is a model for all the shelter residents**. An effective staff is expert at modeling the behavior they want to see in shelter guests. No one is born with good customer service skills. There must be the desire to learn these skills through training and practice.

3. Good customer service makes the client's job easier.

The client's job is to get the most service possible out of the shelter system. For some this may be focusing only on "tonight" and having a safe place to sleep. For others, their goals may be more wide-ranging, such as transitioning out of homelessness, finding permanent work, or seeking substance abuse treatment. **To get the most out of the shelter experience, clients need to believe that the system will help them with their goals.** For instance, if a shelter does not seem safe then the client will not choose it to reach their goal—a safe place for the night. However, when the shelter is thought to be a safe place, and its workers are competent, caring, and respectful, the client is more likely to use the shelter.

Respect, Responsibility & Self-Care:

People who use shelter services should be thought of as guests. By looking at each client as a guest, **staff will see clients as individuals** with unique

characteristics and unique needs. This will help staff meet the challenge of making each resident feel welcome and cared for.

The saying about **"treating others as you would want to be treated"** goes a long way in grasping the concept of customer service. Good customer service depends on the three basic concepts of **respect, responsibility and staff self-care**. These three areas are not separate and distinct. They overlap in many ways and under many circumstances. For instance, respect for a client can be displayed by addressing their needs in a professional and responsible manner. At the same time, responsible professionals look after themselves too, knowing that in order to take care of a client, they must attend to their own physical and emotional well-being. Let's take a look at each of these three basic areas with specific suggestions and techniques on how to provide good customer service.

Respect

When a client enters the shelter, they bring all of their life experience with them. It is impossible for staff to understand, or fully imagine, the total experience of each individual as they come to the shelter for services. Staff need to keep this in mind and suspend their assumptions, judgments, or opinions about a client or why the client may currently be homeless. By not judging clients, staff can communicate better with them and offer basic human dignity and respect.

DO'S AND DON'TS to Showing Respect for Each and Every Client:

1. **Do welcome a client when they come to the shelter.** Make eye contact and greet them warmly with a smile.
2. **Do introduce yourself when meeting a client for the first time.** Do this even before you ask them for their name at check in. It communicates that you are not just interested in getting their name for identification purposes, but also to know them as a person.
3. **Do put the client's needs above your own while on duty.** Never make a client wait for service when it isn't necessary. For instance, social conversations with other staff should stop when a client needs assistance.
5. **Don't wait for a client to come to you.** When you see a client with an obvious need, whether it's an extra blanket, information, or the need to have someone to talk to, approach them with assistance. By anticipating a client's needs you are showing them that they are important.

6. **Don't use your power as a shelter employee to demean, humiliate, or judge a client.** Be aware of your status as a staff person.

7. **Don't discuss a client's business in public areas where other client's may overhear.** Provide privacy (whenever possible) for a client to discuss sensitive information.

8. **Do finish dealing with one client's concerns or needs before attending to another's.** This can be difficult because staff are often pulled in many directions at once. However, by prioritizing needs and focusing on one client at a time, staff are actually able to use their time more efficiently.

9. **Do show concern for a client's personal belongings.** When a client enters a shelter, they usually have everything they own with them. Showing an understanding of the importance of these belongings to the client communicates an overall sense of respect.

10. **Do show tolerance for differences.** These differences may include religious, spiritual, political, and cultural beliefs. For example, a client who identifies as transgendered may wish you to call them something other than their legal name.

11. **Don't blame or reprimand a client in front of other residents.** You may not always have the luxury of enforcing rules and regulations in private to a client who is not compliant. By refraining from loud or obvious criticism of a client in front of others, you maintain the dignity and cooperation of the client.

12. **Do treat all clients equally.** It is common for a resident to ask you to bend a rule or for special treatment to meet their unique circumstance. Staff need to be very careful when approaching this situation as they may appear to be showing favoritism.

Show respect to the clients. Model respect in your actions and you can watch it grow throughout the shelter. Shelter residents look to the staff for assistance and guidance. When guests see that staff have respect for the shelter and its procedures, they are more likely to respect you and each other.

DO'S AND DON'TS to Showing Respect for the Institution, Policies and Procedures:

1. **Do maintain a clean and orderly environment.** Remember, the shelter is not only a workplace, it is someone's home.
2. **Do treat your co-workers with respect.** Try to keep personal conversations with other staff to a minimum when in a client's presence. Never share personal information about other staff with clients.
3. **Don't interrupt other staff's interactions with a client.** Unless there is urgent need, allow other staff to fully concentrate on the client they are working with. If you must interrupt, do so respectfully. Say, "Excuse me, I am sorry to interrupt, but..."
4. **Don't blame or "bad mouth" the institution, your co-workers, or supervisors in front of clients.** When staff have a complaint, criticism, or suggestion for improvement, they should address this in staff meetings or with their supervisors. When clients have complaints or criticisms of the facility or staff, listen and provide them with information on the appropriate means of filing a grievance or complaint.
5. **Do follow policies and procedures consistently.** Reinforce to clients that staff can be relied upon to carry out their duties, and enforce the rules and regulations of the facility in a consistent, competent, and fair manner.

Responsibility

Taking responsibility for your own professional behavior is critical to providing good customer service. A responsible professional understands there is a power relationship between themselves and their clients. However, they never use that power for their own purposes or gain—only in service to the client. The responsible professional is not concerned with pointing out their power to others, but uses it with respect for the client, and with no expectation of something in return.

Examining your own current professional behavior is the best way to serve clients in the future. Being aware of your skills and limitations will help you discover new ways to increase and improve your professionalism.

DO'S AND DON'TS to Taking Responsibility for Your Professional Behavior:

1. **Do be aware of your professional limitations.** Do not attempt client interventions you are not trained or authorized to provide. Seek supervision if you are unsure about how to proceed or act in a situation.
2. **Do take on self-improvement and educational activities.** Take advantage of opportunities for training within the shelter system. Use these opportunities for professional development.
3. **Don't blame others for your mistakes.** Own your errors and take responsibility for correcting them. Staff who are willing to learn from their mistakes model responsibility and trustworthiness for clients and other staff.
4. **Don't lose control of your emotions in front of clients.** Seek help from peers or your supervisor when you feel overwhelmed. It is not a sign of weakness to be emotionally affected by your work. By seeking help you are working to maintain balance in your professional behavior.
5. **Do pay attention to how you present yourself in your demeanor, dress, and hygiene.** It is important that our own standards of behavior, dress, and cleanliness be a model for clients. Check with your supervisor about the policies and procedures of appropriate attire in your work place.
6. **Don't let your personal affairs interfere with your professional duties.** Keeping a client waiting while you finish a personal telephone call shows a lack interest and concern for that client's needs.

Always use sensitivity and professionalism when talking or dealing with a client. Whenever staff work with a client, they must keep the best interest of that client in mind. Maintain a professional boundary, and don't let personal feelings or emotions affect the interaction.

DO'S AND DON'TS of Taking Responsibility for Professional Behavior Toward Clients:

1. **Don't take it personally.** Even when a client is in a blaming or angry mode, remind yourself that by not reacting emotionally you are able to better assess and respond.
2. **Do know the policies and procedures of your facility.** This knowledge allows you to be a resource for clients. When confronted

with a question or situation where you do not know the answer, have a resource list or seek supervision to get the information you need.

3. **Do enforce policies and procedures equally with all clients.** You are more likely to gain the respect of clients who see your actions as fair and balanced than if you treat one client differently from another.
4. **Do know and live up to professional ethics and boundaries.** Never ask for something such as money or services from a client. Remember, you are there to serve the client. They are not there to serve you.
5. **Do your job even though no one is watching or reminding you.** For example, staff may not be supervised during the late hours and this may provide temptation to skip rounds or bed-checks. However, a client's sense of safety may depend on the idea that someone is checking the area where they sleep. Clients need to trust that staff are looking out for them and showing concern for their well-being—even while they sleep.
6. **Don't promise a client something you cannot deliver.** If you make a commitment to a client, even a small one, live up to it! Most clients have a difficult time trusting "the system." When they are promised something that is not fulfilled, it reinforces the idea that the system cannot be trusted. In those unavoidable instances when a commitment or service cannot be provided, do not try to make excuses or lay blame elsewhere. Take responsibility and apologize to the client.
7. **Do know emergency procedures and respond to a crisis situation immediately to ensure a client's safety.** It is the responsibility of every staff member to know their facility's emergency protocols. Know when to call a supervisor or outside help.
8. **Don't let dangerous situations or interactions go unattended.** A client's feeling of safety determines whether or not they will use a shelter. If staff are aware of drug dealing, intimidation, or extortion they need to respond immediately to maintain the safety of clients and staff.

Consistent professional behavior shows residents that the facility can be trusted to provide a safe haven, and offers resources to help them. Shelter work is not easy. Every day, staff are confronted with difficult situations and often difficult clients. Keeping professional boundaries can be hard for staff who see the harsh realities facing many of their clients. That is why working as a team, supporting one another

in the work, and maintaining a strong sense of professionalism is key to providing good customer service for clients who seek assistance in the shelter system.

Self-Care for Staff

Staff who take care of themselves are better able to provide good customer service to clients. Working with clients who experience tremendous challenges and traumatic events can take a toll on the helping professional. When staff are able to recognize signs of work related stress or "burnout" they can take steps to reduce that stress and maintain good customer service.

Burnout

Burnout refers to emotional exhaustion resulting from built-up stress. People who work in the human service professions can burnout due to the emotionally demanding work. In 1995, a psychologist named Charles Figley coined a phrase that referred to a type of burnout he discovered among helping professionals. He called it "compassion fatigue." Most of his work was with people who gave emotional support to disaster and trauma victims, which is very much like shelter work. He discovered that compassion fatigue, like burnout, resulted from the professional's desire to help and their repeated exposure to other people's traumatic events.

If you think you are immune to burnout or compassion fatigue, think again. The very things that make you a good at your work—your concern and compassion for others, a willingness to take on emotionally charged work, and placing others before yourself—make you more prone to burnout. Having a history of trauma or stress related illness increases your risk. **The key to avoiding burnout is to accept that it could happen to you**. Knowing this you are able to lookout for signs and symptoms, and take the appropriate steps to reduce stress. Let's take a look at these signs and symptoms:

Signs And Symptoms of Burn Out and Compassion Fatigue:

- **Emotional:** Fear, sadness, depression, mood swings, feeling empty, overly sensitive, or angry.
- **Physical:** Increased illnesses, headache, muscle ache, stomach problems, fatigue, increased heart rate, sweating.
- **Mental:** Difficulty concentrating, decreased self-esteem, lack of

concern or indifference, disorientation, forgetfulness, intrusive thoughts or dreams.

- **Behavioral:** Impatience, irritability, withdrawal, appetite changes, substance use, sleep disturbance, given to more frequent accidents.
- **Spiritual:** Questioning meaning of life, loss of purpose, lack of self-satisfaction, hopelessness, anger at God, loss of faith.
- **Personal Relations:** Isolation, decreased intimacy, mistrust, overprotection, anger and blame towards family and friends, intolerance, loneliness, increased conflicts.
- **Work Performance:** Negativity, feeling unappreciated, detachment, loss of commitment, staff conflicts, increased absenteeism, irritability with co-workers and clients.

Not surprisingly, the person experiencing these symptoms may not be the first to recognize them. Often family and friends notice early warning signs. Listen to those around you when they express worry about changes they notice. Burn out and compassion fatigue affects not only you, it affects those who love and support you. Symptoms come on slowly over time. When you finally recognize burnout, it is more difficult to treat.

Remedies for Burn Out and Compassion Fatigue

The best way to ward off work-related stress is to detect the symptoms early. Practicing self-care techniques helps you to continue the work. It increases job satisfaction and effectiveness. Finally, looking after yourself models this behavior, for clients. Let's look at some important self-care practices that help to prevent burnout and compassion fatigue, and act as good remedies for staff suffering from the stress of shelter work.

- **Recognize your feelings.** Accepting that you are affected by the difficult nature of your work does not make you weak. It shows that you recognize your feelings as a normal process of working with clients who present difficult and extraordinary issues every day.
- **Talk about your feelings.** Sharing your experience with others lifts some of the burden of carrying these feelings alone. Take time to share what is going on with coworkers. This lets you realize that you may not be alone in your feelings. It reduces isolation and increases your connections to others.
- **Take time for yourself.** When stress feels unmanageable, consider taking time off to rest. Make sure that if you take time off you use that time for activities that you enjoy.
- **Stay connected to your social support.** Family, friends, coworkers, religious and social groups can be valuable in helping you cope.
- **Rest, eat well, and exercise.** This may seem obvious, but stress can knock you off your feet. There can be a temptation to crawl into bed and stay there. Sleep is important, but so are exercise and a good diet. For many, exercise is the number one way to prevent burnout as it increases energy levels and helps to reduce anxiety. Even a daily short walk done for enjoyment can be effective. It's also a great way to spend some quality time with someone supportive.
- **Set time aside each day for relaxation.** Allow yourself some time to unwind, attempting to let go the issues or difficulties of the day.
- **Avoid alcohol and drugs.** The use of substances may make you feel better in the short term but they will only prolong long-term care and recovery from stress.
- **Seek supervision.** Let your supervisor know when you are experiencing greater stress than usual. Perhaps together you can create a plan for reducing burnout. This may include temporarily taking on some different, less stressful responsibilities. This could allow you to have a change of pace or learn a new skill. Or maybe you could arrange for some change in your schedule to break up your work routine.

A "Burnout Self-Exam" has been included with this training. It can help you determine the level of burnout you may be experiencing. This is a good tool for those times you begin to recognize symptoms of stress. Try taking it now and see where you score.

Customer Service Summary

This training focused on the reasons for using a customer service model for providing services within the shelter system. By thinking of clients as guests, shelter staff are challenged to welcome each resident with the goal of making their stay as safe and comfortable as possible. This customer service model is made up of three basic areas that are the foundation of customer service. They are respect, responsibility, and staff self-care. For each of these areas specific suggestions and techniques have been provided to help staff improve their customer service skills. Finally, special attention has been given to staff self-care. It shows the importance of reducing burnout and compassion fatigue among staff. By looking after themselves, staff are better able to be effective, helping professionals who gain satisfaction from their work.

Are you Burning Out?

Review your life over the last six months, both at work and away from work. Then read each of the following items and rate how often the symptom is true for you.

1 = Rarely 2 = Sometimes true 3 = Often true 4 = Frequently true 5= Usually true

1. I feel tired even when I've had enough sleep . . . . . ____
2. I often feel dissatisfied . . . . . ____
3. I feel sad for no apparent reason . . . . . ____
4. I am forgetful . . . . . ____
5. I am irritable and snap at people . . . . . ____
6. I am withdrawn and keep to myself . . . . ____
7. I have trouble sleeping. I wake up frequently during the night or too early . . . . . ____
8. I get sick a lot. I've used most or all of my sick time . . . . . ____
9. My attitude about work is, "why bother" . . . . . ____
10. I get into conflicts with others . . . . . ____
11. My job performance is not its best . . . . ____
12. I use alcohol or drugs to feel better . . . ____
13. Communicating with other is a strain. . . ____
14. I can't concentrate like I once could . . . ____
15. I am easily bored . . . . . ____
16. I work hard but accomplish little . . . . . ____
17. I feel frustrated . . . . . ____
18. I don't like going to work . . . . . ____
19. Social activities are draining. . . . . ____
20. Sex is not worth the effort . . . . . ____

Scoring: ____

20-40 You're doing well.
41-60 You're OK—if you take preventative action.
61-80 You're a candidate for burnout.
81-100 You're burning out.

Over 100 Ways to Take Care of Yourself

Attending to your own needs is the first and most important self-care and stress reduction technique. Practicing self-care will lead to providing the best customer service you can. Reducing stress leaves you physically and emotionally fit. Look at this list and find items that fit you and your situation. The most important thing is to use one or more of these pleasurable activities to help reduce your stress, anxiety, or discomfort. Remember—they won't work if you don't use them!

Soaking in the bathtub.

Getting out of (paying on) debt.

Collecting and organizing a collection (coins, shells, stamps).

Thinking how it will be for you when you finish school.

Recycling old items.

Going on a date.

Relaxing

Going to a movie in the middle of the week.

Jogging, walking, or exercising.

Listening to music.

Buying a household gadget.

Lying in the sun.

Going to the beach—take the N Judah.

Laughing.

Thinking about past trips.

Listening to others.

Reading magazines or newspapers.

Spending an evening with good friends.

Planning a days activities.

Meeting new people

Remembering beautiful scenery.

Saving money.

Going home from work.

Eating good food.

Practicing a martial art.

Thinking about retirement

Repairing something broken.

Working on your car or bicycle.

Remembering the words and deeds of loving people.

Taking care of your plants.

Doodling.

Going to a party.

Thinking about what you'd like to buy.

Playing a sport.

Flying a kite.

Having sex.

Riding a motorcycle.

Singing in the shower.

Arranging flowers.

Practicing religion—going to church or praying with others.

Losing weight.

Thinking "I'm an OK person."

Going skating in the park.

Painting a picture.

Doing something spontaneously on your time off.

Entertaining.

Driving.

Thinking about boyfriend, girlfriend or partner.

Playing a musical instrument.

Flirting.

Doing arts and crafts.

Cooking.

Watching boxing or wrestling.

Going hiking.

Writing an article, poem, or story.

Buying clothes.

Sewing or knitting.

Going out to dinner.

Sightseeing.

Gardening.

Going to the beauty parlor.

Early morning coffee and newspaper.

Watching children play.

Thinking, "I have a lot more going for me than most people."

Going to a concert, show, or play.

Daydreaming.

Watching TV.

Walking at the Embarcadero

Taking photographs.

Teaching someone a skill.

Fishing.

Playing with animals.

Reading fiction.

Being with friends

Being alone.

Writing a diary or journal entry.

Going to an AA, NA, or other 12-step meeting.

Cleaning.

Taking children places.

Dancing.

Going on a picnic.

Thinking, "I did that pretty well" after doing something.

Meditating.

Having lunch with a friend.

Thinking about a happy moment in childhood.

Playing cards.

Solving puzzles.

Having a political discussion.

Shooting pool.

Reflecting how you've improved.

Talking on the phone.

Going to the museum.

Lighting candles.

Getting a massage.

Saying, "I love you."

Thinking about your good qualities.

Going bowling

Having an aquarium.

Lingering over coffee in a sidewalk café.

Doing something new.

Thinking about becoming active in the community.

Working to help others.

Thinking, "I'm a person who copes."

What favorite activities can you add?

Self Test: Customer Service

1. What three areas of professional behavior make the foundation for a Customer Service Model?

2. What could happen if you promise a client something and then not deliver on that promise?

3. Give one reason why using a customer service model helps staff to do their job?

4. Name two ways this training suggests you can show respect for a client who comes to the shelter?

5. Can you think of a way to show respect for a client, that wasn't suggested in this training?

6. What are three of symptoms of burnout or compassion fatigue?

7. What are three ways to help prevent or reduce the symptoms of burnout?

8. Did you take the Burnout Exam?

Name: _____ Date Completed: _____

Supervisor's Name: _____ Date Reviewed: _____

Health Care for the Homeless-Los Angeles

http://www.hhcla.org/index-training.htm

The training and education department of Health Care for the Homeless-Los Angeles provides skill-building training for homeless service providers. These trainings increase the provider's abilities to assist homeless people, and help staff gain a basic understanding of and develop skills in health and safety, mental health substance abuse, case management, counseling and tuberculosis. Training areas include the above, plus confidentiality, boundaries, documentation skills, harm reduction, and substance abuse. A low-cost technical assistance manual is available.

Employer-Employee.Com

http://www.employer-employee.com/Burnout.html

This is a helpful website with some ideas with some ideas about identifying and combating stress in the workplace.

My SelfCare.org

http://www.myselfcare.org

This website has some useful information on ways to take care of yourself when under stress. It also has information regarding trainings and articles that can be obtained through the website.

Stress Links

http://imt.net/~randolfi/StressLinks.html

This is a fun website that has lots and lots of resources to stress reduction and wellness.

Effective Communication

Chapter

3

Why this Training:

People in human service organizations have to deal with the consequences of poor communication. Clients have been ignored, rejected, or treated aggressively on the streets. It is important your communication with shelter guests be respectful, honest, and clear. Effective communication with co-workers is essential to building and maintaining a strong team that provides quality services to clients. This training helps staff improve communication skills by outlining common obstacles that get in the way of effective communication.

Goals of this Training:

1. Understand four basic components of communication.
2. Recognize the influence of nonverbal communication.
3. Explore common obstacles to effective communication.
4. Provide techniques for overcoming and avoiding communication obstacles.
5. Improve listening skills.

Introduction

We begin learning to communicate as infants. Before we learned verbal language we watched facial expressions and listened to tones of voice. This nonverbal information is our first experience in understanding what someone else is communicating. This eventually evolves into our own basic communication style. As we grow and begin learning spoken language from our family, community, and schools, our style of communicating becomes a big part of who we are and how others perceive or interpret us.

When we communicate, 40 to 60 percent of our meaning is lost in the process. This happens because at each step in the

communication there is the possibility for error. Effectively communicating our message and meaning to others requires paying close attention not only to what we are saying but also how we are saying it. It also requires that we be aware to see if others understand our meaning.

Four Components to Communication

There are four basic components to communications. They are interconnected in a way that leaves lots of room for error. These components are:

- **The Sender:** The person communicating.
- **The Receiver:** The person being communicated to.
- **The Message:** Both words and body language.
- **The Environment:** Place and time where the communication takes place.

The Sender and Receiver

When we are in conversation there is a constant change between being the sender and receiver. We take on both roles when conversing. As communication moves back and forth between two people there is a dance of words, gestures, thoughts, and assumptions that help and hinder understanding. This dance happens almost automatically. To increase the effectiveness of our communication we must be able to observe it.

Communication can happen between more than just two people. Within the shelter environment it is common to be sending a message to one person while receiving a message from someone else. As different clients and staff members try to get attention with their questions and requests it becomes challenging to divide your attention between them. There may be many senders and receivers, complicating the process and increasing the likelihood of misunderstanding.

The Message

The content of the communication can determine whether or not it is understood. Think about the message you are communicating before interacting with a client and consider the best way to convey that message—both verbally and non-verbally. For example, is it a confidential message? Can the information be shared in public, or would it be more effective to talk with them alone? When a

person receives private information in a public setting, eliminating the confidentiality and possibly embarrassing the receiver, the message will probably be received with anger and not interpreted correctly. Any message that provokes an angry response is likely to block further communication.

The Environment

The environment where a message is delivered affects its chances of being correctly understood. "Environment" doesn't just mean place, it also refers to the timing of the message. Consider the shelter guest's state of mind before delivering what they may consider bad news. For instance, if a client has just told you that his GA was cut off, it is not the best time to tell him that his case manager wants to see him about a rule violation. Use good listening skills if you have to deliver a message, (such as a meeting with the case manager) to someone who may be in a negative state of mind. Listen first to accommodate the client's emotional state. Provide reassurance that the future will work out, and then deliver your message. To accomplish this, think about ***how*** you will deliver messages ***before*** you deliver them. Doing so is skillful communication.

Nonverbal Communication

Nonverbal communication can clarify or confuse the message. A majority of the meaning we give to words comes not from the words themselves, but from nonverbal messages. Studies suggest that up to 90 percent of the meaning we take away from a communication comes from the nonverbal part of message. Nonverbal communication includes:

- Gestures
- Movements
- Voice tone
- Posture
- Facial expressions
- Eye contact

Voice tone, posture, facial expressions, and eye contact all communicate important information. When all of these things say the same thing, the message has the best chance of being received correctly. If even one of these doesn't match, the message will probably not be received. Think about, not just what you say, but

The Four Roles of Non-verbal Communication:

1 **Supports the Verbal Message:** Nonverbal cues repeat the message the person is saying. For instance, when a client is asked to move away from the counter, a simple gesture of pointing to a chair or couch repeats the message that you wish them to give you some space before you can address their needs.

2 **Substitutes for a Verbal Communication:** Nonverbal cues can sometimes make a point quicker or better than words. For example, shaking our head to mean "no," or telling someone to quiet down by placing our finger to our lips.

3 **Complements or Reinforces a Verbal Message:** Nonverbal cues may add to a verbal message. A boss who pats a person on the back in addition to giving praise can increase the impact of the message. The most common reinforcing nonverbal cue is a smile. This is particularly true in the helping relationship between staff and residents. A smile communicates kindness and sincerity, which complements a positive verbal communication.

4 **Changes the Meaning of a Verbal Message:** Nonverbal cues can be used to change the message of a verbal communication to the complete opposite. If when talking about a client we say, "Oh, he is one of our faaaavorites!" accompanied by a roll of the eyes, the message comes across loud and clear. He is not one of the favorite clients at the shelter—just the opposite. In the shelter environment it is important that staff be mindful when using nonverbal cues in this way. Clients can misinterpret meanings and take offense to what they consider a joke at their expense. It also may set a pattern for using communication that is vague, indirect, or has double meaning. In the shelter, where there are many people of different cultural backgrounds, levels of education, and mental health status, it is best to use clear, direct, and honest communication.

how you say it—and what your facial expressions, voice tone, posture, and eye contact are "saying" as you speak.

We have all had the experience of someone saying one thing but communicating something different through the tone of their voice or body language. These mixed signals force us to choose between the verbal and nonverbal parts of the message. Most often, we will believe the nonverbal aspects. Mixed messages create tension and distrust because they create the perception that the communicator is hiding something or is being untruthful.

Skillful communicators understand the importance of nonverbal communication. They use it to increase their own effectiveness, and to help them understand what someone else is trying to say.

Obstacles to Effective Communication and Ways to Avoid Them

There are many errors that can enter into communication. These occur even when people know each other well. In a shelter setting, communication errors can be common as interactions involve people who may not know each another well, and the environment is often hectic. In shelters, there are many clients served by few staff. This makes communication a challenge because staff usually have to carry out many tasks at once. Recognizing the obstacles to communication is the first step in learning how to overcome them. Let's take a look at the most common obstacles shelter staff face when communicating with clients, and ways to avoid them.

Words and Meaning

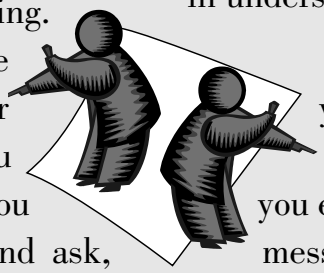
Our choice of words will influence the quality of our communication. No two people will attribute the exact same meaning to the same words. For example, when someone says, "You need to be quiet," different receivers may hear different meanings. Some may interpret the message as a request to "speak in a lower tone," others may hear it as "stop talking altogether." The words we choose impact the meaning others receive.

Use words that best communicate what you mean and convey respect and courtesy. Avoid using words that may be difficult for the other person to understand. Avoid sounding like you are trying to show off what you know rather than being clear. Check in with the person to make sure they have heard and understood what you are saying.

When Verbal and Nonverbal Don't Match Up

When our verbal communication does not match our nonverbal communication, it can result in confusion and misunderstanding. The nonverbal message is often more powerful, and the one we are likely to believe.

Let's say that from across the room you see two clients who seem to be arguing. You cannot hear them but you see one stomp away from the other huffing and puffing. Deciding you better check in with this client, you follow her into the other room and ask, "Sally, I saw you and Karen arguing about something, are you OK?" Sally replies in a loud voice with grimacing face, "I'm fine! We weren't arguing!" Sally's verbal message is saying one thing while her voice and expression are saying something else. You are left to assume that Sally is angry (because nonverbal is the more powerful message), yet you are still no closer to understanding what has happened and why Sally is upset. When verbal and nonverbal communications do not match, more time and energy has to be spent in understanding the message.



When you speak, make sure that your nonverbal communication reinforces what you are saying. When you encounter someone sending a mixed message, try to resist the urge to assume that what they communicate non-verbally is the real meaning. It may be the case, but by asking them to clarify what they are really saying you are removing the possibility for misinterpretation, and having them take responsibility for their own communication.

Assuming We Know the Message

We can be our own biggest obstacle to effective communication. Have you had the experience of being in a conversation where you spent more time thinking about what you were going to say next rather than hearing what was being said to you? This is a common occurrence. By nature, people tend to be self-focused. We are concerned with getting our message out rather than receiving the message being sent. This results in talking past one another and is often the cause of information being lost during communication.

Avoiding this takes practice. It requires that we be open to the idea that what the other person has to say may be something new for us. When you find yourself drifting off mentally, thinking about your own opinions or thoughts on the subject, stop and refocus on the person and what they are saying.

Beating Around the Bush

When we are worried, anxious, or afraid of the reaction someone else will have in response to our message, we talk around the message. We worry that the message will hurt their feelings, or that they will become angry. So instead of being direct, we beat around the bush, hoping the message will get through.

What usually happens is that the other person does not get our real meaning, which leads to confusion and frustration. Can you remember a time when you asked a client if they had followed through with a task you had given them and they responded by telling you about something else completely? What happened? What did you do next?

How do you avoid this obstacle? Be thoughtful but be courageous. Effective communication requires taking risks. You can lower the risks with respectful and courteous acknowledgments, such as "I appreciate your position, but..." or "I can see this is hard for you..."

Having a Bad Day

When we are in the middle of a hectic work shift we might not be aware of our feelings at a given moment. Shelter work requires staff to focus on many things at once, which leads to communication that is given quickly, and sometimes automatically. When we are feeling emotionally and physically well, it is amazing how many simultaneous tasks we can accomplish. However, if we are having a bad day, dealing with difficult emotions, or feeling sick, our communication suffers.

Self-awareness is the key to avoiding this obstacle. Take a moment before you come onto a shift to evaluate how feelings might affect your work. For instance, if you are upset or angry about something that happened at home, consider asking other staff to assist with a difficult or frustrating client. It might be a good idea not to take on as many communication tasks at one time as you usually do. By focusing more clearly on one thing at a time you are more likely to reduce confusion and misinterpretation. It is always a good idea (though not always possible) to try and give full attention to one communication process at a time, no matter what your state of mind.

The substance abuse abbreviation, HALT—Hungry, Angry, Lonely, and Tired—is a good guide to vulnerable periods. If you catch yourself in a HALT condition, try and take care of yourself and watch your communication carefully.

Past Experience

How we perceive communication is affected by our past experience with the other person. Have you ever seen an old friend you haven't talked to in a long time, and were able to pick up right where you left off? On the other hand, have you ever had to talk with someone you had a bad past experience with, and dreaded the thought of having to deal with them again? These are both examples of how our past experiences with someone can affect our communication. Past experiences with residents have a profound influence on how well messages are sent and received.

There are different ways of dealing with this obstacle. Rely on relationships that different staff have with different clients. A particular resident might respond more positively to one staff person. When this is the case, communication will be easier and better understood coming from that staff. This is not always possible, and ultimately, all staff need to be able to effectively communicate with all residents.

To get along with someone you have had a bad experience with in the past, try this: Keep an open mind and decide to have a new experience. Be direct and don't beat around the bush—another communication obstacle that goes hand-in-hand with bad past experiences. Let go of expectations for the interaction so that you can focus on the person and genuinely listen and respond. When communicating, be in the present—not the past. Think about what you want to say before you start talking. This will help to remove personal feelings and past experiences from the interaction.

Cultural Differences

Across cultures there are dramatic differences. These differences include communication styles. This means there are plenty of opportunities for miscommunication when in cross-cultural situations. Cultural diversity is a training in itself (See Chapter 8). Our assumptions about right and wrong behaviors when interacting with others are based in our cultural origin. Cultural factors do not begin and end with language, but are influential in nonverbal communication as well. Issues of time, personal space, privacy, humor, facial expressions, and eye contact are all culturally learned behaviors.

Acknowledging cultural and stylistic differences in communication is not easy. Remain alert to the possibility that there may be a basic reason why a client does

not understand what we are trying to communicate. Be open to learning about the variety of ways that different cultures communicate. For instance, people of Arab origin are accustomed to having very little physical distance between sender and receiver. This lack of person-to-person distance makes others not from this culture uncomfortable, even though no offense is intended. Understanding stylistic differences increases the chance of successful communication. Showing an interest and willingness to learn about someone else's way of life is a first step in developing a positive relationship that facilitates effective communication.

Too Many Distractions

Shelters are filled with distractions. Foremost are the many residents who need the staff's attention. With multiple tasks requiring attention at any given moment, it is amazing how much staff are able to accomplish. Unfortunately there is not enough time to effectively communicate with everyone who needs attention.

Avoiding all of the shelter's distractions is impossible. However, there are two ways to reduce all those preoccupations and to listen and respond effectively:

Prioritize Your Issues: Focus on the most important task. When you are busy, limit your communication to the necessary information. You can still be courteous, and greet clients with a smile and a "welcome." Try and avoid unnecessary conversation with residents, or other staff.

Set Reasonable Time Schedules: If it is obvious that a client is going to need more time than you have at the moment, express interest and desire to help them. Politely explain that you will have to assist them when you can give them all of your attention. Be direct and to the point when you can—but with explanation and courtesy. A smile goes a long way.

Are You Listening?

To understand other's meanings we need to have good listening skills. When providing service to shelter residents, listening is our most important communication skill. Good listening increases our understanding of a client's needs, and helps us meet those needs. Listening is more than just hearing. It is seeing, feeling, and interpreting messages from others. When we are faced with a client whose needs are greater than we can meet, listening is the one gift we can give them. We cannot house all the people who need housing, but we can listen to

those who come to the shelter. If we cannot listen, we should not be in this line of work. Listening requires self-control. It requires that we ignore our own needs and concentrate on the person speaking. Good listening requires that we give cues that we are hearing what is being said and that we are working hard to understand the meaning.

DO'S AND DON'TS of Being a Good Listener:

1. **Do be open to what is being said:** Try to stay away from judgments or opinions while you are listening and be patient while the other person is talking. Take the approach that everyone has something to teach us.
2. **Do let go of your own needs:** Avoid the temptation to start thinking about a response until you have heard the entire message or story. Listening is more than waiting for the other person to finish!
3. **Do show that you are trying to understand:** Remember, understanding someone's point of view does not mean that you have to agree with it. Try to see the other person's point of view despite how you may feel about it.
4. **Do give signals that you are listening:** Nodding your head, maintaining eye contact, or simply uttering "uh huh" as the other person makes a point lets them know you are paying attention. However, do not become a parrot. Clients will quickly pick up on a routine or patronizing response. Be genuine, present, and clear.
5. **Do respond in an interested way:** Show that you are trying to understand the issue being presented. Ask questions to make sure you understand the message and show that you are interested in what they are saying. The phrase, "So what I hear you saying is..." became a staple communication for the authors of this training manual, even though they knew each other well.
6. **Don't ignore nonverbal cues:** Listen to the emotional message as well as the spoken message. Be aware of nonverbal cues, facial expressions, and body language, not just words. Listen between the lines.
7. **Don't pretend to understand:** It is OK to say, "I'm not sure I understand, do you mean...?" The fact that you are working to get the other

person's meaning is important. It is another way of showing you are listening and concerned. Pretending to get someone's meaning, when you don't, only creates further confusion and frustration.

8. **Don't control the conversation:** The only time you should interrupt the other person is to clarify your understanding with a question. If you find yourself trying to figure out what you are going to say next while the other person is talking...STOP! Listen to what they are saying so that you can respond to their message, instead of just trying to get your own message across.
9. **Don't get distracted:** When possible, try to give the other person all of your attention. Avoid answering phones or talking with others when you are listening. This is not easy, and sometimes impossible in the shelter, but try your best. When you do have to be interrupted, apologize and make a mental note of the last thing the other person said so when you return to the conversation you can say, "I'm sorry about that, now you were saying..." This is a great way to show how well you were listening, and helps the conversation pick up where it left off.

Training Review

In this training you learned about a communication model involving the sender, receiver, environment, and message.

You also learned some of the common dangers and difficulties to effective communication and techniques to avoid those dangers.

You learned important techniques to improve your ability to listen to other people.

Finally, you learned some ways to think about communication with people who have very different communication styles.

Overall, effective communication is one of the most challenging areas for shelter workers. Just as learning a language requires practice, learning effective communication does not happen just by reading about the skills. Practice is essential. Learning effective communication techniques will make your work with residents more successful. These skills carry over into many areas of living and practicing them will yield positive results in all areas of your life.

Effective Communication
Self-Test

1) What are the four basic components of communication presented in this training?

2) Name two ways nonverbal communication plays a role in verbal communication.

3) Name three obstacles to effective communication.

4) What are four skills associated with good listening?

5) If you find yourself trying to figure out what you are going to say next while the other person is speaking you should do what?

Name: _____ Date Completed: _____

Supervisors Name: _____ Date Reviewed: _____

Effective Communication Resources

The Center For Nonviolent Communication

www.cnvc.org/org.htm

The Center For Nonviolent Communication is a global organization that envisions a world where all people are getting their needs met and resolving their conflicts peacefully. In this vision, people are using Nonviolent Communication (NVC) to create and participate in networks of worldwide life-serving systems in economics, education, justice, healthcare, and peace keeping. It provides training and seminars to enable people to communicate non-violently. The website includes lists of training resources such as books, videotapes, and on-site trainings.

Transcultural Education for Social Change

worldchange@yahoo.com

Contact: Fredrick Cloyd (415) 642-1817

Transcultural Education for Social Change offers personal coaching, facilitation and consulting, guest speakers, training and development for social change. This group focuses on various aspects of social change and is dialogue-oriented (as opposed to stressing one truth), impactful and educational. Focusing on non-oppositional, yet passionate responses to our various paths for engaging new ideas for critical changes to happen in society. Topics may include: Race, Sexual Orientation, Gender, Social Movements, Spiritualities Psychologies (including Somatics), Class and Able-isms, political forces and more. Sliding cost scale.

Community Boards of San Francisco

3130 24th Street
San Francisco, CA 94110
Telephone: (415) 920-3820
Fax: (415) 626-0595
Email: info@communityboards.org
http://www.communityboards.org

Community Boards of San Francisco is a nonprofit dispute-resolution organization that provides services in San Francisco as well as across the nation and in other countries. In San Francisco, it offers no-cost community mediation services to City residents regarding all types of disputes including those involving money, property, noise, parking, pets, threats, harassment, communication breakdown, interpersonal relations, and more. It also provides resources to schools, communities, jails, and organizations, and offers curricula, training manuals, and training for educators and others.

Akaya Windwood
Telephone: (510) 287-8909
Email: akayaw@earthlink.net
Akaya Windwood provides seminars and group/individual training to develop communication skills and cultural competency.

Chapter

4a

Mental Health Issues in the Homeless Population

This training is designed to help frontline shelter staff work with clients who have varying levels of mental illness. By providing basic knowledge about mental illness, and basic skills in working with mentally ill individuals, this training will help staff feel more comfortable in identifying, approaching, and providing services to this client population.

Goals of this Training:

1. Give staff knowledge of basic types of mental illness and what to expect and not expect from clients who may have mental health challenges.

2. Help staff understand why mentally ill people are more likely to become and remain homeless.

3. Help staff recognize acute mental illness.

4. Help staff develop basic communication skills, which can increase their ability to relate to those with serious mental illness in the shelter community.

Important: This training is not intended to teach frontline staff how to diagnose or provide psychiatric or psychotherapeutic treatment to mentally ill clients. It is intended to help staff have a working knowledge of basic mental health concepts so they become more comfortable working with people within the shelter system who may be mentally ill.

Mental Health Overview

Becoming homeless is a traumatic experience. For many, the psychological response may be severe enough to endanger the client's life. A study of first-time shelter users in New York City, found that 33 percent of men who sought shelter were in extreme emotional distress. Of that 33 percent, 7 percent reported having suicidal thoughts, and 12 percent had some type of major mental illness. This study showed that a high proportion of the men interviewed had either:

- Major mental illness
- Multiple suicide attempts
- Street drug use of over 50 times
- Scored so high on a test of depression that the possibility of suicide was recognized by the interviewer

Myths vs. Realities

There are many myths about mental health and mental illness. This list of myths vs realities explains commonly held misconceptions about mental illness. Understanding the issues will help you to understand what has helped homeless people with mental health problems.

Myth: Mental illness is not really a medical illness—it is either a result of poor parenting or just being "weak in the mind."

Reality: Mental illness or psychiatric disorders, like heart disease and diabetes, are legitimate medical illnesses that can strike in any family. On average, mental illness strikes one percent of all people within their lifetime. Research shows that there are genetic and biological, as well as sociological causes for psychiatric disorders, and they can be treated effectively.

Myth: If someone is suffering from severe mental illness, there is no treatment that will help them.

Reality: Medication and other therapies often allow people with severe and persistent mental illness to live an active and productive life.

Myth: People with a severe thought disorder are violent or dangerous.

Reality: The incidence of violence in people who suffer from mental illness is no higher than in the general population. However, the incidence of violence among those who have both mental illness and a substance abuse disorder is somewhat higher. People suffering from severe mental illness, are more likely to be frightened and confused, rather than angry and violent.

Myth: Medications for mental health take effect rapidly, can 'cure' a person completely, and are safe.

Reality: While some medications do take effect rapidly, most take weeks or even months to have full effect. The same medication does not work for everyone and often several medications need to be tried before a good effect is achieved. Most medications result in the symptoms of mental illness being alleviated, but do not achieve a cure in the sense that the illness then 'goes away' and the person no longer needs medication.

Myth: Depression is a normal part of aging.

Reality: It is not normal for older adults to be depressed. Signs of depression in older

In the general population, it is estimated that one in four people will experience some degree of mental illness in their lifetime. Only a very small number of those people will actually have a severe mental illness that is long lasting. In comparison with the general population, the rates of mental illness, and indeed severe mental illness, are higher for people who are homeless. There are more people with serious mental illnesses among the homeless than the housed. While only

people include a loss of interest in activities, sleep and appetite disturbances, hopelessness and despair. Depression in the elderly is often unrecognized, and it is important for seniors and their family members to recognize the problem and seek professional help.

Myth: Most people with mental health problems need hospitalization.

Reality: Most children, youths, adults, and elders can best be helped by community-based mental health services. Community-based services include: prevention education; crisis stabilization; outpatient counseling; medication; service coordination; community residences; job training; and family, friendship, self-help, and recreational support services.

Myth: People with mental illness never really recover.

Reality: Most mental illnesses are temporary, however, like other illnesses, sometimes they can be disabling. A well-adjusted, functioning person may have an episode of mental illness lasting weeks or months, and then go for years, or even a lifetime, without further problems. Others may have bouts of mental illness, but between these episodes, they feel and function well. Unfortunately, some people suffer chronic mental illness that lasts for long periods of time, even with treatment. No matter how or what kind of mental illness a person suffers, like all of us, they want to be judged on their own merits. They do not want to be thought of only in terms of their illness, or be labeled unfairly because of it.

Myth: Most people who struggle with mental illness live on the streets or are in mental hospitals.

Reality: About two thirds of those suffering mental illnesses are housed, either with their family or in various types of community living arrangements. On the other hand, it is true that many of the homeless have untreated severe mental illness.

Myth: Mentally ill people who live on the streets don't really want treatment.

Reality: Outreach, whether in shelters or on the street, is effective. Most people who are homeless and have serious mental illnesses are willing to accept treatment and services voluntarily. Consistent outreach and the introduction of services at the client's pace are key to engaging people in treatment and case management services. A consistent, caring, personal relationship is required to engage people who are homeless in treatment.

four percent of the U.S. population has a serious mental illness, five to six times as many people who are homeless—20-25 percent—have serious mental illnesses.

Mentally ill people are more likely to become and remain homeless.

It is harder for a person with a serious mental illness to exit homelessness. They are homeless more often and longer than other homeless people. Many have been on the streets for years. The mentally ill homeless are one of the most vulnerable groups within the overall homeless population. It is often their illness that prevents them from obtaining housing.

General facts about homeless people who are mentally ill:

- Up to 50 percent of the mentally ill homeless population have both mental illness and substance use disorders.
- Their symptoms are often untreated, making it hard for them to meet basic needs for food, shelter, and safety.
- They are poor and many are not receiving benefits for which they are eligible.
- Most have had prior contact with the mental health system. These experiences were not always positive. They may have been involuntarily hospitalized or given treatment services or medications they did not feel helped them or had negative side effects.
- Their mental illness symptoms often lead to a lack of self-care such as hygiene issues or not seeking medical care. These can result in untreated health problems such as respiratory infections, skin problems, and risk of exposure to HIV and TB.
- Typically, they are long-term citizens of the communities in which they are homeless.
- Social support and family networks are often gone. They have lost regular contact with their relatives or their family members are no longer equipped to be primary caregivers.
- They are twice as likely to be arrested or jailed, (mostly for minor offenses) than other homeless people.

Help in the Community

There are not enough community-based treatment services or appropriate, affordable housing resources to accommodate the number of people disabled by mental disorders in the US. However, integrated mental health and substance abuse treatment, delivered by multidisciplinary mobile treatment teams, can reduce symptoms and improve functioning in the community. In San Francisco, the Mobile Support and Treatment Team to the homeless fulfills this role. They can be reached at (415) 836-1700. Providing supportive services to people in housing has helped maintain housing, improved mental health, and reduced the costs of homelessness to the community.

Recognizing a client with mental illness.

A person may enter the shelter, or shelter system, with an ongoing mental illness that plays a significant role in why they are homeless. Others may develop mental illness while in the shelter, or as part of a stress response to being homeless. In either case, it is a person's behavior that usually signals staff that this person may be suffering from mental illness. (Specific behavior will be discussed later in this training.)

Understanding mental illness.

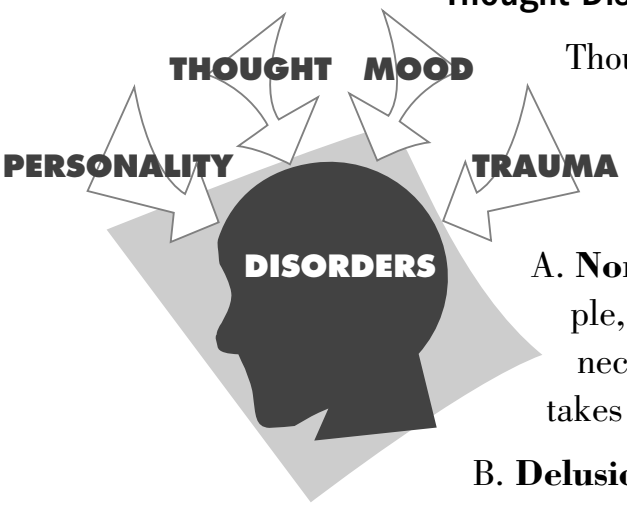
Many myths and misunderstandings surround the subject of mental health. As a result, the community often fears and discriminates against the mentally ill. Because of this discrimination, people suffering from mental illness may not acknowledge their symptoms for fear of being labeled "crazy." Their illness often results in them losing connection with others and they may feel separate or misunderstood. Other people may avoid them because their behavior seems strange or frightening. This compounds the mentally ill person's isolation. Simply trying to understand and acknowledge their isolation is helpful in beginning to provide them with support.

By trying to engage people with mental illness in everyday conversation, and expressing concern for their needs and well being, shelter staff may begin to counteract the loneliness and isolation. For clients whose behavior is so impaired that they are unable to respond to communication from staff, or are unable to express themselves coherently, a simple "hello" or "welcome" from a staff person can encourage the client to accept future assistance. Closing the gap of isolation felt by many mentally ill clients can often be a long process that is taken in small, compassionate steps.

Types of Mental Illness

There are four broad categories of mental illness. Most individuals suffering from mental illness will fall into one of these categories. Depending on the type of disorder, different types of treatment (psychological or medical) may be required. It is important to state again that this information gives an overview of the types of mental illnesses a shelter client may have. It is not intended to be used to diagnose or treat a client's mental illness. Depending on the resources of the shelter you work in, there may or may not be access to case managers or clinicians to whom you can refer the client. At the end of this section you will find a fact sheet about the San Francisco Mobile Assistance Team. This outreach team can help evaluate a particularly distressed client who may need emergency hospitalization.

Thought Disorders:



Thought disorders are often called psychotic disorders and this term covers a wide range of mental illness. The central characteristic of thought disorders is that the client's thinking is:

A. **Non-Linear:** Not Straightforward. For example, the person may think that events are connected, when they are not, or that if he or she takes certain actions, other things may happen.

B. **Delusional:** Strange Beliefs and Thoughts. The person may believe that others wish to do them harm. They may believe they are at the center of a worldwide conspiracy and that they are the only person who knows about it. They may feel that their thoughts can be overheard, or taken from their head without their permission, or that their thoughts are not their own. They may believe that ordinary events have special meaning only for them.

C. **Hallucinations:** The person experiences events that others do not see, hear, or perceive. These experiences have the appearance of reality—an individual may hear his name being called, hear voices say unpleasant things about him, or hear meaningful sounds in usual noises, such as the hum of an air conditioner. They may experience visual hallucinations such as seeing things

that others do not. Depending on the type of hallucination, different people may have different emotional reactions, ranging from acceptance to irritation to terror. People who experience hallucinations may seek to blot them out with alcohol or other drugs because they are so terrible.

D. **Suicidal:** Suicide and self-harm is a significant risk for people with thought disorders. They are more likely to hurt themselves than people with different or no mental health problems. Shelter workers need to remain alert for these behaviors and be prepared to take appropriate action such as calling 911, or the Mobile Assistance Team.

Medications

Medications, called anti-psychotics or neuroleptics can be helpful, though they often have significant side effects. The decision to take or not take medications is the decision of the person with the thought disorder. Medications can also make a person feel worse, even if they help the person to control their behavior and reduce symptoms. Only the person and his doctor can determine the need for medication.

It is not clear as to why individuals develop thought disorders. They generally worsen when the person is under stress. They tend to be persistent, although some people do recover.

DO'S AND DON'TS when working with a person who may have a thought disorder:

1. **Don't try to argue a person out of a disordered thought or belief.** Direct confrontation reduces the possibility of an effective and supportive relationship. Instead, help the person explore how the belief controls their behavior. Do use this belief in a constructive way to help them meet basic needs and continue to reside safely at the shelter.
2. **Don't question the hallucinations by saying,** "Where? I don't see anything." Do attempt to determine if a person is having a hallucination. If their attention seems to wander or they are responding to an event you do not perceive say, "I wonder what you are seeing or hearing right now?"
3. **Do attempt to reassure a person who seems to be anxious.** If they seem disoriented, upset, or they are responding in a way that does not seem connected to their surroundings, ask if they know where they are, what day it is, and how you can help them.
4. **Do gain assistance if a person seems to be disoriented, non-responding, or if their responses do not make sense.** This is especially important if you have had previous experience with this person and their behavior seems out of the ordinary or worsened. They may have a medical condition that has become an immediate problem or a mental health condition that has gotten worse and requires treatment, or even a crisis response. Disoriented and non-responsive people need continued assistance. Your responsibility is to refer them to other staff, such as a case manager, who can assess them and determine what sort of help they need.

Example: A person comes into the shelter that smells so bad he offends others and could be asked to leave. However, he refuses to shower because he has objects such as toy ray guns and bits of string hung from his body. He tells you that these items contain a lot of his power and that if he takes them off he might not be able to move. Instead of telling him that this is not true, suggest that he could keep the objects close by the shower and so that he could still 'pick up' on their power. Let him know you will make sure that nobody steals the objects while he is in the shower.

Personality Disorders:

Personality disorders affect a person's ability to relate to other people. They are sometimes termed "characterological disorders." They may be severe enough that the person is unable to get along with others.

People with personality disorders may:

- Have difficulty making or maintaining close relationships.
- Have difficulty with self-image.
- Feel that they are 'special' and that rules should not apply to them.
- Personalize and misinterpret the meaning of others' communication.
- Exhibit poor impulse control.
- Use drugs or alcohol, or cut or burn themselves.
- Have difficulty considering the feelings of others around them.
- Have difficulty with emotional stability.

DO'S AND DON'TS when working with a person who may have a personality disorder:

1. Don't try and argue them out of their feelings.
2. Do try and validate what they are feeling. (Sometimes, knowing that someone is listening to them can reduce frustration.)
3. Do use gentle humor if possible to help them come down from an emotional peak.
4. Don't make fun of them or their feelings.
5. Do set limits around what you will and won't do and what the shelter can and cannot do. Clarity and consistency are necessary.
6. Do respect their intelligence. People with personality disorders are often very intelligent.
7. Do communicate with your co-workers about the client so that everyone is on the same page regarding the client's behavior. This helps eliminate situations where the client might split staff by giving different information to different staff members.

Mood Disorders:

Mood disorders affect a person's sense of well-being. People with mood disorders may be primarily depressed. They might be happy and then sad, and not know why their mood has changed. When the symptoms of the mood disorder become stronger they may be less able to control their behavior. People with certain mood disorders may be unable to respond appropriately to social situations with acceptable behavior. Substance abuse and mood disorders often go together. People sometimes seek substances of abuse—especially alcohol—to level themselves out.

People with mood disorders may:

- Make hasty or impulsive decisions such as getting married after knowing their partner only briefly.
- Experience bursts of energy for days at a time. During this period, they may need very little sleep.
- Be happy and then sad and not know the reason why their mood has changed.
- Be grandiose, self important, and demanding.
- Feel that nobody understands what they are going through.
- Have periods where they feel sad and worthless.
- Not have enough energy to get out of bed and sleep for long periods of time.
- Feel as if they have no control over their feelings.
- Be ashamed of themselves for what they have done or said after they have recovered.
- Be the life of the party, outgoing, energetic, charming and confident while in a mood elevated state. Then they miss feeling this way when they have recovered.

Medications can help stabilize mood. These medications may have side effects, which can be serious. The decision to take medications is one that can only be determined by the person with the mood disorder and their doctor.

DO'S AND DON'TS when working with a person who may have a mood disorder:

1. Do monitor for increasing symptoms. Mood disorders usually start small and then worsen over time. Be especially alert for someone who seems to need less and less sleep.
2. Don't tell a person that they should get help.
3. Do let them know you are concerned about them. Say: "Mr. Jones, I'm worried that you seem to be needing less and less sleep these past few days. That doesn't seem like you."
4. Don't try and tell someone who seems to be depressed or down on themselves that "it's all in your head" and that "you can feel better if you want to."
5. Do listen for signs that a client feels so hopeless that they might be considering hurting themselves or feeling suicidal.
6. Do discuss with a supervisor or mental health staff the situation of a person you think may be having a mood-related problem at the shelter.

Trauma Disorders:

Individuals with trauma disorders have been exposed to a traumatic event. Trauma disorders limit a person's ability to respond to their environment in productive ways. Children who have been physically or sexually abused, or combat veterans may develop trauma disorders. It is estimated that more than 30 percent of the Vietnam War combat veterans who have become homeless may have a trauma disorder. Trauma disorders are more frequent among women than men. Victims of assault are more likely to develop trauma disorders.

People who have witnessed major disasters such as earthquakes or terrorist attacks may also develop trauma syndromes, as can emergency responders, such as firefighters and police officers. People with trauma disorders may relive the traumatic event in nightmares, or have intrusive recollections, and may startle easily. They may also have other responses that can make life difficult, including feelings of being numb, difficulty communicating their feelings, and problems in relationships.

People with trauma disorders may:

- Have visions or nightmares of the trauma.
- React to others as if they are the abuser or enemy.
- Feel numb, as if there is no use talking about what they feel or experience.
- Appear depressed and lethargic.
- Have physical symptoms, including sleeplessness and physical complaints.
- Have difficulty making or maintaining friendships.
- Have difficulty concentrating.
- Repeatedly pick partners who abuse them.
- Use drugs and alcohol to help numb difficult feelings.
- Need additional support to reside in the shelter environment.

DO'S AND DON'TS when working with people who may have experienced significant trauma:

1. Don't expect to discuss central traumatic events in the shelter environment. Traumatic experiences are often deeply disturbing and difficult for the person to share with others.
2. Do remain supportive and accepting.
3. Do recognize that although individuals with a trauma disorder may not always respond the way you wish them to, they are not acting out at you.
4. Don't raise your voice if a client does not seem to understand what you have just said. Instead, approach them quietly and gently.
5. Do validate the person's experience. If a shelter guest tells you of a personal traumatizing event, say: "Given what has happened to you, it's understandable that you feel that way." Validation is an important support and you may be the only person able to offer it at that moment.
6. Don't blame or suggest the client is at fault for the traumatic event. Do not blame the victim.

7. Do make eye contact. If the person becomes upset at eye contact, stop making it.
8. Do recognize that a first-time shelter guest may find the experience traumatizing. Take extra time with that person, perhaps explaining to them how the shelter operates, even if they have already been through intake. Traumatized people may need things explained to them several times before they fully understand them.

Training Review

In this training section, you have learned about four major types of mental illness disorders—thought, personality, mood, and trauma—and basic suggestions for dealing with each one. You have learned why homeless people are more likely to have significant mental health issues, and why they may remain homeless longer. You learned some of the myths and realities of mental illness, and some of the solutions being used to help homeless people with those serious mental illnesses.

This completes the overview. This is a good time to discuss this material with your supervisor and complete the Mental Health Basic Self-Test.

Mental Health Overview Self-Test

1) What are two goals of this training area?

2) Why is this training area necessary?

3) Why might mentally ill individuals not acknowledge their symptoms?

4) Why are high rates of mental illness found among homeless people?

5) What are the four broad types of mental illness?

6) Why is skillful communication between staff members helpful when working with individuals who have a personality disorder?

7) Give two examples of how a person suffering from a trauma disorder may experience their illness

Name: _____ Date Completed: _____

Supervisor's Name: _____ Date Reviewed: _____

Working with Mentally Ill Clients: A Training Example

The challenge of working with mentally ill clients:

Working with people who are mentally ill is a challenge. People who are mentally ill often respond unpredictably.

People who are mentally ill may:

- Be confused and hide their confusion with anger. They may be afraid to let helpers know how confused they feel.
- Be unable to accept assistance.
- Have terrifying hallucinations.
- Feel they have to do or perform certain actions or else they or the world will suffer drastic consequences.
- Have their time consumed by obsessive, repetitious behavior that others may perceive as "crazy."
- Be disconnected from "normal" social behavior.
- Feel unbearably sad and constantly thinking of suicide.
- Be convinced that everyone else is out to get them.
- Have become disconnected from the common behavioral rules of our society. They are not acting outrageously at you, but they are acting outrageously.

Feelings of anger at the client are common:

Shelter workers sometimes feel frustration and anger towards mentally ill clients. Dealing with these clients can be a profoundly difficult job. The temptation to try to argue a mentally ill client out of their delusional thoughts or behaviors may be strong. It may also be tempting to insist that the client do as you say, to 'up the volume' of your request by increasing the loudness of your voice or your emotional tone.

Clues that you are frustrated and angry at a client:

1. You find yourself saying things like: "Man, he's crazy!" to your coworkers after an interaction with the client.
2. You wish they were no longer staying at the shelter.
3. You wish another staff member would interact with this person.
4. You make jokes at their expense.

These are uncomfortable feelings to have, but they are not uncommon. Mentally ill clients, especially those who are hard to reach, can provoke reactions of fear and anger, instead of curiosity or the motivation to provide assistance and support. It is a good idea to talk to your supervisor about these feelings in a one-on-one, especially if you find yourself acting on any of them.

Delusional thinking is not based in reason, and clients cannot be argued out of their delusions. Mentally ill clients may not understand you, or may be hearing voices that are so loud and persistent that they cannot hear you. Recovered mentally ill clients have said that their hallucinations told them if they listened to anyone, especially a care provider, terrible things would happen to them. These sorts of hallucinatory experiences are not uncommon.

Raising your voice or increasing your emotional tone to let a mentally ill shelter client know you are angry may make you feel better temporarily. But that satisfaction will disappear when you realize that they are not trying to make you angry and you're yelling at someone who doesn't deserve your anger. You'll also realize that your techniques are not going to increase their compliance, help them get better, or understand their situation. When you hold someone responsible for behavior they cannot control, you are only setting yourself up to get angry and stay angry.

Remember, individuals using shelter services may be seriously mentally ill and have difficulties complying with shelter rules and procedures. In such cases, supervisors are responsible for deciding if a client can continue to use the shelter services. But until they make that decision, you may have a lot of interaction with that client.

Empathic Response

This part of the training is not only a demonstration of a technique but also an invitation to think and act differently when interacting with a mentally ill shelter guest.

This basic technique is called empathic response. Empathy is different from sympathy. It means feeling with a person, while sympathy means feeling pity or sorrow for them. An empathic response demonstrates that you understand what the other person is experiencing. Your empathy may assist a mentally ill person to begin to develop a level of trust. Distant and isolated clients who feel supported are more likely to follow your suggestions and direction.

Scenario:

A client enters the shelter. He immediately walks up to the desk and begins to tell a story about how the police are after him, and that they have always been after him.

> Client: "Those police, they tapped my phone. Listen in on everything. They have that bug implant, right here (points to his head at the ear). The Feds, they know about it, won't do anything.
>
> Shelter Staff: "Those bastards!"

At first this intervention might not seem useful, but lets look at it thoroughly. Obviously, the client is delusional and it is a mistake to try and argue him out of this delusion. By arguing with him he may even begin to believe that you are part of the conspiracy. In the end, this increases his mistrust of the shelter and staff and results in him leaving the shelter.

By declaring "Those bastards!" the shelter worker shows that he is not part of the conspiracy, and that he understands what the client is going through. This empathic response builds trust and increases the possibility of the client receiving services.

Many people reject this technique. They say: "By agreeing with the client, aren't I just furthering his delusional thinking?" Let's examine that opinion.

1. The client is likely to find any information they need to support their delusion. Agreeing with them will not convince them that the delusions are any more real.

2, Argument against the delusion is going to fail. The client cannot be convinced they are wrong, and will develop resentment against you for trying.

3, In working with mentally ill and paranoid clients, the most important thing to preserve is your helping relationship. This intervention helps to do that.

4, You are only agreeing with the emotional content—the tone of his experience—not that the police are after him. All you are doing is saying what you think he feels.

Empathic Response is a difficult concept to understand. The best proof that it works is to try it out yourself. There are many situations where a person might use this technique of agreeing with another person's emotional state.

What other situation can you imagine where stating your understanding of another person's emotional state would be helpful? What would the client or co-worker say, and what would be your response?

This is one technique for working with people who are paranoid. This technique is applicable to many different situations, but is challenging to use because it requires you to step outside your own feelings. It requires practice, but if you are able to use it, you will discover how valuable this and other similar techniques can be.

Chapter

4b

5150:
Emergency Mental Health Treatment

This training gives an overview of the emergency mental health system of care in San Francisco. It is helpful for staff to understand what happens to clients when they are involuntarily placed on a psychiatric hold, known as a 5150. This training is meant to provide a basic understanding of the emergency mental health system of care. Whenever staff encounter a client whom they feel is a danger to themselves or others, they must rely on the police or Mobile Crisis Team for assistance. In all situations, staff need to follow their agency's emergency procedures and consult their supervisor.

Goals of this Training:

1. Show why someone is placed on a 5150, involuntary psychiatric hold.

2. Explain what happens to a client who is placed on a 5150.

3. Examine reasons why some shelter clients seem to cycle routinely through the mental health system.

The California Codes Welfare and Institutions, Code Section 5150-5157 is the legal authority that enables a mental health worker or police officer to place someone in the hospital against their will, and under certain circumstances, keep them there. Here is its exact wording:

California Codes Welfare and Institutions, Code Section 5150-5157:

When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team provided by Section 5651.7, or other professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation. This can be found on the web at: www.leginfo.ca.gov/calaw.html

- If a person is not guilty of a criminal offense the only way they can be held against their will is if they are a danger to themselves or others, or is dangerous to themselves because they are gravely disabled. A person held on a 5150 must be held in a locked psychiatric unit for the period of the hold. Simple evidence of mental illness is not sufficient for an involuntary hold. The person must be likely to suffer imminent harm or cause harm to another within the near future.
- Only a police officer or specially trained and designated staff members of Community Mental Health Services can examine a person and determine if they can be held under the provisions of code section 5150. Specially trained staff possess a serially numbered card verifying their authority.
- A 5150 hold lasts for 72 hours. After that, authorities must take further steps to continue to hold the person. These steps include providing the person with an advocate and a judge-held hearing. If a judge decides that the person still poses a risk to others, to themselves, or is so disabled that they cannot care for themselves he can place a 5250 hold that can last for up to 14 days.
- It is difficult to place someone on a 5150 hold because they are gravely disabled. It is necessary to prove that they cannot take care of themselves, and that they are likely to come to imminent harm because they cannot obtain medical care and need it urgently, or cannot obtain food or shelter.
- A 5150 hold does not mean that the person cannot refuse psychiatric medications. Unless the person's condition is life-threatening or extremely disruptive to the locked unit, they may refuse psychiatric medications. A further legal procedure, known as a Riese hearing, is required to make a person take medications against their will.

Sources to help a client who needs a 5150 evaluation:

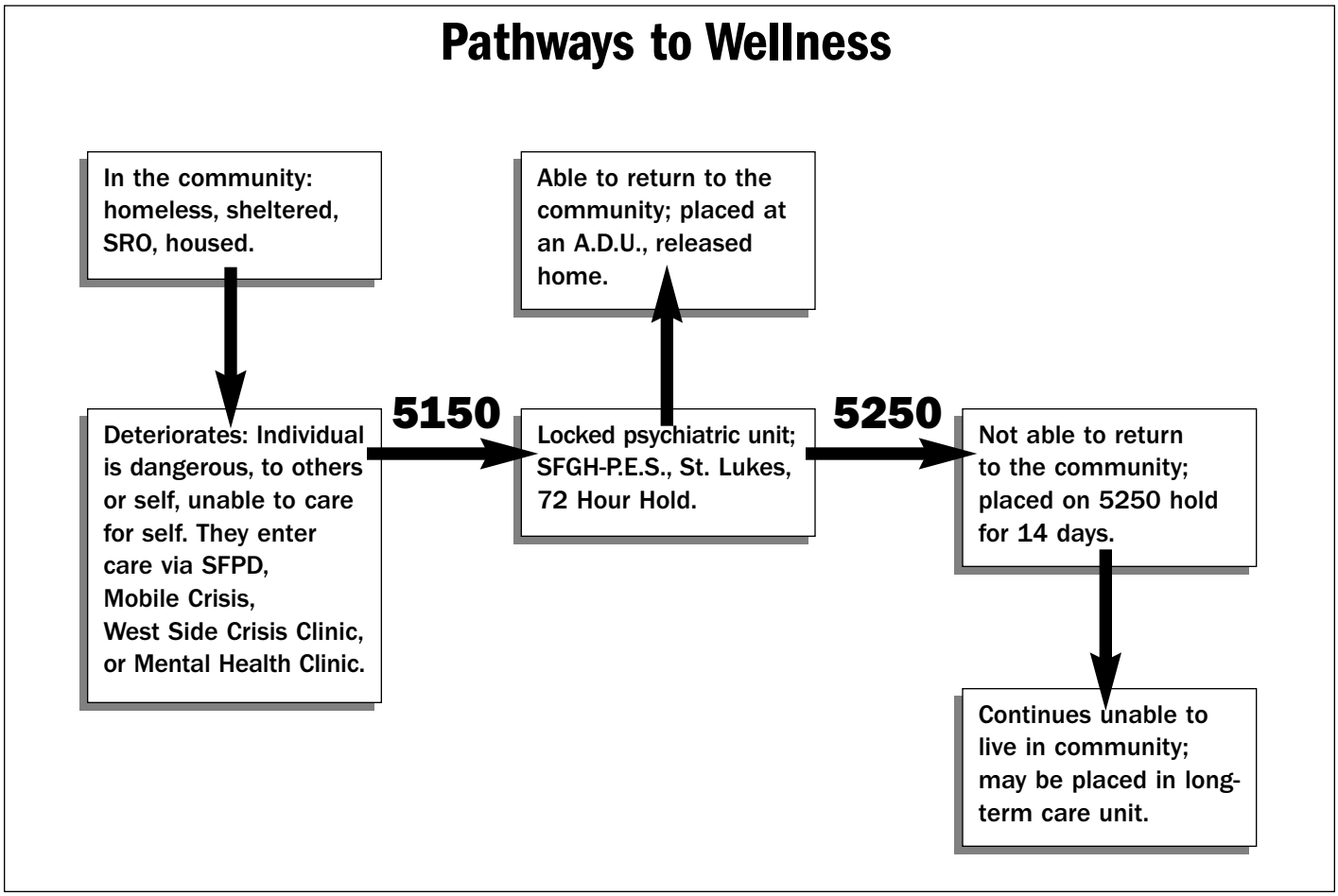
- To assess a client's condition call the Mobile Crisis Treatment Team at **(415) 355-8300**, Monday-Friday, 8:30am-11:00pm, and

Saturday-Sunday, noon-8:30pm. They will ask for a detailed description of the person and the problem they are presenting.

- A person may also be brought to the Westside Crisis Clinic, at 888 Turk Street, **(415) 353-5050**. It is a good idea to call first.
- The police can also place someone who is a danger to themselves or others on a 5150 and transport them to SFGH/Psychiatric Emergency Services.

The 5150 72-Hour Hold

After being placed on a 5150 hold, the individual is taken to a Psychiatric Emergency Service Hospital. This is a locked unit capable of keeping the person safely for the next 72 hours. They are checked in and observed until it's decided they no longer meet the criteria of the Welfare and Institutions Code Section 5150 and can be released, or that they still meet these criteria and are in need of further treatment. If the individual is in need of further treatment they will be transferred to a locked psychiatric hospital unit. There they will be pro-



vided with supportive treatment, which includes social work, nursing care, psychiatry, and medications. After the first 72 hours they are evaluated to determine if they still need hospitalization.

The 5250 14-Day Hold

If a judge decides the person is still dangerous to themselves or others or unable to care for themselves after the first 72 hours, they may be placed on a 5250, a 14-day hold. Eventually, a plan for their return to the community is developed and put into place and they are released. If after 14 days they are still in need of high-level of care, they may be placed in long-term care in a locked facility. This is rare. Usually, a person is discharged from the hospital to an Acute Diversion Unit, considered a step-down placement. ADUs are short-term placements, generally no longer than two weeks. The individual resides in group-home setting, with 24-hour staff on site, available medications and medication support staff (nurses and psychiatrists). The unit is not locked and the clients can come and go as they please. Refer to the diagram below for more information about the system of care in San Francisco.

5150 - Emergency Mental Health Treatment Self-Test

1) What is a 5150?

2) What are the criteria a person must meet in order to be held against their will?

3) What are three resources for emergency mental health assistance?

4) How long does a 5250 last?

Name: _____ Date Completed: _____

Supervisor's Name: _____ Date Reviewed: _____

Chapter

4c

Suicide Prevention: Assessment and Intervention

Basic knowledge about suicide prevention, assessment, and intervention is essential for all shelter providers. For staff working with the homeless this training is vital because there are higher levels of mental illness, trauma, and substance abuse within this population. These factors increase the possibility that a shelter worker will encounter a client who is suicidal.

Goals of this Training:

1. Give staff basic facts and knowledge concerning suicide and suicide prevention.
2. Help staff recognize the risk factors associated with suicide.
3. Give staff the skill to assess if a client is actively suicidal.
4. Give staff the skills to intervene with a suicidal client and to refer the client to appropriate resources.

Suicide Overview

It is not uncommon for someone to think about committing suicide. Most people decide to live, because they eventually come to realize that the crisis is temporary but death is permanent. On the other hand, people having a crisis sometimes perceive their dilemma as inescapable and feel an utter loss of control. As mentioned above, the possibility of suicidal thoughts and actual attempts by homeless people are higher than for the rest of the population because the issues of mental illness, trauma, and substance abuse are more prevalent within the homeless community. Added to these risk factors is the issue of homelessness itself. Homeless people are often cut off from family or support systems. They are more likely to be dealing with chronic medical issues. Often they are not treated for medical or psychiatric issues.

Some basic facts and statistics regarding suicide in the United States:

- In the US, over 29,000 people commit suicide each year. It is the 11th leading cause of death for all Americans. In fact, more people die from suicide than from homicide.
- Males are four times more likely to die from suicide than females, but females are more likely to attempt suicide than males.
- In 2000, white males accounted for 73 percent of all suicides. Together, white males and white females accounted for more than 90 percent of all suicides.
- Firearms are the leading method of suicide, accounting for 60 percent of all suicides in the U.S. Nearly 80 percent of all suicides where a firearm is used are committed by males. Hanging is the second method of choice for males. The second method of choice for females is self-poisoning.
- Suicide rates are highest among Americans aged 65 years and older. The highest suicide rate is found in white men over the age of 85.
- From 1980 to 1996, the suicide rate for African-American males ages 15 to 19 increased 105 percent.

A suicide attempt is a cry for help. It is a warning that something is terribly wrong. Depression can lead to feelings of desperation and hopelessness, and a suicide attempt is one way some people express these feelings. Most people who attempt or commit suicide don't really want to die-they just want their suffering to end. A suicide attempt must always be taken seriously. Without intervention and proper treatment, a person who has attempted suicide may be at risk of another attempt, and possible suicide.

Major Risk Factors for Suicide:

1. A previous attempt or suicidal behavior in immediate family.
2. A history of mental illness.
3. A major loss event.
4. Substance abuse or dependence.

Previous Suicidal Behavior in Self or Immediate Family

A prior suicide attempt or gesture is one of the most important indicators of potential risk for a future attempt. During the assessment of a suicidal client, it is important to get a history of past suicidal thoughts or attempts and to take measures to enhance a safe environment for the client.

Family History of Mental Illness

There is growing evidence that family and genetic factors contribute to the risk for suicidal behavior. Major psychiatric illnesses such as mood disorders, personality disorders, thought disorders, alcoholism, and substance abuse, which run in families, increase the risk for suicidal behavior. This does not mean that suicidal behavior is inevitable for individuals with this family history. It simply means that these people may be more vulnerable and should take steps to reduce their risk, such as getting evaluation and treatment at the first sign of mental illness.

Although most people who suffer from a mental illness do not die by suicide, having a mental illness does increase the possibility. This possibility increases with the added complication of substance abuse or dependence.

Major Loss

People who experience a major loss can be at risk for suicidal thoughts and behavior. "Loss" can be the death or terminal illness of a loved one, divorce or a broken relationship, loss of one's own health, job, or home status. Suicidal thoughts caused by a major loss usually lessen with time. However, this may not be true with elderly clients-particularly those who lost a life partner.

Substance Use

Research has shown that suicide risk is increased by both legal and illegal substance use. Substance use disorders, as it is used here, includes intoxication, binge drinking, withdrawal, as well as substance dependence and substance abuse.

Alcohol and substance abuse contribute to suicidal behavior in several ways. People who are dependent on substances often have a number of other risk factors for suicide, such as depression, homelessness, and trauma. Substance use can be common among people prone to impulsive and high-risk behaviors that result in self-harm. Intoxication by drugs or alcohol may increase suicide risk by

decreasing inhibitions, increasing aggressiveness, and impairing judgment. Additionally, substances such as alcohol make some medications more lethal; making it more likely an overdose attempt will result in death. Between 40-60 percent of those who die by suicide are intoxicated at the time of death.

Assessment

A suicidal person will often give signs of their feelings. Listen for signs of feeling helpless, hopeless, or worthless in someone who appears or complains of being depressed. Statements like, "I'm no good," "Life just isn't worth it anymore," "I can't go on," or "I'd be better off dead" indicate that further assessment is necessary. Other signs that may suggest someone is suicidal are:

- Previous attempts or history of suicide in their immediate family
- Talking about suicide
- Preoccupation with death
- Loss of interest in things most cared about
- Communication that seems deliberate and final
- Withdrawal from friends or people they usually connect with
- Hallucinations telling them to harm themselves
- Putting affairs in order
- Giving things away, particularly cherished or valued items

In assessing a client for suicidal feelings or intent, do not be afraid to use the "S" word. By being open about your willingness to be direct about suicide, you are communicating to the client that it is OK for them to talk about it. Be direct if you suspect someone is suicidal. It's OK to ask, "Are you thinking about suicide?" or "I wonder if you are thinking about killing yourself?"

If you have opened the subject of suicide for discussion and found that the client has been thinking about hurting himself, you should assess the seriousness of their feelings. Try to distinguish whether the client has "suicidal ideation" (thinking about the possibility of suicide without a plan or means to carry it out), or whether they have "suicidal intent" (have thought about suicide and the way to kill themselves, and have the means to do it).

Basic and direct questions to learn the seriousness of a client's suicidal feelings:

How long have you felt this way?

A person who has been struggling with suicidal feelings for a long time shows a serious level of hopelessness.

Have you thought about how you would do it?

If a client has a plan such as "I would shoot myself" or "I would take pills," it indicates a higher level of seriousness. Usually, the more lethal their means, the more serious the possibility of attempt. For instance, shooting oneself may indicate a higher level of risk than taking pills. No matter what the means, if someone has a plan, you should ask:

Have you got a way to do it?

Having the means to carry out their plan, such as "Yes, I have a gun" or "I just got my prescription filled," is very serious and warrants the staff calling the Mobile Crisis Treatment Team or 911 to have the person fully assessed and possibly hospitalized.

PLAID PALS: A Diagnostic Key

Some institutions use this tool to assess suicidal ideation and intent. It is a helpful, quick-glance guide you can review when faced with client who is possibly suicidal.

Plan: Is there one?

Lethality: Is it lethal? Can they die?

Availability: Is there means to carry out the plan?

Illness: Is there mental or physical illness present?

Depression: Is it present or is there a history?

Previous attempts: How many, how recent?

Alone: Is the person alone now? Is there a support system?

Loss: Has there been a recent death, a relationship loss, or a job loss?

Substance abuse: Drugs, alcohol, medications? Current or chronic?

Intervention

First and foremost, remain calm. If you feel overwhelmed, or out of your depth seek assistance from your supervisor or co-worker. Remember, your responsibility is to provide support and gather information so that you can get the person the help they need. Being caring and genuine are the two most important qualities when dealing with someone who is suicidal. It is OK to use the word "suicide" if the person is using ambiguous statements such as, "I just can't go on." Remain calm and use honest, supportive statements to begin assessing the seriousness of their suicidal feelings. Simply talking about their problems for a length of time will give suicidal people relief from loneliness and pent-up feelings, awareness that another person cares, and the feeling of being understood.

1. **Take it Seriously.** People who knew someone who committed suicide often say, "Those problems weren't enough to commit suicide over." You cannot assume that because you feel something is not worth killing yourself over, that the person you are with feels the same way. It is not how bad the problem is, but how badly it's hurting the person.
2. **Listen.** Give the person every opportunity to unburden their troubles and vent their feelings. You don't need to say much and there are no magic words. If you are concerned, your voice and manner will show it. Give them relief from being alone with their pain. Let them know you are glad they turned to you. Be patient, sympathetic, and accepting. Avoid arguments and advice giving.
3. **No secrets.** When a suicidal person says, "Don't tell anyone," that is the part of them that is afraid of more pain. However, the part of them that wants to stay alive is the part that tells you about their feelings. Respond to that hopeful part of the person that wants to live. By encouraging them to be more open about their depression you give them more opportunity to seek help from others.
4. **Use common sense.** Call 911 or the Mobile Assistance Team. Stay with the person until emergency help arrives. Seek consultation and supervision if you feel unsure of the person's immediate danger of harming himself. Calling for professional help, such as the Mobile Crisis Team should always be considered when a person is suicidal. Always communicate suicidal ideation or intention to your supervisor to receive guidance and support.

Suicide Prevention, Assessment and Intervention Self-Test

1) Name one resource staff can use to help assess a client for suicide?

2) Are men or women more likely to kill themselves?

3) What is the most common method for committing suicide?

4) Name three major risk factors for suicide.

5) What is the difference between suicidal ideation and suicidal intent?

6) Sometimes a person will not say directly that they are suicidal. They may imply their feeling with statements such as, "I can't go on," or "It's not worth it anymore." What should staff do in these cases?

Name: _____ Date Completed: _____

Supervisor's Name: _____ Date Reviewed: _____

Important Emergency Resources

Mobile Crisis Treatment Team (MCTT)
(415) 355-8300

Open Monday-Friday 8:30am to 11pm. On weekends and holidays it is open noon to 8:30pm.

If a crisis takes place when MCTT is not available, call 911. Whenever there is an immediate crisis, such as an overdose or if a weapon is involved, call 911.

The Suicide Prevention Hotline
(415) 781-0500

Open 24 hours a day, seven days a week. They are available to consult with staff and speak with clients.

The following information comes from San Francisco Community Behavioral Health Services' Organizational Provider Manual, Fall 2003 Edition. It is intended to help service providers understand who and when to call for assistance to either the police or MCTT.

When In Doubt: CONSULT

- ➤ Client is suicidal/homicidal and has a firearm.
- ➤ Client has a suicide plan and the means to carry it out. If the client has overdosed call 911.
- ➤ Client has command hallucinations to kill or harm self or others.
- ➤ Client is suicidal, has no support system and has just experienced a loss such as the death of a loved one, or learned about an illness.
- ➤ Client has a need to harm self due to paranoia or substance use.
- ➤ Client has a history of becoming psychotic and making poor judgments.
- ➤ Client cannot make reality-based statements about how food, shelter, and clothing will be provided for them.
- ➤ Client has many complicated medical and psychiatric issues, and it's unclear what should be addressed first.

Mental Health, Suicide and Crisis Response Resources

San Francisco Suicide Crisis Hotline
http://www.sfsuicide.org/index2.html
Telephone: (415) 781-0500
San Francisco Suicide Prevention Hotline is the oldest volunteer crisis line in the United States. Founded in 1963, its initial focus was providing telephone intervention to people experiencing suicidal crisis. Gradually, the agency's focus shifted from strictly suicide prevention to more general counseling services. The provide 24-hour service by over 150 trained volunteers with the supervision of a small multidisciplinary staff. It also provides trainings and support for staff who have worked with suicidal clients.

American Association of Suicidology
4201 Connecticut Avenue, N. W., Suite 408.
Washington, DC 20008
Telephone: (202) 237-2280.
www.suicidology.org

American Foundation for Suicide Prevention
120 Wall Street, 22nd floor
New York, New York, 10005.
Telephone: (888) 333-2377
http://www.afsp.org/

Centers for Disease Control and Prevention
National Center for Injury Control and Prevention
www.cdc.gov/ncipc

SAVE: Suicide Awareness Voices of Education
7317 Cahill Road, Suite 207
Minneapolis, MN 55439-2080
Telephone: (952) 946-7998
www.save.org

Suicide Prevention Advocacy Network
5034 Odin's Way
Marieta, GA 30068
Telephone: (888) 649-1366
www.spanusa.org
http://www.dph.sf.ca.us/PHP/MHP.htm

Community Behavioral Health Services, San Francisco.

24-Hour Access Helpline: (415) 255-3737

TDD (888) 484-7200

1380 Harrison Street, San Francisco, California.

Community Behavioral Health Services provides mental health services for City and County residents.

Substance Abuse

Chapter

5a

Addiction Basics

Why this training:

Each day shelter staff members witness and confront substance abuse at their workplace. Substance abuse is often a cause of homelessness and a reason people remain homeless for extended periods of time. Knowledge and understanding of substance abuse, substance use, and addiction is part of the basic toolkit for all workers in the shelter system. By knowing the difference between substance use and substance abuse, and having basic information about addiction, shelter workers can understand necessary interventions and the obstacles to those interventions.

Shelter staff may themselves be in recovery, which presents challenges when providing support to substance users. This training validates the recovery perspective many shelter workers bring to their job. It builds upon this strength and knowledge, and supports shelter staff to bring a professional perspective to the issues of substance abuse within the shelter system.

Goals of this Training:

After completing this training, shelter staff will be able to:

- Examine their own reactions to shelter clients who continue to use substances of abuse despite negative impacts and develop productive responses.
- Recognize the challenge of behavioral change for individuals with addiction disorders.
- Develop an understanding of addiction including tolerance, dependence, and withdrawal.

- Understand the difference between physical and psychological dependence.
- Know the impacts of substance abuse in their community and on homeless people.
- Function effectively with guests who abuse substances.

Facts and Figures

San Francisco is in the grip of a substance abuse epidemic that consumes both lives and dollars. According to national statistics, abuse of heroin is rising at a level not seen in this country since the 1970s. From 1994 to 2002, San Francisco Emergency Department admissions due to substance abuse grew substantially and in 1997 were among the highest in the country. Substance abuse is implicated in a majority of the deaths among homeless and under-housed individuals. In 1998, chemical poisoning caused more than 50 percent of the homeless deaths in San Francisco County. Chemical poisoning is the technical term the Medical Examiner's office uses for overdose. Nationally, a heroin epidemic is starting again—over 30,000 more people went to the emergency room because of heroin use in 2002 than in 1994, an increase of more than 48 percent.

Impact of Substance Abuse

Substance abuse may keep people homeless for extended periods of time. They spend their money on substances instead of obtaining housing. It can endanger individuals and communities through drug related harms, such as crime and increased poverty. Substance abuse may have an impact upon the mental health of drug users and their partners as they deal with the effects of addiction. It also impacts the physical health of drugs users and is related to the spread of diseases such as HIV, hepatitis, and syphilis. Drug users may ignore the impacts of their substance abuse, seek primary medical care less frequently and tend to be higher users of emergency room services.

Substance addiction: A working definition

Introduction: The Bio-Social Model

Substance abuse and addiction are complex topics that often involve personal feelings about the use of drugs and alcohol. In order to provide clarification, a bio-social model of substance abuse is used throughout this training.

A model serves as a blueprint for actions—telling us something about the situation we find ourselves in and giving us guidance for behavior. It is useful to have a good model when dealing with complex issues or topics. A model is like a blueprint for a building-it tells the builders where the pieces go and what it should look like when finished. When we have a model of a problem, we know how to construct interventions and organize our ideas. The bio-social model of substance dependence helps us to understand addiction.

A bio-social model of drug and alcohol dependence suggests addiction is a complex phenomenon with multiple causes. Many people use alcohol and drugs from time to time, but only some become addicted or develop dependency. Most people who use heroin do not become addicted—but for some, the use of heroin can become a lifetime career.

What makes one person more susceptible to addiction? What makes one person complete a recovery program and gain sobriety while another tries multiple programs and is not able to? The bio-social model provides perspectives to assist us to answer these questions.

Formerly, it was believed that addicts were 'weak' and unable to resist drugs. This led to treatment that looked more like punishment than assistance in overcoming the problem. Now, the 'weak person' or 'immoral addict' model is generally discarded. It is currently thought that addiction is a disease process. We know from genetic studies that there is about 40 percent greater chance of being addicted to alcohol if a parent was an alcoholic. This seems to be true even if the alcoholic parent did not raise the child.

Social factors also play a role in the development of addiction and addictive behavior. People who have been traumatized as children, a social factor, are far more likely to develop substance dependencies than people who have not had a traumatic experience. All of these are examples of social factors that influence addiction. Peer group composition and peer group pressure are also social factors that strongly influence the use of drugs in someone's life. The term bio-social

model comes from the idea that addiction potential most often arises from both inherited factors and social experience.

Four Factors that Contribute to Addiction

1. **Genetic History:** Inherited from parents
2. **Childhood Experience:** Family and peer groups
3. **Current Peer Group and Life Situation**
4. **The Drug's Addictive Potential**

An Addiction Measure: The Common Yardstick

Because shelter guests may deny their addiction's severity, having a way to measure addiction is helpful. Clients who are questioning their addiction, or evaluating impacts of substance abuse on their lives may consult shelter workers for support. Having a measuring tool—the common yardstick—helps the staff member evaluate the impacts of substance abuse with the shelter guest. In this training, you will be presented with the three-feature model that forms the common yardstick.

Three-Feature Model of Dependence

Substance abuse treatment professionals suggest that there are three main features of addiction, and that if all three are present then the person is substance dependent.

Abuse: The drug use continues despite negative consequences in the person's life, such as disrupted relationships, loss of housing, loss of work, and contacts with the criminal justice system.

Tolerance: The individual needs increased amounts of the substance to achieve the desired effect and seeks out the substance regardless of its availability.

Withdrawal: When the person does not have access to the substance, they experience unpleasant physical and psychological effects or may substitute similar substances to avoid these affects.

Substance-dependence includes physical and psychological dependence. A person who is physically dependent upon a substance of abuse has withdrawal symptoms when the drug is not available. These vary depending upon the degree of the addiction and the substance. A person who is psychologically dependent has a difficult time managing emotional states without the drug. They may com-

plain of feeling bad and experience anxiety, fear, or worry when the drug is no longer available.

Do Not Give Up Hope

Many clients who use shelter services meet the three-feature definition of substance addiction. Shelter workers who have personal substance abuse experience may want to 'show the way' to addicted shelter guests, help them to understand their addictive behavior, and get them treatment. Other workers may not have substance abuse and recovery personal experience, but both groups will want to help shelter guests who seem 'stuck' in addictive behavior. Shelter workers may become frustrated when the shelter guests reject their assistance and continue a self-destructive pattern. When frustrated, staff may treat the guest angrily, assume the guest cannot or does not want to change, and then stop offering them assistance.

Everybody Says You're a Bad Penny.

One client who had stayed in shelters for many years, trapped in addiction to methamphetamine, relates his story in his own words.

"I had been in treatment many times, like five or six. Every time I would leave treatment. I would stay sober for only a little while. Once I think, I got a month (clean)—that was about the longest. Then I went to Walden House, where I had been before, and this counselor said, she said, I remember it to this day, she said, 'Everyone says you're a bad penny.' (Because I'd been through there so many times and always gotten high) 'But baby, nothing in this world is too good for you.' And that stuck out in my mind, and it is with me to this day."

This client no longer uses drugs and has a sustained period of sobriety. He credits the long-term belief of the counselor in his goodness and his belief in God as the reason he was able to recover. It is not always possible to tell what interventions make a difference.

It is important for staff members to remember the following:

1. People will only change and decrease addictive behavior when they want to, and sometimes only when there is no alternative. If at their "decision point" treatment is available, they may engage in treatment and change their lives. There are no guarantees that this will happen.
2. For some, there are no consequences that will motivate them to stop using. This does not mean you should not try to assist them.

3. Your relationship with the shelter guest is extremely important. Do not sacrifice the relationship you have with the guest because they won't change in the way you think they should. Instead, emphasize to the guest that you will be there for them as much as they and their substance abuse will let you.
4. Let the client know that while you may have a problem with their behavior, this is different from having a problem with them. Tell them, "I hate what this drug is doing to you. It feels like you are really stuck. I wonder if you can see that your life could be different."
5. A bio-social model of substance abuse suggests that a person who continues to use substances despite negative consequences needs more treatment not less. Depriving a relapsing person of assistance (withdrawing your support), because their substance abuse has increased doesn't make sense. Increase your contact with those in relapse or those trying something new to reduce their substance abuse.

Self-Protection and Addressing Addicted Clients

Clients who present with sustained substance abuse challenge shelter staff—especially staff in recovery—in several ways. A key challenge is how to tolerate denial statements of clients who do not admit the power of their addiction. Another is how to deal with feelings of frustration and anger toward clients who repeatedly relapse, do not access treatment, or simply, and often angrily, turn away staff trying to assist them.

A classic statement of denial that confronts a staff member who understands the power of addiction happens when the client says they can control their use:

"It's OK. I'm only going to smoke a couple of 20-shots when I get paid this week. The rest of my money is going toward getting a place."

The staff member knows that this client is speaking from a place of denial and is probably unable to smoke only this amount of crack. Furthermore, this client has been staying at the shelter for a long period because he spends most of his money on crack cocaine. What can the staff member say that will let the client know that this self-expectation is unrealistic? Is there anything the staff member can say to help the client, without making them so angry about not feeling trusted that they walk away and not come back?

Two Possible Responses:

"Let's make a deal. This time, try it your way. But if it doesn't work out the way you think it will, maybe we can talk about doing something different next month." This response does not directly confront the client's denial and builds for future contact around the issue. In this way, the comment maintains the relationship.

Or:

"What do you want me to say to you if this doesn't work?" This comment helps build for the future and puts the power to determine the resolution into the client's hands. Putting the power into the client's hands tends to reduce the chance that the shelter guest will experience guilt and anger at the staff member.

Both of these interventions protect staff members from feelings of frustration and resentment at stuck clients by building for future interventions, maintaining the relationship and allowing the staff member to express their own feelings in a positive way.

Training Review

In this training section you have learned about the complex bio-social model of addiction and the three key features often active in the lives of people addicted to substances. You also learned about the need to take steps to continue and maintain the relationship with people who are continuing to use substances to the point that they suffer drug related harm. Finally, two interventions were presented that assist the shelter guest to develop greater motivation for change while retaining the relationship with staff. This builds hope for the future, and assists the staff member to deal with the frustration that this work can provoke.

Addiction Self-Test

1) What are the four factors commonly known to be responsible for addiction to substances in the adult?

2) What are the three features indicative of addiction?

3) A biosocial model of addiction suggests that two main factors are responsible for drug dependence. What are these two factors?

4) What is physical dependence?

5) What is psychological dependence?

6) What is the main objective in working with substance abusers who deny the severity of their abuse?

Name: _____ Date Completed: _____

Supervisor's Name: _____ Date Reviewed: _____

Common Drug & Alcohol Addiction, Treatment and Rehabilitation Terms

Abstinence: To refrain from the use of chemicals to which a person may be addicted.

Addict: A person who has an uncontrollable craving for a mind-altering substance.

Addiction: A dependence on alcohol, drugs, or sex that becomes a physical and psychological craving. No consequence or hurt can stop an addiction.

Alcoholic: A person who drinks alcoholic substances habitually. One who cannot fight the craving once it starts.

Alcoholics Anonymous: A voluntary, anonymous, self-help organization of individuals who have a problem with their consumption of chemicals whether drugs or alcohol. Abstinence is achieved through a 12-step process and a setting of one alcoholic sharing like experiences with another alcoholic.

Alcoholism: A disease characterized by the excessive consumption of and dependence on alcoholic beverages, which could lead to physical and psychological harm and could impair social and vocational functioning.

Al-Anon: A 12-step process for loved ones who have been affected by an alcoholic or addict. It introduces alcoholism to those who might not understand the disease. It teaches coping skills and how to become supportive of the alcoholic yet not enable them.

Amphetamine: Synthetic amines (uppers) that act with a pronounced stimulant effect on the nervous system.

Barbiturates: A class of drugs used in medicine as hypnotic agents to promote sleep or sedation. Some are also useful in the control of epilepsy. All are central nervous system depressants and are subject to abuse.

Binge Drinking: The consumption of five or more alcoholic drinks in a row on at least one occasion.

Blood Alcohol Concentration (BAC): The amount of alcohol in the bloodstream measured in percentages.

Chemical Dependency: A physical and psychological habituation to a mind or mood altering substance such as alcohol or drugs.

Cocaine: An alkaloid, methylbenzoylecgonine, obtained from the leaves of the coca tree. It is a central nervous system stimulant that produces euphoric excitement.

Depressants: Drugs that reduce the activity of the nervous system (alcohol, downers, and narcotics).

Designer Drugs: Illegal drugs are defined in terms of their chemical formulas. To circumvent these legal restrictions, underground chemists modify the molecular structure of certain illegal drugs to produce analogs known as designer drugs. Most are related to amphetamines. This can cause neurochemical damage to the brain.

Detoxification: A treatment for addiction to drugs or alcohol intended to rid the body from addictive substances.

Downers: Barbiturates, minor tranquilizers, and related depressants.

Drug: A drug is any chemical substance that alters mood, perception, or consciousness.

Drug Abuse: Pathological use of prescribed or un-prescribed chemical substance.

Dual Diagnosis: Substance abuse or chemical dependency in addition to or co-existing with a psychiatric disorder.

Enabling: Allowing irresponsible and destructive behavior patterns to continue by taking responsibility for others and not allowing them to face consequences of their own actions.

Families Anonymous: A 12-step, self-help recovery and fellowship of support groups for relatives and friends of those who have alcohol, drug, or behavioral problems. They share their like experiences, strengths, and hope with each other and with new members.

Habituation: The result of repeated consumption of a drug that produces psychological but no physical dependence. The psychological dependence produces a desire (not a compulsion) to continue taking drugs for the sense of improved well-being.

Hallucinogens: Drugs that stimulate the nervous system and produce varied changes in perception and mood.

Hashish: The concentrated resin of the marijuana plant.

Heroin: A semi-synthetic derivative of morphine originally used as an analgesic and cough depressant. In harmful doses it induces euphoria, making users think they are removed from reality, tension, and pressures.

Inhalants: Inhalants include a variety of psychoactive substances, which are inhaled as gases or volatile liquids. They include glue, gasoline, paint thinner, and other household products that are not considered to be drugs.

IVDU: Intravenous Drug User. Also, injecting drug user. Someone who uses a hypodermic syringe to inject drugs into their body.

Intervention: When someone who cares for the alcoholic or addict makes a healthy decision to introduce the process of recovery to the sick person. It is when one steps into the addict's or alcoholic's path and tries to veer their direction to a healthier one. If taken in the right direction, one may find that a new life has just begun.

LSD: LSD distorts perception of time and space, and creates illusions and hallucinations. It comes in liquid form and most often swallowed after being placed on small pieces of paper. It increases heart rate and blood pressure. Symptoms are nausea, chills, flushes, irregular breathing, sweating, and trembling.

Marijuana: Marijuana is prepared by crushing the dried flowering cannabis top and leaves into tea like substance, which is rolled into a joint and smoked. The user usually experiences a distorted sense of time and distance, and suffers from reduced attention span and memory loss. Symptoms may include impaired judgment, slow reaction time, confusion of time sense, and limited motor skills.

Methadone: A synthetic opiate with action similar to that of morphine and heroin except that withdrawal is less severe. It is used as a substitute for heroin in the treatment of addicts.

Methamphetamine: A stimulant commonly referred to as uppers and speed. It is found in powder, pill, and capsule forms and can be inhaled, swallowed and injected. The effects are alertness, euphoria, loss of

appetite, dilated pupils, elevated heart rate, increased breathing and elevated body temperature. Terms to describe methamphetamines are: meth, crank, crystal, ice, glass, or speed.

Narcotics: A class of depressant drugs derived from opium or related chemically to compounds of opium. They are very addictive if used regularly.

Narcotics Anonymous: A self-help organization of individuals who have a dependence on drugs and want to commit to a life of abstinence. One addict helping another to achieve the same goal goes a long way and could save someone's life.

Opiates: Drugs derived from opium such as morphine and codeine, together with the semi-synthetic congeners such as heroin.

PCP: PCP is also known as Angel Dust. It is a synthetic substance that is chemically related to ketamine, which is widely used in anesthesia. Symptoms may include blurred vision, diminished sensation, muteness, confusion, anxious amnesia, distortion of body image, thought disorder, and variable motor depression or stimulation, which may include aggressive or bizarre behavior.

Physical Dependence: When a person cannot function normally without the repeated use of a drug. When the drug is taken away, the person has severe physical and psychic disturbances.

Recovery: A lifelong process of change to abstain from alcohol/drug usage. A character building process, which increases the chance of staying clean and sober.

Relapse: To fall back into the former state of drinking or using once treatment or recovery has begun. The act of going back to old behavior or regressing from sobriety.

Sober Living: A semi-structured residential setting of alcoholics and addicts who have completed treatment and need continued support for up to a year.

Sobriety: Abstinence from consumption of alcohol or drugs.

Steroids: A large family of pharmaceutical drugs related to the adrenal hormone cortisone.

Stimulants: Drugs that increase the activity of the nervous system, causing wakefulness.

Tolerance: A state in which the body's tissue cells adjust to the presence of a drug. The term "tolerance" refers to a state in which the body becomes used to the presence of a drug in given amounts and eventually fails to respond to ordinarily effective dosages. Therefore, larger doses are necessary to produce desired effects.

Twelve Step Programs: A process of abstinence taken from the founders of Alcoholics Anonymous used by millions of alcoholics and addicts as a starting point into a new life. The steps represent an admittance to ones self that one has a problem with alcohol or drug abuse, a cleansing process of shame, guilt, and resentments, a character building process, an amending process and a process of giving back for the new life that one has received.

Uppers: Refers to stimulants.

Withdrawal: The symptoms that one may have when detoxing from alcohol or drugs. This may include: nausea, insomnia, anxiety, dementia, convulsions, sweating, trembling, weakness and seizures.

Overdose Detection and Response

Chapter

5b

Goals of this Training:

After completing this training, shelter staff will be able to:

- Take appropriate action when a person is under the influence of a substance of abuse or medication, or may have overdosed.
- Discuss with shelter guests their relationship with substances of abuse.
- Increase knowledge and understanding of drug overdose and its prevention.
- Recognize stimulant and narcotic overdose presentations.

Overdose: A Definition

Overdose occurs when a person takes more of a drug, or combination of drugs, than their body can handle. Essentially, this is a form of poisoning. The drugs overwhelm key organ systems—the lungs, heart, liver, kidneys, and brain. The person suffers damage or may die. The injury from drug overdose may occur shortly after the person takes the drugs or later.

Any drug, including Tylenol, can cause an overdose. However, street drugs of abuse, alone or in combination with other drugs, cause the majority of overdose injuries and deaths that shelter staff are likely to see.

Opiate Overdose

What drug is responsible for the greatest number of overdose injuries?

Opiate class drugs (also called narcotics), pose the greatest risk of overdose. Within this class of drugs are heroin, OxyContin, Percodan, Percoset, Darvon, codeine, and methadone. In San Francisco, opiate drugs are responsible for the greatest number of deaths and emergency hospitalizations. Stimulant drugs, such as crack cocaine, and methamphetamines, are responsible for the next greatest quantity of overdose injuries.

Below we review signs and symptoms of overdose and the appropriate action to take for each of these drugs.

How does overdose occur with opiate drugs?

These drugs depress a person's respiratory system. If they take too much of the drug they breathe slower and slower and may stop breathing altogether. Addicts sometimes call this "forgetting to breathe." Once a person stops breathing, death from heart failure follows.

Opiates Combined with Other Drugs

Opiate drugs in combination with alcohol and valium-class drugs (also called benzodiazepines) can be dangerous. These drugs are sometimes prescribed to alleviate anxiety, however they are highly addictive and popular on the street. Commonly abused benzodiazepines include Klonopin, Xanax, and Valium. Many street users obtain these drugs from doctors or illegal sale on the street. These drugs increase the effect of opiate drugs and make them last longer. Like opiates, alcohol and benzodiazepines can depress the respiratory system, which can result in an overdose. Shelter staff should be aware of the possibility of overdose with opiate drug users who appear intoxicated or smell of alcohol.

Methadone

Methadone is a legal opiate drug given to opiate addicts. It helps them lead more normal lives, as they do not seek an illegal drug on a daily basis. Methadone is

The Three Groups Most at Risk for Opiate Overdose

The Three Groups Most at Risk for Opiate Overdose
Group I: Inexperienced opiate users who cannot judge their tolerance.

They do not know how much drug produces the desired effect and may take enough to produce an overdose.

Group II: Older, more experienced, and long-term opiate users.

Typically, they are in their 40s or 50s and have a tendency to get high alone. They obtain a quantity of the drug stronger than expected or lose track of how much of the drug they have taken into their body. Because they are not with others when they use drugs, they are likely to overdose alone reducing the possibility of rescue.

Group III: Opiate users who recently exited from treatment or jail.

These users have gone through withdrawal from the opiate drug and do not realize that their tolerance has decreased. They tend to use the drug amount they used before treatment and since they have little or no tolerance, overdose. In a study in Santa Cruz, California, more than 30 percent of injecting drug users stated that they did not change the amount of drug after a period of abstinence.

longer lasting than heroin, so a single oral dose every 24 hours prevents withdrawal symptoms. However, it may also cause an overdose. Because it is a longer-acting medication than heroin, it may take several hours after taking the drug before the person has the symptoms of an overdose. Symptoms of methadone overdose are the same as for any other opiate. Methadone in combination with benzodiazepines or alcohol may be particularly lethal. Some people who take methadone may use also heroin. Combining methadone and heroin increases the risk of lethal overdose.

Recognizing Opiate Overdose

Overdose Detection:

Overdose can happen at any time. Shelter guests may come to the shelter under the influence of opiates or use opiates during their shelter stay. Staff can detect overdose by learning the symptoms given in the table below and monitoring guests for the presence of these symptoms.

MILD	MODERATE	SEVERE
Uncontrollable Nodding	Awake—unable to talk	Unconscious
Inability to focus	Body is very limp—sways when standing.	Skin color change to blue/gray. May be seen first around the lips. ACTION: Monitor respiration. Prepare to do CPR/Rescue Breathing. Call 911.
Excessive drooling	Erratic or very shallow breathing	Not breathing. ACTION: Initiate Rescue Breathing. Call 911
Pale Skin	Vomiting	No pulse. Initiate CPR ACTION: Call 911
Incoherent Speech	Hard to awaken: Returns to sleep immediately.	Choking or Gurgling. ACTION: Call 911. Monitor respiration.

Before Lights-Out

If you find a shelter guest who is not conscious, attempt to wake them. If they cannot be awakened call 911 and have the guest monitored while you do so. Check for breathing and heartbeat to see if CPR is necessary.

If a shelter guest has moderate symptoms of overdose consult with supervision in order to determine if medical assistance should be summoned to care for the guest. Guests who are intoxicated from opiates frequently deny the need for assistance. They may say that they are simply tired or 'out of it' and have no need for assistance.

Shelter staff should ask the shelter guest who shows overdose symptoms if they have taken any pills or medications and what they think is responsible for their condition. Say, "Mr. Jones, I'm worried about you because you don't seem to be able to stay awake. What do you think is the reason for this?" Consider asking if they have taken any pills or medication that might be responsible for their condition. This may be especially important if you need to call 911 and the person is suffering from a condition caused by both the use of street drugs and prescription medications.

Lights-Out Awareness

Opiate users often use heroin right before lights-out because symptoms of withdrawal during the night prevent sleep. Staff should pay attention to known opiate users during the night hours, listening for unusual breathing patterns. Breathing that has a long pause between breath intake and breath exhalation may be a symptom of overdose. Consider taking the following action: Call the guest's name in your attempt to wake him up. Your worksite may permit you to shake or pat an apparently unconscious shelter guest in an attempt to wake him or her. Seek guidance from your supervisor about how to wake an apparently overdosed shelter guest.

The symptom checklist above is only a general guide. Every person has a unique response to chemical poisoning. Symptoms that may not seem serious can change rapidly and only medical personnel can make decisions in this regard. Whenever staff are in doubt that a shelter guest is safe, then the staff should call for medical assistance. Do not be afraid of hurting a guest's feelings by requesting medical intervention. Your job is to help shelter guests remain safe. Remember, an observed overdose is a *preventable death*. Do your part to assist people to continue their lives, safely.

Stimulant Overdose

How does overdose occur with stimulants?

Stimulant drugs may cause overdose with different signs, symptoms, and treatment needs from that of opiates. Stimulants in common use in San Francisco include methamphetamine (crystal, crank, ice) and cocaine, including crack. These drugs are capable of causing lethal reactions in users, including stroke, cardiac arrest (heart attack), and changes in mental status and behavior. While death is less likely with stimulant overdose than with opiates, it must be treated as a serious matter.

Who is at risk for overdose from these drugs?

Anyone who uses stimulant drugs is at risk. Incidents of fatal heart attack and stroke have happened after only one use of stimulant drugs. Unlike the different characteristics of those most affected by opiate overdose risk, stimulant abuse seems to be an equal-opportunity risk. Everyone who uses shares the risk equally.

Three Risks of Stimulant Overdose

1. Damage to the cardio-vascular system. Because these drugs irritate the heart and interfere with normal heart beat people who overdose on stimulant class drugs may have heart attacks and strokes. They may become unconscious. CPR may be needed to maintain respiration and heart function until an ambulance and emergency medical personnel respond.
2. General collapse and body temperature increase may take place due to the interference of the stimulant. A stimulant overdose may cause seizures, heart problems, loss of consciousness, and a potentially fatal condition resembling heat stroke.
3. Behavioral complications. People suffering from an overdose of stimulant drugs may behave bizarrely. They may have hallucinations (such as hearing voices), or develop ideas that others are out to get them or want to harm them (paranoia). If they act on these ideas, they may place themselves, staff, and other clients in jeopardy. Altered behavioral states are signs of a possible stimulant overdose and need treatment by emergency medical/mental health personnel to assist the person to regain control of their behavior.

Recognizing Stimulant Overdose

Shelter staff should remain alert for behavior changes, especially with someone who does not have a pattern of aggressive behavior who becomes aggressive. Signs such as burns around the mouth suggest the person may be smoking enough methamphetamine or crack cocaine to cause an overdose.

MILD	MODERATE	SEVERE
Incoherent Speech	Inability to focus ACTION: Alert supervision, consider calling 911.	Seizures. ACTION: Monitor, call 911
Extreme Paranoia	Vomiting ACTION: Treat as medical health emergency, monitor and consider calling 911.	Unconsciousness ACTION: Monitor, Call 911
Pale Skin	Foaming at the Mouth —treat as above—	Choking/Gurgling. ACTION: Monitor, Call 911
Jaw/Teeth Clenching	Pressure/Tightness of chest —treat as above—	Not breathing. ACTION: Begin rescue breathing, call 911.
Aggressiveness	Unable to talk —treat as above—	No pulse. ACTION: Begin CPR, call 911
Minor shakes	Unable to walk —treat as above—	
Excessive sweating	Erratic pulse	
Clammy Skin	Violent actions-Alert Supervision, call 911.	
Very Rapid Pulse		

Alcohol Overdose

Alcohol poisoning, although rare in the shelter environment, can be a risk. The overdose mechanism of alcohol involves two possible risk areas: too much alcohol can render someone unconscious, also known as passing out, and they may subsequently vomit. If they inhale the vomit, they may choke to death. A second risk is that they consume so much alcohol that their brain's respiratory system ceases to function. In general, these two events are more common among teenagers and young adults who have little experience judging their alcohol tolerance.

Alcohol may cause behavioral problems for clients. They may behave in ways that violate shelter rules. Clients who arrive intoxicated may be referred to McMillan Stabilization Center drop-in at 39 Fell Street for detoxification and stabilization. Nursing staff will monitor them there. Ask your supervisor about the appropriate response to clients who arrive at the shelter intoxicated.

A Shelter Worker's Story

This guest came in one night. He was a really nice guy, always volunteering around the shelter, friendly to the staff. Even if he didn't get a bed he'd help put away the coffee service snack at the end of the night. He came in one night and right away we began getting calls to the front desk that he was acting strange. He went to the laundry room and tried to kiss a resident. He came up from the laundry room to the front desk where we tried to talk with him about his behavior. He wouldn't talk and ran up the stairs. Then we got a call that he was up on the men's floor making threats to a staff member. We went up there and he charged at us, saying that we were full of it. We had to take him to the floor. Even when we had him down he was still struggling. We called 911 and the police arrested him. Later, it turned out he had smoked a lot of crack and some speed that day. Even though he was denied service he came back to apologize. He was ashamed of what he had done.

This frontline worker's report is an excellent summary of how someone's usual behavior can change under the effect of stimulants. They may become aggressive and hypersexual and lose control of their behavior.

Drug Overdose
Self-Test

1) What is the Training Goal of this section?

2) What is an overdose?

3) What drug class is responsible for most drug overdose in San Francisco?

4) What are the characteristics of the three groups of opiate users prone to overdose?

5) What are the three risk areas posed by stimulant overdose?

6) Who is most at risk for stimulant overdose?

Name: _____ Date Completed: _____

Supervisor's Name: _____ Date Reviewed: _____

Harm Reduction

Chapter

5c

Why this training

Substance use and substance abuse is complex. Within the last five to ten years, there has been increased recognition that abstinence and recovery-based treatments do not help all those who are harming themselves and their communities with their use of substances. Instead, a harm reduction treatment model provides an opportunity to engage those individuals who are:

1. Behaving in ways that cause themselves and their community harm.
2. Not interested in stopping their behavior suddenly, but might be able to consider how to reduce harm to themselves and their community.

Shelter staff need to be flexible in their approach to shelter guests abusing drugs and alcohol. Staff need to be able to develop interventions that directly address harms experienced by shelter guests as a result of substance abuse. Specific shelters are designated 'wet' environments, meaning that shelter guests are not excluded because they are intoxicated at entry. This is a harm-reduction model of services and staff need to understand the reasons that this philosophy of service must be provided.

Goals of this Training:

After completing this training, shelter staff will know:

- The difference between a harm-reduction and abstinence based intervention.
- The basic philosophy underlying harm-reduction.
- Why a harm-reduction practice is a necessity for shelter staff.
- How a harm-reduction practice assists staff to maintain contact with people who harm themselves and their communities with substances of abuse.

After completing this training, shelter staff will be able to:

- Identify a harm-reduction intervention and use it with shelter guests when appropriate.
- Assist shelter guests to discuss how they can work to reduce the harm from substance use and abuse in their own lives.
- Understand how an abstinence-based, recovery model approach complements and supports a harm reduction approach.

Harm Reduction Overview

Harm reduction originated as a public health approach aimed at reducing substance-use related harm experienced by users and their community.

The first harm reduction approach focused on reducing the spread of HIV. This happened in communities with a high percentage of drug users who shared syringes that could spread the virus. Public health workers decided that providing clean syringes would result in fewer HIV infected addicts. This was the beginning of the needle exchange program. These programs have reduced the spread of HIV among addicts and their sexual partners.

This approach has proved extraordinarily effective in several foreign countries. In the late 1980s, Liverpool, England practiced needle exchange and had about a 10 percent death rate from HIV disease among injecting drug users. During the same time, surrounding counties, which did not have a needle exchange program, experienced an 80 percent death rate. The conclusion was obvious—giving new hypodermic syringes to injecting drug users saved lives.

As with needle exchange programs, a harm reduction approach seeks to reduce the dangers associated with drug and alcohol abuse. This can be a challenge to service providers who may believe that a harm reduction approach enables continued drug or alcohol abuse.

What's so bad about enabling?

Evaluating whether or not a harm reduction approach enables drug use is important. Using the example of the hypodermic syringes distribution, (or needle exchange), is helpful. While it is true that distributing unused hypodermic syringes assists users to inject the drug into their bodies (enabling) it is worth considering the following:

1. People who are addicted to injection drugs are going to continue to inject drugs whether or not they have access to clean hypodermic syringes.
2. People who are re-using hypodermic syringes are much more likely to get HIV disease.
3. Addicts who are dead of HIV disease don't get into substance abuse treatment programs.
4. Addicts with HIV disease have sex with others and may not use condoms, increasing the spread of HIV.

Today, harm reduction based treatment starts by working with individuals "where they are at" regarding their drug or alcohol use. This treatment approach does not require a person to abstain to receive treatment. The first step to recovery may not be abstinence. Sometimes the first step is to assist the person to evaluate what harms-for them and their community-are connected to their substance use.

A shelter that lets an intoxicated client stay—if their behavior is not a problem—is practicing a harm reduction approach. Asking an intoxicated person to leave the shelter, or refusing admission, decreases contact with that person, leaves them outside, and does not assist them to reduce their use of substances.

Abstinence based treatment does not work for everyone, but those people still need support. That belief forms the harm reduction philosophy. Beneath this attitude is a recognition that people who cannot stop using drugs or alcohol tend to get sick and need expensive and scarce care. We may not be able to get a person to decide to be sober, but this does not mean they should not have access to shelter, medical care, and housing. Put another way, denying care when it is needed is not a good motivator for sobriety, and in the end costs a great deal in hospital, jail, and emergency room expenses.

Two Branches of Harm Reduction

There are two ways to provide harm reduction. Some programs have a low access threshold. This means that the program is simple to access. The client only needs to fill out a few papers or do a minimal interview at intake with a few, non-invasive questions. This approach is more successful with disorganized people who are using drugs or alcohol, and who may be put off by long intakes with many questions. The core principle in such programs is: "First, let's get the person in without confusing or alienating them. Then we can treat the problem." An example of a program like this is a drug treatment program that posts vacancies each morning. If you come to the door when there is a vacancy, they will take you in without requiring a trip to detox or physical health clearance.

The other branch of harm reduction is a high behavioral tolerance program. These programs with high tolerance accept that their clients may present with difficult and challenging behaviors. But they have decided that if this difficult behavior does not injure staff or clients, it will not result in denial of services. The core principle in such a program is "Let's not ask the person most difficult to serve to leave, because then they will not get the service they need."

Both of these approaches are in use in San Francisco.

Harm Reduction Basic Assumptions

There are a number of basic assumptions at the heart of harm reduction philosophy:

1. Our culture will never be drug or alcohol free. Addiction will be always be an issue for our society. Legal and illegal drug and alcohol use is part of our world-the harm reduction approach works to minimize harmful effects rather than condemn or ignore the behavior.
2. Harm reduction philosophy acknowledges that some ways of using alcohol and drugs are safer than others.
3. The denial of basic services to those addicted to alcohol and drugs damages both the user and society. Use or addiction alone should not be the determining factor for providing or withholding services. By providing a safe and caring environment, shelters and public institutions can offer alternatives to drug and alcohol use.
4. Changing behavior around drug and alcohol abuse and dependence is a step-by-step process. Complete abstinence is the final step.

Harm reduction recognizes that care providers assist in this process by offering education and treatment that is non-judgmental and non-coercive. They recognize that any movement in the direction of reduced harm (no matter how small) is a positive step. At its core, harm reduction philosophy embraces the concept of maintaining basic human dignity in dealing with addiction.

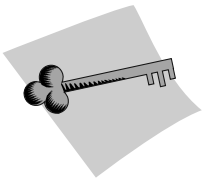
Harm Reduction and Abstinence Are Not in Conflict

Some people think the principles of harm reduction are directly opposed to an abstinence-based recovery model. However, they are not in conflict. A harm reduction program may precede abstinence, may assist in keeping users in treatment who are not ready or able to engage in abstinence treatment, or who, in recovery terms, have not hit bottom and decided to change. Some individuals may never hit bottom, and instead continue to use substances of abuse while suffering homelessness, physical damage, and mental illness. For those people, a harm reduction treatment is appropriate.

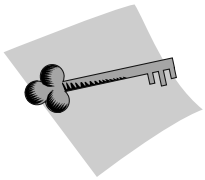
Harm reduction philosophy may also accompany abstinence-oriented treatment. For instance, a substance abuse treatment program can decide to use a harm reduction approach with users who relapse while in treatment. The relapsed client is asked to either leave treatment and "come back when ready" or told the consequences of their relapse, and asked to detox if necessary to continue their treatment. Allowing the client to continue in treatment is the harm reduction approach.

Three Keys to Harm Reduction Approach

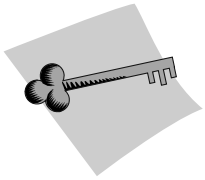
How can shelter staff effectively deliver harm reduction interventions? There are three keys to maintaining an effective harm reduction position with clients seeking and using shelter.



Don't Judge: Work to develop a non-judgmental relationship with substance abusing clients. Treat intoxicated or 'high' shelter users without showing them you disapprove of their behavior. (As long as they can follow the rules of the shelter). This means that your tone of voice, actions, and overall communication should not blame them or be perceived as judgmental.



Step-By-Step: Present the idea that shelter guests who use drugs and alcohol can take steps to reduce the harm. For example, if you know someone who frequently spends all their money in the beginning of the month, and you are familiar with this person, you may ask them if they have thought about 'putting up' some of their money so it can last out the month.



Reduce Assumptions: Do not assume that you and the shelter guest agree about what is harmful in their life. Let the client know that you are there to work with them to reduce the harm to them and their community. Sometimes, guests can hear this more if you name the harm as "stress." If you have witnessed a pattern of harmful behavior, do not assume that the shelter guest knows or feels that it is a harmful pattern. Ask how they feel about what is going on in their lives. Just asking is supportive if done in a non-judgmental manner. Remember, style has a lot to do with a harm-reduction conversation. The success of these conversations depends not only on what you say but how you say it. This is the most challenging and delicate of the three keys.

These three keys are a starting point to develop a relationship of support, trust, and respect with people who are harming themselves. People who are hurting themselves usually feel guilty and angry about their behavior. Sometimes these feelings are externalized, which means that the person gets angry with others who suggest he is hurting himself. People who feel guilty and angry with themselves have a difficult time trusting others and may respond angrily when they feel guilty. Respecting the pace of communication and allowing them to drive the conversation is more likely to result in a successful harm reduction conversation. Remember, the most important thing is to create a trusting, working relationship that allows you to present harm reduction information.

Harm Reduction
Self-Test

1) Who is harm reduction most appropriate for?

2) What was the first population to be served with harm reduction principles?

3) Admitting intoxicated but behaviorally contained individuals to shelter is a harm reduction intervention. Why?

4) What is the first principle of harm reduction philosophy?

5) What are two branches of harm reduction treatment?

6) What are three keys to substance abuse harm reduction interventions at the frontline staff level?

Name: _____ Date Completed: _____

Supervisor's Name: _____ Date Reviewed: _____

Treatment Access Program, San Francisco

1663 Mission Street, Suite 204
San Francisco, CA 94103
Client Self Referrals: (800) 750-2727
Service Provider Referrals: (415) 522-7100
http://www.dph.sf.ca.us/php/tap/TAPresources.htm

Substance Abuse Assessment/Placement/Referral Services and Screenings for Detoxification Services
Hours: Monday to Friday, 8:00 a.m.–5:00 p.m.
Engagement Support Services open to the public on a drop-in basis.
Pre-treatment group: McMillan Drop-In Center
Monday to Friday - 3:00–4:00 p.m.
Acupuncture: McMillan Drop-In Center
Monday, Tuesday and Thursday, 1:30 to 2:45 p.m.

Addiction Alternatives

http://addictionalternatives.com/

This website offers education and resources on substance addiction and harm reduction. It focuses on alternative treatments to 12-Step Programs.

www.metrokc.gov/health/apu/harmred/heroin/heroin-overdose.ppt

This is a slide show in PowerPoint presentation format. Provides useful harm reduction education to providers as well as helping users to understand heroin overdose prevention practices.

www.harmreduction.org/hrti/cur/OD

This is a slide show about assisting individuals to prevent overdose. Overall website references harm reduction philosophy, information, and thinking. It is simple and easily to understand.

http://www.overdoseprevention.org/

This is the Santa Cruz needle-exchange web site. It has excellent information about prevention of drug overdose and how to educate users.

http://www.drug-statistics.com/news-1.htm

Narconon of Southern California Website. It includes information and statistics about treatment principles, usage of drugs, and risk assessment.

The Harm Reduction Training Institute, Oakland

www.harmreduction.org/
HRC Oakland Office
1440 Broadway, Suite 510
Oakland, CA 94612
Telephone: (510) 444-6969 ext. 10

This website is a valuable harm reduction and substance abuse treatment resource. It provides free, easily downloaded pamphlets and other educational materials on a large variety of issues, including specific street drugs, overdose, and illness. The website also links to The Harm Reduction Coalition's Training Institute in Oakland, CA. The Oakland training institute has an ongoing training calendar with a variety of topics for frontline staff working with active users in an outreach capacity. Other trainings include: domestic violence, de-escalation, AIDS/HIV, Hepatitis, and many others. To go directly to printable brochures on a wide range of subjects, point your web browser to: http://www.harmreduction.org/brochure.html

Below are some of the brochures available. They can be viewed or printed from the website, and ordered in hard-copy for minimal production costs. These brochures are in PDF format. You will need to have Acrobat installed on your computer to view them. Acrobat can be downloaded for free at http://www.adobe.com/support/downloads/new.htm

Intervention with Escalating Clients

Chapter

6

Homeless shelter guests face constant stress, frustration, and difficulty obtaining the necessities of life. This may result in a client temporarily losing the ability to control their behavior. Clients with mental health or substance abuse problems may also have difficulty with behavior control. These clients are called escalated.

Staff responsibilities when dealing with an escalated client:

1. Help the escalating client to reduce their level of agitation. A client who is denied services is not able to obtain shelter or needed services. The staff's effective de-escalation means the homeless shelter guest may be able to continue to receive services.
2. Assist the client, staff, and other shelter guests to stay safe.
3. Ensure that the appropriate consequences for violent and threatening behavior are applied.

Because shelter staff are prohibited from physically intervening (controlling a clients behavior by physical means), all de-escalation interventions are developed and applied by using communication skills.

Goals of this Training:

1. Explain the four reasons why a client's behavior escalates.

2. Provide specific communication interventions to help the shelter guest control their behavior.

3. Help staff understand the difference between a 'respondent' and 'operant' state and why this difference is important in the management of assaultive behavior.

4. Help staff assess and manage their own self-control while responding to escalated clients.

5. Provide the shelter with security assessment information.

6. Provide ways to care for staff after a critical incident.

Introduction

When confronted by a threatening or escalating client we need to make our response match the level of danger presented by their behavior. If we under-respond, it is likely that the behavior will continue to escalate. On the other hand, if we over-respond the client may be scared, denied services, or lose trust in shelter staff. It also means that other clients will begin to believe that shelter staff typically over-respond and may wonder if they are at risk.

In most cases, appropriate verbal responses defuse a situation and decrease the potential for violence. This is what is meant by de-escalation—helping a client regain control over their behavior. Successful intervention with an escalating client establishes a safe environment for staff and clients. It models appropriate behavior, good communication skills, and helps to preserve the dignity of the acting out resident.

When responding to an escalating situation it is important to remember that no two situations are ever the same. Not every incident can be successfully negotiated. Even when experienced professionals use effectively administered techniques, critical incidents may lead to physical violence. However, by maintaining self-control and using good observation and communication skills (both verbal and non-verbal) most escalating situations can be defused.

Motivations for Escalating or Assaultive Behavior

The cause of an assault—either threatened or attempted-may seem complex. Frequently a client's history will give clues as to how or why they respond in a violent or escalated way. There are four basic motivations that prompt a client to escalate and threaten others. These four motivations are:

1. Fear
2. Frustration
3. Manipulation
4. Intimidation

In managing a client's assaultive behavior, it's important for the shelter worker to look for the cues that point to one of these motivations. Determining the reason for escalating behavior helps to determine the responses—both verbal and non-verbal—to the behavior.

Fear and Frustration

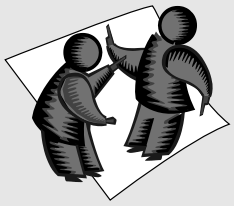
Let's take a look at the first two possible motivating factors for a client's escalating behavior:

1. **Fear:** A person will fight (or flight) when they feel they are under attack or when they believe someone is going to take away something necessary to their well being. This can occur when a person is denied a shelter bed or other survival necessity.
2. **Frustration:** A person may threaten or attack others (or destroy property) as an expression of rage caused by pent-up frustration.

Both of these emotions are known as **respondent states**. This means the client is "responding" to a perceived threat, a loss of control, a feeling of vulnerability, or a combination of these. In other words, the client's fear or frustration becomes so overwhelming that they begin to lose control over their behavior. Approximately 80 percent of escalating events that result in assault are prompted by feelings of frustration or fearfulness.

Scenario for Discussion: A frustrated client

A first-time shelter client comes to MSC-S shelter seeking a bed and is re-directed to the South Beach Resource Center, where he is fingerprinted, photographed and provided a bed at A Man's Place. After he walks to A Man's Place, he is told he will have to wait until the computer system comes back up so that he can check in. When the system does come back up, the frontline staff member cannot find a record of his reservation and asks the client to wait until he finishes checking in other clients and can call South Beach.



The frontline staff member knows that this problem with CHANGES happens sometimes and all he has to do is call to log the client in. However, the first-time client is frustrated and afraid that he will not get the bed he was promised. Waiting off to one side, he begins to pace, saying under his breath, "You guys are just jerking me around. You don't have any bed for me." He then approaches the desk and tries to speak with the frontline staff member, who says, "I told you to wait until I am finished with these gentlemen." The staff member stops checking people in and looks at the first-time client. He does not resume checking people in until the client moves back to the offside position, indicating by his non-verbal language that the client is delaying the entire process.

The goal when de-escalating a client who is acting from frustration or fear:

- Reduce the perceived threat.
- Help the client feel more in control.

Manipulation and Intimidation

Now let's look at the second two motivations for threatening or escalating behavior: manipulation and intimidation. Though less common than fear and frustration, these two motivations arise from a client's attempt to control the environment in order to get something.

3. **Manipulation:** A client may begin to lose control—or pretend to lose control—becoming impulsive and explosive in order to manipulate others into giving into their demands.
4. **Intimidation:** A client will try to get what they want by calm, threatening behavior. This is the least common of the four motivations, however, it is the most dangerous and requires the greatest care with regard to intervention.

These last two motivations are known as **operant states**. This means the client is "operating" in a calculated way in order to have their needs or desires met.

Scenario for Discussion: Client attempts manipulation on staff

A client comes to the front desk and says, "You can let me go to my Narcotics Anonymous meeting at Post and Mason, right?" The desk monitor replies, "Let me check and see if you have permission." He flips through the book and sees that there is no off-site pass for the client to go to the meeting. He tells the client, "Your case manager didn't put a note in your file here. You are not going to be able to leave the shelter after hours for a meeting without a note or a pass." The client then says: "But my counselor said it was OK, and that I should just tell you. Other people get to go out to meetings and I should too. You aren't doing your job right because you won't let me go out to my meeting and I am going to tell my case manager about this tomorrow."

Scenario for Discussion: Shelter visitor attempts to intimidate staff

An individual comes to the front desk of Next Door Shelter. He tells the staff member, "I'm looking for my brother." The staff member says, "We can't tell you if your brother is here or not because of confidentiality requirements." The man repeats, in a loud, menacing voice, "I said, I'm looking for my brother. I came here to find him. Confidentiality or no, you are going to tell me if he is here." He leans over the counter until his face is inches from the face of the desk monitor, and repeats, "You are going to tell me if he is here." This individual is attempting to intimidate the staff member.

Determining the Motivation Causing the Behavior

How can you tell what type of motivation is prompting a client to escalate? There is no sure way to detect a client's motivation, but there are telling signs that will help you make an educated guess. These signs will also help you begin to intervene in a way that de-escalates the client and the situation.

Fear

Our intuition can often tell us that a client is feeling fearful, and may be about to escalate, act out, and require our intervention. A person will usually exhibit fear with a tense and rigid posture, as though they are ready to defend themselves. The frightened client may look around as though they want to flee or hide. Their skin is often ashen and their eyes are fearful and wide. Their speech can take on a whining or pleading manner and they often speak in short bursts. Their breathing may be rapid and irregular. Clients who have a history of being abused or victimized often escalate out of fear.

Frustration

Escalating or acting-out behavior caused by frustration is the client's irrational attempt to gain control of the source (or perceived source) of the frustration. The frustrated client exhibits angry, tense behavior. They often move from an exasperated tone of voice that changes to an angry, loud, and menacing quality. As they become more frustrated their face turns red or blotchy and they may begin sweating as their blood pressure increases. Finally, their breathing can become deep, long and heavy, or puffing and they become very focused on what they perceive as the source of their frustration.

Clients with a history of low frustration tolerance, impulsive behavior, or poor judgment, are more likely to be motivated by frustration.

Manipulation

A client using manipulation is attempting to obtain or avoid something through indirect means. This can be particularly dangerous if the threat of violence is used to achieve that goal. Remember, behind many manipulative demands is a legitimate request. Clients have been socialized—or taught—that manipulation is the only way to get something, and they exhibit this behavior when it is not necessary. They don't realize that they might have gotten what they wanted if they had simply asked for it in a clear and appropriate manner. Listen closely to what the client is asking for. Often times, you will find that you can meet their request, and take the opportunity to help them understand that clear, non-manipulative, communication can produce positive results.

The manipulative client will use one or both of these methods:

- Temper tantrums
- Splitting and confusion

The temper tantrum usually begins with the client making a calm but unreasonable request. If the request is not met, they will appear to begin to lose control, screaming, stomping, and crying. The goal of this behavior is to create such a scene that you will give them what they want just so they will go away or calm down.

Splitting and confusion is meant to create friction among staff by setting up conflict or confusion between them. This can be accomplished by giving different story versions or requests to different staff members. Sometimes the client will introduce irrelevant matters into the discussion so that their goals are unclear. Often in the commotion, distraction or confusion, the client will get what they want. Children often do this when they tell their dad, "But mommy said it was OK."

Manipulative behaviors are not always easy to spot. However, once you have experienced this type of motivation from a client you can learn their "style." So, your history with a client can be your first clue. Usually, a manipulative request comes in a voice that is trying to elicit pity. If that is not successful the next clue is likely to be a series of accusations, such as, "I thought you were supposed to help me!" or comparisons, "The person here yesterday let me do it!" Often their tone is aggressive.

Clients who have a history of assault will usually escalate first to threats and then to action against property or objects when they feel deprived or persecuted.

Intimidation

When a client uses intimidation to get what they want, it is usually a calculated response that threatens danger if their desires are not met. "I don't want to have to hurt you" is the underlying message in this type of response. Though it is the least common of the motivating factors for escalating or threatening behavior, it is the most dangerous. When it comes to intervention, intimidation requires the greatest care.

The intimidating client usually uses quiet, almost rehearsed, speech with a calm demeanor that is basically unremarkable except that they may use a menacing voice. Usually threatening words and posture are present. Their demands are organized and deliberate. Clients who use intimidation often crowd the person they are talking to as a way to threaten harm. There is a very recognizable pattern in the signals that indicate intimidation. First, a clear demand is stated. If this is not met, it is followed by a credible threat of harm along with the option of just giving them what they want and having the threat removed. Finally, refusing this demand may be met with an attempt to assault.

Clients who have a history of extortion or criminal assault most often exhibit this type of behavior.

Preparing to Intervene

When intervening with an escalating client staff must rely on two important skills:

- Self-control and Awareness
- Observation

Self Control

When confronted by an escalating client the first and most important tool at our disposal is the ability to maintain self-control. Developing self-awareness that lets us remain calm, yet alert, is a basic requirement of professional behavior. At first it may seem difficult to control our automatic responses to an escalating, dangerous, or stressful situation. However, just recognizing your own response—such as heart racing or shaking—is the first key to gaining self-control.

By recognizing your responses under stress you can develop pre-planned techniques for maintaining control over those responses. Providing service to the homeless client population is stressful, and this stress can accumulate over time. Stress management skills can help reduce this stress, which may be expressed as sadness, depression, or anger at yourself, clients, or management. Good stress management and self care skills can help maintain emotional balance and good professional judgment and reduce the possibility that you will act out feelings of helplessness, anger, and sadness when dealing with shelter guests.

Essential Features of Self Control

1. **Self-Assessment:** Be aware of your own physical and emotional state. Being aware of your current mood, attitude toward the client, and motivations will affect the performance of your interventions with an escalating client.
2. **Know Your Limits:** How far might you go if you lose your temper or are terribly frightened? Often when faced with a frightening situation, there is a fight or flight impulse. We either confront the situation head on to protect ourselves, or get away from the situation as quickly as possible to maintain our safety.
3. **Regain Self Control:** Effective self-control requires awareness of your mind and body. For example, if you become tense—tight muscles and racing heart—your self-control plan may be to take a deep breath and relax your muscles. If a client is acting out and your impulse is to act in a punishing way back, your plan may be to delay your response until you are completely calm.

Assessing Self Control

1) Have you ever been in a dangerous situation where you were physically threatened?

_____
_____
_____
_____

What happened?

_____
_____
_____
_____

2) What was your initial reaction to this threat? Fight (control) or flight (escape)?

_____
_____
_____
_____

What did you end up doing?

_____
_____
_____
_____

If you have never been in that kind of situation, what do you think your reaction would be if you were in a threatening situation? Fight or Flight?

_____
_____
_____
_____

Think about your personal reactions when faced with a threatening, or very stressful situation:

_____
_____
_____
_____

What do you notice about your:

Emotions _____
Breathing _____
Vision _____
Speech _____
Thoughts _____

What methods did you use (if any) to control your:

Emotions _____
Breathing _____
Vision _____
Speech _____
Thoughts _____

Observation

Your ability to recognize early signs of a client's escalating behavior, or situations that may prompt escalating behavior, can dramatically increase your ability to maintain a safe environment. Important observation points:

1. **Past Behavior:** Knowing whether a client has a history of past violence, or what interventions have been helpful in the past to calm the client, can be helpful in de-escalating a situation. The greatest indicator of a client's potential for violence is whether they have been violent in the past.
2. **Precipitating Event:** Identifying the immediate stressors or situations that are prompting the client to escalate will provide a starting point for defusing the situation.
3. **Behavior Changes:** Recognizing the client's behavior changes from a calm to an escalated state will give important clues to their motivation—fear, frustration, manipulation, intimidation.
4. **Current Intoxication:** Alcohol tends to make people more impulsive. If a person has been drinking, they may react more strongly than they would when sober. They may be less inhibited and express their feelings more freely. Recent use and withdrawal from stimulant drugs may have the same effect.
5. **Social Standing:** Knowing if the person's reputation is affected by the situation's outcome. In situations where peers are watching, an escalating client may feel unable to accept a proposed solution and instead continue to escalate. These individuals are essentially acting out of frustration because they feel peer pressure. A good way to deal with this is to ask them to 'walk and talk' with you away from their peers to arrive at a resolution. This reaction is more common with people who have held memberships in organizations such as street gangs, former prison inmates, or those who feel peer pressure and have a poor ability to relate to authority.

Crisis Intervention

Depending on the motivation behind escalating behavior different types of intervention are appropriate for de-escalating the client's behavior and the overall incident.

The Fearful Client:

Fearful clients are simply trying to feel less threatened and afraid. The goal when intervening with a fearful, escalating client is to reduce the threat perceived by the client.

1. **Calm:** Stay calm and breathe. Maintain a relaxed, but confident and concerned manner. Your gestures should be slow and deliberate. Keep your hands in full view, with your palms up.
2. **Distance:** Maintain a non-threatening distance between yourself and the client—8 to 10 feet if possible.
3. **Tone:** Your voice should be firm, but calm and reassuring. If you know their name, use it when talking with them.
4. **Words:** Use logical, simple language and encourage calm reflection. Promise to help, if possible. Do not promise anything you cannot deliver.
5. **Eye Contact:** Do not force eye contact but give it freely if the client seeks it. Keep in mind that some cultures discourage or limit eye contact. For example, some Native Americans believe that direct eye contact is only permitted with close family members. Follow the cues of the client with regard to eye contact.
6. **Touch:** Do not initiate physical touch unless you are sure that the client will take it as a reassuring gesture and it will not be dangerous. Even then, physical touch should always be offered and not given without permission. Touch should be light, using slow movements. Important: If you do not have a history with the client, use careful consideration before making physical contact. Overall, unless you are absolutely sure that non-invasive touch will be permitted, for example, a hand on the shoulder, it is best to play it safe and use calm, reassuring words and tone to express your support.

The Frustrated Client:

Frustrated, escalating clients can provoke an "out of control" situation. The goal for de-escalating the frustrated client is to help them regain control.

1. **Calm:** Stay calm and breathe. Use firm, commanding gestures, with your hands in clear view. Keep in mind that any indication that you are losing self-control may increase the client's own escalating behavior.
2. **Tone:** While your gestures may be firm (such as pointing to a chair for the client to sit in), use a quiet but firm voice. The tone of your voice should be just soft enough to make the frustrated client listen carefully to hear you.
3. **Position:** Try to stay directly in front of the client (if possible), remaining out their striking range. Standing too close can be seen as a challenge, while moving far away from the client may communicate fear or vulnerability.
4. **Words:** Use repetitive, assertive communication and commands that are without threat. Do not use complicated or involved language. Remember, your goal is to assist the client to regain control. To accomplish this, keep it simple and clear. "I need you to sit down and be calm." "Put down the paperweight and let's talk."
5. **Eye Contact:** Use direct eye contact and expressions that indicate your firmness.
6. **Physical Contact:** Do not attempt physical contact with the client.

The Manipulative Client:

The manipulative client attempts to confuse or distract staff in order to get what they want.

The goal in intervening with the manipulative client is to remain detached.

1. **Detach:** Avoid getting sucked into the situation. Remain detached from the behavior of the client.
2. **Gestures:** Showing disapproval through non-verbal communication can signal to the client that you are not willing to get into the game. Eye rolling, arm folding, or sighing are good examples of detachment.
3. **No Anger:** Do not respond with anger. An angry response is often a cue to the client that they are getting to you.

4. **Distance:** Try to remain at a safe distance from the client. If possible, turn slightly away to indicate non-involvement, but do not turn your back on the client.
5. **Tone:** Use a tone of voice that is flat, even slightly bored or mechanical. Give quiet, repetitive, broken record-type commands that are intended to de-escalate. "Move away from the desk." "We are not getting into this again. Sit down."
6. **Unemotional:** Avoid getting into the specifics of the client's demands. Do not get pulled into a discussion about the client's interactions with other staff. Remain matter-of-fact.
7. **Eye Contact:** Avoid eye contact by focusing on the client's shoulder or chin.
8. **Physical Contact:** Avoid physical contact of any kind.

Remember, recognizing manipulation is easiest when you have experience with the client. It can be difficult, especially with a new client, to distinguish this type of behavior from other motivations. If you find yourself reacting to a client that seems to be motivated by frustration, but then realize during the intervention that they are really manipulating you, change your intervention.

The Intimidating Client:

This is the most potentially dangerous motivation for escalating behavior. Studies show that only about 1 percent of the population will fall into this category. Still, it is important to know how to intervene in this type of situation. The goal of de-escalating an intimidating client is to make the consequences for their behavior clear.

1. **Calm and Clear:** Stay calm and breathe. Do not use ambiguous communication such as "maybe," "I don't know," or "it depends." This type of communication can encourage the client's belief that they can get demands met with threatening behavior.
2. **Clear Consequences:** State the consequences of their behavior. An intimidating client is usually very self-centered and not concerned with the outside world. Use direct statements of the consequences and repeat them as often as necessary. "Well, if you are violent, then the police will be called and you will be arrested."

"If you continue to bother other clients you will not receive any further services." Make sure the consequences you are stating are realistic and not exaggerated. When you are clear about what will happen to them if they follow through on their threats or behavior, they are more likely to retreat.

3. **On Your Guard:** Stand up and be ready to react quickly, but not so reactive that you appear afraid. If possible, keep your back to an exit for quick retreat and try not to get blocked by the client. Try to keep an obstacle, such as a desk, counter, or chair, between you and the client.
4. **Tone:** Keep your tone of voice matter-of-fact or monotone. Show as little emotion as possible. Do not scream, shout, or use threatening tones. This can signal that you are vulnerable.
5. **Eye Contact:** Eye contact should be used effectively but sparingly. For example, use it to emphasize a statement such as the consequences, but don't maintain it.
6. **Physical Contact:** Avoid physical contact and remain prepared to evade attack.

Recovery

It's OK to Fall Apart After a Critical Incident

It's natural to feel overwhelmed after a critical incident. Feeling threatened or attacked creates both physical and emotional stress. The fight or flight response is activated, resulting in the release of adrenaline and other body chemicals that enable a good response to danger. However, these responses may persist for some time after the event. People require some time to decompress from the peak performance required during a critical incident.

Restoring physical and emotional balance after an incident is vital to your mental and professional well being.

Symptoms related to post incident stress:

- Anxiety, nervousness, or fear
- Irritability
- Sleep loss or excessive sleep
- Fatigue
- Loss or increase in appetite
- Loss of interest in activities usually enjoyed
- The desire to consume more alcohol than usual
- Intrusive dreams
- Frequently thinking about the event

These are normal reactions to an abnormal event! However, we suggest that people who have recently been involved in a critical event, carefully monitor their alcohol consumption and resist the desire to use substances. Alcohol use is not the best way to deal with the naturally resulting feelings that everyone has after a critical incident—and alcohol use, while it has a sedating effect and temporarily relieves anxiety—prevents processing the incident effectively.

The best means of recovery from a stressful event is to talk about it. Talk with someone you trust, a close friend, or colleague. Talk as much as you need to, and as often as you need to. If many staff members are involved in a situation, take time together to discuss what happened. Focus on feelings, fears, or anything that is important to the members involved. This time should be free of blame or trying to figure out "what went wrong." This is a time for support and understanding. It is a chance for staff to talk about their emotional experience. This should not be part of an evaluation process. Evaluation—a review to see if further actions should have been taken or procedures were followed—is a separate activity.

If the incident is extreme—a life or death situation, physical violence, use of a weapon, hostage situation, or bomb threat—counseling is strongly recommended. Short-term counseling can be very helpful in recovery from traumatic events. In San Francisco, the Mobile Support and Treatment Team (MOST) provides these services to community partners, at (415) 836-1767 and Community Behavioral Health Services at (415) 255-3400.

Other important ways to help alleviate post critical incident symptoms is to exercise and eat well. After a few days have passed, if you still find yourself not

wanting to do things you usually enjoy, such as going to the gym or having dinner with friends, attempt the activity anyway. You may find that you will feel better and "kick start" yourself back to a more normal routine. If several weeks pass without your symptoms improving, consider seeking professional counseling to help you regain your emotional and professional balance.

The Challenge of Security and Safety Self-Assessment

It is often difficult for shelter service organizations to find the time and funds necessary to assess their safety procedures and protocols. However, regular assessments are crucial to maintaining a safe environment, as well as taking corrective action after a critical incident. The results of these periodic assessments should be distributed to all staff, as well as be reinforced by supervisors following a critical incident. It is a supervisor's responsibility to support frontline staff to follow the policies and principles developed after the assessment. Supervisors must also orient new staff to safety and security procedures.

What follows is a sample security assessment outline that can be used by your shelter to examine your existing safety and security procedures. This sample assessment is not meant to replace existing policies. Your shelter has its own specific issues regarding client population, physical structure, and staff/client ratio. It is hoped this sample security assessment will prompt discussion among staff, both frontline and management, as to how best enhance and ensure a safe shelter environment.

Security Needs Assessment

Conducting a Security Needs Assessment is the first step in preparing to deal with a potentially threatening situation. It determines the strengths and challenges at your site and helps staff handle critical incidents.

1. Threat potential.

In general, what is the overall threat potential of your clients? Review incident reports for the last two or three years to see how often violence, or threats of violence, occur at the shelter. If these reports are not available, consider developing a system to ensure future reports are retained and accessible. Include a check-off notation on the incident report that indicates whether the incident was a verbal threat or if it escalated to violence. This allows rapid review every few years of all incidents.

Important: Individual client assessment for the possibility of violence is essential. The only reliable indicator of a client's potential for violence is a past history of violence.

2. Creation of behavioral contracts.

If a client is escalated or threatening, but not denied services, the shelter staff needs to set firm limits. These limits should clearly define specific behaviors that will lead to consequences such as discontinued services or a rescheduled appointment. While this may seem to duplicate the rules handed to clients at sign-in, posted in the shelter, and available from Shelter Grievance, it is still important to create the behavioral contract with the client, in person, after an incident. If possible, this document should be created with the Shelter Grievance Advocate or shown to them if the client has requested their services. The behavior contract is a written document detailing behaviors that will result in clear and specific consequences. Each client who behaves in a way that suggests they might be violent, or becomes abusive, should participate in the development of the behavior contract. The client then signs this document.

3. Clothing

Appropriate clothing can help reduce the risk of harm to shelter staff in an escalating or threatening situation. You should be comfortable in your attire, feel good about yourself, and the way you are dressed. Also be aware that some ways of dressing can pose possible risks in critical incidents involving physical violence.

Consider how you are dressed right now. If you were going to be working with a potentially dangerous client today, is there anything you are wearing that might cause you injury if you were attacked?

Attire checklist:

- ❑ Earrings: Can they be grabbed easily?
- ❑ Ties\Scarves\Necklaces: Are they a choking hazard?
- ❑ Glasses
- ❑ Clothing: Restrictive or comfortable and easy to move in?
- ❑ Shoes: Can you move quickly in them?
- ❑ ID's and Laminated Badges: If they are worn around the neck they should be on breakaway chains or straps. Otherwise they can be used to choke the wearer.

It is not necessary to change your fashion habits entirely. However, be aware of your personal attire and what might cause you harm. If you have to respond to an emergency in another part of the building and on the way you have time to remove dangerous items, such as scarves or hoop earrings, do so.

4. Physical Surroundings

What are possible weapons in your work place? Is furniture arranged so that staff and clients have clear access to exits? This is especially important in interview rooms and semi-private areas. Scissors and letter openers should be stored in desk drawers, not on top. Chairs should be heavy enough to reduce the chance they will be thrown. Coffee pots and full mugs should be placed out of client reach. When dealing with an escalating client it is important to provide them with an easy way to leave. When you sit in an office or interview room make sure that you are not trapped by a desk and don't have anything that blocks you from getting to the door rapidly.

5. Procedures and Planning

The staff's ability to maintain self-control and work as a team can determine how well they will handle an escalating or emergency situation. These suggestions can help staff plan for emergency situations:

- **Install a silent alarm.**
- **Create code words indicating a need for help.** Many sites subject to critical incidents utilize a code word or code-phrase. One code-phrase used in hospitals is "I need the blue chart." When another staff member hears that it means, "Call 911. There is a critical incident in progress." All staff should agree and drill on the code-phrase.
- **Program 911 into the speed dial.** A one-button dial on a telephone handset can both reduce the time required to access a 911 operator and be a less obvious way to call for help.
- **Have a formal review.** After a critical incident, review the incident with the staff members involved. Evaluate the response in terms of teamwork and the interventions used. This will help develop skills for future incidents.

- **Clearly document incidents.** A properly written incident report enables staff to assess their response and make any needed improvements. A clear and concise report can protect individuals or the agency from misrepresentation of facts by others.

6. Post Response

Consider obtaining the services of an outside facilitator to assist in the staff's debriefing after any critical incident, such as a violent incident at the shelter, suicide of a client or staff member (on or off premises), or death of a client at the shelter overnight. Community Behavioral Health Services at (415) 255-3400, can assist in locating a local debriefing team that has had specific training in Critical Incident Stress Management to accomplish this task.

Training Review

In this training you have learned the four motivations for escalating behavior on the part of client and specific interventions for each motivation. These interventions include the use of body language, vocal tone, verbal technique, and eye contact depending upon the motivation underlying the escalating behavior. After reading this training material please practice the techniques through role-play with your co-workers or supervisor. This will greatly enhance the skills necessary to de-escalate clients or defuse a potentially violent situation.

You have also learned having an emotional response after a critical incident is normal. When these emotions come up it's important to take care of yourself. You should also talk with other staff members and take part in a group process of debriefing and evaluation. Finally, this training has provided the agency with the ability to assess its policies and procedures to determine if adequate measures exist to protect your safety and the safety of the clients.

De-escalation Self-Test

1) Why are de-escalation skills necessary in the shelter environment?

2) What is the first, overall, and most important reason that shelter staff need to learn de-escalation skills.

3) List **four** goals of this training?

4) What does it mean to 'de-escalate' an escalating client?

5) What are the **four** motivations for assaultive behavior.

6) Why is it important to know the different motivations for assaultive behavior?

7) What does it mean when a client is in a "respondent state"?

8) What is an 'operant state'?

9) What is the first solution to be considered if a client is manipulating to get a need met?

10) Name three observations that can help determine if a client is potentially violent?

11) What is the best way to help yourself recover from a critical incident?

Crisis Prevention Institute, Inc.
3315-K North 124th Street
Brookfield, WI 53005
Telephone: (800) 558-8976
http://www.crisisprevention.com/

The Crisis Prevention Institute has training and trains trainers. It also has violence prevention materials, including wall posters and handouts.

Michael Arrajj, R.N.,
1550 Grove Street
San Francisco, CA 94117
Telephone: (415) 921-8910

Michale Arrajj has worked in health care for 28 years—10 of these were spent on the Psychiatric Emergency Services at San Francisco General Hospital. Since 1992, Mr. Arrajj has been the trainer for Community Behavioral Health Services on the subject of violence prevention and crisis de-escalation techniques. This training draws on many sources, including the Professional Assault Response Training © (P.A.R.T.), a format developed by Dr. Paul Smith. A workshop approach is preferred to maximize active participation and dialogue.

Chapter

7

Working with Homeless Seniors

Why this Training:

The aging process is normal for all of us, although the patterns vary. This training emphasizes observing a senior's behavior, habits, and limitations so as to develop trust and a supportive relationship.

The number of homeless seniors in the shelter system is growing. Shelter workers serve both senior first-time shelter users and seniors who have been using shelter services for some time. Seniors who use the shelter have special needs that are different from those of other shelter guests. Shelter workers must be sensitive to the needs of homeless seniors and prepared to respond those needs. Seniors and elders seeking shelter may be more physically and mentally vulnerable than other shelter users in ways that are not obvious to the front-line staff.

Goals of this Training:

The goal of this training is to provide knowledge regarding:

1. A senior's vulnerability to housing loss.
2. The problems confronting seniors in shelter environments.
3. The responsibility to detect and report senior abuse to the appropriate agencies.
4. Emergency help for seniors from crisis providers.
5. Specific health and welfare conditions of seniors that require a response.
6. Shelter accommodations that benefit seniors.

After you complete this training you will:

1. Be able to detect senior abuse.

2. Know the appropriate agencies to report senior abuse.

3. Be aware of the unique needs of seniors in shelter.

   This is the only section of your training manual that addresses the needs of a specific population using shelter. This training was included because it is a fact of life that we all grow older and may need increased assistance. The seniors we see in shelter today may be us tomorrow.

Seniors Reflect on the Shelter Experience

A focus group of formerly homeless seniors, said that what they most wanted from shelter staff was to be treated with dignity and respect for their age, capabilities, and challenges.

They said that shelter staff should, **"Be there to help or assist, provide understanding with compassion, respect the diversity of seniors, and treat seniors with tact and tolerance."** It was their experience that seniors were not always treated with sensitivity and that reasonable accommodations were not usually available. (Senior Focus Group, Canon Kip Community House 10/21/2003)

Homeless Seniors on the Rise

Homelessness is a national, state, and local problem that has continued to grow at an increasing rate. Of all the homeless individuals who seek shelter every night (either through shelter systems or through their own means) as many as 10 percent are over the age of 65. The 2000 Census suggests that by 2020 the number of people over the age of 65 will be 20 percent of the population. This is largely due to the aging "baby boomers." Due to a decrease in available jobs and affordable housing in most urban areas—where shelter systems, health care, and income assistance are most available—the elderly segment of the homeless population is expected to increase dramatically. California's elderly population, already the largest in the nation, will nearly double in the next two decades (US Census Bureau, 2000). As a result of this increase of older people using shelter services it is important to address some of the issues they face.

Shelter staff must treat seniors in shelter with recognition of their age and experience, and provide assistance to the greatest extent possible. One focus group member suggested that shelter staff needed to have "love, understanding, and respect for elders." Other members suggested that seniors, especially first time shelter users, might be disoriented as they begin to understand they no longer have housing. Seniors may be fearful they cannot survive the shelter environment, not obtain a bed on a given night, not know who to trust in the shelter, and have difficulty facing the challenges of homelessness.

Being in an unfamiliar environment, learning new rules, being told when to sleep and wake up is stressful for seniors. Problems that younger residents may feel they can overcome may overwhelm a senior beginning an episode of homelessness. Not all seniors utilizing shelter services have these difficulties—don't stereotype. However, shelter staff must remain sensitive and on the lookout for first time senior shelter users, those with medical issues and problems with hearing and vision that require accommodation.

Senior shelter guests present a difficult task for frontline workers. How do staff communicate a special respect for the wisdom and experience of these guests when there is already a huge demand on staff time?

We must accommodate our seniors to the greatest extent possible, even when that accommodation is not an easy one. Here is a useful test of your own feelings and behavior: "Are you treating this senior as if he or she was your own grandfather or grandmother?" **Only by accepting our seniors and honoring them in shelter will we be able to serve them in a way that gives true support and enables them to exit homelessness.**

Scenario for Discussion

A shelter worker made a practice of giving unoccupied beds to senior men who would have otherwise had to sleep on the floor, instead of placing those beds in a nightly lottery. (This is before CHANGES.) He did this because of his respect for seniors and his perception of their needs. Was this wrong or right?

Medical Needs

As a person ages they may catch more illnesses as their immune system becomes weaker. This is particularly true with illnesses such as colds and flu. Of the total number of deaths from flu each year, the majority of these deaths occur in the elderly. Be on the look out for elderly clients who show signs of illness, particularly during the winter months and cold and flu seasons. Use your referral resource list to help seniors access medical care. Ask the seniors if they got their flu shots in September or October, and if not, know where they can get one. If your facility uses case managers, refer these clients for case management. Seek supervision if you are worried about a particular client. If you hear a senior shelter guest with a deep cough, consider speaking directly to that person about seeking a medical evaluation. Pneumonia is a real possibility and if untreated, can be deadly.

Self Care

Seniors may have difficulty with self care. They may need more assistance with accessing the facility's services, such as bathrooms, showers, or laundry facilities. Consider placing elderly clients closer to these facilities in the shelter. Frequently, seniors need to urinate several times during the evening and if their bed is far from the bathroom it's harder on them.

Staff have an obligation to be aware of the needs of seniors and make accommodations whenever possible. For example, please try to place seniors on cots or beds. If placed on a sleep mat, a senior may have difficulty getting up without assistance, especially those with arthritis or mobility problems. Do not assign seniors top bunks, which can be difficult to climb in and out of.

Give seniors extra time to read and understand rules. Staff may need to explain the rules and take time to do so. Reduce distraction and noise when working with senior shelter residents. For example, don't give important information in a noisy front desk area while checking in other residents. Take the senior aside to a quiet area or office to review rules and procedures. This demonstrates respect.

Be kind to older eyes by keeping a large type version of rules and information sheets for seniors with low-vision problems or those who have lost vision aids, such as glasses.

Communicating Respect for Age

Formerly homeless seniors identified respectful treatment as one of the most important things a shelter can provide. Because seniors are potentially more vulnerable to psychological injury than younger individuals, lack of respectful treatment is more damaging.

Examples of how to communicate respect:

- Address a senior as Mr. or Mrs., unless requested to do otherwise.
- Do not hurry through interaction with seniors who may need additional clarification about what you are saying. Take time to communicate the matter completely.
- Do not use a commanding tone of voice unless not doing so places them in danger. Saying: "Please Mr. Jones, could you come up out of the shower in a few minutes? Shower time is over," communicates respect, as opposed to, "George, come up out of the shower now."
- Consider placing seniors first in line for food service or check-in and check-out.

What other ways do you think you can communicate respect for homeless seniors staying at the shelter you work in? Take the time to think about this and discuss it with your supervisor.

Self Neglect

If a senior client, who has had good hygiene or self-care, begins to neglect themselves, they may have a physical or mental health problem. Consult with a supervisor if you notice such a problem or are concerned about an elderly person in the shelter who seems to be going downhill.

Common signs of self-neglect:

- Not taking medications, or refusing to seek medical treatment for serious illness.
- Forgetfulness, such as leaving personal things unattended or forgetting to lock a locker.
- Poor hygiene that seems to be getting worse.
- Not wearing suitable clothing for the weather.

- Confusion or disorientation. Not knowing what day it is, what time it is, or where they are.
- Unexplained and obvious weight loss, lack of appetite, or stated desire not to eat.

Most of the cases reported to adult protective services are self-neglect. This may be associated with declining health, isolation, Alzheimer's disease or dementia, or drug and alcohol dependency. Seek supervision or make a referral to case management if you notice elderly clients who seems to be unable to care for themselves as well as they did in the past. If these resources are not available and you see an older person with an urgent need, call the Elder Crisis Team. They are available for consultation. Contact information for these services is listed at the end of this section.

Social Services

Many elderly, homeless clients do not receive social services even though they are eligible. Keep a resource list available for all staff regarding local access to government and private services that assist older people. These services include social security offices, housing possibilities, senior service centers, medical facilities, and elder crisis services. Consulting your supervisor or making a

What is Elder Abuse?

Over 200,000 California residents are victims of elder abuse every year (State of California, Office of the Attorney General, Dec. 2002). Elder abuse occurs throughout society. Socio-economic status, geographic location, race, gender, or ethnicity, do not provide a barrier against elder abuse. There are no exemptions from this crime. The only common factor is the victim's age.

Elder abuse is a term referring to anyone who knowingly, intentionally, or negligently acts in a way to cause harm, or a serious risk of harm, to a vulnerable adult age 65 or older.

In California, certain individuals are required to report elder abuse. You should ask your supervisor if you are one of these mandated reporters. However, it may be wise to proceed as if you are a mandated reporter in order to fully protect seniors who may stay at the shelter.

The California Welfare and Institutions Code, section 15630, which specifies who is a mandated reporter and what needs to be reported, can be found at:
www.elder-abuse.com/eadacpa.htm

referral to a case manager can make a big difference for an older person struggling with homelessness. Seniors should not have to remain homeless because they were not referred to case management services when they needed them.

What is Reportable Elder Abuse:

- **Physical Abuse:** Inflicting, or threatening to inflict, physical pain or injury on a vulnerable elder, or depriving them of a basic need.
- **Emotional Abuse:** Inflicting mental pain, anguish, or distress on an elder person through verbal or nonverbal acts.
- **Sexual Abuse:** Non-consensual sexual contact of any kind.
- **Financial Abuse:** Illegal taking, misuse, or concealment of funds, property, or assets of a vulnerable elder.
- **Neglect:** Refusal or failure by those responsible to provide food, shelter, health care, or protection for a vulnerable elder.
- **Abandonment:** The desertion of a vulnerable elder by anyone who has assumed the responsibility for care or custody of that person.
- **Mental Suffering:** Subjecting a person to serious emotional distress through threats, harassment, or other forms of intimidating behavior.

Warning Signs of Elder Abuse

Observing one of the signs listed below does not necessarily indicate elder abuse, however, witnessing any of them should prompt questioning (or a referral to a case manager) to determine if the person is being abused. Many elders will not seek help if they are being abused, but suffer in silence, because of fear or embarrassment.

Physical signs:

- Bruises, pressure marks, broken bones, abrasions, and burns may be an indication of physical abuse, neglect, or mistreatment.
- Unattended medical needs, poor hygiene, and unusual weight loss are indicators of possible neglect.

Caregiver Behavior:

- Belittling, threatening, or other abuses of power to control a spouse are indicators of verbal or emotional abuse.
- Strained or tense relationships, frequent arguments between a caregiver and the elderly person.

Behavioral Warning Signs

- Withdrawal, the senior is less communicative.
- Confusion or forgetfulness.
- Helplessness or anger.
- Acting hesitant, frightened, or unwilling to talk.

What should staff do if they suspect Elder Abuse?

Consult your site supervisor before reporting a suspected elder abuse to Adult Protective Services (APS). Making a report breaks shelter guest confidentiality so you should proceed carefully. It is possible to consult anonymously by describing the situation and, without providing names, ask if you have witnessed a reportable elder abuse.

Call the APS unit's 24-hour hotline at (415) 557-5230 to report elder abuse. Maintained by the Department of Aging and Adult Services, it provides in-person, face-to-face response to all reports of abuse to an elder or dependent adult. APS responds immediately to life threatening circumstances and within 10 days to all other reports of abuse.

Adult Protective Services provides:

Consultation: Workers at this number can tell you if the behavior you witnessed is reportable and constitutes abuse. They can give you guidance regarding the Department of Aging and Adult Services Adult Protective Services unit's likely follow-up.

Emergency Services: As part of the APS 24-hour emergency response system, a number of emergency services are available to clients, including emergency food, shelter, transportation, and in home support services.

Case Management: Investigation of the protective issues, assessing the needs of the client and the client's family, services plan development, referral and service arrangement, counseling, monitoring, and follow-up.

Any time you make a report of abuse or consult with a duty worker at the Adult Protective Services Unit, you should record the date and time of your phone call, the name of the person you spoke with, and what they said.

Below is a list of agencies that can assist you in the event of elder abuse or an elder client in crisis:

Senior Crisis Response:

Central City Older Adult: 558-5900
Monday–Friday, 9:00am–4:00pm

Mobile Crisis Treatment Team: 355-8300
Available 8:30am–11:00pm and able to come to your location

Urgent Older Adult Services:
Monday-Friday, 9:00am-4:00pm

Southeast/Potrero/Bayview:	558-5900
Chinatown/Northbeach:	352-2000
Richmond/Sunset:	386-6600
Western Addition/Haight:	474-7310

Scenario for Discussion:

A young shelter resident has made friends with a senior residing in the shelter. Each night they stand in line together to check into the shelter and eat dinner together. You become aware that the younger resident is signing up for a laundry slot and doing the senior's laundry along with his own. Frequently he returns to the shelter and provides items of food and toiletry for the senior resident. The younger resident also tells you that he is "taking care of Mr. Jones, because he can't take care of himself very well."

On the 23rd of the month you witness the younger shelter resident asking the older resident for a $50 loan. He tells Mr. Jones, "I've been helping you so much and now I'm just asking for a little something. If you aren't going to help me out, then I'm going to stop helping you, because you don't care about me." You are also aware that he frequently has gone to the store for the senior and purchased cigarettes and other items for Mr. Jones and suspect he may not return the change.

Working with Homeless Seniors
Self-Test.

1) Why is this the only population specific training in the manual?

2) As the society ages, what changes are likely among the shelter population?

3) What did formerly homeless seniors say was the most important skill a shelter staff worker could demonstrate when dealing with a homeless senior?

4) What are three possible warning signs of elder abuse?

5) What is the agency responsible for dealing with elder abuse in San Francisco?

6) What are three possible accommodations that may be helpful in dealing with seniors in shelter?

7) What should a staff member do upon detecting possible elder abuse?

Name: _____ Date Completed: _____

Supervisor's Name: _____ Date Reviewed: _____

Senior Advocacy and Training Resources:

The San Francisco Consortium for Elder Abuse Prevention

Institute on Aging
3330 Geary Boulevard
San Francisco, CA
Telephone: (415) 447-1989, ext. 513
Fax: (415) 447-1250
Email: elderabuse@ioaging.org

Training. Each year the Consortium provides training to over 1,000 professionals, advocates, volunteers, and students on how to identify, prevent, and treat the effects of abuse.

California Community Partnership for the Prevention of Financial Abuse

http://www.bewiseonline.org/events.shtml

This site offers scenarios for training in the prevention and detection of elder abuse.

Goldman Institute on Aging

3330 Geary Boulevard
San Francisco, CA 94118
Telephone: (415) 750-4180
http://www.gioa.org/

Institute on Aging (IOA) is a non-profit organization with over 25 years of experience helping seniors to live independently in the community. Each program aims to enrich the lives of even the most frail seniors.

The Elder Abuse Website

http://www.123-elder-abuse.com/

This offers general resources that deal with the needs of seniors, senior abuse, and reporting abuse.

San Francisco Department of Aging and Adult Services

875 Stevenson Street, 3rd Floor
San Francisco, CA 94103
Telephone: (415) 355-3555
Fax: (415) 355-6785
http://www.ci.sf.ca.us/site/daas_index.asp?id=22332

The Department of Aging and Adult Services (DAAS) is the central San Francisco governmental unit charged with the care of seniors and dependent adults.
Contact: Edith Chang-Lee, LCSW. Edith.chan-lee@sfgov.org

Senior Action Network

965 Mission Street, Suite 705
San Francisco, CA 94103
Telephone: (415) 546-1333
Fax: (415) 546-1344
http://www.senioractionnetwork.org/
info@SeniorActionNetwork.org

Senior Action Network (SAN) is a San Francisco advocacy organization devoted to issues that affect senior communities. Their website provides an array of resources focused on assisting seniors.

National Coalition for the Homeless (NCH) – Fact Sheet #15

This informative fact sheet can be accessed at the NCH website following this link:

http://www.nationalhomeless.org/elderly.html

Elder Abuse Law Center

http://www.elder-abuse.com/statwelfarecode.htm

This website provides a comprehensive guide to California law regarding Elder Abuse.

Alzheimer's Association

www.alz.org

This site offers information about Alzheimer's disease and its treatment. Information for care providers for those who have Alzheimer's.

American Association of Retired People

www.arp.org

A nationwide advocacy organization for people aged 50 and older.

California Adult Protective Services

www.dss.cahwnet.gov/cdssweb

A state mandated program charged with investigating situations involving elder and dependent adults who are reported to be in danger due to abuse, neglect, exploitation and hazardous or unsafe living conditions.

California Department of Aging

www.aging.state.ca.us

Administers a broad base of home and community based services throughout California, working with the Area Agencies on Aging that serve seniors and people with disabilities.

Also works with public and non-profit agencies throughout the state.

Elder Crisis Response:

Urgent older Adult Services:

Monday–Friday, 9:00am–4:00pm

Central City Older Adult: (415) 558-5900

Mobile Crisis Treatment Team

(415) 355-8300.

Available 8:30am–11:00pm and able to come to your location.

Other Older Adult Service Delivery Sites

Southeast/Potrero/Bayview: 558-5900

Chinatown/Northbeach: 352-2000

Richmond/Sunset: 386-6600

Western Addition/Haight: 474-7310

Cultural Competency and Diversity in the Shelter Setting

Chapter

8

Why this training:

The San Francisco shelter system and its staff serve people from many cultures. Shelters that train their staff in cultural competency are better able to provide quality services and respect differences when working with the culturally diverse resident population.

Training Goals:

- Help staff examine their own cultural identification.
- Learn about the impact of the culture of homelessness.
- Examine three key areas of cultural differences.
- Provide staff with specific techniques to help bridge cultural differences.

Introduction

In developing this training, there was a wide range of opinions as to how important a role cultural diversity played in staff training at homeless shelters. These opinions suggested that residents and staff represented a variety of different cultural backgrounds, and that this diversity was a strength in providing services to homeless people. The overall perception was that it is more important to treat every client and staff member as an individual than to have extensive, population-specific, cultural diversity training. This idea has value but we must also recognize that our own cultural identity influences how we perceive and communicate with others. When we develop awareness of how our own cultural origin influences these aspects of our work with clients, we will better understand and assist clients who come from different cultural backgrounds.

In the shelter environment many clients have a strong awareness of social prejudice based on their poverty and homeless status. This can leave them open to feelings of being discriminated against because of their race, culture, and sexual orientation. This is completely natural. Whether or not real prejudice is present, perceived prejudice on the part of a client (or anyone) is an issue that needs to be talked about. In other words, not only do staff need to take special care that prejudice and bias do not play a role in their work, they also need to remain aware that even the perception of prejudice and bias can negatively affect their work with residents.

Defining Terms

It is a requirement of the Department of Human Services that all shelter services be provided in a culturally competent way. What does this mean? As we strive for clarity and understanding with those who are different from us, let's define some terms.

Cultural Competence: Behaviors, attitudes and policies in the shelter that help staff work well with people not of their own culture.

Stereotyping: Making generalizations about a person while ignoring their unique differences.

Culture Blindness: Ignoring cultural differences as if they did not exist. The way to decrease cultural blindness is to ask questions and be willing to learn about other people's cultures.

Discrimination: Treating people differently based on their minority status—actual or perceived.

Ethnocentrism: Not accepting another's culture or worldview. "My way is the only way," is the message behind ethnocentrism.

Learning From Other People's Cultures

Some people believe culture refers only to knowledge, attitudes, beliefs, or behaviors associated with race or ethnicity. However, cultural identity also includes a person's age, gender, physical or mental capacity, disability, class status, level of education, spirituality and religion, sexual orientation, and regional influences such as coming from the south, or mid-west. These issues can be difficult to discuss and identify.

Many people feel anxiety when issues of race, ethnicity, or cultural differences are raised. This anxiety could prevent us from learning about the differences and similarities between us. It is necessary, as shelter workers serving a diverse population, to discuss aspects of race, cultural, and ethnic identity. Our direct experience with other cultures challenges the way we see those cultures and gives us a broader view of how people see the world. A good example of this is the fact that the best way to reduce a person's prejudice against gay people, is knowing someone who is gay.

The Culture of Homelessness

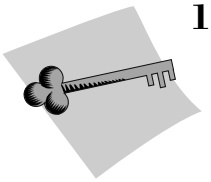
Shelter staff should recognize that homeless people have shared beliefs and attitudes developed from living in poverty without housing. These beliefs and attitudes form a common experience and culture for many homeless people. Fearfulness and distrust of "the system," and people who work in it are examples of cultural beliefs found among homeless people. Homeless people experience a rejection from the larger society that puts profit above housing needs. This rejection can make them feel alienated even around people who work in shelters. Despair and alienation are most commonly expressed as anger, often at the people helping homeless shelter clients exit homelessness. Many homeless people will say that shelter staff are 'poverty pimping,' making their living off homeless people. Even though this anger is expressed toward shelter employees, staff should not take it personally. See it as a result of the client's experience of rejection by society. Recognize that trust and understanding come slowly to

Change the Homeless Stereotype

Have you ever told someone that you worked in a homeless shelter, and they expressed surprise and gratitude that you could work with "people like that," or "those people?" If you haven't had this experience, how would you feel if you did? Most people's experience with someone who is homeless has been seeing them asking for change on the street, sleeping in a doorway, or in newspaper articles. Most people do not know someone who is, or has experienced, homelessness, even though many are only one paycheck away from homelessness. Shelter staff have an opportunity to address the stereotypes and biases towards people who are homeless by sharing their experiences with those less informed. One of the duties of shelter workers (in addition to direct service) is to help change the stereotypes and misunderstanding that exist in the community and to advocate for fair treatment of people who are homeless.

homeless shelter clients. Be open to understanding what the shelter client experiences as a result of their homelessness. This allows you to skillfully deal with the individual concerns clients present and respects their common experience.

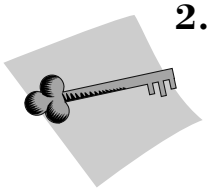
Three Key Areas of Cultural Difference



1. **Communication Styles:** Our communication can vary widely depending on if we are speaking within our own cultural group or with someone from another group. Even when the words and phrases are the same, they may have different meanings, or be used in different ways across cultures.

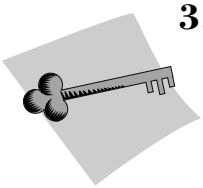
   Example: The word "queer." For some, it may be a derogatory term to describe a gay or lesbian person, but within the gay community many use "queer" as a positive term to describe themselves or their community.

   Example: Non-verbal communication styles. European Americans may think a raised voice with a lot of hand gestures means there is conflict and anger, while African American, Jewish, or Italian Americans may see it as exciting discussion among friends.



2. **Conflict:** While some cultures may see conflict as a good thing, other cultures view it as something to be avoided. Generally, in the U.S., conflict is seen as a sign of trouble. When it is present, the solution is often to have a face-to-face meeting to deal with the issues. This is not the case for many Asian cultures that experience open conflict as embarrassing, or even shameful. They may prefer to work out conflict quietly and discreetly. Knowing that different cultures perceive and react to conflict in different ways can help staff consider how to approach conflict in the shelter.

   Example: Silence doesn't mean harmony. Just because a client from a conflict-minimizing culture may be less open to discussing a problem with someone else does not necessarily mean they have less of a problem with that person.



3. **Task Completion:** Different cultures have different styles in approaching and completing tasks. Differences include different concepts of time, the importance of relationships, and different beliefs as to the rewards of task completion.

   Example: Working together. Latin cultures place a high premium on relationship building—getting to know one another—before a task is started. European cultures are more likely to jump right into a task and let the relationships develop along the way. Neither of these approaches is better or worse. Both groups can be very committed to achieving the overall goal, and both can place importance in the relationships of those working on the task. They just pursue it differently.

It is important for shelter staff to recognize these differences as they attempt to assist residents and co-workers in accomplishing their goals. Recognizing that culture can play a role in how a client approaches issues of housing, mental health or substance abuse treatment, and employment allows staff to change their approach to match the client. It helps staff to remain more patient with clients who may be taking longer in completing those life tasks.

Techniques for overcoming biases and stereotypes

Don't ignore differences. Cultural blindness leaves us in the dark and is offensive to those who view their culture as an important part of who they are. Taking the steps to ask about and learn from differences between ourselves and someone else opens us to a broader view of what the world has to offer.

Recognize your own biases or stereotypes. Be aware if your thoughts and assumptions are based on someone's appearance, accent, or language. Ask yourself if your treatment of them is affected by these assumptions. Convey the same level of respect to every individual.

Use existing staff resources! Is there anyone on staff who speaks another language or has experience working with a particular culture or group? Create a "cultural resource bank" at the shelter so that staff can help one another when faced with difficult cultural barriers. Be sensitive to residents whose first language is not English. Be willing to spend more time with them so that you understand their needs. Look for language resources among staff, or even among other clients—if appropriate.

Become informed. Learn about the history and culture of other groups. Check out your assumptions about different cultural groups by asking questions in an open and interested way.

Examining Our Own Cultural Identifications

Let's take a look at questions that encourage us to look at our own cultural values. These questions are personal. You are not expected to share them with anyone if you do not wish to. They are meant to help you think about how you might wish to be perceived with regard to your own culture or cultures.

What are some important groups you belong to? Are you active in a church, a singing group, a hobby group, an ethnically identified club, or a school? How and why are they important to you? How did you come to belong to this group? What do they give you and what do you give in return?

What values and beliefs are important to the groups you identify with? How do those values and beliefs affect other areas of your life, such as your relationships with family, friends, co-workers, or clients?

Do you ever experience the feeling of standing out because of one aspect of your identity? What does that feel like? Have you ever felt afraid, or in danger because of this?

Is there an aspect of your cultural identity that helps you work better with certain clients? Do you find it easier, or more appealing to work with a resident who comes from the same culture as you?

If someone from another culture wanted to learn something about your culture, what would you share first? Are there any particular stories you could tell them that would help share this part of your identity? Stories convey powerful messages about you, your family, community, and cultural identity. How would you feel about being asked to talk about this part of yourself?

What are some words you would use to describe the group you identify with? What are some words that others might use to stereotype your group or culture? How do you think these stereotypes began?

What stereotypes or assumptions would you change first with regard to the way your culture or group is viewed?

Consider your work place environment. Do you see any differences among staff, or between staff and clients that create obstacles to understanding or cooperation? Are these differences addressed? Are they ignored? If they are ignored, why is that? How can you address them?

Watch your words. Avoid using language that identifies a person by their race, culture, sexual identity, or disability when it has no relevance to the topic at hand.

Don't take offense. Do not become defensive if accused of misunderstanding someone else's culture. Be willing to admit that you might not understand, but that you would like to try. Admitting our deficiencies opens us to learning something new, and models open and respectful communication to residents.

Be open to discussing the past. Try to view historical events from the other person's (or culture's) point of view. Acknowledging past oppression sets the stage for better understanding here and now.

Don't Assume Anything

Just because someone comes from a particular cultural background or group does not mean that they share all the beliefs and attitudes associated with that group. Don't stereotype! More and more as we encounter multi-ethnic families, children raised by same-sex parents, increased immigration, transgender people, and physically challenged people, we are challenged to examine and change our assumptions, biases, and stereotypes. Working within the shelter system, staff who are culturally competent are able to provide sensitive and caring services to the diverse guests who walk through the doors.

Cultural Competency and Diversity
Self Test

1) Define Cultural Competence:

_____
_____
_____

2) Why might someone not want to ask someone else about their culture?

_____
_____
_____

3) What it the message behind "Ethnocentrism?"

_____
_____
_____

4) Name three key areas of cultural differences.

_____
_____
_____

5) What might be a common cultural attitude that homeless persons have towards institutions?

_____
_____
_____

6) What is one way that staff can work together to help create a culturally competent shelter environment?

_____
_____
_____

7) By working in the shelter system, and having direct experience with homeless individuals, shelter staff can help the larger community do what?

_____
_____
_____

Name: _____ Date Completed: _____

Supervisor's Name: _____ Date Reviewed: _____

Larry Yang, LCSW

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Larry Yang is a psychotherapist and consultant/trainer in cultural competency—giving workshops, presentations, and trainings in diversity and multicultural issues. He was most recently a Clinical Social Work Supervisor in the Department of Psychiatry of UCSF and SFGH, serving as Program Coordinator for Diversity and Multicultural Services. Mr. Yang provides leadership in developing training programs in the areas of cultural competency and the provision of mental health services to diverse populations. His work includes developing cultural competency assessment and evaluation methods.

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Alma Soongi Beck is an attorney and diversity consultant specializing in multicultural awareness, Gay, Lesbian, Bisexual and Transgender issues, Conflict Resolution, and team building strategies. Ms. Beck also provides referrals to other training professional on various topics.

Webster's World of Cultural Democracy

www.wwcd.org

This website offers a variety of pages on cultural diversity and competency. It is very informative and easy to read. Specifically, the page titled "A More Perfect Union" (http://www.wwcd.org/action/ampu/index.html) is an excellent online resource.

National Healthcare for the Homeless: Cultural Competency Information Page

www.nhchc.org/cultural.htm

This website is aimed at healthcare providers who work with homeless populations, but the information is still relevant and informative for anyone working in homeless services.

Language Line Services – Translation Service

1 Lower Ragsdale, Building 2
Monterey, CA 93940
Toll Free: 1 877 862-1302
www.LanguageLine.Com

This translating service agency is available by phone to provide language services to organizations. They develop agreements with organizations and provide training on accessing their services, which are charged by the minute and then billed monthly.

National Coalition for the Homeless

www.nationalhomeless.org

This is a comprehensive website that relates to homelessness in the United States. They have developed a transgender resource and recommendations guide for shelters. It is highly recommended that shelters print out Transitioning our Shelters: A Guide to Making Homeless Shelters Safe for Transgender People to be used as a reference in the work place. You can get it for free at www.nationalhomeless.org/civilrights/transgender.html

Supervision for Supervisors and Trainees

Chapter

9

Why this Training:

Good supervision builds capable staff who are well trained, follow instructions, and remain in their job. This training assists supervisory staff to become great supervisors and support their employees.

Goals of this Training:

1. Motivate employees to be productive and understand shelter guests' needs.
2. Provide techniques for effective supervision.
3. Help supervisors deliver effective feedback to frontline staff.
4. Create a positive workplace culture of open communication, tolerance, and ability.
5. Examine different supervisory styles.

Introduction:

Providing shelter to homeless single adults is a little like constructing a building. The supervisor is a cornerstone, a key piece that holds up the structure. To do their job right, front-line employees need a secure foundation. The supervisor must provide that foundation of understanding and knowledge about acceptable work practices and behavior. Each of these is the employees' responsibility—but it is the supervisor who must provide the guidance, support, and feedback that helps the employee to do their best. Employees need to understand what is expected of them—and it is the supervisor's responsibility to communicate this information in a way that can be best understood.

What Is Supervision?

Supervision is providing frontline staff with ongoing support in two main areas:

1. **Performance:** Assist staff to review their performance, troubleshoot challenges identified in their work, and provide feedback as to how they can improve their response to these challenges. This area sometimes includes giving advice.
2. **Growth:** Assist staff in their professional growth. Help them identify growth opportunities, whether this is advancement within the organization—towards increased income and responsibility—or the larger social-service arena and educational possibilities. Growth, especially for new employees, means assistance to help them learn their job and to be able to perform to high standards. This area includes helping staff to recognize barriers to growth, internal and external, and identifying solutions. An internal barrier is a challenge located within the employee's knowledge, skills, or attitude. An external challenge is one that is presented by the lack of resources or opportunities that limits the employee's opportunities. Helping a staff member to identify a challenging area and to develop an action plan to deal with the challenge is one of the more difficult supervisory issues—especially for new supervisors.

Depending upon the model of supervision in place at your facility, this training may: repeat what you already know and do, or it may suggest new methods of supervision. Even if you are already practicing the methods and procedures laid out in this training, continue to proceed through the training because there may be fresh ways of looking at old problems.

Frontline staff who support shelter guests may not know what supervision involves. Do not expect that a person who has not had previous supervision will know how to use supervision. The supervisor's main role with all staff is to help them understand supervision, its purpose, and how it will proceed. This is accomplished by:

A. Explaining the purpose of supervision.

B. Providing supervision with employees over a period of time.

C. Creating an environment where neither you nor the staff members are afraid of supervision experiences.

Goals of Effective Supervision:

There are three goals of effective supervision. An effective supervisor must assist employees to:

1. Develop a productive agency culture.
2. Develop their skills and professional abilities in the workplace.
3. Have effective responses to the tension, stress, and interpersonal problems found in the shelter workplace.

Creating a Productive Workplace Culture

Your supervision should result in a positive workplace culture. Learning how to do this isn't easy, and for most people, does not come naturally.

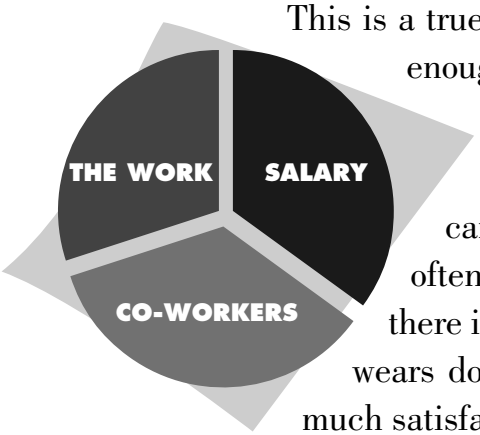
An agency culture is the group of values, norms, and shared experience that help to govern employee and sometimes client behavior. A positive, productive agency and workplace culture results in employees who:

- Want to perform at peak efficiency
- Understand and apply the values of the agency effectively.
- Want and work to improve their skills.
- Recognize personal growth opportunities and accept change-oriented feedback.
- Suggest ways to improve their own work, as well as shelter policies and procedures.

A positive workplace culture makes for results!

1. Employees want to work in a positive workplace culture, so sick time and employee turnover is reduced.
2. Theft, hostile behavior, and employee non-compliance is reduced because employees feel their goals are allied with the agency's goals.

Three Elements of Workplace Motivation



This is a true pie. All the slices must add up to the whole. If there is not enough of one, there must be more of another for an employee to stay motivated.

In shelters, usually the salaries are not very high. The work can be difficult, demanding, and challenging because staff are often dealing with people who are desperate for housing because there is not enough shelter for them. The constant fight for resources wears down both clients and staff. It is a necessity that staff get as much satisfaction from relationships with their coworkers and the feeling that they are helping others as they do from the work. It is the supervisor's responsibility to make sure that this can happen, even though it is not always possible, as everyone values each slice of the pie differently.

A worker who depends on salary for job satisfaction is going to have a hard time working in a shelter, be hard to motivate, and may soon quit. On the other hand, a worker who gets a lot of satisfaction from the work, and enjoys their relationships with coworkers, may be prepared to accept a relatively low salary. How supervision supports and takes care of employees, both individually and as a group, is key in developing a positive workplace culture—especially in the absence of high salary possibilities. In this model of workplace job satisfaction, good supervision makes the difference.

Standard Supervisory Tasks:

There are two supervisory tasks at the heart of supervision. The first is the individual meeting where you give advice, examine challenges, and set goals. The second is the performance evaluation and review. Let's look at these two elements:

1. The individual meeting with a staff member: The frequency of these meetings will vary depending upon the situation. This training recommends that you have an individual meeting with each supervisee at least once a week. At this meeting, both parties should bring an agenda that they have thought about during the week. The agenda is a list of issues that both parties need to talk about. An agenda can be constructed during the meeting itself, but this training recommends using a standardized format each week that can be built on or changed as necessary.

Ten Questions to Assess Your Workplace's Positive Culture

1. Do employees show up on time?
2. Have most employees used all of their sick time?
3. Do employees seem to enjoy staff meetings?
4. Do your employees reject what you say? Do they let you be an effective supervisor? (It is hard to supervise someone who will not let you be effective. Sometimes, all you can do is work with them to identify other employment opportunities.)
5. Do your employees enjoy their jobs or are they there only because they need a paycheck?
6. Is your interaction with employees fun for you?
7. Is humor part of your presentation with employees? Do you laugh with them? Do you laugh with co-workers?
8. How do you feel about the work you do?
9. How do you feel about your supervisors? Do you feel supported and encouraged?
10. Do you have hope about your work, your possibilities, and the possibilities for your staff?

Answering these questions is a valuable guide to determining whether your supervision is effective, your employees motivated, and your workplace one which demonstrates a positive agency culture. Remember, at a workplace with a positive culture, people take on tasks and duties not just because they are paid, but also because they want to.

Studies of workplace show that a mix of three things motivates workers to do their jobs—the money, the work, and the relationships they have with others in the workplace.

2. Written performance review and evaluation: This provides feedback to the employee about their performance, knowledge, skills, and attitude since the last review. All organizations should use standardized documents to evaluate staff members—but they need to be more than forms that nobody wants to bother with until they are due. A supervision document that evaluates a staff member's performance should list clearly and honestly the employee's accomplishments, the challenges they have faced, and their continuing growth areas. A supervision document should be delivered to the supervisee before it is finalized to give them an opportunity to contribute their own remarks. Then it should be discussed before the worker signs off and accepts it.

Supervisory Meeting Blueprint:

This is a "template," one possible agenda for the weekly meeting:

1. **Begin with a check-in:** Ask how the staff member has been feeling about their work this week or since you last met. Check-in's help to normalize the interaction with the supervisor and are reassuring. A useful check-in question, "So how's it been going since we last met."
2. **Hotspots:** These are burning issues that the staff member needs to discuss. What have the challenges in their work been in the past week or since the last meeting? How has the staff member handled, or attempted to handle, these challenges. Challenge areas include: Relations with other staff and relations with shelter guests. A hotspot is any matter that the staff members need to troubleshoot or get advice about. It could be a relationship with another staff member or a work problem. See the sample supervisory agenda, at the end of this section.
3. **Troubleshooting and giving advice:** This is the problem solving section of the meeting. Most successful supervisors find a balance between giving advice, (which allows the employee to define their *own* solutions), and telling the employee what they must do. As the employee grows in skills and abilities, they should always be asked if they see a solution to the challenge.
4. **Feedback:** This part of the meeting gives the supervisor the opportunity to discuss with the employee how they are doing, evaluate their present and past performance, and problem solve.

Supervisory Decision Making:

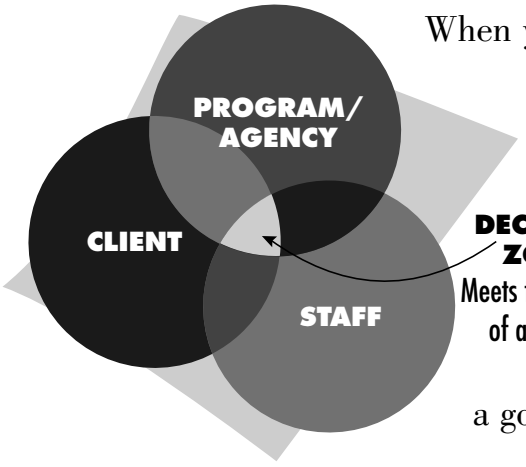
Supervisors often have trouble making a decision. This usually happens with decisions that are complex and that require the supervisor to decide between competing needs.

Example: Should an employee who is making mistakes be allowed to continue making them with corrective supervision and closer observation, or should those responsibilities be taken away? The decision to provide closer more hands-on supervision, and to check for mistakes—means more demands on the supervisor's time. This is only one example of the balancing act supervisors need to perform. One way to decide this question is to look at the different needs that have to be balanced. Any supervisory decision has to be evaluated in terms of:

- Program needs: Does this decision reflect the values of the mission statement and the goals of the program?
- Staff needs: Does this decision reflect the needs of the staff?
- Shelter guest: Does this decision reflect the needs of the shelter guest?

Any decision weighted towards only one of those three need areas is not going to meet the needs of the other two. In most cases it's a lopsided decision. If you find yourself making lopsided decisions that don't reflect the needs of any one of the three groups that you support, it is a good idea to evaluate what is forcing this series of lopsided decisions.

Meet the Needs of All Three:



When you need to make a decision, propose one solution to yourself and see whose needs it meets. Use this graph to remember that the best decisions usually fall into the three-way intersection of the client, program, and staff needs. Not all decisions can meet all needs, but when they do, they have a much better chance of working out the way you want them to. Discuss this idea with your staff. Showing staff that their decisions should acknowledge the needs of the three groups is a good way to get people to realize that they are making decisions

Supervision Styles:

There are different ways to supervise. Clearly the style that works the best is the one most likely to produce results that satisfy the needs of all of the groups in the graphic on the previous page. Not only do you need to know how to make decisions, but also what decisions to make, how to give the results to others, and the best process for helping an employee grow. There are two styles of supervision presented in this training, the ***autocratic*** and the ***participatory***. Each supervisor should choose which model suits them best, along with their agency, staff, and clients. Before you move to the next paragraph, try assessing yourself using the Motivation Quiz you will find at the end of this section.

At first, the autocratic style of supervision may seem easier. By making all the decisions, you don't have to worry about getting agreement from the others.

Autocratic Supervision Style

Autocratic means that the supervisor makes all or most of the decisions.

Makes decisions mostly on their own and then announces them to others. Little opportunity for input is provided to others as the decision is being made.

Has a great need for control and is unwilling to take risks or allow others to take risks.

Enforces decisions according to established standards or their own view. Permission to bypass norms must be approved.

Focuses on the final product and is extremely task oriented.

Uses primarily punitive action or 'consequencing' to maintain discipline.

Doesn't feel the need to listen to others, or bring other employees into discussions.

Participatory Supervision Style

Participatory means the supervisor consults others. The work is viewed as a partnership.

Consults with others before making a decision. At times, the decision may be a group decision.

Is willing to delegate and to take reasonable risks.

Uses standards as guidelines, but trusts employees to take risks in unusual situations and adjust policy accordingly, without necessarily asking for approval first.

Focuses on the way people work together—relationships are important and the decision making process is also important.

Uses positive reinforcement (motivation, incentives, rewards) to maintain discipline.

Encourages discussion; may spend a lot of time listening to others.

Which style of supervision do you prefer? Why? Which style of supervision have your supervisors in the past most often used? If the style of supervision you-and most other people-prefer is the participatory style, why is it that most people have autocratic supervision experiences?

However, the responsibility you bear is enormous. You will find that you are so busy with instructions, details, and checking up on everyone, that you will have little time to do the rest of your work. The autocratic style also tends to foster resentment among staff.

The participatory style allows employees to have responsibility in the decision making process and are more likely to take responsibility for carrying out the decision. Though it may take more time to get staff's input on important matters, in the long run, it makes for better relationships in the workplace, which is key in retaining employees. At the end of this chapter you will find ***The Ten Commandments of Participatory Supervision***. You may wish to copy this page and put it on the wall where you can refer to it.

There is a lot of literature for supervisors, ranging from the inspirational work of popular managers, to technical and educational training material for supervisors. This training is only a beginning. You owe it to the people you supervise and the clients in your shelter to learn as much about supervision as you can.

You will find a list of resources below and we hope that you will make it a point to check them out, find ideas that work for you and your staff, and continue to grow and develop as an employee and as a supervisor who can promote staff growth and development. The system of care you serve in is continuously changing—a hallmark of work in the modern environment—and keeping up, remaining interested, alert, and learning will make you a good supervisor and help your employees become supervisors in their own right.

Standard Supervisory Agenda

1. Welcome and check-in.
2. Hotspots: Things we need to make sure we discuss. Anything that the employee feels must be discussed this meeting.
3. Old business: Follow up on last meeting. Tasks that the employee is working on, and requests of the employee that the supervisor is following up on.
4. New business: Decisions the supervisor and employee have arrived at and the action steps needed to reach the goal.
5. Feedback about performance issues from supervisor to employee. Note: some employees become increasingly anxious toward the end of the meeting because they know that feedback will be delivered. If, you notice this, consider asking the employee if they would prefer feedback about issues earlier in the meeting.

Feedback

There are three kinds of feedback:

A. **For your information:** These are matters you have come to notice during the course of the week that are not very important and do not require significant behavioral change or correction on the part of the employee. For instance: "I noticed that you were a little late a few times this week. I just wanted to let you know and tell you I am available to strategize about how to get to work on time if we need to."

B. **Presentation:** This feedback area covers how the employee has been relating to other coworkers and shelter guests during the week. For example: "I noticed that when shelter guest John Doe came to the desk yesterday, you seemed angry with him. Is there anything that he does that is making you angry?" Another example: "Last week you mentioned that Mary (a co-worker) isn't answering the phones when you are at the desk and leaving you to deal with all the calls. When you approached her about it, you told her clearly what you wanted. I wanted to let you know that I appreciate the direct way you dealt with the matter. Has the problem gotten better?" Notice that the supervisor first compliments the employee and then asks the important question. It is always better to begin a question with a reflection upon what makes you ask it and to start the question, if possible, on a positive note.

C. **Problem areas:** These are the most difficult supervisory areas to address in the feedback section. They may concern workplace performance, presentation, or any area of the employee's duties. Feedback on problem areas is tricky because the supervisor has to find a way to communicate the problem and that the problem is not with the employee but with their behavior—something the employee can change.

A good technique is to ask the employee if they have noticed the problem. Attempt to provide positive feedback on another issue before introducing the problem. Then, you can move on to action steps about the feedback. The idea is to develop action steps—what you will do, and what the employee will do, about the problem area.

Frequently employees will not accept that a supervisor can provide support and help with action steps. See the scenario below for information about how to deal with this problem.

Scenario for Discussion: Repeated lateness to the worksite.

The scenario below takes place after the issue has already been raised several times, first as a hotspot, later as a "for your information" feedback item in supervision conversations. Now, the situation is at the point where if the employee continues to be late, further disciplinary action—verbal warning and written warnings—will be initiated. In other words, this scenario takes place at the end of the informal process of supervision, at the point where a continued lateness may result in the beginning of formal disciplinary action.

Supervisor: "So John, you are a really good worker here, when you are here. However, you are having a problem getting to work on time. I noticed this week that you have been late three times this week. Why don't we take a few minutes to strategize on how you can come to work on time and really deal with this problem?

John: "It's OK. I don't need any help in this. I just have to get to work on time."

Many supervisors might back off at this point or they might emphasize the punitive aspects and consequences if the employee continues to be late. However, a better tactic is to continue the conversation.

Supervisor: "Lets figure out what led you to be late your last workday. I know that you don't want to be late and that if we can figure out how to improve your on-time performance, this isn't going to be a problem anymore. You were due in at 8:30. What do you think made you late."

John: "I don't know, really. I take the BART in from Oakland and missed my train."

Supervisor: "What train do you take? When does it come to your station?"

John: "I have to get on the train by 8:00."

Supervisor: "So if you miss the 8:00 train you are going to be late?"

John: "Yes."

Supervisor: "Well, if you're late, standing on the tracks as the train has left, I want you to call in with your ETA. And, I think we need to figure out why it's hard for you to get to the train station by 7:45, so you can be sure to catch that 8:00 train. What do you think is getting in the way?"

John: "Well, sometimes I don't hear the alarm the way I should and go back to sleep."

Supervisor: "OK. Does your alarm have a 5 minute snooze?"

John: "No, it doesn't."

Supervisor: "It might be helpful if you buy one so that you don't oversleep again. What do you think?"

John: "Yeah. I probably should."

Supervisor: So our action step for today is that you will get the alarm clock with snooze function and we will see how it goes between this week and the next.

In this scenario, the supervisor helps the employee troubleshoot the reason for his tardiness, develop an action step that helps fix the problem and lets the employee know that the problem is the employee's behavior and not who they are as a person. The following week, the supervisor should make sure to bring up with the employee how they are doing in this respect and continue to troubleshoot the problem.

Training Review

Now that you have completed this training, you have learned:

- The goals of supervision.
- How to evaluate the supervisory style and practices at your site.
- Two models of supervision—the participatory and the autocratic.
- How to provide feedback to employees that can be correctly heard and used.
- The idea that decisions must accommodate the needs of all the groups working and using the shelter as well as the agency itself.

Supervisory Practices
Question Sheet

How is supervision done at your facility or site?

What do your employees expect from supervision?

What kind of supervision do they currently have?

What do you think they should have?

Motivation Quiz

The following quiz is based on the 10 qualities employees identified in an extensive survey as the most important. Rate yourself on a scale of 0 to 5 (0 = Poor and 5 = Excellent) on how well you help to provide these qualities to those you supervise.

1. I respect those who work for me. . . . . ____
2. I try to let employees know that the work they do is meaningful. Whenever possible, I try to make the job more interesting. . . . . ____
3. I recognize employees for their efforts and am properly appreciative. . . . . ____
4. I inform employees about issues that concern them, growth opportunities (including other jobs available within and without the agency) and I am properly appreciative. . . . . ____
5. I listen to employees. . . . . ____
6 I help employees see the end results of the work they do. . . . . ____
7. I encourage employees to think for themselves. . . . . ____
8. I try to present challenging opportunities for employees.. . . . . ____
9. I am an efficient manager.. . . . . ____
10. I provide opportunity for increased skill development for each employee. . . . . ____

SCORING:

42-50 Excellent
30-36 Good
31-41 Very Good
20-29 Fair
0-19 Room for Improvement

Supervision Self-Test

1. What are the goals of supervision?

2. What is agency culture?

3. What are the three elements of motivation in the workplace?

4. What are the two main areas supervision is concerned with?

5. What are the two main supervision tasks?

6. What three elements need to be kept in balance when evaluating decisions?

7. What is an internal barrier to employee growth?

8. What is an external barrier to employee growth?

9. What are the two supervision models reviewed in this training?

10. What is the best way to present feedback to the employee?

11.Who holds decision-making responsibility in the autocratic supervision model?

12.Who holds decision-making responsibility in the participatory supervision model?

13.Which model uses the threat of consequences or negative reinforcers?

14.Which model uses positive reinforcers?

15.Why is it important to delegate responsibility?

Name: _____ Date Completed: _____

Supervisor's Name: _____ Date Reviewed: _____

The Ten Commandments of Participatory Supervision

1 *Thou shalt involve people in planning their work.* A first step to being an effective supervisor is to involve your workers in the planning process as much as possible, including their personal work plans. If they have a say in the plan, then they will be more committed to carrying it out. Sometimes, this is called ownership, or fingerprinting.

2 *Thou shalt communicate plans with all concerned.* Make certain that plans, activities, and expectations are communicated to all concerned. A work plan for the employee does this well.

3 *Thou shalt assign responsibilities and let your employees know what is expected of them.* Assign responsibilities and make certain everyone understands who is responsible for what. No other single action can help you more to be an effective supervisor.

4 *Thou shalt always link supervision with the work.* Supervision should be clearly linked with the work and followed by a fair evaluation of its performance.

5 *Thou shalt allow feedback. You don't know everything.* Provide open channels for feedback. Listen to your employees, coworkers, and associates.

6 *Thou shalt make on the job training an integral part of your supervision.* When visiting your workers at their posts make it a point to observe their performance, offer help, and suggest ways to improve. Hold a brief meeting on the floor when you make your rounds, or at the start of shift. Bring employees together for a one-day or half-day training workshop. Providing opportunities for people to improve will help them improve.

7 *Thou shalt play a supportive supervisory role, not a punitive role.* In direct supervision, be helpful and supportive, rather than a punitive disciplinarian. Supervision is a means for strengthening workers, helping them do a better job, improving their skills and building their image up among coworkers and those they serve. Build them up!

8 *Thou shalt be in touch frequently with employees on shift.* Make rounds frequently. See each person under your supervision at least once a shift, and see some more frequently depending upon work and location. It is demoralizing for workers to be left by themselves, seemingly ignored, and out of touch with the rest of the staff. Your contact shows interest. Visits present opportunities for on the job training. Meet. Talk. Circulate

9 *Thou shalt delegate!* Delegation is the sign of a good manager. Assign work to those who can do it and try to test those who think they can't. This is how you teach. Delegation relieves you, the busy supervisor, of the need to concentrate on the routine and it trains others. Push work down! Have confidence in your employees' ability to perform. It is not fair to assume they can't do the job if you haven't given them the chance.

10 *Thou shalt be firm and fair, and share mutual respect with employees.* These commandments suggest a human and participatory approach to supervision, in other words, understanding, support, and consideration of the employee's point of view. It is equally important to be firm when making decisions that affect employees and taking disciplinary action when required. If these actions are done fairly-when all the facts are in and all sides heard—the other employees will respect them. Firmness, fairness, and mutual respect are elements of a good supervisory style.

The Center for Human Services

http://humanservices.ucdavis.edu/about/index.asp
UC Davis Extension
University of California
1632 Da Vinci Ct.
Davis, CA 95616-4860
Telephone: (530) 757-8643
Fax: (530) 754-5104
human@unexmail.ucdavis.edu

The Center for Human Services is a national leader in disseminating knowledge and skills in the human services. It provides trainings in ethics and boundaries, customer service, and supervision. Through professional services and training, The Center translates research and theory into practice. It also fosters partnerships that create opportunities for individuals, agencies and communities, and it improves the quality of life for vulnerable children, adults, and families.

The Richardson Company

http://www.rctm.com/app/Category/96.html

The Richardson Company is an online company specializing in books, videos, and training materials focused on assisting supervisors to manage staff effectively. Special attention is paid to providing materials that measure and enhance performance. Prices appear reasonable and items can be ordered in single-unit quantities.

Next Door/Episcopal Community Services Sanctuary

Lindsay Coleman, Director
1001 Polk Street, San Francisco, CA 94102
Telephone: (415) 292-2180

Next Door provides training in supervision for homeless shelter staff identified as potential leaders at their worksites.

Arriba Juntos/HOMEWORC Project

http://www.arribajuntos.org/
1850 Mission Street, San Francisco, CA 94110
Telephone: (415) 487-3240

Sponsors of the HOMEWORC Project, it provides training and support to individuals working in the homeless service industry, who are seeking to improve their skills.

CPR Resources

Chapter

10

There are a number of CPR training centers in the Bay Area. We included these four major providers based on comprehensiveness of the training, ability to provide both onsite and offsite training, and their cost.

It is important to look at several factors when determining which CPR training provider is best for your organization. First, look at your agency's certification requirements. Some CPR training organizations certifications last one year, while others last two years. If your organization does not require annual re-certification, then it might be more cost effective to pay for two-year certification. Second, consider the cost effectiveness of having someone in your organization trained as a certified CPR trainer. One homeless shelter found this to be quite effective. They purchased their own training materials and resuscitation mannequins, and now can provide their staff with CPR training at any time that is convenient.

The American Red Cross – Bay Area Chapter

Health and Safety Services
85 Second Street, 8th Floor
San Francisco, CA 94105
Main Telephone: (415) 427-8000
Workplace CPR Training: (415) 427-8095
www.bayarea-redcross.org

The Red Cross provides onsite and offsite trainings in CPR. For onsite workplace trainings, a minimum of eight students is required. Your organization must provide the space and a TV and VCR. Non-profit agencies are provided a 20 percent discount. CPR certifications are good for one year. First Aid certifications are good for three years. They have easy online registration for individuals needing courses. The American Red Cross provides a training the trainer course and sells or rents training aids.

San Francisco Paramedics Association

657 Mission Street, #302
San Francisco, CA 94105
Telephone: (415) 543-1161
www.sfparamedics.org
Executive Director: Theresa Farina (Contact for Non-Profit Discount)

SFPA provides CPR and First Aid Training. Both of the certifications are good for two years. Non-profit agencies are provided a 20 percent discount with arrangements made by the Executive Director, Theresa Farina. SFPA has a long history of working with non-profit agencies in San Francisco and provides frequent off-site and on-site trainings.

American Safety

2675 Geary Street, Ste. 203A
San Francisco, CA 94118
Telephone: (415) 921-8600
Email: stscproffice@aol.com
www.cpr.cpr.com

This CPR and First Aid training organization provides certification that is valid for two years and First Aid training valid for three years. They provide off-site and on-site trainings. On-site workplace trainings require a minimum of 14 students. This organization provides convenient weekly classes at their facility. There is online registration at their website.

Fast Response

1015 University Avenue
Berkeley CA, 94710
Telephone: (415)-575-0911
(510) 849-4009: Operations Director, to arrange discounts.

Fast Response provides adult CPR training and First Aid training with two-year certification for each. A 10-minute walk from the Berkeley Bart station, they provide CPR every Saturday and some Sundays. Adult CPR training takes an hour and a half. First Aid training takes three and a half hours. They can provide on-site trainings at your facility. This agency works with non-profits who have tight budget constraints. Fast Response is willing to work with each individual organization to determine fees that meet budgetary requirements.

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