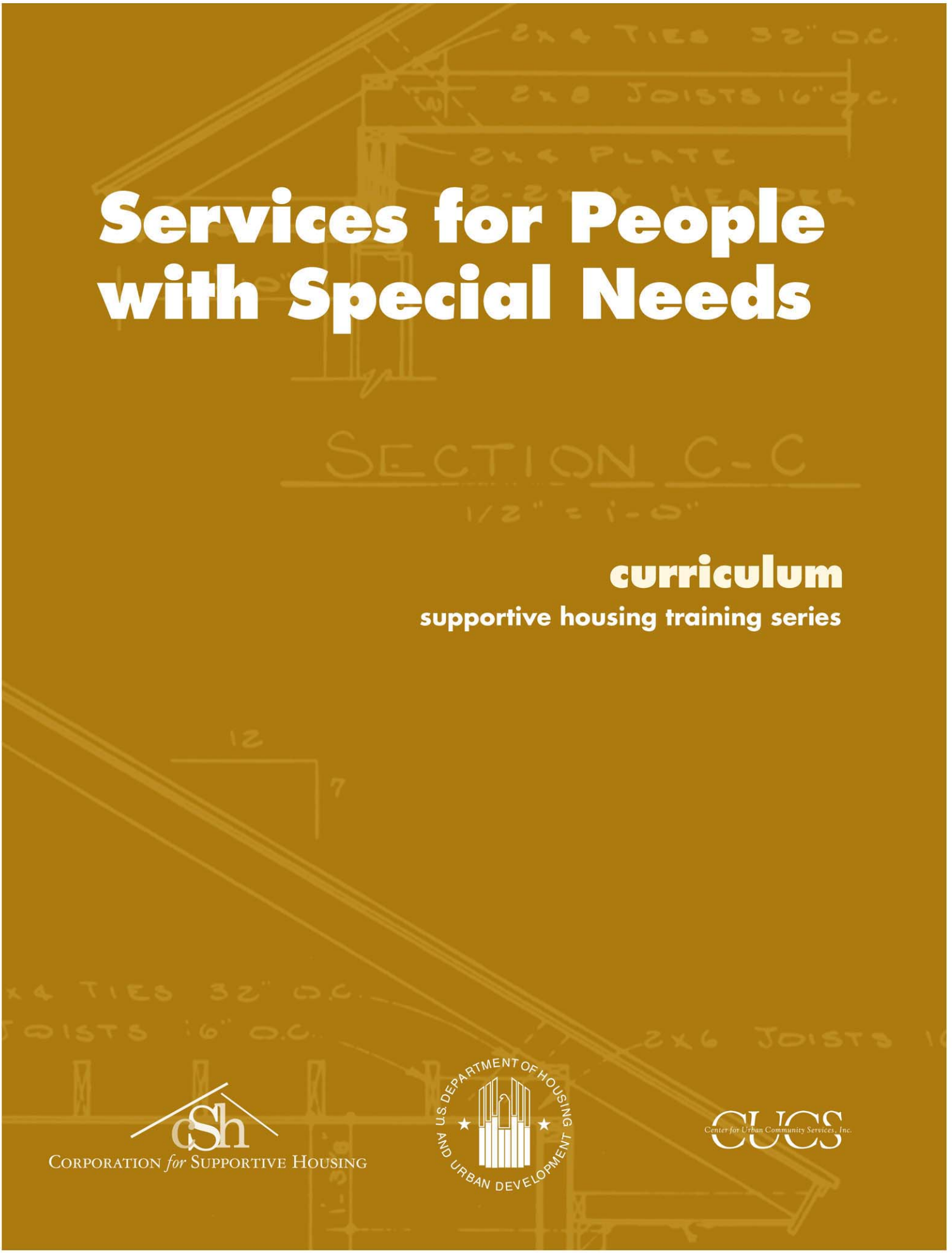
Services for People with Special Needs

curriculum

supportive housing training series



CSH
CORPORATION *for* SUPPORTIVE HOUSING

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

CUCS
Center for Urban Community Services, Inc.

Services for People with Special Needs

Curriculum

Developed by Center for Urban Community Services

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Services for People with Special Needs is part of the Supportive Housing Training Series. This training series currently includes eleven curricula providing best practices and guidance on supportive housing development, operation and services.

The full series is available for downloading from the Department of Housing and Urban Development website.

For more information:
U.S. Department of Housing and Urban Development: www.hud.gov
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HUD CURRICULUM
SERVICES FOR PEOPLE WITH SPECIAL NEEDS

PURPOSE AND GOALS: This six-hour training for non-clinical staff and beginning clinical staff of supportive housing will explore the variety of special needs of some tenants of supportive housing. The goal is to assist participants to understand the spectrum of special needs and develop a positive, professional relationship with tenants. At the end of the training, participants will be able to identify the signs and symptoms of a host of special needs and respond in a supportive and professional manner.

AGENDA

I. INTRODUCTION (30 minutes)

II. UNDERSTANDING MENTAL ILLNESS
- A. Understanding Psychosis (20–30 minutes)
- B. Overview of Mood Disorders (20–30 minutes)
- C. Symptoms of Personality Disorders (20–30 minutes)
- D. Group Exercise (20–30 minutes)

III. UNDERSTANDING SUBSTANCE ABUSE
- A. Signs & Symptoms of Substance Use (20–30 minutes)
- B. Theories of Addiction (20–30 minutes)
- C. Stages of Change (25–35 minutes)
- D. Group Exercise (20–30 minutes)
- E. Understanding Recovery (20–30 minutes)

IV. UNDERSTANDING HIV/AIDS
- A. Overview of HIV/AIDS (20–35 minutes)
- B. Transmission Of Virus (20–35 minutes)
- C. Universal Precautions (20–35 minutes)

V. FOSTERING A POSITIVE RELATIONSHIP
- A. Key Supports Needed (25–35 minutes)
- B. Defining a Professional Relationship (25–35 minutes)
- C. Establishing a Professional Relationship (25–35 minutes)
- D. Group Exercise (25–35 minutes)

VI. CONCLUSION (10–20 minutes)

HANDOUTS

1. Agenda
2. Psychotic Reactions
3. Mood Disorders
4. Personality Disorders
5. Signs and Indicators of Substance Use
6. Models of Addiction and Recovery
7. Stages of Change — Highlights
8. Harm Reduction
9. Components of Relapse Prevention
10. HIV/AIDS Fact Sheet
11. HIV/AIDS Transmission Questionnaire
12. Universal Precautions Guidelines
13. Supports Needed In Housing
14. Staff Role and Boundaries
15. Building a Professional Relationship
16. Bibliography

TRAINER'S PREFACE FOR SPECIAL NEEDS CURRICULUM

I. Brief Summary of Curriculum Content

The curriculum contains at least six hours of verbal content. This does not mean the entire content must be covered. Depending on the intended focus of the training and the format (exercises and small group discussions vs. large group presentation), portions of this training can be elaborated, abridged and/or deleted.

II. Trainer Qualification

Key to the successful delivery of the curriculum and to participants learning is the qualifications of the trainer. What the trainer brings to the training session — including their knowledge about the subject being taught, their experience in supportive housing and their training or teaching skills — will impact the quality of the training and the outcomes. This curriculum is intended for use by individuals with the appropriate constellation of talent and ability to manage the learning of others in addressing the issues that emerge in providing support to tenants of supportive housing. The person should have an understanding of the issues faced by clinical staff as well as building support staff.

III. Good Training Practice

A. How People Learn

People learn through a combination of lecture, visual aids and participation. The more actively they are involved in the process, the more information they will retain. For this reason, eliciting answers from the group rather than presenting material is usually preferable. Additionally, it is important to include exercises that stimulate interaction and experiential learning and not spend all of the time lecturing. Be aware, however, that group participation and discussion take more time than straightforward presentations and may cut down on the amount of content possible to cover. What is minimized or deleted from the curriculum should be based on the assessment of the group's learning needs and the goals initially contracted with the group.

B. Know Your Audience

The type of setting that the trainees work in and their roles will determine the areas of the curriculum that the trainer will focus on. Gathering as much information about the group beforehand is recommended. In order to create a safe and effective learning environment, it is recommended that the maximum number of participants not exceed thirty people.

C. Introductions and the Training Contract

Introductions should provide the trainer with more information as to who is the audience. The trainer will want to know the person's name, their program and their role, and what they hope to get out of the training. The trainer should then clarify what will and will not be covered. This is the training contract.

D. Acknowledge and Use Expertise of the Participants

This is important as it allows people to learn from each other, builds group cohesion, keeps people involved and establishes an atmosphere of mutual respect.

E. Flexibility

Throughout the training the trainer should continually assess the needs of the group and revise the amount of time devoted to each specific topic. Responding to the needs and interests of the group must be balanced with the agreement to cover certain topics. It is the trainer's job to respond to the needs that arise and yet stay focused on the subject matter. Since this curriculum covers a variety of special needs, including Mental Health, Substance Abuse and HIV/AIDS, there will be instances where some groups will want more information on one topic over the other. For example, if the training is being presented to housing projects that offer services specifically to HIV+ or PWA tenants, the trainer may decide to extend the dialogue about this special need.

IV. Training Content

A. Sequence of Content

Depending on the area of practice of your audience (for example, assisting persons living with HIV Disease, dual diagnosis or serious mental illness), the trainer may want to begin the training with that area, and/or be sure not to shorten or cut out these specialty areas. Additionally, the trainer will go more in depth about clinical issues with an audience, such as new social service staff, and less so with building management. With a mixed group, the trainer needs to find a middle ground on this issue.

B. Flexibility of Content

In **Section II**, **Understanding Mental Health**, it is helpful to elicit examples from trainees of all three diagnoses; however, if time does not permit, this section can be done in a lecture style. Additionally, the trainer may consider not including, or abbreviating, the exercise in this section.

The trainer has a bit more flexibility in **Section III**, **Understanding Substance Abuse**. The Signs and Symptoms of Substance Use can be reviewed briefly on flipchart or handouts if the trainer feels the participants already have a general understanding of this topic. The Theories of Addiction section can also be reviewed briefly on flipchart with a strong emphasis on the Bio-Psycho-Social Model. The Stages of Change agenda item is important but can be abridged, keeping in mind that the two most relevant stages to this training are "pre-contemplation" and "contemplation." Most housing projects have some basic understanding of persons in the "preparation," "action" and "maintenance" stages. The group exercise included in this section is designed for use only when all stages are covered in the training.

In **Section IV**, **Understanding HIV/AIDS**, it is helpful to have the transmission quiz on flipchart and elicit group responses. This process can be quick. Universal Precaution workshops are offered in many communities by the local health department. If this section is shortened, trainer should encourage participants to get more detailed training on universal precautions from local providers and to study the handout provided.

If the trainer is pressed for time when arriving at **Section V**, **Fostering a Positive Relationship**, a quick review of the Key Supports Needed will suffice. It is helpful, although more time consuming, to elicit from the participants the key supports. Establishing a Professional Relationship can also be abridged, but be sure to emphasis "setting boundaries."

C. Personalizing Content

In order to personalize the training, it is important for the trainer to offer case examples or anecdotes regarding the topic. This can also be achieved by eliciting personal stories from trainees. Using these relevant stories will make the training more interesting and personal.

D. Matching Content to a Target Audience

This training is targeted to new social service staff and all levels of building management staff (e.g., front desk clerks, maintenance, office staff, administrators) with little or no experience in working with special needs tenants.

V. Time Management of Content

Each section of the agenda has time frames allotted. The trainer should be aware that if a great deal of time is devoted to one topic area, other content areas might be sacrificed. Group exercises can always be abridged, if necessary, for time's sake. For example, if the group exercise involves dividing into four groups to work on four separate cases, the trainer may consider having each group work on a smaller number of cases. This will shorten the report back time, but will not eliminate the group process. Elicitation and discussion take more time than lecturing but less time than small group exercises. The trainer needs to balance this with the fact that lecturing is also the least effective way to learn.

The trainer will find that each time this curriculum is trained, it will vary. Being mindful of good training practice and making adjustments to the timing and sequence will allow for a tailored training that will be most beneficial to participants.

I. INTRODUCTION (30 minutes)

TRAINER NOTE: This section should include an introduction of the trainer, a review of training incidentals (hours, breaks, coffee, bathroom locations), a brief overview of the training goals and objectives. This is followed by a roundtable introduction of trainees and any areas related to tenants' special needs that they hope will be addressed.

TRAINER STATES:

- This training was developed for staff working in supportive housing. By supportive housing, we mean housing with some type of social service or mental health program that is available to the tenants on-site or mobile.
- We will look at key services of supportive housing that assist tenants maintain stability and their housing.
- In order to create an environment that is helpful to tenants, we will also be looking at defining staff roles and how those roles assist tenants to maintain housing.
- We will end today's training by looking at how to maintain a professional relationship with tenants. Hopefully, you'll leave here with a better understanding of why people behave the way they do and with some skills that will help you interact professionally with the tenants and staff in your buildings.

TRAINER NOTE: Trainer will introduce him/herself to trainees, including experience in either supportive housing or service delivery. Each trainee is asked to introduce him/herself by stating name, agency, staff role and what s/he hopes to get out of the training. Trainer should write concerns of trainees on flipchart. The trainer will review agenda on flipchart and link trainee concerns to agenda items for the day. See ***HANDOUT #1: AGENDA*.**

EXERCISE: "IT'S NOT MY PROBLEM." Trainer should have five to seven small (nerf) balls. Have the participants form a standing circle. Explain that trainees will be playing a game called, "It's Not My Problem." Show them one of the balls (hide the rest) and instruct them that the ball is the problem and when it is thrown to them, they want to get rid of it as quickly as possible. Further instruct them that the only way they can get rid of it is by calling out someone's name, and while throwing the ball, to call out, "(Name), it's not my problem," The Trainer will begin the process by throwing the first ball (problem). Once the ball has changed hands several times, the Trainer will introduce a second, third and fourth ball into the game by following the process outlined above. Allow the

game to continue for three to four minutes after all of the balls (problems) have been introduced.

TRAINER ELICITS: WHAT KINDS OF FEELINGS CAME UP FOR PEOPLE WHEN THEY WERE PLAYING THIS GAME? [Expected responses include: Anxiety, confusion, feeling overwhelmed, relieved to get rid of the problem.]

TRAINER ELICITS DOES ANYONE THINK THAT PERSONS WITH SPECIAL NEEDS ARE EVER DEALT WITH IN THIS WAY? [Expected responses include: Yes, workers are busy, it may not seem as it is their role, passing the buck.] HOW DO YOU THINK BEING TREATED IN THIS MANNER CAN MAKE A PERSON FEEL? [Expected responses include: Angry, abandoned, rejected, hopeless.]

Regardless of a person's role in supportive housing, it is in everyone's best interest to respond to a tenant who may be voicing or demonstrating a need for support. By not responding, worker's run the risk of the problem becoming a crisis, making it more difficult to manage for all staff.

LEARNING POINTS: Trainer is establishing the learning contract for the day with the trainees. It is important to indicate what will and what will not be covered in the training based on responses from the trainees and reviewing the agenda. Trainees will understand that everybody has a role in supportive housing.

II. UNDERSTANDING MENTAL ILLNESS (10 minutes)

TRAINER STATES: Our training focuses on tenants who have special needs. Understanding some of these needs allow us have a better understanding of our role and to better provide support to our tenants.

Before we discuss mental illness, I want to mention a few important things.

- The major resource for diagnosing mental illness is The Diagnostic & Statistical Manual of Mental Disorders (DSM-IV) published by the American Psychiatric Association.

- The manual gives a complete description of all the mental disorders, including the criteria for assigning a person with a diagnosis. The DSM-IV categorizes symptoms, not people. A person is not his or her illness. A diagnosis tells us only one thing about a person.

TRAINER NOTE: If possible, trainer should have a copy of the DSM-IV to pass to participants for viewing.

- Everyone, whether diagnosed with a mental illness or not, falls somewhere on the "Continuum of Mental Health." During times of distress most people need additional support to function well.

- Today, we are talking about people living in supportive housing with a diagnosed mental illness who may have long term functional difficulties.

- Serious mental illness cannot be cured; however, like diabetes or high blood pressure, it can be managed. Many symptoms can be treated with medication, ongoing support, low stress and minimal pressure.

- Many people with mental illness identify themselves as someone in recovery. Recovery often includes peer support, a higher degree of self-determination and activities focusing on empowerment and de-stigmatization of mental illness.

- People living with mental illness in supportive housing can get additional support from community resources including day treatment programs, mental health outreach teams, crisis centers, clubhouses, peer support, private physicians, therapists and others.

LEARNING POINT: The trainer introduces and normalizes the issue of mental illness.

II.A: PSYCHOSIS (20–30 minutes)

TRAINER NOTE: See ***HANDOUT #2: PSYCHOTIC REACTIONS*.**

TRAINER STATES: Psychotic reactions occur in people for a variety of reasons. Before we look at what might cause a psychotic reaction, let's define what psychosis is.

TRAINER ELICITS: WHAT IS PSYCHOSIS? [Expected responses include: break with reality, disturbance in thoughts, disturbances in perceptions.]

TRAINER ELICITS: WHAT IS REALITY? [Trainer will give examples of seemingly psychotic behavior that in the context of culture is normal. In the southwest, there are indigenous tribes that believe the sun will rise only if the "shaman" chants for it. In cultures outside of this tribe, this may seem psychotic. In the context of this tribe, it is not psychotic.]

TRAINER STATES: Reality is defined by what is shared by the majority of people in a given cultural context. A person who is psychotic is not able to function or care for himself or herself in any cultural setting. They are generally unable to take care of daily needs or what is called Activities of Daily Living (ADL) skills.

- Psychosis causes a severe disturbance in thinking, perception and behavior.
- Disturbances are bizarre and extreme.

Let's start by looking at disturbances in thinking. This will often take the form of a delusion.

TRAINER ELICITS: WHAT IS A DELUSION? [Expected responses include:]

A delusion is a fixed and false belief system not based in reality but true for that person. These beliefs must be extremely bizarre or they cannot be called delusions. There are two common types of delusions: Grandiose and Paranoid or Persecutory.

TRAINER ELICITS: WHAT MIGHT BE AN EXAMPLE OF A GRANDIOSE DELUSION? [Expected responses include: Someone who thinks they are the President, royalty, historical figures, or feel they can control the world.]

TRAINER ELICITS: WHAT MIGHT BE A PARANOID OR PERSECUTORY DELUSION? [Expected responses include: Someone who thinks they are being sought by CIA or aliens and feels they will be punished or killed when found.]

TRAINER STATES: Other phenomena in psychosis can include 'disturbance in thought process." This is when one thought does not coherently follow another. An example of this might be, "I was on my way there yesterday because the stars are out tonight and red is my favorite food." This disturbance in the thought process may be referred to as word salad because the words seem to be just thrown or tossed together like a salad.

Now let's look at disturbances in perception. People experiencing psychosis often have disturbances in perceptions. These are called 'hallucinations.'

TRAINER ELICITS CAN ANYONE GIVE AN EXAMPLE OF A HALLUCINATION? [Expected responses include:]

There are five types of hallucinations: auditory, visual, tactile, olfactory and gustatory.

- AUDITORY is when a person hears things or voices that are not really there. Be particularly aware of command hallucinations: when a voice is commanding or telling a person to do something.
- VISUAL is when a person sees something that isn't there. You may see someone waving their hands as if to shoo something or someone away. They might be having a conversation with someone who isn't there.
- TACTILE is when a person feels something that isn't there. They might feel bugs crawling on them.
- OLFACTORY is when someone smells something that is not there. Perhaps they smell a fire.
- GUSTATORY is when a person tastes something that isn't there. They may have the sensation of extreme bitterness in their mouths.

A person may have delusions as well as various kinds of hallucinations all at the same time.

- This may cause a person to have 'behavioral disturbances.'

Now that you have a better understanding of psychosis, you can see why people with psychotic disorders or who are having a psychotic reaction might behave strangely.

TRAINER ELICITS: WHY? [Trainer will address how internal beliefs, stimulation and fears interfere with behavior. All the internal stimuli we've discussed makes one behave strangely.]

TRAINER ELICITS: CAN ANYONE GIVE AN EXAMPLE OF STRANGE BEHAVIOR THEY'VE SEEN WITH PSYCHOTIC TENANTS? [Expected responses include: Excessive makeup, wearing multiple layers of coats, taking two steps then stopping, repeating, completely isolating, talking about bizarre ideas.]

While hallucinations are not based in our reality, they are, in fact, a reality for the person experiencing them. The delusions and hallucinations are as real for the person as I am standing here talking to you.

When you are engaged with a tenant who is actively psychotic, you want to be supportive; however, you do not want to agree or disagree with the content of the delusion.

TRAINER ELICITS: WHY DO YOU THINK THAT IS? [Expected responses include:]

- By agreeing, we can inadvertently push the tenant deeper into the psychotic content.
- By disagreeing or confronting it, we can potentially alienate the person. Would you want a relationship with someone who did not believe you?

Instead, we want to engage the tenant in a shared reality while keeping in mind that hallucinations and delusions are real for the person experiencing them.

- Listen to what is being said and look for a piece that might make sense and is a shared reality.
- Document the behavior and alert social service staff (or your supervisor) of what you're seeing at once.
- Educate yourself about your role in a crisis so that you are prepared if one should occur.
- Try to create an environment in the building that is supportive and non-threatening.

The social service staff role is different from the building staff role. Social service staff will take a more pro-active approach with a tenant who is actively psychotic.

- Worker will assess if the person may be having a psychotic reaction and if there is a need for the person to see a physician.
- Worker may assess that the tenant needs hospitalization and facilitate that process.
- Worker will assist the tenant to deal with stressors in his/her life and help him/her from becoming isolated.
- Social service staff also offer help with Activities of Daily Living (ADL) skill building.

As you can easily see, it is important for communication to occur when you do see a tenant in a potential crisis. Oftentimes, building staff may see the first signs of psychosis.

TRAINER ELICITS: WHAT ARE SOME CAUSES OF PSYCHOSIS? [Expected responses include:]

- Schizophrenia
- Drugs Use
- Periods of Extreme Stress
- May Accompany Certain Personality Disorders
- May Accompany Someone With Severe Depression
- Organic Mental Disorders [result of a physical problem/illness that effects the brain, including head injuries, untreated syphilis, cancer, Alzheimer's and AIDS dementia, prolonged alcoholism, substance abuse and heart disease]

In our buildings, the most common reason for psychosis is schizophrenia. The exact cause of this brain disease is not known. Studies show that the brain shape of a schizophrenic person is different than that of someone without this disease. There also appears to be a genetic or hereditary factor. Statistics show that with 1 schizophrenic parent there is a 15% chance of developing it. In the general population, there is only a 1% chance of developing schizophrenia. Housing that provide services for tenants with schizophrenia should include case management, support for medication management and monitoring, psycho-education for tenants and staff, as well as employment/educational opportunities tailored for special needs tenants.

LEARNING POINTS: Trainer wants participants to understand the three hallmarks of psychosis: disturbances in thinking, perception and behavior. Participants should also have a better understanding of how each of these disturbances manifest. Participants' knowledge of intervention tools for dealing with active psychosis should increase.

II.B: MOOD DISORDERS (20–30 minutes)

TRAINER NOTE: As with Psychosis, this section will be a lecture but should utilize substantial eliciting. See ***HANDOUT #3: MOOD DISORDERS*.**

TRAINER STATES: Another special need you will often see in tenants of supportive housing are Mood Disorders.

- Someone diagnosed as having a mood disorder is probably experiencing grave depression or intense mania.
- We all have bad and good moods. Some of us might be more naturally hyper while others are lower in energy.
- This does not mean you have a mood disorder. There are mood disorders that are less severe than the ones we will now discuss.
- We are talking about the mood disorders that are severe and cause significant problems for the person for a significant period of time. They interfere with an individual's ability to function in everyday circumstances.

MAJOR DEPRESSION

TRAINER ELICITS: WHAT BEHAVIORS MIGHT YOU SEE IN SOMEONE SUFFERING FROM MAJOR DEPRESSION? [Expected responses include: hopeless, tearful, loss of pleasure, guilty, unable to concentrate, angry, suicidal, possibly psychotic.]

- A person who is suffering from Major Depression may or may not be psychotic. If they are, it is likely that they will be more paranoid than grandiose.
- Like schizophrenia, mood disorders are believed to be a biochemical problem with a genetic predisposition. If someone is bio-chemically susceptible to depression, meaning that they are bio-chemically weak in that area, the illness is more likely to emerge if there is also a precipitating factor in the person's life (e.g., For many, breaking a long-term relationship can be difficult, but eventually, most persons are able to return to a "normal routine." Persons with a bio-chemical susceptibility, however, may find it much more difficult or impossible to recover from such a loss.)

Many people believe that someone suffering from Major Depression can be cheered up; if they tried harder they could feel better.

- This is like saying to someone with Diabetes that if they wanted to, he or she could talk himself or herself out of their illness.

- Relief from depression of this kind has nothing to do with will power.
- With a medical illness, medication is needed to affect the person's physiology.
- Expecting a depressed person to cheer up can make them feel worse by compounding their depression with feelings of self-blame and guilt.
- They often already blame themselves for their circumstances and will likely experience our suggestions as further blame.

The opposite of depression is mania.

- People may have an illness called Bi-Polar Disorder, which was formerly known as Manic Depression.
- Symptoms of Bi-Polar Disorder include shifting from depression to mania repeatedly; or another way of looking at it is shifting from one "pole" to another.

TRAINER ELICITS: WHAT ARE SOME OF THE SYMPTOMS OF MANIA? [Expected responses include: Euphoria, grandiosity, inconsistent with reality, extreme irritability, pressured speech, excessive energy, hyper, inflated sense of self worth.]

- People who are experiencing mania may have grandiose delusions and a grandiose sense of their own capabilities.
- Bi-Polar Disorders can impact a person's judgement. People may not be realistic about their capabilities. They can be harmful to themselves by engaging in unsafe sex, spending a great deal of money, not sleeping, being unable to focus and a host of other potentially dangerous behaviors.
- Because of the intensity of manic symptoms, the person is usually very difficult to talk with.
- A person diagnosed with Bi-Polar Disorder can shift between depression and mania on a rapid cycle while others may experience a much slower transition.

Being hyper or energetic does not mean your are manic; having a hard time, not being happy about certain things or feeling low energy does not mean you have a diagnosis of Major Depression.

TRAINER STATES: Again, the role in providing support is determined by your function in the supportive housing setting. Let's look at the role of building or property management staff first.

- When engaged with a tenant who is suffering from a depressive episode, it is helpful to let the person know that you can see how badly they feel, but that

there is help for their problem and that they need to talk to their case manager.

- We can reassure the person that there is treatment for depression and it is usually extremely effective.
- Major Depression is the #1 cause of suicide. So both building support staff and clinical staff will be on the look out for this. IF YOU SUSPECT A TENANT MAY BE COMTEMPLATING, GESTURING OR HAS THE POTENTIAL FOR SUICIDE, LET SOMEONE IN SOCIAL SERVICE STAFF KNOW IMMEDIATELY. TAKE ANY SIGNS SERIOUSLY. Know the protocol in your agency.
- If you notice any signs of depression you must notify clinical staff.
- Document the behavior and alert social service staff (or your supervisor) of what you are seeing at once.

TRAINER STATES: As with psychosis, the social service staff role is different from the building staff role.

- A qualified professional should assess the need for medication evaluation or facilitate a hospitalization, if necessary.
- Prevent the person from becoming isolated.
- Respond to information from building staff that may indicate immediate support is needed.

Again, housing that provide services for tenants with mood disorders should include case management, support for medication management and monitoring, psycho-education for tenants and staff, as well as employment/educational opportunities tailored for special needs tenants.

LEARNING POINTS: Trainees will have a better understanding of the vast difference between the opposing "poles" of depression and mania, signs and symptoms of major depression and mania including the potential for reckless and dangerous behavior during a manic episode. Participants will have increased intervention tools for dealing with mood disorders.

II.C: PERSONALITY DISORDERS (20–30 minutes)

TRAINER NOTE: Trainer will lecture on this topic. Due to the general lack of general public understanding of this diagnosis, trainer will not elicit as much. Trainer may decide to list all 11 Personality Disorders on flipchart. See ***HANDOUT #4: PERSONALITY DISORDERS***.

TRAINER STATES: A diagnosis you will sometimes see in tenants is Personality Disorders.

- Personality Disorders were previously understood to have to do with upbringing, but more recent studies indicate a bio-psycho-social cause.
- Most experts believe that Personality Disorders are influenced by biological factors and dysfunctional early childhood experiences. A child in a difficult situation finds one way of getting his or her needs met. The child then grows up learning to act a certain way in order to survive in that situation and it becomes the way they function throughout their life. He or she never learned new ways of coping or behaving.
- It is important to remember that most people with a Personality Disorder do not see himself or herself as the problem, but believe that others are to blame. This type of person can be very frustrating to be around and because the person is not psychotic, it can be hard to believe they are not behaving this way on purpose. They do, in fact, have a disorder and cannot help the way they act. They do not know other ways.
- There are 11 types of personality disorders. The diagnosis will relate to the personality trait that is causing the main problem for the individual. (e.g., If a person tends to relate to people in an angry, argumentative way, always looking for a fight, and disrespecting the rights of others, he or she may be diagnosed as having an Anti-Social Personality Disorder. He or she will not be able to see their behavior as the problem, but more likely will focus on how others treat them. If a person is unable to make everyday decisions without an excessive amount of advice or reassurance, expecting others to take care of him/her, s/he might be diagnosed as having a Dependent Personality Disorder. The person does not see the problem as their dependency, but as others' unwillingness to take care of him or her.)
- Unlike with Schizophrenia and Mood Disorders, medication does not change the underlying personality problem.
- Medication may be taken for other problems, such as depression or anxiety which frequently accompany personality disorders.

- Most Personality Disorders do not involve psychotic symptoms. However, some people with the diagnosis of Borderline Personality Disorder may, at times of stress, show symptoms of psychosis.

TRAINER STATES: Borderline Personality Disorder (BPD) is a common diagnosis in some supportive housing settings.

- People with BPD have often experienced abuse and neglect as children or what many define as an invalidating childhood experience. The caretaker does not acknowledge difficulties. Children in this situation learn not to trust their feelings, their view of their environment, or their capacity to control it. The result is self-blame and self-doubt and an intense need to cling to something for stability. Anger and frustration are natural reactions to this type of environment.
- Not surprisingly, the primary problem is difficulty maintaining on-going relationships. The person wants closeness desperately and pushes for that to occur. He or she may be very charming, friendly and likeable when you first meet. Once a person with this disorder gets close to you, he or she feels frightened and resentful at how much s/he needs you. This often results in the person rejecting or verbally attacking you to protect himself or herself from getting hurt because s/he perceives you will not meet his or her needs.
- It is NOT POSSIBLE to meet his or her needs no matter how much you may try. He or she will never feel or perceive that you care enough about them or are doing enough for them.
- People with this diagnosis tend to see everything in black or white and feel you are either completely supportive or totally rejecting. There is no middle ground.
- People with this disorder may do something called 'splitting.' (The person may say to you that you are the best worker in the building, and you are the only one who understands his/her problem. Maybe a week later, s/he tells your co-worker how wonderful he is and that you are the worst worker the agency ever had. People with this disorder try to split staff or set people up against each other.)

TRAINER ELICITS: HOW MANY OF YOU KNOW TENANTS WITH THESE CHARACTERISTICS IN YOUR BUILDINGS? [Expected responses include: Participants will usually have some experience with tenants matching these definitions and be willing to share stories.]

TRAINER STATES: Persons with personality disorders can be very difficult to deal with and it is very important not to take what's said personally. People with this disorder will have a lot of demands and never feel satisfied.

- All staff should work together to have a clear agreement as to how to respond.
- Persons with BPD may have significant trouble responding to boundaries and will often test them with staff. Providing structure and setting limits help most tenants feel safe. Be polite and courteous but do not get too personally involved.
- If you feel a person is splitting, suggest a three-way conversation.
- Don't take sides on the issue and inform staff of what's happening.
- Expect to feel angry with this person at times. It would be helpful for you to talk to your supervisor. Do not allow yourself to be provoked. People with BPD can be very provocative.
- Social service staff is trained to provide support by setting clear boundaries and offering concrete services for tenants with BPD.
- It is important that you inform social service staff of any provocative behavior of a tenant.

It is important to remember that for this person, this type of behavior has worked in the past as a way of getting his or her needs met. This behavior is not intentional or malicious. It is part of the personality and is the only way the person knows how to be.

LEARNING POINTS: Personality Disorders are a result of bio-psycho-social factors. Negative behavior traits are not intentional but a symptom of the disorder. There is a link between abusive childhood experiences and Borderline Personality Disorder.

II.D: GROUP EXERCISE (20–30 minutes)

TRAINER NOTE: Trainer will ask trainees to form groups (5–8 in each). Each group will be asked to make a list on flipchart of what their role is in helping manage a particular diagnosis. Each group will work with a diagnosis (Psychosis, Mood Disorders or Personality Disorders). Give the group 15 minutes to process and have each group present to larger group what they determined their role of support is. Have persons with similar job roles work in groups together.

Support Staff Expected Responses:

- [Psychosis, Mood D/O, Personality D/O] Be supportive.
- [Psychosis, Mood D/O] Do not agree or disagree with delusional content.
- [Psychosis, Mood D/O] Engage the tenant in a shared reality.
- [Psychosis, Mood D/O, Personality D/O] Document the behavior and alert social service staff (or your supervisor).
- [Psychosis, Mood D/O, Personality D/O] Try to create an environment in the building that is supportive and non-threatening.
- [Psychosis, Mood D/O, Personality D/O] Helpful to let the person know that you can see how badly he or she feels.
- [Psychosis, Mood D/O, Personality D/O] Let him or her know that there is help for their problem and that they need to talk to their case manager.
- [Psychosis, Mood D/O, Personality D/O] Know the protocol for crisis.
- [Personality D/O] Be courteous but do not get too personally involved.
- [Personality D/O] If you feel he or she is splitting or pulling you into a lengthy discussion about an issue, refer them to a case manager.
- [Personality D/O] Don't take sides and inform staff of what's happening.
- [Personality D/O] Expect to feel angry with this person at times. It would be helpful for you to talk to your supervisor.
- [Personality D/O] Do not personalize.

Clinical Staff Expected Responses:

- All of the above plus:
- Assess the need for medication dose or increase.
- Assess need for hospitalization and facilitate that process.
- Assist the tenant to deal with stressors and set limits when necessary.
- Assist from becoming isolated by contracting with them to ensure safety.

LEARNING POINTS: Trainees will have an opportunity to think about and process what their role is in supportive housing with tenants who are living with mental illness.

III. UNDERSTANDING SUBSTANCE ABUSE

III.A: SIGNS AND SYMPTOMS (20–30 minutes)

TRAINER NOTE: Transition from mental health to substance abuse by identifying both as special needs requiring special skills. Trainer will elicit a large portion of this section and write answers on flipchart for signs and symptoms. See ***HANDOUT #5: SIGNS AND INDICATORS OF SUBSTANCE USE*.**

TRAINER ELICITS: WHAT ARE SOME OF THE PHYSICAL SIGNS A PERSON MAY BE USING SUBSTANCES? [Expected responses include: Weight loss, dilated pupils, staggering, sweating, smell of alcohol, poor ADL skills, etc.]

TRAINER ELICITS: WHAT ARE SOME OF THE BEHAVIORAL SIGNS A PERSON MAY BE USING SUBSTANCES? [Expected responses include: running in and out of the building, stealing, rent arrears, borrowing money, isolating, getting into disputes.]

TRAINER STATES: By your responses, it's clear you have a lot of knowledge concerning substance use and abuse in your settings. Because this behavior can potentially compromise a person's housing, it is very important to have an understanding of addiction and some standard intervention guidelines. Let's look at some guidelines:

- Interventions used with substance abusers do not yield quick results. Recovering is an ongoing process and people need support to stay sober.
- If someone here is in recovery, remember that recovery is different for everyone. Don't put your expectations of recovery on another. You are employed to perform a job; therefore, you should not sponsor a tenant for a 12-step program.
- Set limits and do not lend money.
- Never agree to keep substance use from social service staff.

  TRAINER ELICITS: HOW DO YOU RESPOND IF A TENANT ASKS YOU IF YOU CAN KEEP A SECRET? [Expected responses include: "I'm glad you have that kind of trust in me, but I must let you know that it's part of my job to share information that effects the tenants."]

- Support the tenant's relapse prevention program. It's appropriate to give them encouragement if they talk to you about their 12-step meetings**.**

  TRAINER ELICITS: HOW DO YOU SHOW SUPPORT? [Expected responses include: Listening and encouragement.]

- Do not let the tenant know you're disappointed if they relapse.

TRAINER ELICITS: WHY? [Expected responses include: Would push person into isolation, denial and further into relapse.]

- Although it is not helpful to have lengthy discussion with someone when he/she is high, staff can still remain supportive by ensuring the tenant's safety.

LEARNING POINTS: Participants will recognize signs and symptoms of use. Participants will learn basic guidelines for interacting with this population.

III.B: THEORIES OF ADDICTION (20–30 minutes)

TRAINER NOTE: Have the various theory headings on flipchart with the word "BIO-PSYCHO-SOCIAL" at the bottom. See ***HANDOUT #6: MODELS OF ADDICTION AND RECOVERY*.**

TRAINER STATES: How a problem is defined determines in large part what is done about it. There are no universally accepted explanations for addiction. We will present the most popular models that attempt to explain why people become dependent/addicted.

- The MORAL MODEL is not professionally espoused but is the prevailing model for our society regarding addiction. According to this model, addicts make a choice to use and are immoral, weak-willed people deserving of shame. This makes it difficult to talk about his or her drug problems or admit to relapse. It's important to realize how this model interferes with our work.

- The DISEASE MODEL is the most prevalently used professional model and suggests that addiction is caused by physiological deficiencies or inherited genetic traits. Physiological characteristics cause addicts to react differently than non-addicts to both ingestion of a substance as well as to withdrawal. The person cannot control the use despite the adverse consequences.

- The SELF-MEDICATION MODEL is based on the notion that individuals use/abuse substances to self-soothe unpleasant mood states, feelings and emotions in attempt to gain emotional equilibrium. This is particularly relevant to mentally ill people who may use substances for years to control thoughts and behaviors.

- The SYMPTOM MODEL is based on psychoanalytic theories of personality and development. It suggests persons' use is due to unconscious, internal conflict resulting from having unsuccessfully passed through a developmental phase.

- The LEARNING MODEL states that addiction is a learned behavior. Drinking and drugging can be learned in families or social settings.

- The SOCIAL MODEL sees social factors as the cause of addiction. Social arrangements that produce alienation, frustration and despair cause people to turn to drugs.

When trying to understand why some people who use become addicted and others do not, no one model can suffice. People use for a variety of factors: biological, sociological and psychological or what is referred to as the BIO-

PSYCHO-SOCIAL MODEL. This model is the most useful in determining how to provide support, because it looks at a number of issues. It helps us to focus on the unique needs of each individual who is dealing with addiction. For some people, social factors may be the pressing issue, for others, it may be more biological.

While this is not a theory to explain why people use, HARM REDUCTION is a model of intervention that has had a huge influence in program design and housing. Developed in Europe in response to the spreading AIDS epidemic, this model suggests a new way of dealing with an age-old problem from a public health perspective. Given that there will always be a portion of the population that becomes dependent on chemicals, Harm Reduction stresses that morality should be removed from the solution. Instead of focusing on how to make people stop using, the idea here is to minimize the negative consequences of use to the person using and to the society.

While a Harm Reduction approach can have an ultimate goal of not using or reducing use, the immediate goal is to diminish the negative impact of use, not the use itself. Treatment starts where the tenant is at with a goal of heightening awareness and building motivation to change. Interventions may include providing supportive counseling, clean needles, clean places to use, condoms, Methadone maintenance, prescribed heroin, wet housing, serving a big breakfast to people actively drinking and any other method that minimizes the negative consequences of use.

LEARNING POINTS: Participant will understand the counter-productive effects that the Moral Model imposes on persons and an appreciation for the importance of considering a host of factors when looking at addiction based on the Bio-Psycho-Social Model of addiction. Trainees will have an understanding of harm reduction as a model of intervention minimizing the negative consequences of use.

III.C: STAGES OF CHANGE (25–35 minutes)

TRAINER NOTE: Trainer should have a pie chart on flipchart illustrating the Stages of Change and corresponding interventions. Although, a lot of information is available on this topic, trainer may want to shorten it if participants are not social service staff. See ***HANDOUT #7: STAGES OF CHANGE—HIGHLIGHTS & 8. HARM REDUCTION.***

BRIEF LECTURE:

While there are many treatment approaches to help people address addiction, many supportive housing projects find the Stages of Change model to be very effective. In dealing with addiction, it is important to be aware of where a person is at in his or her awareness of the problem behavior and in his/her desire to change. The Stages of Change model was developed based on research of how people make changes. Researchers Prochaska, DiClemente and Norcross came up with stages that a person moves through, from denial to making a change and maintaining the change in their life.

STAGE 1: PRECONTEMPLATION

- Defined as unawareness or under-awareness of a problem.
- May see defensive behavior, including denial, externalization and minimizing.
- May comply with treatment demands because they are being threatened with loss of housing but not likely to continue since there is no internal motivation.
- INTERVENTIONS
  - Ask the person to tell you their "story." Don't push focus to drug use.
  - Using the tenant's own experience helps raise awareness about how the substances affect his/her life, both positively and negatively.
  - Work on mutual goals, not necessarily related to substance use.

STAGE 2: CONTEMPLATION

- Defined when a person is aware that a problem exists but has not made a commitment to change.
- The contemplation stage is characterized by ambivalence and may last a long time.
- INTERVENTIONS
  - Elicit pros and cons of substance use from the person.
  - Help build awareness of negative consequences of use.
  - Continue work on mutual goals.
  - Allow freedom to look at all sides of the issue.

STAGE 3: PREPARATION

- Pre-action stage can last a long time.
- More open to hearing others' perception and to talking things out.
- INTERVENTIONS
  - Help person to continue to assess the need for change.
  - Explore other activities to replace substance use-related ones.
  - Find ways for person to mourn the loss of substance use.

STAGE 4: ACTION & RELAPSE

- Defined by reaching the point of taking action by modifying behavior and environment from one day to six months.
- Because many supportive housing projects require a period of sobriety, many tenants have been at this stage before.
- In relapse, the person has moved away from an obtained level of abstinence and recovery.
- Relapse, though not desirable, is normal in the process of change. It is rare to overcome a problem on the first attempt. Slips and relapses need to be seen as normal, expected occurrences. *How a relapse is perceived and handled can influence how long it lasts and how negative its consequences.*
- INTERVENTIONS
  - Help person to understand and avoid triggers.
  - Encourage ventilation around person's sense of loss.
  - Offer support and encouragement.
  - Incorporate relapse prevention into service plan.

STAGE 5: MAINTENANCE

- Stage in which people work to prevent relapse
- Consolidate gains made during action.
- Extends from six months and beyond, past the initial action.
- INTERVENTIONS
  - Help person to build self-esteem and decision-making skills.
  - Reinforce relapse prevention skills.
  - Connect person with a wider support network.

WHAT'S IMPORTANT ABOUT THIS MODEL?

- Interventions should match where a person is at in terms of this continuum.
- In order for change to occur, it has to be a positive process.
- Working together with the tenant and offering choices helps build self-esteem and self-efficacy.
- Resistance is often a result of not understanding where someone is.
- Instead of focusing on getting consumers clean and sober, workers should be focusing on raising awareness and helping move people from one stage to another. In this way, his or her expectations will be more realistic.
- It is normal for people to move back and forth in terms of their desire to change.
- Relapse is normal.
- It is normal to go around "stages" several times. (Not indicative of failure).

TRAINER NOTE: Trainer has the option of including the following exercise.

LEARNING POINTS: Participants will learn the stages-of-change model as it applies to substance abuse by tenants in supportive housing. Trainees will understand how pre-contemplation and contemplation pose additional problems for workers when assisting tenants with substance abuse concerns. An understanding of the appropriate interventions for each stage will be gained.

III.D: GROUP EXERCISE (20–30 minutes)

STAGES OF CHANGE

TRAINER NOTE: Trainer will ask trainees to form dyads. Once in dyads, the first person will describe to his or her partner a person they know who is trying to change a behavior in their life. It is more relevant if the change has to do with substance use but any change is acceptable. Afterwards, the person listening will try to identify at what Stage of Change the person is in based on the information stated. Trainer will allow a few minutes for this process.

Trainer will call time and ask dyads to switch roles and have the second person relay a short biography on someone they know. Both participants will have an opportunity to identify for the other the Stage of Change they feel the tenant is in.

Trainer will process in larger group the findings of this exercise.

LEARNING POINTS: Trainees will have an opportunity to apply the concept of persons being at a certain point in the Stages of Change. Trainees will have a better understanding of how they may consider intervening with this person and others in the future.

III.E: UNDERSTANDING RELAPSE (20–30 minutes)

TRAINER NOTE: Trainer can have flipchart hi-lighting the major points of relapse and relapse prevention. See ***HANDOUT #9: COMPONENTS OF RELAPSE PREVENTION*.**

TRAINER STATES: While staff may be delighted that a tenant has taken steps to enter recovery, you need to keep in mind that relapse is normal and to be expected. With addiction, relapse is the rule rather than the exception.

TRAINER ELICITS: HOW MANY PERSONS HAVE MADE A NEW YEAR'S RESOLUTION IN THE LAST FEW YEARS? HOW MANY HAVE KEPT THEM? [Expected responses include: Participants will inevitably indicate unsuccessful attempts to change behavior. This does not make them bad or weak persons but simply indicates they were not completely ready to change. Site the parallel for persons in recovery.]

- You need to reframe your thinking about RELAPSE. Instead of viewing it as a failure, you want to see it as an opportunity for learning.
- You want to avoid "catastrophizing" the slip or relapse. In offering support, you help to avoid demoralization.
- Affirm that relapse is a NORMAL occurrence in the process of change. As a rule of thumb, it takes a person six times attempting recovery before they successfully negotiate sobriety.
- How you respond to a tenant's relapse (or how it is perceived) can influence how long it lasts and how negative its consequences.

TRAINER ELICITS HOW CAN BUILDING STAFF ASSIST A TENANT THEY THINK MIGHT BE IN RELAPSE? [Expected responses include:]

- Remaining supportive
- Do not express disappointment
- Do not be judgmental
- Let social service staff know if you observe behavior indicating relapse

Social service staff will assist the tenant in using this relapse as an opportunity for learning. In working with persons in recovery, social service staff will offer assistance in the following areas:

- Identify triggers
- Develop coping strategies
- Psycho-education
- Explore positive alternatives and use of leisure time
- Learning from prior relapses
- Help tenant maintain housing
- Refer to appropriate community resources (e.g., day programs, AA, NA, Double Trouble meetings, detox, rehab centers)

LEARNING POINT: Participants will learn that relapse is a normal part of recovery and the importance of being supportive.

IV.A: HIV & AIDS OVERVIEW (20–30 minutes)

TRAINER NOTE: Trainer will present a simple explanation of the means by which HIV enters the body, infects T-Cells (CD4-Cells) and infects the immune system. See ***HANDOUT #10: HIV/AIDS FACT SHEET***

TRAINER STATES: In your buildings, chances are you will also have tenants living with HIV disease and/or AIDS.

TRAINER ELICITS: HOW MANY OF YOU HAVE KNOWN OR KNOW OF SOMEONE WHO IS HIV POSITIVE? [By show of hands, we can see how much it affects many of our lives.]

TRAINER NOTE: Trainer draws a circle representing T-Cell with "receptor sites" and speck of HIV outside the cell. Trainer points out its journey as it "docks" and enters the T-Cell in order to replicate (reproduce). The result is a cell full of HIV, which breaks out of the T Cell (killing it) and infects other (uninfected) T-Cells in the body.

- The HIV virus is weak outside the human body (it can be disabled by bleach, isopropyl alcohol, hydrogen peroxide, and some detergents).
- In order for infection to occur, the virus must enter the bloodstream and find a white blood cell (T-Cell).
- It infects the T-Cell, which co-ordinates the body's immune response.
- HIV is a retrovirus; it uses the T-Cell to create HIV virus leading to a decrease in T-Cells and an increase of HIV (viral copies).
- Shortly after infection, a person will become "infectious." For some, the time frame between being infected and being capable of potentially infecting others may be as brief as 24 hours.

TRAINER NOTE: Trainer can use the analogy of a bank robber being video taped to explain the production of HIV antibodies.

TRAINER STATES: When someone robs a bank a video camera photographs the "perpetrator." This picture enables the police to look for someone who looks like the picture.

- An antibody is a protein that recognizes a pathogen or germ and carries the image of the invading germ, helping the body to mount an immune response.

- Initially it was believed that the HIV antibodies didn't "recognize" the HIV manufactured in the T-Cells.

- We now know that the antibodies do destroy virus, but cannot keep up with the viral replication and damage to the immune system.

- During the "window period," the body is creating antibodies to respond to the virus. During this window period, a person would test negative although infected because the tests look for "antibodies," not "virus." The average "window period" for 99% of those tested is 1–3 months (formerly 3–6 months.) Once an antibody is produced; a person will test "positive" for HIV.

- Until 1987 AIDS could only be diagnosed by the presence of an opportunistic infection. More recently, other criteria are used to diagnose AIDS, including "Wasting" (loosing >10% of body weight with no apparent cause), pulmonary TB, two or more bouts of bacterial pneumonia per year, stage 4 cervical cancer, and a T-Cell count of under 200.

- Presently, the criteria for an AIDS diagnosis can vary from state to state. It is important to understand the criteria as most benefits are effected and/or linked to these diagnostic criteria.

- Opportunistic infections "take advantage" of the body's depleted state.

- Until AIDS, opportunistic infections were rare and most often seen in people who were undergoing chemotherapy or an organ transplant.

- When a person has AIDS, there are different illnesses that can occur.
    1) bacterial infections, such as pneumonia or TB
    2) fungus such as shingles
    3) blisters caused by a herpes virus
    4) cancers such as Karposi's Sarcoma, skin and cervical cancers.

- AIDS can also cause dementia, which could include psychotic symptoms, personality changes, memory and judgment impairment.

PROGRAMMATIC ISSUES INCLUDE:

- Maintain clear confidentiality protocols. Confidentiality laws help respect and protect a tenant's right to privacy. The confidentiality laws vary from state to state. Be sure to be familiar and respect these confidentiality requirements.

- Consider assessment for reactive depression and suicidal ideation. Building staff should alert social service staff if they see signs of depression in any tenant.

- In developing employment opportunities, social service staff should be mindful of medication cocktails and the need to design accommodation for taking medication multiple times daily.

- Social service staff should provide links to peer support.

- Social service staff should provide grief support.

- Housing programs should provide education for both staff and tenants on HIV/AIDS and Universal Precautions.

LEARNING POINTS: Participants will have a better elementary understanding of HIV and its impact on the immune system. They will also learn the criteria for an AIDS diagnosis.

IV.B: HIV/AIDS TRANSMISSION (20–30 minutes)

TRAINER NOTES: See ***HANDOUT #11: HIV/AIDS TRANSMISSION QUESTIONNAIRE***. Trainer will ask trainees to take a few minutes to fill out the questionnaire and assure them that the questionnaire is for their use only. After trainees complete questionnaire, trainer should have flipchart listing each of the categories listed on questionnaire and ask trainees "Yes or No?" for each.

TRAINER STATES: Most of us have contact with HIV positive persons regularly. It may be riding on public transportation, going to the symphony, family members, friends, neighbors, co-workers and tenants. Let's look at a questionnaire about how the HIV virus is transmitted. [Allow time for trainees to answer questionnaire].

TRAINER ELICITS: CAN YOU GET HIV FROM [following]?:

- The Air [no]
- Toilet Seats [no]
- Oral Sex [yes]
- Eating Food Made by Someone w/AIDS [no]
- Anal Sex [yes]
- Breast Milk [yes]
- Tears [no]
- Vaginal Sex [yes]
- Sweat [no]
- Sharing Needles [yes]
- Holding Hands [no]
- Hugging [no]

A person who has HIV should protect themselves from getting sick by avoiding high-risk behavior like sharing needles and having unprotected sex or traveling to areas with poor hygiene/sanitation. They should avoid drugs, alcohol and nicotine, eat well and reduce stress.

TRAINER ELICITS: WHAT CAN YOU DO TO BE HELPFUL IF YOU KNOW SOMEONE IN YOUR SUPPORTIVE HOUSING PROJECT HAS HIV/AIDS? [Expected responses include: Be supportive, don't withdraw or pull back. Talk with your co-workers if you need support. Be aware of your own feelings and fears. Be watchful for depression/suicidal thoughts or attempts. Building staff should let clinical staff know.]

LEARNING POINTS: Participants will learn what types of behavior put a person at risk for contracting HIV and more importantly, what types of behavior do not put a person at risk. Additionally, they will have an understanding of what type of support is needed from staff.

IV.C: UNIVERSAL PRECAUTIONS (20–30 minutes)

TRAINER NOTE: Have flipchart prepared reviewing major points of Universal Precautions. See ***HANDOUT #12: UNIVERSAL PRECAUTIONS GUIDELINES***.

BRIEF LECTURE:

Since your role in housing might sometimes mean exposure to body fluids, it is important to know how to keep yourself safe from infection. Universal Precautions are a set of risk-reduction measures, outlined by the Centers for Disease Control, to be used by anyone coming into contact with the blood or body fluid of another person. These precautions can help reduce the risk of infection with blood-borne viruses, such as HIV, hepatitis B, herpes viruses and other retroviruses.

Body fluids to which UNIVERSAL PRECAUTIONS apply include:

- Blood Semen Vaginal Secretions

Body fluids* to which UNIVERSAL PRECAUTIONS do not apply include:

- Feces Saliva Nasal Secretions Urine
- Sputum Sweat Tears Vomit

* The exception would be if any of the above fluids contained *visible* blood.

TRAINER STATES: Of course, good infection-control practices should still be used when handling all body fluids, such as wearing gloves and washing hands after contact. Treat everyone with the same degree of caution. There is no way to know who is infected with a blood-borne infectious disease, so when handling body fluids, assume everyone might be potentially infected.

UNIVERSAL PRECAUTIONS:

- Barriers keep potentially infectious substances from contacting blood stream.
- No current evidence suggests that hepatitis B or HIV can penetrate intact skin.
- Inspect hands before coming into contact with any body fluids, checking for openings in the skin barrier (rashes, cuts). Use latex or vinyl gloves checked for holes before wearing.
- If possible, use a facemask and something to cover your clothes.

- Using gloves, pour bleach, peroxide or isopropyl alcohol onto the body fluid. Cover with paper towel and mop up.
- Gloves should be thrown away immediately and always wash hands properly after handling any body fluids.
- Never attempt to recap a used needle. Instead, dispose of them in a readily available Sharps Container immediately after use.

LEARNING POINT: Participants will be better prepared to take universal precautions in the event they encounter body fluids that need cleaning and they have a knowledge base to share with co-workers and/or tenants on this issue.

V. FOSTERING A POSITIVE RELATIONSHIP

V.A: KEY SUPPORTS NEEDED IN HOUSING (25–35 minutes)

TRAINER NOTE: Trainer will acknowledge that each program is different but should include some key supports, which will be listed on flipchart for reference. See ***HANDOUT #13: SUPPORTS NEEDED IN HOUSING***.

BRIEF LECTURE:

The primary goals of most supportive housing projects are to help tenants maintain their housing and maximize their capacity for independent living. Some people will need life-long supports to accomplish these goals. Others may need them for a few years or a few months. Still others may need varying levels of support at different points in their lives. Supportive housing, where tenants can live as long as they need or want to, provides an opportunity to serve a range of people based on their individual needs.

In order for supportive housing to be effective, it must address the service needs of the tenants. In large part, social service staff addresses these needs. However, without building management (cleaning, maintenance, security, administrative and others), tenants might not be able to maintain housing. Supportive services focus on helping tenants meet the obligations of their lease and develop the skills to live with stability in the community. Services in supportive housing are meant to be flexible and adjust to the changing needs of tenants rather than tenants adjusting to fit into the supportive service program.

TRAINER EXERCISE: Trainer will have participants break into groups and list the key supports they feel make an ideal program. Trainees will report their lists back to the larger group. Trainer will support the ideas with a focus on developing a key list of essential supports based on the following.

There are no two supportive housing projects that are identical. Some offer many on-site supports while others may refer to other agencies. The key supports needed may vary from project to project. They are, in part, defined by the tenant population, staffing patterns, budgets and the mission of the organization. However, there are some basic key supports that most housing projects offer:

- Assistance with budgeting and paying rent
- Access to employment
- Tenant involvement in the ongoing development of the supportive housing project, including house rules and services offered

- Medication monitoring and management
- Daily living skills training or assistance, particularly meal preparation, housekeeping, developing support networks and socialization
- Medical and health services
- Counseling and support in achieving self-identified goals
- Assistance in meeting lease obligations and complying with house rules
- Referrals to other services or housing
- Conflict-resolution training
- Substance abuse counseling
- Entitlement advocacy
- Community building

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

In many supportive housing projects, tenant participation in services is not a condition of tenancy. Social service staff will design the service program to meet the needs of tenants and make them as appealing as possible. Often, tenants become engaged in services when he or she identifies a need for assistance. In any case, service staff must work to engage tenants in ensuring they live in safe, decent and healthy environments.

LEARNING POINT: Participants will have an understanding of some of the key supports needed to assist tenants in maintaining their housing and to reach their optimal level of independence.

V.B: DEFINING A PROFESSIONAL RELATIONSHIP (25–35 minutes)

TRAINER NOTE: Trainer will present the following on flipchart and either illustrate with or elicit examples for a number of these categories. *See* ***HANDOUT #14: STAFF ROLES AND BOUNDARIES*****.**

TRAINER STATES: To begin our discussion about interacting with tenants and creating a positive relationship, let's first discuss your role in supportive housing. Whether you work in social services, the office, provide maintenance or security, your roles put you in positions to interact with tenants regularly. We know it's helpful to be friendly, but it is also important to know that you are not the tenant's friend. Let's look at how friendships differ from a professional relationship.

- COMMON GOAL: In the jobs you perform at work, the common goal is to help tenants maintain themselves in supportive housing. All of you contribute. This is part of what makes the relationship professional vs. personal.

- DEALING WITH DIFFICULT BEHAVIOR: Anyone working in supportive housing is required to be supportive and to deal with behavior you would not have to deal with at a different type of job setting or off-the-job site.

- TAKING THINGS PERSONALLY: You cannot personalize the behavior of the tenants. Sometimes a tenant will be upset about something else and take it out on you. That does not mean you let tenants abuse you. Set limits by asking them to calm down and talk to you later, but don't react as though it's a personal insult.

- ENFORCING RULES: Set limits based on program norms, not based on your personal feelings. Do not argue or yell back at someone. You might call in a caseworker to help deal with the situation.

- TERMINATION OF THE RELATIONSHIP: Unlike with friends, you cannot stop talking to a tenant or choose not to see them again if they are mean or disrespectful. The only way to end a relationship with a tenant is to resign.

- SELF-DISCLOSURE: Tenants and their friends disclose information to one another. Employees should not. It would be difficult to enforce program rules if tenants see you as their friend. People need clear boundaries in order to feel safe. With friends, you can disclose as much about yourselves as you want to.

- CONFIDENTIALITY: Do not share information about one tenant with another tenant. You would share it only with other staff.

TRAINER STATES: Each program has it's own set of professional guidelines. However, there are some steadfast "professional don'ts" that apply to everyone. They include:

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

TRAINER ELICITS: WHY ARE THESE RULES SO IMPORTANT? [Expected responses include: Things will get out of control, backfire, unethical.]

TRAINER ELICITS: WHAT MIGHT YOU SAY IF A TENANT ASKS WHERE YOU LIVE, YOUR PHONE NUMBER OR IF THEY CAN TAKE YOU OUT? [Expected responses include: Rely on agency policy, remind person of your role, do not be punitive or judgmental, be kind and respectful, tenants may need to test boundaries.]

General guidelines regarding answering personal questions.

- If you cannot clearly see how answering a person's question is helpful to him/her, do not answer it.
- If you are not sure if you should answer, do not answer it.
- If the tenant is acting in a particularly strange way or making you feel uncomfortable, speak with your supervisor.
- You may disclose personal information as a way to "normalize" or "universalize" the tenant's feelings. Sometimes it helps people to feel better if they know that other's experience what they are experiencing (e.g., sharing that you too hate going to the dentist).

LEARNING POINT: Participants will be able to distinguish the difference between being a friendly professional and being someone's friend, and understand the benefits to both tenants and staff of setting professional boundaries. They will also understand basic "professional don'ts" and how to respond to provocative inquiries.

V.C: ESTABLISHING A PROFESSIONAL RELATIONSHIP (25–35 minutes)

TRAINER NOTE: Trainer will present these three tools (Empathy, Trust and Respect) on flipchart and illicit examples of each. See ***HANDOUT #15: BUILDING A PROFESSIONAL RELATIONSHIP*.**

TRAINER STATES: There are tools that can assist you in establishing a professional relationship. Some basic tools that apply to anyone working in supportive housing include empathy, trustworthiness and respect. Let's look at each one:

- EMPATHY is an important part of a professional relationship, particularly in a human service setting.

  TRAINER ELICITS: WHAT IS EMPATHY? [Expected responses include: The ability to imagine or understand how a person might be feeling in a particular situation. Empathy does not mean we take on the feelings of the other person. You do not have to have the same experience in order to be empathic (e.g., psychosis). The feelings are what we can empathize with. We have all felt afraid, angry, sad or other feelings. When we listen with empathy, it's important not to assume that the person feels what we would feel in that situation.]

- BEING TRUSTWORTHY**:** Being trustworthy benefits you as well. People's behavior tend to be more problematic if they do not trust you.

  TRAINER ELICITS: WHAT MAKES A PERSON TRUSTWORTHY? [Expected responses include: Following through on what you say you'll do, being predictable, consistent and respectful. There are many reasons why some people in supportive housing are not very trusting. They may include paranoia, past rejection by significant others, unhelpful workers in the past, or experiences of victimization.]

- CONVEYING RESPECT: A critical element in the development of a helping professional relationship is the ability to treat tenants respectfully. When someone feels disrespected he or she will be more difficult. Think of how you feel and act when someone is not showing you respect.

  TRAINER ELICITS: HOW DO YOU RESPECT SOMEONE WHOSE BEHAVIOR CONTRADICTS YOUR VALUE SYSTEM? [Expected responses include: Do not allow our values to interfere with our role, avoid judging, separate the person from his or her behavior.]

LEARNING POINT: Understand that showing empathy is not only helpful to tenants, but also in the workers' best interests as tenants' behavior is likely to be less problematic. Learn the role of trust in supportive housing.

V.D: GROUP EXERCISE (25–35 minutes)

CASES IN WHICH BOUNDARIES NEED TO BE SET

TRAINER NOTE: Distribute two cases to dyad or group of four. One person is the worker, one the tenant, and the other two are observers. Role play one scenario. For the second scenario, the two observers become the worker and tenant and the other two become observers. Worker should respond to the tenant as if actually talking to him or her. Emphasize that this is a role play, not a discussion. Return to large group and share experience. **Trainer should direct "workers"** to decide how they will answer the question and decide if they feel limits should be set. How will they do this in a professional, supportive way? **Trainer should direct "tenant"** to respond as s/he thinks a tenant would based on what the worker is saying. Don't be more difficult than you think a tenant would be, and don't be easier. If what the worker says raises your defenses, act accordingly, and if you feel less defensive respond that way. Start the role play with the "tenant" stating what is in quotes.

1. A tenant says, "Can I please borrow two dollars? I have absolutely no food and no money left." This is probably true since you know they have difficulty budgeting and have no substance abuse problem. *(TRAINER KEY: Lending money is not appropriate. Refer to caseworker.)*

2. A tenant recently in recovery is having a hard time and says to you in a very sincere tone, "Are you in recovery?" *(TRAINER KEY: Depending on your program philosophy, this may or may not be appropriate.)*

3. A tenant is constantly telling you how nice you look and how you are the best-looking person in the building. *(TRAINER KEY: Worker must assess whether the motivation for these statements is purely innocent or contains other innuendoes. It is important to set clear boundaries regarding these sorts of statements.)*

4. A tenant suffers from periodic, though infrequent, bouts of depression. He or she says, "You are the only one here who it helps me to talk to when I feel that way. I would never use it a lot, but could I have your home phone number for those times?" *(TRAINER KEY: Giving out your personal number is not professional. Politely decline. Document and refer to case worker.)*

5. A tenant tells you that he is going to miss curfew tonight because he is going out with a friend and won't get back until late. He asks: "Could you just not mention this to anyone? Would you let it slide since I did tell you in advance?" *(TRAINER KEY: Worker must be consistent in responding to violations. Responding differently may jeopardize your relationship with other tenants.)*

6. A tenant says, "I'm so glad that I met you because now you are my best friend and I've never felt happier." *(TRAINER KEY: Worker must convey that s/he is there in a professional capacity and that although s/he cares about the person, it is not a friendship. A goal may be to connect this person with others in the community.)*

7. A tenant who has been flirtatious with you in the past, says, "I heard that the movie playing on the corner is fabulous. Would you like to go see it with me?" *(TRAINER KEY: Worker may suggest a group outing and reiterate his/her role.)*

8. A tenant says, "I know you like coffee mugs so I bought this set of 6 for you." *(TRAINER KEY: It is helpful if the program has clear policies regarding accepting gifts. Worker may accept gift for the entire community to use.)*

9. A tenant who is getting used to the neighborhood and who is regularly discussing this with you, says, "Do you have to deal with a lot of crime in your neighborhood? Where actually do you live?" *(TRAINER KEY: Worker may give a vague answer and respond to the person's concern about safety.)*

10. You unexpectedly see a person from your program on the street over the weekend. She says, "Hey, I've got nothing to do today. Where are you headed?" *(TRAINER KEY: Worker keeps conversation short and sweet. Expresses she is busy and tells person s/he is looking forward to seeing them on Monday.)*

LEARNING POINT: Help trainees set limits in a way that is honest but still sensitive to the tenant. Trainees should understand not to be punitive or judgmental. Tenants may need to test boundaries. Setting limits may hurt or anger them, but it does not mean it is bad for us to do this. You do it in a kind, professional and respectful way.

V.E: CONCLUSION (15 minutes)

TRAINER NOTE: Trainer will put closure to training by reviewing most salient points of training. Trainer should ask trainees if there are any questions or comments about the content of the training.

TRAINER STATES: We covered a great deal in today's training. Before we close, let's review a bit of what we learned today. We started by talking about a variety of special needs that included mental health, substance abuse and HIV/AIDS.

TRAINER ELICITS: WHAT WERE SOME OF THE MAIN POINTS WE DISCUSSED REGARDING MENTAL HEALTH? [Expected responses include: understanding that every person has mental health needs that move along a continuum, understanding psychosis, mood disorders and the roots of personality disorders]

TRAINER ELICITS: WHAT WERE SOME OF THE MAIN POINTS WE DISCUSSED REGARDING ADDICTION? [Expected responses include: models of addiction, stages of change, understanding relapse, and signs and symptoms of abuse]

TRAINER ELICITS: WHAT WERE SOME OF THE MAIN POINTS WE DISCUSSED REGARDING HIV/AIDS? [Expected responses include: understanding HIV/AIDS, transmission routes, and universal precautions]

TRAINER ELICITS: AND FINALLY, WHAT WERE SOME OF THE MAIN POINTS WE COVERED IN OUR DISCUSSION OF FOSTERING A POSITIVE RELATIONSHIP? [Expected responses include: understanding our role in supportive housing, providing key supports and maintaining a professional relationship]

You have a number of handouts in your folders covering most of what we discussed today.

LEARNING POINT: Trainees will review significant points of the training and clarify any remaining questions.