A PUBLICATION OF THE HCH CLINICIANS' NETWORK

HEALING HANDS

Vol. 4, No. 3 ■ June 2000

Eliciting Behavioral Change: Tools for HCH Clinicians

The following article summarizes currently recommended strategies for eliciting health-related behavior change which clinicians and their homeless clients are finding useful. Subsequent articles focus on the experience of individual practitioners in dealing with some of the most critical and persistent health problems their homeless patients face to which lifestyle modification is at least part of the solution — psychoactive substance dependency, chronic disease management and sexually transmitted disease, particularly HIV.

Changing ingrained habits to improve or protect our own or someone else's health is an arduous task for anyone. Among the behaviors most difficult to change are those related to diet, exercise, sexual practice and the use of addictive substances. Learning to control chronic disease or mental illness through lifestyle changes and adherence to prescribed medication poses similar challenges. For persons experiencing homelessness, these tasks are complicated by factors often beyond their control — limited access to water, a healthy diet and a safe place to rest or heal. Minimal financial resources, isolation from a supportive community, competing subsistence priorities and increased exposure to violence, disease and other hazards may result in a sense of powerlessness that further undermines self-esteem and belief in capacity for change.

Standard approaches to health education and promotion often fail to address these barriers, presupposing that information alone is sufficient to induce lifestyle change, or that the locus of change should be in individuals alone rather than in the broader constellation of their lives. A more realistic approach involves a holistic assessment of individual and environmental factors influencing behaviors that are damaging to health, and the development of creative strategies to address them by caregivers in partnership with their clients.[1]

LEVELS OF INTERVENTION According to **Alan Berkman, MD**, an internist at Columbia University in New York, there are three basic kinds of behavioral change strategies:

- **Individual Counseling** – a one-to-one "clinical model," most appropriate for substance abuse counselors, case managers and therapists;
- **Small Group interventions** – based on cognitive/behavioral strategies to develop self-efficacy (empowerment) and coping skills;
- **Facility or Community-level interventions** – to create policies and behaviors within services or systems that promote desired behaviors in individuals.

Scientists and clinicians at Columbia University think it is important to address behavioral change on as many of these levels as possible.

STAGES OF CHANGE The Transtheoretical Model of Change was derived from research demonstrating that for most people, behavior change occurs gradually, in predictable stages — precontemplation (disinterest), contemplation, preparation, action, maintenance and relapse. The cycle is usually repeated several times before a new behavior is firmly established. The clinician's role is to identify a client's stage in the change process, select appropriate interventions to facilitate movement to the next stage, and assist in devising strategies for relapse prevention. This model has been applied to smoking and alcohol cessation, exercise, diet and contraceptive use.[2]

CLINICAL TOOLS Health care practitioners serving homeless persons are using a variety of approaches to facilitate behavior change, at multiple levels of intervention. Widely accepted strategies and techniques are briefly summarized below, with references provided for readers interested in more detail.

> "Habit is habit, and not to be flung out of the window by any[one], but coaxed down-stairs a step at a time."
>
> **Mark Twain, 1894**

Motivational Interviewing (MI) – *"a directive, client-centered counseling style for eliciting behavior change by helping people to explore and resolve ambivalence,"* originally developed to facilitate treatment for alcoholism. Central to the "spirit" of MI is a nonconfrontational manner that elicits motivation to change rather than imposing it through coercion, persuasion or the use of external contingencies (which often trigger resistance). Essential to this process is the development of an empathic relationship through which the client comes to see that a change in his/her behavior is both desirable and possible. Clinicians report that MI is most effectively used in the precontemplation and contemplation stages of change, and to help clients re-engage in the change cycle following relapse. A similar approach was developed in

the mental health field for persons with co-occurring substance abuse and mental illness who could not meet traditional substance abuse treatment readiness criteria.[3]

Harm Reduction vs. Abstinence – *Harm reduction refers to activities designed to reduce or minimize the damage caused by high-risk behaviors, with the ultimate goal of eliminating them.*[1,4] This pragmatic approach places first priority on reducing destructive consequences of behaviors that threaten individual and public health, rather than insisting on abstinence as a prerequisite to therapeutic intervention. Current applications include needle exchange and methadone maintenance programs and outreach programs that distribute educational materials, syringes, condoms and bleach kits, and facilitate contact with other services.[4] Proponents of abstinence or "zero tolerance" as a primary goal contend that harm reduction programs inadvertently sanction and reinforce high-risk behaviors they are intended to ameliorate. Contingency management approaches to behavior change, based on the use of rules and consequences, are often preferred by advocates of this view.[5] Although most addiction treatment programs in the United States require abstinence as a prerequisite for participation, clinicians are divided on this issue.[4]

Ethnographically Based Social Skills Training – *small group interventions to effect behavioral change based on careful investigation of actual client behaviors and an intimate understanding of subjects' daily lives* — how they spend their time, what activities interest them, and potential structural barriers to desired change.[7] This approach requires cultural sensitivity — *awareness of and responsiveness to attitudes and values shared by members of particular social, religious or ethnic groups, including their views of illness and health care.* Clinicians using this approach also target their interventions to clients' cognitive and developmental levels, relevant gender differences and sexual orientation.

SOURCES & RESOURCES:

1. McMurray-Avila M. *Organizing Health Services for Homeless People: A Practical Guide* (1997): 294–296: *www.nhchc.org/organizingservices.html.*
2. Zimmerman GL, Olsen CG and Bosworth MF. A 'Stages of Change' Approach to Helping Patients Change Behavior, *Am Fam Physician* (March 2000); 61: 1409–16: *www.aafp.org/afp/20000301/1409.html.*
3. Rollnick S and Miller WR (1995). What is Motivational Interviewing? *Behavioural and Cognitive Psychotherapy;* 23: 325–334: *www.motivationalinterview.org/clinical*; Sciacca K. Removing Barriers: Dual Diagnosis and Motivational Interviewing, *Professional Counselor* (February 1997); 12: 41–46.
4. Marlatt AG (Ed), Lewis DC and Abrams DB. *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors* (October 1998): 390 pages; Canadian Centre on Substance Abuse National Working Group on Policy. Harm Reduction: Concepts and Practice: *www.ccsa.ca/wgharm.htm.* See also: *www.lindesmith.org.*
5. National Institute on Drug Abuse. Access to Housing and Job Training Helps Recovering Homeless People Stay Drug Free, *NIDA Notes* (July/August 1997); 12(4): 7–9: *www.nida.nih.gov /NIDA_Notes*; National Institute on Alcohol Abuse and Alcoholism. Project MATCH Manuals and 1996 research findings: *http://silk.nih.gov/silk/niaaa1.*
6. Glasgow RE and Eakin EG. Issues in Diabetes Self-management in Shumaker SA, et al. (Eds). *The Handbook of Behavior Change*. New York: Springer Publishing, 1998.
7. Susser E, et al. Human Immunodeficiency Virus Sexual Risk Reduction in Homeless Men with Mental Illness, *Arch Gen Psychiatry* (March 1998); 55(3): 266–72. ■

Dealing with Substance Abuse & Dependence

James Dixon, BSW, directs the Community Health Centers' Homeless Medical Clinic in Colorado Springs, where he is actively involved in outreach to unsheltered homeless people. Substance abuse is the primary behavior that keeps them on the streets, he says.

In Dixon's experience, contact with a family member, particularly a child, is often key in motivating clients to begin recovery. "People must have a reason to change that makes sense to *them*, not just to someone else," he insists. "They also need help in gaining confidence that they *can* change. That may take awhile." To rekindle hope, he asks clients what they really enjoy doing, then helps them find a way to do it. When one client said he liked to play the guitar, Dixon helped him get one on loan. The guitar became a source of inspiration to cut back on drinking enough to get a day job, which he has kept for four months — long enough to afford a motel room.

Clients must come to the HCH clinic sober to receive non-emergent care. "Sobriety enables them to follow prescribed treatment and understand the reason for it," explains Dixon. Skeptical about harm reduction, he finds that substance abusers won't use bleach kits consistently, but when required to be sober to get services, they do it. "I want people to take responsibility for their own lives," he says. "Until they do, no behavior will change." Dixon models the accountability he wants to inspire in his clients. "If I say I'll be at camp with a coffee pot for the fire on Wednesday at 5:00, I'm there."

> "Studies have shown that at any given time, only about 20% of drug users are willing to be involved in abstinence-oriented treatment programs. In the past, we had nothing to offer the remaining 80%. We needed a lot more tools in our toolbox."
>
> **Patrice Morhart, MSW, HCH Los Angeles**

Patrice Morhart, MSW, is Clinical Director of an outpatient drug treatment program at Homeless Health Care Los Angeles, and a clinical consultant for needle exchange programs at four sites in downtown LA. She works with clients on "any behavior that influences their well being or quality of life" including substance abuse, sexual behavior and getting housing, entitlements and other services. She sees a large number of homeless injecting drug users over age 50.

"Treatment that requires abstinence is appropriate for only a certain segment of drug users," notes Morhart. "With the abstinence approach retention is poor, outcomes are not great, and you miss a lot of folks. Harm reduction is just a way of broadening our approach to substance abusers."

Morhart educates clients about proper vein care, safer drug using techniques, and how to avoid spreading infection. She distributes supplies to protect their safety — clean cotton, cookers, alcohol pads, syringes, disinfectants, vitamins, abscess kits for wound care, and citric acid. She adopts a nonjudgmental attitude to inspire trust and establish therapeutic rapport, and helps clients develop their own goals. Focusing on small changes fosters success, enhances self-esteem, and helps clients move

closer to abstinence, she says. Maintaining an ongoing relationship is essential to foster commitment to further treatment or change in drug use. "As life starts to improve, clients become more self-motivated."

Seth Ammerman, MD, is a pediatrician at Stanford University and Packard Children's Hospital. His clinical and research interests include risk-taking behaviors of medically underserved and homeless adolescents. "The biggest morbidities I see in teens are behavioral," he says. "The most widely abused substance is tobacco. Polysubstance abuse is also common."

Ammerman advises clinicians working with patients of any age to find out what their personal motives are for engaging in a particular behavior, and what they know about its risks and benefits. "Don't assume anything," he says. Motivational interviewing should be tailored to a patient's cognitive level and developmental stage.

Cognitively, early adolescents (10–13) and many mid-adolescents (14–16) are concrete thinkers. "Their own experience is their primary reality; the future is perhaps a month away. If you are discussing behavior change with young adolescents, focus on the here and now." Many adolescents don't perceive any risks in substance abuse. Warnings about eventual heart/lung disease may have no personal meaning for them, but money is a big issue. "You might ask what else they could do with money they spend on cigarettes every week."

Developmentally, young adolescents are focused on puberty and may be interested in how smoking affects their growth and development. Mid-adolescents, focused on peers and social issues, may be more concerned about how smoking makes them look or smell. "This is a good time to use peer counseling — to learn why other teens cut down on smoking and how they did it."

Normally, there is a gradual evolution into abstract thinking by late adolescence, explains Ammerman. Older adolescents (17-21) can think in months or years, understand how others' experience relates to them personally, and appreciate possible future consequences. But in times of stress, even people who are usually good abstract thinkers tend to focus on the immediate. Because substance abuse can impair abstract reasoning ability and delay social development, chronic substance abusing adults often act like adolescents. "Deal with these individuals as concrete thinkers," he advises.

To avoid turning clients off when discussing smoking, substance abuse, birth control and safe sex, Ammerman first explains what the interview will be about. "Most kids want to talk about these things. They don't find you too intrusive as long as you set the stage," he says. Another way to let patients know you are open to discussing these issues is to use a written questionnaire. "Be explicit about confidentiality. Trust is a big issue with homeless adolescents, who may have been exploited, abused or neglected by significant adults in their life. Get to know them and let them get to know you. Build trust and rapport over time." ■

PRACTICAL TIPS FOR WORKING WITH TEENS

- Speak from a health perspective, not a moral or legal perspective.
- Let clients know they have a choice.
- Point out that substance abuse may be controlling them; teens like to feel in control.
- Have clients pick one behavior to change at a time; specify a quit or reduction date.
- Don't set clients up for failure; acknowledge that habits are hard to break.
- Discuss why goals are hard to meet and how to handle particular situations better next time.

Seth Ammerman, MD,
Stanford University

Promoting Self-Management of Diabetes

Clinical Nurse Specialist **Cindy Schaefer, RNC, MSN**, is Site Coordinator at St. Anthony's, one of ECHO Community Health Care's three service sites in Evansville, Indiana. St. Anthony's is a full-service primary care provider where 25% of patients seen are homeless and the rest are very poor. Many clients move in and out of homelessness. ECHO is a participant in the Midwest Cluster of the Diabetes Collaborative, one of several chronic disease management initiatives sponsored by the Bureau of Primary Health Care.

Schaefer is actively involved in efforts to improve diabetes care by effecting changes in health care delivery systems and clinical practices, and in patient behaviors through individual and small-group interventions. At the *systems level*, direct service providers are working through small, experimental change cycles to shift the focus of clinical interventions from acute to preventive care. Results include development of multispecialty Cluster Clinics, a personal care card (portable medical record) and a resource directory for service providers to help homeless persons living with diabetes.

Individual interventions help patients recognize diabetes symptoms and learn how to control them. "Make it personal," suggests Schaefer. "Ask, 'Is your vision blurry? As your blood sugar comes down, your vision should improve.' Constant hunger and thirst make homeless people feel desperate. Meet basic needs first. Help clients figure out a way to take their medications on a regular basis, and where to store them safely." Schaefer also helps clients set realistic self-management goals, and records progress toward meeting them. Exercise, dietary control and adherence to prescribed medication are necessary to reduce blood sugar levels and prevent or reduce diabetes symptoms and complications. Because nicotine exacerbates vascular complications of uncontrolled diabetes, smoking cessation is a primary goal for many patients. "Our providers find that until smokers reduce tobacco use to one-half pack a day, nicotine patches and other drug treatments aren't effective."

Group-level interventions are used to motivate and reinforce diabetes self-management skills through education — what diabetes is, how it progresses and can be managed — and through peer support groups in which patients informally discuss what they are experiencing and how they are trying to control their disease. "Information about what works from peers may make a greater impression than advice from a clinician," remarks Schaefer.

Patients' HbA_{1c} levels are measured every three months. Results are recorded in a computer registry that enables tracking of individual and aggregate levels over time. "By trending these data, we can show our patients the real, measurable effects of their behavior changes," Schaefer explains. "Since joining the Diabetes Collaborative, our clients' HbA_{1c} levels have dropped from an average of 13.7 to 7.8 [7 is normal]. I tell

patients we can reduce their blood sugar level from 12 to 8 with medications, but only they can bring it below 7 through exercise and diet. That really hits home."

Look holistically at what is going on in your patients' lives, advises Schaefer. "Are they newly homeless and panicked? If so, you may have to deal with issues other than lifestyle changes first, such as helping them stay in one place for a week. Most homeless people are struggling to meet basic needs. You can't make behavior changes such as smoking cessation until needs for food, shelter and security are met. Don't just focus on giving directions and measuring outcomes." ■

Preventing Sexual Transmission of HIV

Ezra Susser, MD, DrPh, professor of epidemiology and psychiatry at Columbia University, heads departments at the Mailman School of Public Health and the New York State Psychiatric Institute. He also works with researchers at the HIV Center for Clinical and Behavioral Studies on preventing the sexual transmission of HIV. His recently published research focuses on severely mentally ill homeless men, most with co-morbid substance abuse disorders.[7] "Our work addressed both the ecology and illness of these homeless patients through individual and group sessions," explains Susser. The study was ethnographically based on an intimate understanding of subjects' daily lives and the use of stories that would hold their attention.

"We found that men in homeless shelters like watching videos, playing cards, and (like other men) talking about their sexual exploits," reports co-investigator **Alan Berkman, MD**. The initial intervention was called Sex, Games and Videotapes. "We made it fun and interactive by distributing cards with HIV myths on them. If clients thought a myth was true, they went to one side of the room; if false, to the other. They were also timed putting condoms on bananas. Everyone's performance improved. "Activities like these increase self-efficacy," he says. Investigators built in lots of repetition, so if clients missed a session, they could pick up key points in subsequent sessions. The curriculum is designed for use in mental health programs by anyone experienced with this population. [*To obtain published articles or a manual, call 212/740-6316 or contact Dr. Berkman at ab376@columbia.edu.*] Berkman's current work uses "peer educator activists" to reinforce learning through teaching others. "Almost no one changes behavior on the basis of information alone," he observes. "You also need motivation, repetition, positive feedback and acting out of new skills."

Pamela Collins, MD, a psychiatrist at Columbia, developed a similar intervention for mentally ill women in residential and inpatient treatment facilities, many of them formerly homeless. "Most women at highest risk for HIV are impoverished, exposed to coercion and violence, and lack autonomy in their sexual relationships," she says, "so we focus on self-initiating activities including the use of female condoms and spermicides." The approach features general sex education, discussion of ways to reduce HIV risks, practice inserting the female condom, and role-playing (how to talk to a partner or daughter). Individual training is reinforced by group sessions modeled on a talk show; clients play guests or experts, and facilitators are hosts. "Know what is really happening in your clients' lives," Collins advises clinicians. "Then try to figure out how you can help change occur within those contexts." ■

Healing Hands is a publication of Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council.
P.O. Box 60427, Nashville, Tennessee 37206-0427 ~ For membership information, call (615) 226-2292 or visit www.nhchc.org.

HCH Clinicians' Network
P.O. Box 60427
Nashville, TN 37206-0427