

# Whole-Person Care for People Experiencing Homelessness and Opioid Use Disorder: A Toolkit

**Part I: Understanding  
Homelessness and Opioid Use  
Disorder, Supporting Recovery,  
and Best Practices in  
Whole-Person Care**

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**HOMELESS &  
HOUSING  
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## I. Welcome

Welcome! We're glad you're here. Thank you for your commitment to serving people who are experiencing homelessness and opioid use disorder in your community. They are among the most systematically marginalized and excluded members of our communities.

Opioid use disorder, also known as OUD, is a complex brain disease that may be present alongside or contribute to additional mental and physical health conditions and social, relational, legal, employment, housing, and other challenges.<sup>1</sup> Like other substance use disorders, OUD is associated with a history of trauma, compounded by the deeply traumatic experience of homelessness. Having a substance use disorder can contribute to homelessness and housing instability and make it harder for people to exit homelessness. While experiencing homelessness, individuals may be unable to access, engage with, or sustain treatment and recovery-support services. Physical health concerns may further exacerbate these challenges. Far too many people experiencing homelessness and OUD face further difficulties as they navigate systems that perpetuate racism, stigma, and discrimination, which create barriers to recovery, housing stability, and overall health and well-being.

You have the opportunity to be present for and support people in what might be their greatest time of need. It is not an easy task, but it may be the most important work of your life. It can be a profound privilege to walk alongside people and elicit their hopes, marvel at their resilience and resolve, and support them as they take steps toward recovery and wellness.

This toolkit offers you information and resources to provide whole-person care for people experiencing homelessness and OUD. We hope the ideas and practices contained within these pages will be a valuable resource, helping you to further develop and deepen your knowledge and practical skills. Some of these ideas may challenge you; we also hope they inspire and energize you.

We encourage you to share this toolkit with your colleagues and bring these ideas and practices to your supervision meetings, staff meetings, and breakroom conversations. We encourage you to learn from and partner with people with lived experience in your programs and communities. They will be instrumental in helping you prioritize, strengthen, tailor, and implement the strategies in this toolkit.

## II. Whole-Person Care: A Framework for Supporting Recovery and Housing Stability

*“If trauma is disconnection, then healing is reunification or the discovery of the embodiment of that connection.” –Gabor Maté*

The whole-person care framework is rooted in best practices for serving people who are far too often mistreated and systemically marginalized. We believe this framework is essential to meet people where they are, with dignity, respect, and compassion. It is also essential to look beyond one specific issue or problem presented by an individual, and instead see the intersecting challenges and strengths that make up the whole person. We must recognize and consider these factors in partnership with the person seeking care. In this section, we will introduce six core elements of whole-person care. The following toolkit sections will help you put these concepts into practice and provide specific approaches and examples.

### Whole-Person Care: Core Elements

- Person-Centered
- Trauma-Informed and Healing-Centered
- Recovery-Oriented
- Racially Equitable
- Non-stigmatizing
- Housing-Focused

### Person-Centered

Often, we design our service systems to prioritize the needs of the system, funder, and service provider over those of people we serve. Person-centered approaches put the person and their goals at the center. To be person-centered is to partner with the people you serve and offer choices and shared decision making. Being person-centered encourages people to take an active, self-directed role and to define the goals and outcomes that matter most to them, rather than prioritizing the system or the service providers’ goals for that person. Being person-centered also requires providers to recognize and move past their own biases, assumptions, and judgments about a person and what is best for them.

### Trauma-Informed and Healing-Centered

Rates of trauma are extraordinarily high for people experiencing homelessness, as well as for people with opioid and other substance use disorders. Many have experienced violence, abuse, loss, and dislocations from an early age. Intergenerational and racial trauma also shape many lives, and disproportionately so among people experiencing homelessness. The experience of homelessness itself is traumatic, and marked by the loss of safety, stability, and community. To be a trauma-informed service provider is to root your care



in an understanding of the impact of trauma and the specific needs of trauma survivors. People can and do recover from trauma. Whole-person care offers services and environments that support healing and avoid causing additional harm. A healing-centered lens looks holistically at how individuals experience trauma and healing collectively as they pursue recovery and housing stability.<sup>2</sup>

## Recovery-Oriented

People can and do recover from substance use disorders and mental illness. Being recovery-oriented is to hold out hope, walk alongside people on their individual journeys, and connect people with a range of recovery support services. There are many pathways to recovery and no single “right” way to enter and sustain recovery. Being recovery-oriented means recognizing that recovery is a nonlinear process of change that may require different supports at different phases.<sup>3</sup> Recovery is distinct from treatment, deeply individualized, and community based.

## Racially Equitable

Centuries of discriminatory and dehumanizing practices, policies, and laws have perpetuated systemic inequity for Black, Indigenous, and people of color (BIPOC) across generations. Current-day housing segregation paired with entrenched interpersonal, institutional, and systemic racism have led to BIPOC experiencing homelessness at disproportionate rates in the United States.<sup>4</sup> Racial discrimination persists in excluding BIPOC from accessing safe and affordable housing, health care, and behavioral health treatment. It is critical to design and deliver racially equitable services and to be antiracist in our practices and policies to ensure that everyone has the supports necessary to move into, and sustain, long-term housing in communities of their choice where they can thrive.

## Non-stigmatizing

Persistent myths and misconceptions about opioid and other substance use disorders create damaging and corrosive attitudes that stigmatize people who live with this disease. People experiencing homelessness are also labeled and stigmatized. Stigma causes further damage when it becomes internalized. It creates untold barriers and challenges to engagement, wellness, and recovery. Whole-person care is the antidote to stigma. It is critical to challenge stigma with awareness and employ affirming, nonjudgmental, non-stigmatizing language, beliefs, and practices.

## Housing-Focused

Having a safe, affordable place to live is essential for people to move beyond the chaos and “survival mode” of homelessness. Once housed and with their basic needs met, people are more likely to have the capacity to begin to tap into their hopes and goals regarding how they want to live their lives. A stable place to live provides an opportunity for people living with OUD to consider moving into a process of recovery. Housing choice is critical to whole-person care. Some individuals prefer independent housing while others choose structured, supportive, or congregate settings that support their personal recovery goals. These preferences—and the person’s preferences for engaging in services and supports—may change over time.



## Whole-Person Care: Mind-Set and Heart-Set

As care providers, the “way we are” with the people we serve is vitally important. They want to know if we’re “real.” Are we trustworthy, authentic, and transparent? Are we pretending to care, or do we genuinely care?

Our mind-set and heart-set have significant influence on people’s willingness to trust us and accept the help we offer. This mind-set and heart-set must be genuine and sincere. We cannot fabricate it; we express it through our body language, nonverbal facial expressions, tone of voice, attitudes, intentions, and the words we speak. This mind-set and heart-set is what “brings life” to the helping relationship.

We offer four cornerstones for developing a mind-set and heart-set set rooted in whole-person care for people experiencing homelessness.<sup>5</sup>

### PARTNERSHIP

Partnership is rooted in a deep respect for the life experiences, strengths, hopes, and goals of the people you serve. In a partnership, you form a collaborative working relationship to help the person. Your primary expertise is as a guide who helps to elicit the person’s own motivation. You are guided by the knowledge that you *and* the people you serve bring important ideas, expertise, and wisdom to the relationship.

### ACCEPTANCE

Acceptance asks us to meet people where they are. It asks us to hold an unwavering belief in every person’s inherent worth and potential. It asks us to be empathic and seek to understand where they are coming from, how their life experiences have shaped them, and their hopes for the future. It asks us to focus on *what’s strong* rather than *what’s wrong* with people, and to honor people’s autonomy in making decisions for themselves.

### COMPASSION

Compassion asks us to recognize that we all suffer and we are all connected. It asks us to walk alongside people in their suffering and experiences of homelessness, trauma, racism, mental illness, addiction, grief, stigmatization, and denial of rights. Through compassion, we offer the gift of a safe space, sitting together, and listening wholeheartedly. With compassion, we are in solidarity, acting *for* and *with* people.

### EVOCATION

The mind-set and heart-set of evocation embodies the belief that people are the foremost experts on their own lives. Therefore, we want to evoke—literally *call forth*—from people what’s important to them,

Imagine taking a drink of a carbonated beverage that has gone flat. It still tastes vaguely like itself, but the fizz has gone out of it. It’s no longer worth drinking, and you’ll probably pour it down the drain. The spirit, or the *mind-set* and *heart-set*, of providing care is the “fizz” of whole-person care approaches. It’s what conveys that you’re genuinely interested, even delighted, in getting to know the person. It’s what demonstrates that you have the person’s best interests in mind. It’s the attitudes and beliefs about the person that we communicate. It’s the sum total of hundreds of tiny words and actions that help us feel connected to each other, human to human.



their knowledge, wisdom, and aspirations. In conversation with a person about a particular concern or change goal, we often use evoking skills such as open questions, reflective statements, affirmations, and summaries, all of which invite a person to think more deeply and elaborate on their situation.

“There is a strength, a power even, in understanding brokenness, because embracing our brokenness creates a need and desire for mercy, and perhaps a corresponding need to show mercy. When you experience mercy, you learn things that are hard to learn otherwise. You see things you can’t otherwise see; you hear things you can’t otherwise hear. You begin to recognize the humanity that resides in each of us.”

—Bryan Stevenson, *Just Mercy: A Story of Justice and Redemption*

## Learn More

[Michelle’s Story](#), Invisible People [YouTube]

[Invisible People](#) [HTML]

[My Recovery Journey: Steven Samra](#), C4 Innovations [YouTube]





# III. Understanding Homelessness and Opioid Use Disorder: Intersecting Factors and Fragmented Systems

*“The true measure of our character is how we treat the poor, the disfavored, the accused, the incarcerated, and the condemned.” –Bryan Stevenson, *Just Mercy: A Story of Justice and Redemption**

Homelessness and opioid use disorder (OUD) are distinct, although often interrelated, public health crises in the United States. These crises have been worsened by the effects of the COVID-19 pandemic, which has had a negative impact on mental health, substance use, housing stability, and economic stability for many. COVID-19 also laid bare the persistent racial inequities that drive disproportionalities in those who experience homelessness and addiction, and who can secure housing and supportive services. It is important to understand these intersecting issues and how they affect the people you serve.

## Homelessness

According to the U.S. Department of Housing and Urban Development’s (HUD’s) *2020 Annual Homeless Assessment Report to Congress*, 580,466 people were counted as homeless during the 2020 Point-in-Time (PIT) count, a 2.2 percent increase over 2019.<sup>6</sup> The actual number of people experiencing homelessness, however, is likely to be much higher, due to how homelessness is defined for this purpose (see **Who Is Considered Homeless?**).<sup>7</sup> Among this population, the prevalence of substance use disorder and mental illness is disproportionately higher than in the general population.<sup>8,9</sup> Opioid and other substance use is interrelated with homelessness, increased risk of overdose and related health conditions, as well as barriers to long-term recovery, wellness, and housing stability. One study documented a nine-fold increase in overdose risk among adults who were homeless, compared to those stably housed.<sup>10</sup>

People experience homelessness in the United States because of structural and individual factors. **Structural factors** include lack of access to affordable housing, low wages, unemployment, racism, and reductions in public funding for behavioral health services. **Individual risk factors** include mental illness, substance use disorder, a history of traumatic experiences, poverty, legal system involvement, and lesbian, gay, bisexual, transgender, and queer or

### WHO IS CONSIDERED HOMELESS?

There are multiple definitions of homelessness used in the United States. For example, the PIT count is based on HUD’s definition of literal homelessness: “An individual or family who lacks a fixed, regular, and adequate nighttime residence.” Many consider this to be a narrow definition as it does not consider people who are in unstable, precarious, or inadequate housing situations.

The Health Services Resource Administration under the U.S. Department of Health and Human Services defines homelessness to include people living in transitional or temporary housing or who are at risk of losing housing. Further complicating the picture, there are different definitions used to identify youth and students experiencing homelessness, which take into account substandard, untenable, or inadequate housing situations.



questioning (LGBTQ+) identity (especially for youth). Combined with structural factors rooted in racism, stigma, and discrimination, these social determinants increase the likelihood that someone will experience homelessness and remain unstably housed. Housing is also a key social determinant of health and people experiencing homelessness have higher rates of illness and early mortality rates than people who have housing. Poor health is both a result and a cause of homelessness, as illness and disability can rapidly lead to unemployment, poverty, and homelessness. Essentially, “homelessness is a key driver of poor health, but homelessness itself results from accumulated adverse social and economic conditions . . . . The social determinants of homelessness and health inequities are often intertwined, and long-term homelessness further exacerbates poor health.”<sup>11</sup>

While the experience of homelessness is different for everyone, it is deeply traumatic. The lack of safety and control and the myriad dangers, indignities, and threats exacerbate and compound symptoms of mental health and substance use disorder. Increasingly, housing policy makers and advocates recognize the importance not only of housing, but of long-term housing stability. In communities that lack sufficient affordable housing, time-limited housing subsidies may only leave people ping-ponging among precarious housing and homeless shelters.<sup>12,13,14</sup> Housing and service interventions must address factors that drive stability. These factors include offering services and supports that meet people *where they are* and provide an opportunity for individuals to engage in recovery-oriented activities, as they define and select them.

## Opioid Use Disorder

Across the United States, more than 10 million people over age 12 report a substance use disorder, including more than 2 million who have an OUD.<sup>15</sup> Opioid overdoses can happen as a result of misusing illicit as well as prescription drugs, including medications prescribed to treat OUD.<sup>16</sup> Recent data show that opioid overdoses have been rising rapidly since the onset of the COVID-19 pandemic in spring 2020, and were already on the rise before then, increasing by 5 percent from 2018 to 2019. In recent years, overdose risk has also grown because of synthetic opioids such as fentanyl.<sup>17</sup> A recent study found that opioid overdose is the leading cause of death among people experiencing homelessness in one city (Boston, Massachusetts), with adults age 25–44 who were experiencing homelessness being 9 times more likely to die from an overdose than those who were housed.<sup>18</sup>

Opioids are highly addictive. OUD-associated medical conditions result from behaviors related to opioid use (e.g., injection drug use) or from direct pharmacologic effects of opioid use. This distinction is key, because it underlines how much of the harm of opioid use comes from unsafe injection practices that can be addressed through harm reduction interventions (See the section “[6. Support Harm Reduction](#)”).<sup>19</sup> Medical complications of injection-drug use include hepatitis C, human immunodeficiency virus (HIV), and bacterial infections, such as skin and soft tissue infection or infective endocarditis (infection of the heart valves, lining, or muscles).<sup>20</sup>

Additional medical complications arise from the direct pharmacologic effects of opioid use. Chronic pain has a complex bidirectional relationship with OUD. Approximately 40 percent of individuals in methadone maintenance programs have chronic pain.<sup>21</sup> Additionally, researchers estimate that 10 percent of chronic pain patients misuse prescription opioids.<sup>22</sup> Individuals with OUD are also at higher risk of hypogonadism, sleep-disordered breathing, cardiovascular disease, and mortality, including myocardial infarction and stroke.<sup>23,24,25,26</sup>

Life-saving, evidence-based treatment for OUD exists and includes a combination of medication-assisted



treatments, psychosocial counseling, and recovery supports.<sup>27</sup> Access to medications, however, varies by community; systemically marginalized populations—such as people without homes, people in rural areas, or people in or exiting jails and prisons—are more likely to experience limited access.<sup>28,29</sup>

Among people experiencing homelessness, additional barriers include a lack of insurance, income, and transportation; rigid program and scheduling requirements; lack of childcare and family-centered care options; isolation and disconnection; and the need to navigate multiple systems.<sup>30,31</sup> Overall, significant gaps persist between the services needed, and services received by people with substance use disorder.<sup>32</sup> Often people with OUD as well as those experiencing homelessness face additional co-occurring physical and mental health conditions, which deepen the complexity of treatment and recovery.<sup>33</sup>

Internalized and interpersonal stigma and misperceptions about OUD compound these challenges. Many individuals with OUD, including service providers, may lack knowledge about the availability of multiple, evidence-based, person-centered pathways to treatment and recovery. These might include a range of individual and community-based supports spanning harm reduction, medication-assisted, and abstinence-based philosophies and practices, which are valid for different people at different times in their recovery journeys. The availability of housing options also varies by community. There may be limited access to recovery housing, which is a preferred choice for some individuals who are prioritizing recovery from illicit drug use. Overall, affordable housing and independent as well as supportive, low-barrier housing options remain scarce across the United States, regardless of the model.

“For many [people experiencing homelessness], survival is more important than personal growth and development, and finding food and shelter take a higher priority than drug counseling. Many [people experiencing homelessness] have also become estranged from their families and friends. Without a social support network, recovering from a substance addiction is very difficult. Even if they do break their addictions, [they] may have difficulty remaining sober while living on the streets where substances are so widely used. Unfortunately, many treatment programs focus on abstinence only programming, which is less effective than harm-reduction strategies and does not address the possibility of relapse.”  
—National Coalition for the Homeless<sup>34</sup>

## Racial Inequities

No public system in the United States is untouched by racism, including housing and behavioral health, along with broader health care, criminal justice, education, and many others. We must understand these racial disparities within the larger, historical context of systemic racism, discriminatory housing policies, and racist drug policies that have devastated Black communities.<sup>35,36,37,38,39</sup>

One of the most significant structural factors shaping who is likely to experience homelessness in the



United States is racism. There are significant racial disparities in who experiences homelessness.<sup>40,41</sup> Black, Indigenous, and people of color (BIPOC) are disproportionately more likely to experience homelessness than white people. Black Americans are three times more likely to experience homelessness than the general population. Black people make up 13.4 percent of the general population, but make up 39 percent of the homeless population.<sup>42,43</sup> Comparatively, white Americans make up 76.3 percent of the general population, but only 48.3 percent of the homeless population.<sup>44,45</sup> Overrepresentation of Black people experiencing homelessness is consistent in every state and 98 percent of continuums of care (CoCs).<sup>46</sup> Indigenous and people of color are also disproportionately represented among people experiencing homelessness. Native Americans are four times more likely; and Pacific Islanders are nine times more likely to experience homelessness than white people.<sup>47</sup>

Black Americans have been systematically excluded from accessing quality, affordable housing through Jim Crow laws, racial restrictive covenants, redlining, and other discriminatory practices that created residential racial segregation in American cities. Such policies targeted specific racial and ethnic groups for exclusion from the possibility of home ownership and the opportunity for intergenerational wealth accumulation.<sup>48,49,50</sup> Research shows that racial residential segregation relates to a range of structural inequities such as poverty, life expectancy, educational outcomes, and economic mobility. BIPOC Americans who grow up in racially segregated neighborhoods are less likely to have access to quality housing, education, nutrition, health care, employment, and other opportunities enjoyed by white people growing up in racially segregated neighborhoods.<sup>51</sup>

While the opioid overdose epidemic disproportionately affects white people, OUD is increasingly affecting communities of color, which are less likely to receive evidence-based treatment and more likely to be criminalized for opioid use. Since 2000, opioid overdose deaths have nearly doubled among Black people.<sup>52</sup> While opioid overdose rates in general decreased between 2017 and 2018, they increased among Black and Latinx people over the same period.<sup>53</sup> This finding suggests that prevention, treatment, harm reduction, and recovery supports for OUD are not reaching BIPOC communities. There are racial disparities in who has access to the medications approved for OUD treatment, with Black people being less likely to have access to buprenorphine and methadone.<sup>54</sup>

Black people are more likely to be criminalized for drug use than white people. While Black people represent 12 percent of those who use drugs, they represent 38 percent of those arrested for drug offenses, and are 10 times more likely to be incarcerated for their drug use than white people.<sup>55</sup> In effect, Black people with OUD are more likely to be incarcerated rather than receive services, while white people are more likely to receive treatment.<sup>56,57,58</sup>

## Learn More

[\*Addressing the Opioid Epidemic: How the Opioid Crisis Affects Homeless Populations\*, National Health Care for the Homeless Council](#)

[\*Opioid Abuse and Homelessness\*, National Alliance to End Homelessness](#)

[\*Racial Inequalities in Homelessness, by the Numbers\*, National Alliance to End Homelessness](#)

[\*The Roots of Structural Racism\*, Othering and Belonging Institute](#)



## IV. Supporting Recovery

### Understanding Recovery

People can and do recover from opioid use disorder. Recovery looks different for everyone – there is no one-size-fits-all approach. Supporting recovery for those experiencing OUD requires a commitment to supporting multiple pathways to recovery and the recognition that what may work for one person may not be effective for another. There is no single *correct* pathway to recovery.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a “process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” This process of change is highly individualized. Therefore, the activities, services, and philosophies—the things that support a person’s recovery—will look very different for each person you serve. Since each individual attempting recovery is unique, recovery pathways must be adaptable and customizable over time.

Behavioral, spiritual, psychological, cultural, and other needs all drive which pathway a person chooses, as do economic resources.<sup>59</sup> Access to transportation and available services also play a role. Different supports may be required at different phases in the recovery journey, so adaptability and customization of supports are critical to sustain an individual’s recovery. These individualized pathways are important both in honoring the needs and desires of the person seeking recovery, as well as providing them with choices and options to consider for their recovery journey.

SAMHSA identifies 10 guiding principles of recovery. As service providers, it is important to fully immerse ourselves in these principles and consider how we integrate them in our work. How might you modify your interactions with service participants to align with these guiding principles?

1. **Recovery emerges from hope.** *We hold out hope for everyone, no matter how little hope they have for themselves. How do we communicate hope to others?*
2. **Recovery is person driven.** *We center the person, their needs, desires, and strengths, as well as support self-determination and self-direction. How can we incorporate shared decision making in our practice?*
3. **Recovery occurs via many pathways.** *We offer and affirm all pathways to recovery. There are no “wrong” pathways to recovery. No single approach is better than another. How can we learn about recovery resources for different pathways that might be available in our community?*
4. **Recovery is holistic.** *Recovery affects every area of a person’s life, and recovery supports must address the whole person— mind, body, spirit, and community—on their journey toward recovery. Are we seeing the whole person when we meet with participants?*
5. **Recovery is supported by peers and allies.** *Peers who have “been there” offer unique, valuable support and help people believe that recovery is possible. How can we incorporate peer support across service offerings?*
6. **Recovery is supported through relationship and social networks.** *People recover in communities through social connection and support. How can we support connection for people who are disconnected?*



7. **Recovery is culturally based and influenced.** *Recovery supports must resonate and align with an individual's cultural values, beliefs, and practices. What community partners might help to offer a range of culturally responsive recovery support services (e.g., churches, cultural associations, community groups)?*
8. **Recovery is supported by addressing trauma.** *Recovery supports must be trauma informed. How are we incorporating trauma-informed approaches in our interactions with participants?*
9. **Recovery involves individual, family, and community strengths and responsibility.** *Individuals, family members, and communities have responsibilities for supporting recovery and devoting resources to provide opportunities for recovery. How can we support the involvement of family and community members who can offer social support on the recovery journey?*
10. **Recovery is based on respect.** *Recovery is supported through respect that transcends stigma and discrimination against people with substance use disorders. How are we taking steps to address and reduce stigma against people with OUD who are experiencing homelessness?*

## Recovery and Medications for OUD

There are three U.S. Food and Drug Administration (FDA)-approved medications for treating OUD that require a prescription: methadone, naltrexone, and buprenorphine. Federal rules and regulations govern how they are prescribed. Given their role in recovery pathways, medications merit a brief overview in this section.

Medication for opioid use disorder (MOUD) refers to taking medications alone for treatment of OUD. Medication-assisted treatment (MAT), also called medication-assisted recovery (MAR), involves taking medication combined with counseling, behavioral therapies, peer support, or other supports. Historically, medications were seen as an add-on to other addiction treatment modalities (hence *medication-assisted*). That view has changed since new research emerged to underscore the effectiveness of MOUD.<sup>60</sup> MOUD, MAT, and MAR are all evidence-based treatment and recovery pathways.

Medications for treating OUD can be taken on a short- or long-term basis. There is no standard length of treatment, and they may be taken long-term, similar to how people manage chronic conditions like diabetes or high blood pressure by taking maintenance medications. There is no one-size-fits-all approach to treating OUD with medication. If a person is taking medications on a long-term basis, they are considered to be in recovery and remission from OUD.

There are many [misconceptions and myths](#) about medications for OUD, however, that lead to stigma and discrimination against people who use medications as part of their recovery pathway. It is important to affirm that people who take medications to treat opioid use disorder are in recovery.





## LEARN MORE

[10 Common Myths About Opioid Use Disorder](#), RIZE Massachusetts [YouTube]

[Myths and Misconceptions: Medications for Opioid Use Disorder \(MOUD\)](#), Providers Clinical Support System, SAMHSA [HTML]

[Know Your Rights for Individuals on Medication-Assisted Treatment](#), SAMHSA [PDF]

[Decisions in Recovery: Treatment for Opioid Use Disorders](#), SAMHSA [HTML]

[Medications for Opioid Use Disorder: TIP 63](#), SAMHSA [HTML]

## Recovery Supports

Distinct from treatment services, recovery supports are nonclinical, strengths-based, and community-based. They are highly individualized and should be flexible and customizable, as an individual's needs for support often change over time. They provide structure, connection, community, purpose, as well as the emotional and practical support needed to sustain recovery and create a stable and healthy life in recovery.

Recovery support services include 12-step groups like Alcoholics Anonymous or Narcotics Anonymous, but they should not be limited to them. Ideally, service providers offer people a full menu of recovery support services and let people try different approaches to determine which combinations of supports are most helpful. However, the availability of recovery support services varies across communities.

Recovery support services can be tangible, instrumental supports such as housing, childcare, or transportation. They also include mutual aid groups, life-skills support, employment or education supports, legal assistance, or connections with a recovery community and sober social activities. Assisting people with navigating and accessing available resources and services is itself a valuable recovery support service. Recovery supports may also include exercise, mind-body practices, volunteer work, hobbies, religion or spiritual traditions, and community roles. Essentially, a *recovery support* is anything that supports an individual's recovery.

In this section, we describe essential recovery support services that should be part of the continuum of recovery services in your community. If you do not already have a list of available recovery support services and referrals, we encourage you to reach out to community partners and collaborate to create a community-specific directory of recovery services that can be posted online, in public places, and shared with people experiencing homelessness and OUD, as well as the people who serve them.



## Reflection Questions: Recovery-Oriented Practice

- Do you believe that recovery from OUD is possible?
- Do you believe there is only one “right” pathway to recovery from OUD?
- Is your approach to serving the program participant driven by your goals, your employer’s goals, or by the person’s own goals?
- Do you have friends, colleagues, or people in your professional network who are in recovery from OUD who share their wisdom and experience with you?
- What words do you use to describe people with OUD?
- Are you aware of and able to refer participants to the full range of available recovery supports in the community (that ideally reflect multiple pathways)? How might you learn more about available recovery supports?

## Peer Support

*Peer support workers*—also called *peer recovery coaches* or *peer specialists*—are people in recovery from substance use disorders or mental illness who are trained to use their lived experience skillfully in supporting others on their recovery journeys. Peer support workers bring their own experience of recovery to inspire hope that recovery is possible. They are uniquely positioned to engage people with OUD, help them understand and explore options, connect them with community resources, and problem-solve challenges. They walk beside people on their recovery journey and provide validation, multiple forms of support, and self-help education, and link people to tools and resources.

*Peer support* for people contemplating entering recovery or in recovery from a substance use disorder can be broken down into four types:

1. **emotional**, *showing that they care, offering empathy and compassion for an individual’s challenges;*
2. **informational**, *providing accurate, nonbiased information about recovery, services, and supports;*
3. **instrumental**, *helping people navigate their recovery journey and connecting them with resources, such as housing, health care, benefits, legal assistance, food, and clothing; and*
4. **affiliational**, *connecting people with a community of people in recovery and recovery-focused social activities.*

Peer support services are always strengths-based, person-centered, empowering, respectful, and voluntary. Peer support workers work in a range of settings that may include behavioral health agencies, recovery community organizations, drug courts, hospital emergency departments, or mobile crisis response units. They may work one-on-one, as part of a team, or by facilitating support groups.





## LEARN MORE

[Peers Supporting Recovery from Substance Use Disorder, SAMHSA's Bringing Recovery Support to Scale Technical Assistance Center Strategy \[PDF\]](#)

[Recuperación de Trastornos de Consumo de Sustancias Con El Apoyo de Pares, SAMHSA's Bringing Recovery Support to Scale Technical Assistance Center Strategy \[PDF\]](#)

[National Practice Guidelines for Peer Specialists and Supervisors, National Association of Peer Supporters \[PDF\]](#)

[Peer Support Toolkit, City of Philadelphia Department of Behavioral Health and Intellectual disABILITY Services \[PDF\]](#)

## RECOVERY COMMUNITY ORGANIZATIONS

Recovery community organizations (RCOs) are grassroots nonprofit organizations led by people in recovery, family members, and recovery allies. While RCOs vary in structure and services, they typically share a commitment to peer support in all forms; participatory, person-centered, and inclusive processes; recovery advocacy; and multiple pathways to recovery. Find out if there is a RCO or recovery community center in your community. They can be an enormously valuable source of recovery support, community connection, and education for the people you serve. There is no comprehensive national directory of RCOs, however, the [Association of Recovery Community Organizations](#) lists its member organizations and there are a few state-level directories of RCOs.

## LEARN MORE

[Association of Recovery Community Organizations: Members on the Map, Faces and Voices of Recovery \[HTML\]](#)

## MUTUAL AID SUPPORT GROUPS

Recovery-focused mutual aid groups are perhaps the most well-known form of recovery support. They are based on mutuality and *peerness*: people who share the same problem or struggle who meet regularly to support each other and exchange information. There are many different types of mutual aid groups, including those for friends and family members of people with a substance use disorder. Traditionally, groups meet in person. As a result of the COVID-19 pandemic, however, a large number of groups now offer online formats, increasing access for those with an internet connection and device. The following list describes various types of mutual aid groups. It is not exhaustive.

**12-Step Mutual Aid:** These are the most widely available groups and include [Alcoholics Anonymous](#), [Narcotics Anonymous](#), and [Double Trouble in Recovery](#), among others. They follow a structured, step-based framework; require abstinence; and typically involve a sponsor and the person's commitment to surrender to a higher power.

**Secular Mutual Aid:** Groups adhere to an explicitly non-spiritual, nonreligious approach to recovery



and follow a variety of formats. Examples include [Secular Organizations for Sobriety \(SOS\)](#), [Women for Sobriety](#), [LifeRing](#), and [SMART Recovery](#).

**Faith-Based, Nonsecular Mutual Aid:** These groups vary, but all focus on a spiritual or religious pathway to recovery that can be specific to one tradition or nondenominational. Their structure and processes vary. Examples include [Buddhist Recovery Network](#), [Celebrate Recovery](#), [Jews in the Rooms](#), [Millati Islami](#), and [Overcomers Outreach](#).

**All Recovery Mutual Aid:** Groups are typically found at recovery community organizations and do not follow any formal framework. They offer a welcoming space for individuals to connect and support one another, regardless of their recovery pathway.

**Physical Activity Mutual Aid:** This form of mutual aid focuses on exercise and physical activity as a key recovery support. [The Phoenix](#) is one example.

**Medication-Supported Mutual Aid Groups:** While many of these groups may be informal and limited to large cities, they focus on mutual support among people using medications as part of their recovery. [Medication-Assisted Recovery Anonymous](#) is a group that draws from the 12-step tradition.

## LEARN MORE

[Guide to Mutual Aid Resources, Faces and Voices of Recovery \[HTML\]](#)

## RECOVERY HOUSING

Recovery housing provides a safe and stable place to live while recovering and is very important to prevent homelessness, which can cause relapse and other complications. Also called *sober homes* or *recovery residences*, recovery housing typically offers mutual aid and peer support and requires abstinence. The size, structure, level of support, and quality can vary considerably across different recovery residences, as do state regulations governing them. There are no federal regulations for recovery housing. In addition, there are often length of stay limits. The [National Alliance for Recovery Residences \(NARR\)](#), along with its state affiliates, promotes a code of ethics, certification, standards, and best practices for recovery housing.

Due to historical roots in the 12-step tradition, many recovery residences are reluctant to accept people using medication as part of their treatment and recovery pathway. Recovery residences typically exclude people using any psychoactive substance and strive to minimize the risks of drug diversion, which could cause harm to the entire community. As a consequence, there is often limited availability of recovery housing for people who are taking medication as part of their recovery pathway. It also can further stigmatize and exclude them, perpetuating [myths and misconceptions](#). There is a need to develop recovery residences that are MOUD- or MAT-proficient and inclusive.<sup>61</sup>



## LEARN MORE

[Recovery Housing and Homelessness, Changing the Conversation Podcast \[HTML\]](#)

[Helping Recovery Residences Adapt to Support People with Medication-Assisted Recovery, National Alliance for Recovery Residences, National Council for Behavioral Health, and C4 Innovations \[PDF\]](#)

[Choice Matters: Housing Models That May Promote Recovery for Individuals and Families Facing Opioid Use Disorder, U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy \[PDF\]](#)

## RECOVERY CAPITAL

You may have heard the term *recovery capital*. It refers to the resources—physical, emotional, social, relational—that help support individuals entering and sustaining recovery. Recovery capital will look different for everyone. It is often broken into three categories: personal, family/social, and community.

**Personal recovery capital:** This encompasses an individual’s available physical and personal resources. It includes access to housing, health care, transportation, food, and economic resources. A person’s personal resources include their attitudes, abilities, skills, and knowledge, as well as their sense of meaning and purpose.

**Family/social recovery capital:** This category includes social and familial relationships that support recovery, as well as access to a supportive community of people who are in recovery or recovery-focused social events.

**Community recovery capital:** Communities have an important role in creating recovery-friendly environments. A community with rich recovery capital offers a full continuum of treatment and recovery services, including peer support, recovery community organizations, and other resources that reduce stigma and help people enter and maintain recovery.

As service providers, our role is to help build community recovery capital by providing recovery-oriented services and supports, affirming that recovery is possible, addressing stigma and discrimination, and supporting clients to build their recovery capital. We must be very careful to avoid assuming that there are certain recovery capital requirements or that a lack of recovery capital means that someone will not sustain recovery. Recovery is a dynamic, complex, individualized process and there are no rules about the types or amounts of recovery capital that will lead to sustained recovery. There are many factors that influence an individual’s experience entering and sustaining recovery.

## LEARN MORE

[My Experience in a Medication-Assisted Treatment \(MAT\) Program: Steven Samra, C4 Innovations \[YouTube\]](#)



# V. Whole-Person Care: Best Practices

“Best practices are done for or with people, not on or to them.”—adapted from William R. Miller<sup>62</sup>

In this section of the toolkit, we’ll dive into best practices for whole-person care. Each section includes information about challenges faced by people with opioid use disorder who are experiencing homelessness, and offers strategies, approaches, and resources to deepen your knowledge and practice of whole-person care. We’ll cover the following eight areas of best practice:

1. *Use person-first language*
2. *Practice cultural humility*
3. *Understand and reduce stigma*
4. *Be trauma-informed and healing-centered*
5. *Take a whole person approach to outreach and screening*
6. *Support harm reduction*
7. *Understand how people change*
8. *Maintain healthy boundaries*

## 1. Use Person-First Language

“Words are important. If you want to care for something, you call it a ‘flower’; if you want to kill something, you call it a ‘weed.’” —Don Coyhis

So often we use words without really thinking about what they mean and convey. Yet, our words may unintentionally reflect damaging beliefs and project them onto the people we serve. This harmful language can also have an impact on program design, policies, funding, and systems. Words create meaning and shape reality. The dismissive labels our society often uses to describe people experiencing homelessness or opioid use disorder express explicit and implicit biases toward substance use, people with substance use disorders, and homelessness.<sup>64</sup> Stigma and stigmatizing language perpetuate these biases, which can pose barriers to accessing and engaging in substance use treatment and receiving quality care.<sup>65</sup>

Labels also keep us from seeing the whole person in all of their complexity. Labeling people obscures

### REFLECTION: CASE MANAGER

Think of the job title *case manager*. What cases are being managed? Are they people reduced to being considered only as occurrences of diseases or conditions (that is, *cases*)?<sup>63</sup> Contrast this with the role of “people manager,” which is typically a human resources specialist working in a business environment. Why are some people considered *cases* and other people considered *people*?

Further, the term *manager* implies that such cases are entities to be managed. What would it look like to describe our roles as *supporters, partners, or navigators*? How can we be more person-centered?



their value and worth as human beings and fellow community members. We must move beyond these labels and use language that always puts the person before the condition. We call this person-first language. When speaking of OUD, we can use medically accurate language that describes it as a medical disease, like diabetes or cancer. Labels such as *addict* or *abuser* or *junkie* reflect and reinforce ignorance and stigma rather than actually describing a person’s medical condition.

In fact, research shows that using positive terms such as *person with a substance use disorder* or *person with an opioid use disorder* generates a stronger positive implicit bias than traditional, stigmatizing language such as *addict* or *opioid addict*.<sup>66</sup>

Table 1: Non-stigmatizing Language<sup>67</sup>

Words to Use	Words to Avoid
<b>person experiencing homelessness, person who is unhoused</b>	the homeless, homeless person, street person, hobo
<b>person with disabilities</b>	handicapped, disabled, special needs, crippled
<b>person with a substance use disorder</b>	addict, substance abuser, drug abuser, user, junkie, druggie, drunk, abuser, alcoholic
<b>person with an opioid use disorder</b>	oxy-addict, meth-head
<b>person in recovery</b>	ex-addict, former user, former addict
<b>substance use disorder, opioid use disorder, addiction</b>	substance abuse, addictive disorders, drug habit, problem, abuse
<b>medication for opioid use disorder or MOUD</b>	substitution or replacement therapy, substituting one drug for another
<b>positive or negative</b> (when referring to toxicology screen results)	clean, dirty

Person-first language always puts the person before the descriptor, like saying *people experiencing homelessness* instead of *the homeless* or *homeless people*. By putting the person first, we help to slowly chip away at deeply embedded implicit and explicit biases. When we talk about *the homeless*, it’s easy to have an “us” versus “them” mind-set. This language fosters the belief that *they* are different from *us*.

It’s important to remember that homelessness or OUD are just single experiences out of many in a person’s life. They are not the defining features of a person’s life. No one deserves to be defined by one experience. While person-first language may sometimes feel awkward, it conveys respect and views someone as a whole person, not a condition. It is 100 percent worth the effort to struggle with using it.

We challenge you to spend some time observing the language you use or hear others using daily to describe the people you serve. What patterns do you see? What shifts can you make? Consider reviewing the language encoded in your organization’s intake forms, signage, and policies. What do these words convey?

What are ways that you can raise awareness with others about the negative impact of stigmatizing language and offer person-centered, recovery-oriented alternatives?



## LEARN MORE

[Words Matter](#), The Grayken Center for Addiction, Boston Medical Center [PDF]

[Homelessness 101: Person-Centered Language—What Is It?](#), Coalition for the Homeless [PDF]

[People First Language Articles](#), Disability Is Natural [HTML]

## 2. Understand and Reduce Stigma

### THE LIVED EXPERIENCE OF STIGMA

After entering recovery in 1999 from homelessness, complex trauma, substance use, criminal justice involvement, and mental health challenges, Steven began medication-assisted treatment in 2000 for OUD. These are his words.

*Drugs didn't kill me. It was the stigma that almost killed me. Fentanyl never killed me because I knew the risks of fentanyl.*

*What almost killed me was what I was hearing from my 12-step brothers and sisters—my own people, my community—saying MAT would not be good for me. They told me that using methadone is “replacing one drug for another,” “it’s social control,” “methadone is not ‘real’ recovery.” And I was hearing this from people I admired and trusted who were in recovery. Who would know better than them? I put off joining the program for a long time, and during that time, I overdosed on heroin three times.*

*If you are a person experiencing OUD who is also experiencing homelessness, your first contact with the treatment system is usually an outreach worker. Understandably, lots of folks are not going to be open about the scariest and most vulnerable truths in their lives at that first point of contact. This outreach worker or case manager is a stranger, and they may be operating under their own stigmatized beliefs, asking you questions: “What’s wrong with you? You should do the 12 steps. You should be in treatment. You’re going to kill yourself if you keep using.”*

*When I was a case worker, I saw this all the time: services were used coercively; mandating that people successfully attend 90 12-Step meetings in 90 days in order to even be eligible for housing services. That is impossible for anyone, never mind when you are experiencing homelessness or withdrawal symptoms or both. And every time you aren’t able to meet the impossible standards, you lose faith in the system and your ability to recover.*

*Many providers don’t believe you can recover. They may never say they don’t believe in you, but from how they look at you and talk to you, you know. You absolutely know.*



## WHAT IS STIGMA?

Stigma is a composite of ignorance, prejudice, and discrimination. It is the judgment, disdain, and ostracization cultivated and directed toward people marginalized by society. Stigma interferes with an individual's societal participation while denying them dignity and self-respect. Stigma overlaps with racism and discrimination, but it differs in a few respects. While race can be a stigmatized status, the stigma concept encompasses many statuses and characteristics, such as disability, gender identity, sexual orientation, HIV status, and housing status. We must be aware of the compounding corrosive effects on our service participants who hold multiple stigmatized identities.<sup>68</sup>

Stigma creates one of the primary barriers to treatment for OUD.<sup>69</sup> It is essential to recognize and acknowledge the burden of stigma on the people we serve, as well as on those who refuse to engage with services. Stigma's impact on treatment access and participation can destroy self-esteem, isolate, and marginalize those trying to seek treatment, and create a pervasive sense of hopelessness. Misconceptions about substance use disorder generate and sustain damaging attitudes that stigmatize people who live with this disease. We can encounter these beliefs anywhere. For example, when hospitalized for an overdose, some doctors and nurses may express shaming and blaming attitudes toward the patient. Often, healthcare staff lack sufficient education or training to fully understand the disease of substance use disorder and what supports recovery. We must assume that the people we serve have experienced treatment and interactions that were not trauma-informed, person-centered, or evidence-based.

In addition, there are those who stigmatize certain pathways of recovery, such as medication for OUD, even within communities of recovery. As Steven's narrative describes, some people feel strongly that their own pathway to recovery is the only *right* pathway. This attitude can be damaging as it negates the value of multiple pathways of recovery and shames those who need different types of support. In particular, MAT or MOUD pathways have been misunderstood and stigmatized, especially in groups that have prioritized abstinence from all substances, including prescribed medication to address behavioral health concerns. Further, people experiencing homelessness typically encounter stigma, disenfranchisement, and blame for their circumstances.

These attitudes can cause tremendous damage. We must be aware of the ways in which the people we serve regularly encounter intersectional stigmas that compound to make interactions with service providers and treatment systems challenging and often traumatizing. This can also lead to internalized stigma, adding to the difficulty in seeking and sustaining engagement with services and other supportive resources.

Stigma falls into three types, described in Table 2. It is critical to understand the different types of stigmas, and how they intersect and compound each other:

- Self-stigma
- Interpersonal or community stigma
- Institutional or societal stigma





Table 2: Definitions of Three Types of Stigma

Stigma Type	Definition
Micro or internalized <b>self-stigma</b>	The judgments and negative opinions people who are the recipients of public or societal stigma hold about themselves. People internalize the stigma they encounter and receive and begin to believe they are true, developing the structures of shame and guilt that can cause isolation, loss of will, and feelings of hopelessness and worthlessness.
Public <b>interpersonal and community stigma</b>	The attitudes and feelings expressed by many in the public toward people with OUD. These include family and community ties, relationships with peers and, in some cases, those who provide treatment and care. Public stigma involves three processes: <ul style="list-style-type: none"> <li>• Identifying differences</li> <li>• Connecting those differences to stereotypes</li> <li>• Separating <i>us</i> from <i>them</i>, ensuring that the stigmatized individual or group experiences a marked loss in social status</li> </ul>
Macro or structural <b>institutional and societal stigma</b>	The laws, policies, protocols, and practices that produce and maintain stigma at local, regional, and national levels—and within institutions and organizations such as in healthcare and legal settings. This stigma can result in reduced resources, exclusion from decision-making bodies, and diminishing rights to privacy and self-determination.

## PRACTICES TO REDUCE STIGMA

There are many ways that we can reduce the burden of stigma on those we serve. We can start by examining our own internalized stigma and the ways we see interpersonal and societal stigma reflected in service delivery. Building an awareness of the corrosive effects of stigma can help us understand why it is so vital to always treat people with OUD who are experiencing homelessness with dignity and respect.

We must view the people we serve holistically, by learning about their histories and appreciating their strengths, resiliencies, humor, creativity, resourcefulness, and other unique qualities. As we see and appreciate the whole picture of each unique individual, we break down the barriers that allow us to *otherize* people and begin to build authentic connections.

We must be evidence-based in our information and attitudes. We must be informed and aware of the way that we and others talk about OUD and its treatment and recovery. We must base our information on science and take the time to correct misconceptions about OUD when we hear them. Education and awareness are the best antidotes for stigma.

Think about how you work with peer support workers—also called peer recovery coaches or peer specialists—and view their lived experience of substance use disorders and recovery. Do you see their *experiential credential* of lived experience on equal footing with academic degrees? Do you defer to their judgment or expertise? Uplifting people who have recovered from OUD is a powerful way to reduce stigma and inspire those who doubt recovery is possible. Peer support workers are critical in this work. In addition to partnering as





an equal with peer support workers, you can make space for people to share their recovery journeys and how they encountered stigma and the ways they continued to move forward in the face of stigma and shame. You can partner with people in recovery to tell their stories, demonstrating that recovery is possible.

Table 3 provides an overview of ways to reduce stigma, from the built environment to the way we interact with people we serve.

Table 3: Practices to Reduce Stigma

Practice Area	Questions and Considerations
<b>The building and entrance</b>	<input type="checkbox"/> Is the reception area or entryway welcoming and inviting? <input type="checkbox"/> Is it a place you want to be? <input type="checkbox"/> Is the building accessible? <input type="checkbox"/> Are there comfortable places to sit?
<b>Warm welcome</b>	<input type="checkbox"/> How are people received when they enter the building? <input type="checkbox"/> Are they greeted with dignity, kindness, and respect? <input type="checkbox"/> Are they given clear directions?
<b>Messaging and language</b>	<input type="checkbox"/> Are you using science-based, non-stigmatizing language to describe OUD? <input type="checkbox"/> Is the available literature non-stigmatizing? <input type="checkbox"/> Do posters and decorations deliver positive and affirming messages? (Or do they broadcast punitive attitudes, such as <i>Drink and Drive and You're Going to Jail?</i> ) <input type="checkbox"/> Do your mission statement, policies, brochures, and participant forms communicate respect, affirmation, and positive regard for individuals with OUD? Consider reviewing these materials for stigmatizing language and replacing them with more inclusive language.
<b>Sessions</b>	<input type="checkbox"/> When meeting with people, do you slow down and be present for their experience, meeting them where they are? <input type="checkbox"/> Do you attune to the experiences of the person you are serving, taking into consideration that they may be having a trauma response, experiencing withdrawal, or processing the side effects of these experiences? <input type="checkbox"/> Are you talking about OUD, treatment, and recovery with science-based strategies?
<b>Peer involvement</b>	<input type="checkbox"/> Is peer support part of your program? <input type="checkbox"/> Do you share sources of hope or models of possibility where feasible with those you are serving?
<b>Multiple pathways</b>	<input type="checkbox"/> Does the person you are serving know their treatment options (such as MAT, harm reduction, or 12-step programs)? <input type="checkbox"/> Are options presented in an unbiased manner? <input type="checkbox"/> How are you empowering people to make their own decisions?



## LEARN MORE

[Recovery Oriented Language Guide](#), Mental Health Coordinating Council [PDF]

[“Stigma and the Toll of Addiction,”](#) Nora D. Volkow, The New England Journal of Medicine [PDF]

[Words Matter: How Language Choice Can Reduce Stigma](#), SAMHSA [PDF]

### 3. Practice Cultural Humility

A person’s cultural identity and beliefs shape how they experience illness and wellness, and how they view substances, substance use, and the recovery supports that resonate with them. As service providers, our own cultural identities and beliefs influence how we approach and deliver services. *Culture* is the framework through which people see and make sense of the world. It is complex and fluid. Age, race, ethnicity, class, gender identity, sexual orientation, socioeconomic status, national origin, immigration experiences, and other identities and experiences further shape cultural identity.

We can be unaware of the ways that culture molds our own beliefs and values because our cultural *lenses* create our version of what is the *norm*, especially if our norm aligns with the dominant cultural group in our society. As service providers working with people from diverse backgrounds, it is important that we cultivate awareness of how our own cultural identity, experiences, and beliefs shape the assumptions and values we bring to our work. This awareness is fundamental if we are to understand others’ experiences more fully. We must learn to step back and think critically about what experiences shape us and why.<sup>73,74</sup>

This reflection process is at the heart of practicing cultural humility. It involves critical self-awareness of our assumptions, beliefs, and values. We start by looking at our own social environment and upbringing, and how they shape the way we see the world, those we serve, our motivations for doing this work, our goals, and how we see homelessness and OUD. It is an ongoing process of lifelong learning with no end point. Through the practice of cultural humility, we strive to offer culturally responsive services that welcome, honor, and respond to people from diverse cultural, social, and linguistic backgrounds.<sup>75</sup>

Cultural humility requires us to question our assumptions. In the United States, for example, *whiteness* is often the unspoken norm and white people do not learn to see whiteness as a cultural formation that espouses certain values and beliefs above others. For white people, learning to see whiteness and put it side by side—rather than above or below—other cultural, racial, and ethnic identities is a critical step in practicing cultural humility. It is important to note that a person does not need to be white to have

#### DEFINITIONS

**Cultural humility:** A lifelong process of awareness, reflection, and self-critique to learn about other cultures that begins with an examination of our own cultural identities and beliefs. Entering relationships with others with the intent to honor their values, beliefs, and customs.<sup>70,71</sup>

**Cultural responsiveness:** Being culturally aware of how your personal values and biases may influence your perceptions of people you serve, their problems, and your professional or therapeutic relationship. Having cultural skills that enable you to respond in a way that is respectful, culturally sensitive, and relevant.<sup>72</sup>



internalized the values of whiteness.

Cultural humility helps us to excavate our implicit and explicit biases. We all have implicit and explicit biases. An *implicit bias* is an unconscious association, belief, or attitude toward any social group that developed through our cultural socialization. In contrast, *explicit biases* are conscious associations. Implicit biases lead people to unconsciously attribute certain qualities or characteristics to all members of a particular group, a phenomenon known as *stereotyping*. In fact, research shows that implicit bias is often a stronger predictor behavior and decision making than our explicit beliefs.<sup>76,77</sup>

Implicit bias gives us a framework for understanding the underlying factors driving overt racism in our society. Challenging implicit bias can help us align our good intentions with our desired outcomes. To learn more about implicit bias, take the [test designed by the Project Implicit](#) researchers. You may want to share the test with colleagues, discuss your results, and consider changes you might make to your practice.

In sum, practicing cultural humility means not making assumptions about people and their experiences, beliefs, and cultural identity based on how they present or other preconceived notions. It entails asking questions respectfully and being willing to learn from people. It means committing to an ongoing process of self-reflection, awareness, and self-critique and showing respect, openness, humility, and a willingness to learn in all our interactions with the people we serve.

“Recovery is culturally based and influenced. Culture and cultural background in all its diverse representations—including values, traditions, and beliefs—are keys in determining a person’s journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet everyone’s unique needs.”

—SAMHSA’s Working Definition of Recovery

## LEARN MORE

[3 Things to Know: Cultural Humility](#), Hogg Foundation for Mental Health [HTML]

[Talking About Race: Whiteness](#), National Museum of African American History and Culture [HTML]

[Implicit Association Test](#), Project Implicit [HTML]



## 4. Be Trauma-Informed and Healing-Centered<sup>i</sup>

| “Trauma that is not transformed is transmitted.” –Richard Rohr

Some people experience very few traumatic events in their lives. Others experience chronic traumatic stress that often starts in early childhood and can have a major impact on how they understand themselves, view the world, and interact with others. It is very likely that the people you serve have experienced significant trauma exposure in their lives. People who have experienced multiple traumatic events might not relate to the world in the same way as those who haven't. It is important to provide trauma-informed and healing-centered services and responses that are uniquely sensitive to the needs of those who have experienced trauma.<sup>79</sup>

### DEFINITION

**Trauma-informed care:** A strengths-based service delivery approach grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.<sup>78</sup>

We consider an experience to be *traumatic* if it involves a threat to one's physical or emotional well-being, is overwhelming, results in intense feelings of fear and lack of control, and leaves people feeling helpless. Ultimately, it changes how a person feels about themselves, others, and the external world. Be aware of the impact of race-based traumatic stress on Black, Indigenous, and people of color participants that results from accumulated experiences of racism and discrimination. It is often unrecognized and underappreciated in our society, leaving those experiencing it with little support. Every episode of racially motivated violence—especially those that receive extensive media coverage—may exacerbate trauma.

People can recover from trauma, and we can provide services and environments that support healing. To be *trauma informed* is to root your care in an understanding of the impact of trauma and the specific needs of trauma survivors. Healing-centered engagement expands the trauma-informed lens to move beyond the focus on individuals and to take a more holistic approach. It recognizes that trauma is not only an individual experience, but a collective one; that we need to treat individuals while also addressing the root causes of trauma in neighborhoods, families, schools, and other institutions. We also must look beyond the impact of trauma and find ways to create new opportunities and foster growth and well-being.<sup>80</sup>

It is important to be able to contextualize a person's behaviors in their lived experience and collaborate with them to identify the services and supports that will promote safety and healing. Above all, we must strive to avoid causing additional harm to those we serve. A framework for providing trauma-informed, healing-centered care includes these aspects:

- understanding trauma and its effects,
- creating safe physical and emotional spaces,
- supporting control and choice, and
- integrating trauma-informed care across services and systems.

i. Content in this section is adapted from trauma-informed care training and technical assistance materials prepared for SAMHSA by C4 Innovations (formerly the Center for Social Innovation) under the Homelessness Resource Center contract (contract number HHSS280200600029C), with permission from the authors.



## UNDERSTANDING TRAUMA AND ITS IMPACT

Understanding traumatic stress and its impact is essential. Trauma survivors, particularly those who have experienced early childhood trauma or developmental trauma, often develop a set of survival skills that help them to manage past trauma. These survival strategies (like substance use, withdrawal, aggression, or self-harm) make sense given what people have experienced. But they can be confusing and frustrating to others and often get in the way of current goals.

Without an understanding of trauma, providers may view those they serve in negative ways. Providers might describe behaviors as *manipulative*, *oppositional*, or *unmotivated*. Yet, it may be better to understand these behaviors as strategies to manage overwhelming feelings and situations. Trauma-informed training can help service providers understand these responses, react with compassion, and view them in broader context.

## PROMOTING PHYSICAL AND EMOTIONAL SAFETY

Traumatic experiences often leave people feeling unsafe and distrustful of others. Creating a sense of physical and emotional safety is an essential first step to building effective, helping relationships. Here are examples of safe physical environments:

- Well-lit spaces
- Security systems
- The ability for individuals to lock doors and windows
- Prominently posted information about rights and policies
- Culturally familiar signs and decorations
- Child-friendly spaces that include objects for self-soothing

These practices can help create a safe emotional environment:

- Providing consistent, prompt, and respectful responses to individuals
- Asking people their preferences; specifically, what works and what does not work for them
- Being clear about how you will use personal information
- Permitting people to engage in their own cultural and spiritual rituals
- Providing opportunities to participate in group activities that promote agency and community

## SUPPORTING CONTROL AND CHOICE

Situations that leave people feeling helpless, fearful, or out of control remind them of past traumatic

“Racial oppression is a traumatic form of interpersonal violence which can lacerate the spirit, scar the soul, and puncture the psyche. Without a clear and descriptive language to describe this experience, those who suffer cannot coherently convey their pain, let alone heal.”

—Kenneth V. Hardy



experiences and leave them feeling re-traumatized. Here are some ways to help individuals regain a sense of control over their daily lives:

- Teach emotional self-regulation skills, such as breathing exercises and techniques for grounding and soothing
- Keep individuals well informed about all aspects of their care
- Provide opportunities for input into decisions about how a program runs
- Give people control over their own spaces and physical belongings
- Collaborate in setting service goals
- Assist in ways that are respectful of and specific to people’s cultural values
- Maintain an overall awareness of and respect for basic human rights and freedoms

## INTEGRATING CARE ACROSS SERVICE SYSTEMS

Becoming trauma-informed means adopting a holistic view of care and recognizing the connections between housing, employment, mental and physical health, substance use, and trauma histories. It means working with community partners in housing, education, child welfare, early intervention, and mental health. Partnerships enhance communication among providers and help minimize participants’ experiences of conflicting goals and requirements, duplicated efforts, or feeling overwhelmed by bureaucracy, red tape, and the different rules and requirements across systems or services. These connections help build relationships and resources to provide the best quality of care possible. Becoming trauma informed means a transformation in the way that providers meet the needs of those they serve. These ideas are only a beginning. Change happens as organizations and providers take these ideas, in combination with their own, and use them to evaluate and adapt their approaches to care.<sup>81</sup>

### LEARN MORE

[\*The Future of Healing: Shifting from Trauma Informed Care to Healing Centered Engagement\*, Shawn Ginright \[HTML\]](#)

[\*Healing the Hidden Wounds of Racial Trauma\*, Kenneth V. Hardy \[PDF\]](#)

[\*Understanding Trauma, Addiction, and the Path to Healing: A Conversation with Gabor Maté\*, Be Here Now Network \[HTML\]](#)

## 5. Take a Whole-Person Approach to Outreach and Screening

Assertive, compassionate outreach and engagement are essential for helping people experiencing homelessness connect with needed support, services, and resources. It involves contacting people who are living in abandoned buildings, parks, encampments, vehicles, culvert pipes, under bridges, on the streets, or in other places. Many people living in these places do not receive services by site-based homeless services and feel disconnected, alienated, and marginalized.

Whole-person outreach is low-threshold, person centered, non-stigmatizing, racially equitable, trauma



informed, and housing centered, using the framework and approach described in this toolkit. The emphasis is on building trusting relationships through believing in people’s inherent worth and potential, using non-stigmatizing language, demonstrating respect, and becoming aware of the impact of stigma, trauma, and racism on the people you meet. Developing positive, trusting relationships is essential in facilitating access to basic and urgent services, supports, and care for individuals who are unable or unwilling to visit an emergency shelter or homeless services provider.<sup>82</sup>

## CORE ELEMENTS OF EFFECTIVE STREET OUTREACH TO PEOPLE EXPERIENCING HOMELESSNESS

The United States Interagency Council on Homelessness created [a resource](#) that defines and describes four core areas of best practices for effective street outreach:

1. Street outreach efforts are systematic, coordinated, and comprehensive.
2. Street outreach efforts are housing focused.
3. Street outreach efforts are person-centered, trauma-informed, and culturally responsive.
4. Street efforts emphasize safety and reduce harm.

## LEARN MORE

*Core Elements of Effective Street Outreach to People Experiencing Homelessness*, U.S. Interagency Council on Homelessness [HTML]

*Tips for Outreach Workers by Outreach Workers*, Homeless Hub [HTML]

*Initial Contact (episode 1) PATH Street Outreach Video Series*, SAMHSA [YouTube]

*Follow Up Visit (episode 2) PATH Street Outreach Video Series*, SAMHSA [YouTube]

*Connecting People with Services (episode 3) PATH Street Outreach Video Series*, SAMHSA [YouTube]

*PATH Street Outreach Video Series Discussion Guide*, PATH, SAMHSA [PDF]

## ON SCREENING AND ASSESSMENT

The U.S. Department of Housing and Urban Development requires communities and regions to partner with their Continuum of Care (CoC), the body that coordinates homeless services in their area. As part of this approach, CoCs must have a Coordinated Entry System that is responsible for outreach, intake, and assessment of people experiencing homelessness and link them with appropriate services and housing. The goal of this approach is to ensure that CoCs prioritize resources for those with the greatest needs, and that people efficiently link to services appropriate for their situation.

Each community may determine which screening and assessment tool works best for their context. You’ll likely be using the screening and assessment tools used by the CoC in your community. Within the whole-person care framework, it’s particularly important to take a trauma-informed, person-centered, non-





stigmatizing approach to screening and assessment. It's also important to situate screening and assessment tools in a larger framework of racial equity, and to ask questions about who benefits and who doesn't from the use of certain screening tools.

The most commonly used assessment in the United States is the Vulnerability Index–Service Prioritization Decision Assistance Tool, or VI–SPDAT.<sup>83</sup> Developed as a multipurpose tool, many CoCs decided to use it to assess need for the Coordinated Entry System. Recent analysis, however, found that VI–SPDAT creates prioritization patterns that are not racially equitable.<sup>84</sup> Despite being overrepresented in Coordinated Entry Systems compared to the general population, BIPOC, particularly Black individuals, are 32 percent less likely than white individuals to receive a high prioritization score. This means that they are less likely to get priority access to permanent supportive housing. Further, the subscales do not equitably capture vulnerabilities across races, and most subscales tilt toward capturing vulnerabilities that white people are more likely to have.<sup>85</sup>

This analysis prompts us to think critically about the tools we use, the way that we build biases into seemingly neutral tools, and the unintended negative consequences for those we serve. If your community is using the VI–SPDAT, share the racial equity analysis with providers in your CoC, and discuss including other factors for prioritization. Communities can also conduct their own community-specific racial equity analyses to identify patterns and create solutions that address inequities. HUD's [COC Racial Equity Analysis Tool](#) helps communities identify groups of people disproportionately represented among people experiencing homelessness and begins to analyze the contextual factors that may be causing these disparities.

## CHARACTERISTICS OF EFFECTIVE OUTREACH WORKERS

**Flexible.** Able to readily change directions, literally and figuratively, as needed.

**Nonjudgmental.** Able to suspend or refrain from making judgments based on one's own personal opinions, biases, or standards; involves accepting people "where they're at;" different from approval.

**Respectful.** To regard as worthy; words and behavior must be congruent.

**Relaxed.** Easy to talk with and able to initiate conversation in a nonthreatening manner.

**Tactful.** Able to help people acquire services without alienating other service providers; able to treat law enforcement as allies while still defending the rights of individuals they serve.

**Patient and assertive.** Capable of employing both characteristics concurrently.

**Resourceful.** Able to find creative ways to engage people and meet their needs.

**Centered, grounded.** Has a healthy sense of self and boundaries.

**Calm and clear-headed.** Able to react using both characteristics in emergency situations.

**Cautious and alert.** Aware of possible danger.

**Independent and able to take initiative.** Capable of operating on one's own while being strong team players.

—adapted from *Organizing Health Services for Homeless People* by Marsha McMurray-Avila (1997)





## LEARN MORE

[A Guide to GPRA Data Collection Using Trauma-informed Interviewing Skills, SAMHSA \[PDF\]](#)

[CoC Analysis Tool: Race and Ethnicity, U.S. Department of Housing and Urban Development \[HTML\]](#)

[Coordinated Entry Systems Racial Equity Analysis of Assessment Data, Catriona Wilkey, Rosie Donegan, Svetlana Yampolskaya, & Regina Cannon, C4 Innovations \[PDF\]](#)

## 6. Support Harm Reduction

*Harm reduction* recognizes, for better or worse, that substance use is part of our world. It focuses on minimizing the *harm* associated with substance use, instead of rejecting or condemning those who use substances. It acknowledges that traditional abstinence-only approaches will not reach everyone and that we need additional approaches. Harm reduction attempts to meet people where they are and measures success not by sobriety, but by positive behavior change, no matter how small, upon which we can build future recovery efforts.

Taking a harm-reduction approach means that we recognize the limitations of forcing someone into sobriety and honor a person's autonomy in deciding their own path and timeline. It means we believe that all people are capable of change and will do so when they are ready and when their circumstances allow. In the meantime, harm-reduction interventions focus on keeping them safe, healthy, and alive. For example, people who inject drugs are at risk of a range of serious health issues associated with unsafe injection practices. By teaching people safe injection practices, we reduce their risk of contracting and spreading infectious diseases such as hepatitis C and HIV. Safe injection practices also reduce the risk of bacterial infections, including endocarditis.<sup>86</sup>

Although harm reduction practices—such as giving clean needles to someone who is injecting drugs or giving condoms to someone engaging in sex work—may seem counterintuitive on the surface, the effectiveness of these interventions is undeniable. Among many benefits, the Centers for Disease Control and Prevention found that persons who access harm-reduction services, such as needle exchange programs, are three times more likely to quit injecting substances and access treatment.<sup>87</sup> The power of harm reduction may lie in its ability to navigate the underlying forces at play that are driving addictive behaviors.

Harm reduction acknowledges the reality that substance use is not simply about *making poor choices*, a premise on which many traditional treatment interventions have been built. Rather, it appreciates that there are many factors leading a person to use substances, including experiences of poverty, racism, and discrimination, as well as individual factors like biology, social isolation, and traumatic experiences.

We must acknowledge that blaming and shaming approaches of the past may have only compounded a person's trauma and feelings of isolation and shame, inadvertently perpetuating the addictive behaviors. As service providers, it is critical to examine our own attitudes and practices—and those of our organization and colleagues—to see what remnants of punitive, shaming attitudes toward people who use substances might still be present. These attitudes—often reflected in TV, movies, news media, and other social media—predominate among American cultural values. These attitudes persist, despite the latest research showing that substance use disorder is a chronic and treatable medical condition, and that addiction is a brain disorder caused by complex interplay among biology, environment, and behavior.<sup>88</sup>



In contrast, taking a harm-reduction approach acknowledges substance use disorder as the complex disease it is, and responds by offering nonjudgmental, compassionate, person-centered care. We accept the person just as they are, actively using or not, and seek to support them in whatever ways *they* decide are useful and feasible. As service providers, our primary goal is to provide this consistent positive regard. Over time, this approach will begin to dismantle feelings of shame, which in turn, begins to loosen the compulsion to use.

Harm reduction allows us to build trust and develop relationships with the people we serve, who are often distrustful and skittish due to past experiences of discrimination, shaming, and rejection from family members, treatment systems, and society at large. As case managers using harm-reduction strategies, we become a safe space where a person can and will turn to when they are ready to make a change.

## HARM-REDUCTION STRATEGIES FOR OPIOID USE DISORDER

There are three focal areas for harm reduction for people with opioid use disorder:

1. *injection safety,*
2. *overdose prevention, and*
3. *infectious disease transmission.*

For each area, we list multiple strategies for reducing harm and protecting people who are using substances. Bear in mind that not all strategies will work for everyone, so we provide a menu of options so participants can choose what works best for them.

Remember, this is just a starting point. These are strategies that have proven helpful to many people with OUD, but each person's needs are unique. Don't be afraid to be creative when it comes to developing tailored harm-reduction strategies. Sometimes the magic happens outside the box.

### Injection Safety

- Understand that some injection sites are more dangerous than others:
  - ↳ arms are safest,
  - ↳ hands and feet are less safe, and
  - ↳ the groin, neck, and head areas are very risky places to inject.
- Rotate injection sites to protect veins.
- Use a tourniquet to make preferred veins easier to find.
- Wash hands and use an alcohol swab to clean the injection site to prevent bacterial infections.
- Use a new needle every time. Needles quickly become dull, potentially causing damage to veins.
- Use the thinnest (highest gauge) needle possible to make the smallest possible puncture wound.
- Use sterile water to dissolve substances for injection to minimize bacteria exposure.
- Use new filter, cooker, and other injection equipment each time to prevent the growth of bacteria and spread of infectious diseases.



## Overdose Prevention

- Don't use alone. Use with a friend, FaceTime with a trusted person, or use apps, such as Brave, that provide supervised consumption through technology anytime.
- Stay with the same dealer. Obviously, we do not hold dealers to medical standards, but you are more likely to know what you're getting from someone you have bought from before.
- Go low and slow. Use small amounts of the substance at a time and slowly build on your high to give yourself a chance to see how it's going to affect you.
- Use only one substance at a time. Avoid mixing drugs, if at all possible, especially benzodiazepines, alcohol, or other respiratory depressants.
- Keep naloxone (NARCAN®) nearby and visible. It doesn't do you any good if it is in your pocket and no one knows it's there. Keep it in your lap or near you where another person can see it.
  - ↘ Most needle exchange programs distribute naloxone.
  - ↘ You can purchase naloxone at major pharmacies without a prescription, and most insurance plans cover it.

## Infectious Disease Transmission

- Use clean needles and injection equipment.
- Keep a personal supply of injection equipment (do not share).
- If sharing injection equipment, use early in line.
- Take pre-exposure prophylaxis (PrEP), a daily oral medication that reduces your risk of getting HIV if you are exposed to the virus.
- Use condoms or other barriers to prevent transmission of body fluids.
- Use lube to prevent tearing and reduce the risk of blood exposure.
- Get tested on a regular basis for infectious diseases such as hepatitis C, HIV, and sexually transmitted infections.
- If testing finds an active infection, get treatment to protect your health and prevent further spread of disease.

### LEARN MORE

[What Is Harm Reduction?](#), Harm Reduction International [HTML]

[SAMHSA Opioid Overdose Prevention Toolkit](#), SAMHSA [PDF]

[Access Harm Reduction Overdose Prevention and Education Program Participant Guide](#), Boston Public Health Commission [PDF]

[Find Harm Reduction Resources Near You](#), National Harm Reduction Coalition [HTML]



## 7. Understand How People Change

### WHAT DOES IT MEAN TO HELP?

How do we support people in making positive changes in their lives? Even under the best of circumstances, we know that change is difficult. It's even more daunting for individuals with opioid use disorder who lack stable housing. One starting point is to look at our role in supporting people through change: *What does it mean to help?*

A common assumption is that helping others means giving them your best advice (usually with the expectation that they'll act upon it). Of course, if they don't, it's their fault. It turns out that this method is rarely effective unless a person genuinely wants your advice. Most people are *less* interested in what we think they should do, and *more* interested in talking about their situation with someone who listens and seeks to understand them.

When we engage in advice-giving that attempts to persuade, convince, entice, cajole, bribe, guilt-trip, or use other means to *get* people to change, it often results in people digging in their heels and defending the status quo. These conventional helping methods, however well-intended, are coercive by nature. *People don't like being pressured to change, even when it's in their best interest.* The desire for autonomy runs deep and efforts to persuade others to change are usually counterproductive.

As *helpers*, we need to start by acknowledging that we do not have the power to change people. We can only change ourselves, and that's hard enough! Others might change their behavior temporarily in reaction to what we say or do. Motivation for *lasting change* must come from within a person, not from without.

We may be unable to change people, but we *can* make a difference in their motivation to consider change based on how skillfully we facilitate conversations about change. This is where our power lies. As the author Madeline Hunter says, "They say you can lead a horse to water but you can't make him drink. But I say, you can salt the oats!" It's our task to help program participants become thirsty for change.

### MOTIVATIONAL INTERVIEWING

The evidence-based practice *motivational interviewing* (MI) offers a particularly valuable set of principles and skills to help you partner with participants in exploring change. MI is a way of talking with people about change: "a collaborative conversation style for strengthening a person's own motivation and commitment to change."<sup>89</sup> In other words, it is a way of helping people talk themselves into changing.

The MI approach grew out of the treatment context for people with alcohol use disorder. In 1983, an article by psychologist William R. Miller first described the techniques. Historically, especially in the United States, a highly confrontational, shame-based approach characterized treatment for substance use disorder. Providers believed that this approach would erode people's denial so that they would come to their senses and recognize their need to change. Not surprisingly, this approach was mostly ineffective.

With the 1991 publication of William R. Miller and Stephen Rollnick's formative book, *Motivational Interviewing*, service providers learned an alternative way to engage people with substance use disorders—*helping conversations*. The authors described a way of interacting based on a particular conversation style and use of specific communication skills and strategies.

The second edition published in 2002, *Motivational Interviewing: Preparing People for Change*, further refined the MI approach, provided an emerging research base for MI, and described its use in new settings



including health care, behavioral health, corrections, and schools. A third edition (2013), *Motivational Interviewing: Helping People Change*, expanded the original MI approach and included new concepts and strategies. Today, a robust body of research and practice supports MI, which is practiced around the world.

MI takes the view that people have difficulty changing because they feel two ways about it: they're ambivalent. Part of them wants to change *and* part of them has reasons not to change.

- *"I want to get housing, and yet I'm not sure I could handle it."*
- *"Heroin help ease my pain while I'm on the streets, but I can't keep going like this."*
- *"I'd like to get a job, but who's going to hire somebody like me?"*

Ambivalence is quite normal and we all experience it. Sometimes, however, we get stuck going back-and-forth between feelings for long periods without being able to resolve the dilemma.

In MI, once we identify a concern or change goal, we become a guide, helping explore the person's ambivalence, and more importantly, eliciting the individual's own motivation to change. Typically, we discuss areas like these:

- Their reasons for considering change
- Possible risks and benefits of making change
- How they might go about making the change in order to be successful
- How important or urgent the need is to change
- The individual's level of confidence in moving forward
- Who else could help support the change
- Possible next steps

Find a colleague or friend and try the Taste of Motivational Interviewing activity to get a sense of what this type of conversation is like.

### **ACTIVITY: A TASTE OF MOTIVATIONAL INTERVIEWING**

Pair up with someone for a brief conversation. One of you will be the Speaker and the other will be the Listener.

#### Speaker Instructions

Talk about a change you're considering making or dilemma you're facing.

#### Listener Instructions

Invite the Speaker to talk about a change they're considering making or a dilemma they're facing.

Listen carefully with a *goal of understanding* the Speaker's situation or dilemma.

Give *no advice*; let the Speaker be their own expert.



Ask these questions and listen with interest to each response:

- *Why* would you want to make this change?
- *What* would be at stake if you don't change?
- *How* might you go about it to succeed?
- *What* are your three best reasons to do it?
- *Who* could support you?

Give a *short summary* of what you heard the speaker say about their motivations for change.

Then ask, *So what, if anything, do you think you'll do?*

The intent of MI is to create a natural, flowing conversation between two people where they explore a particular issue or concern. While not formulaic or scripted, a MI conversation does feature the following key ingredients artfully mixed together:

- Four elements of the underlying *spirit of motivational interviewing*
- Four processes that guide the conversation
- Four core conversational skills
- Seven aspects of *change talk*

## MI SPIRIT: FOUR ELEMENTS

The mind-set and heart-set of whole-person care, as mentioned previously, are adapted from and inspired by MI's *way of being*:

**Partnership.** Collaborating with the participant's own expertise.

**Acceptance.** Communicating empathy and affirmation.

**Compassion.** Standing in solidarity with people and their difficulties; promoting their welfare, giving priority to their needs.

**Evocation.** Eliciting the participant's own perspectives and motivation.

## FOUR PROCESSES TO GUIDE A CONVERSATION

MI conversations have purpose and direction. They seek to help people identify and explore their hopes, values, and change goals using an empathic, guiding approach. This guiding approach generally moves through four processes that tend to be sequential. Here are sample questions used in the four processes of motivational conversations:

**Engaging** – Establishing a relational foundation; getting to know someone and building trust; understanding that this is an ongoing process.

- Upon meeting for the first time: "It's good to meet you. What would you like me to know about yourself?"



- “It’s good to see you again. What’s been going okay? What’s been hard?”
- “How did your appointment with Social Security go? How was your visit to the clinic?”
- “What’s been on your mind lately?”
- “As you look to the future, what are some things you’re hoping for?”

**Focusing** – Finding a strategic direction; figuring out where to focus attention.

- “What’s most important to you to focus on today?”
- “Would you be interested in working together to find a safe, affordable place to live?”
- “I’m concerned about that cough/abscess/limp. Can we talk about what you’re doing to take care of it?”
- “Would it be OK if we talked a bit about your use of substances?”

**Evoking** – Helping people prepare for change; drawing out their own desires, reasons, and ability to change (with a focus on opioid use).

- “What role do opioids play in your life?”
- “What do opioids do for you?”
- “What concerns, if any, do you have about using opioids?”
- “If you were to seek treatment, what would be a few reasons for doing so? What benefits do you think treatment might have?”
- “What approach do you think would work best for you?”
- “Given everything else in your life, how important is it to you to address your opioid use?”
- “How confident are you that you could make a change?”

**Planning** – Moving toward action; developing a specific change plan that the person is willing to implement

- “What next step(s) are you able and willing to take?”
- “How can I and others support you?”

## OARS: FOUR CONVERSATIONAL SKILLS

### Open Questions

Open questions invite people to reflect on various aspects of their lives and express their hopes, ideas, thoughts, and feelings. Open questions gather information (versus facts), create an open, nonjudgmental tone, demonstrate genuine interest and respect for the person, invite reflection and elaboration, and affirm autonomy and self-direction.

### Affirmations

Affirmations are statements that recognize the good stuff about a person. They emphasize people’s



strengths more than their deficits, and focus on their efforts more than their achievements. Affirmations must be genuine. They are typically observational statements about a person's behaviors, attitudes, qualities, knowledge, skills, and efforts. Affirmations often help people recognize strengths they have difficulty seeing for themselves. They can also build a person's confidence in being able to change.

## Reflections

Reflections are statements that *bend back* to people what we hear them saying in an effort to understand *where they're coming from*. In other words, to see the world through the other person's eyes. This kind of listening means giving a person your full attention. We do this with our words, actions, and body language. Reflective listening is the cornerstone skill of MI.

## Summaries

Summaries are a series of statements that draw together two or more things that someone has said previously. It is basically a paragraph of selected reflective statements. Deciding what to include in a summary depends on the situation. The statements might include a combination of conveying understanding, noting a person's ambivalence, and highlighting the person's change talk. Offer summaries at various times in a conversation to draw ideas together and guide the conversation.

## SEVEN ASPECTS OF CHANGE TALK

When using MI techniques, we want to keep our ears attuned to what participants are saying, particularly when it comes to the *language of change*. Linguists have identified seven main ways in which people express their interest in changing, or what MI calls *change talk*. Research shows that when people talk in a meaningful way about changing, they are more likely to enact change. We want to recognize these various aspects of change talk and invite participants to elaborate on them.

It's worth noting that change talk is not always easy to evoke or identify. Often, change talk comes attached to language about keeping things the same, or not changing, called *sustain talk*. Sustain talk is one side of ambivalence; change talk is the other. When we hear sustain talk, we shouldn't ignore it. Instead, we acknowledge it in order to show understanding while giving our primary attention to the change talk side of ambivalence. Change talk related to a particular topic often begins with the following sentence stems:

### *Preparatory change talk:*

- **D**esire to change (I want, like, wish)
- **A**bility to change (I can, could)
- **R**easons to change (if . . . then)
- **N**eed to change (I have to, got to)

### *Mobilizing change talk:*

- **C**ommitment (I will, I promised myself . . .)
- **A**ctivation (I'm willing, I'm ready to)
- **T**aking steps (I went to a support meeting)

In summary, whenever we enter into a conversation with someone about a particular change or change





goal, it's important to incorporate the spirit, processes, and skills of MI to elicit and explore why and how people might change. We encourage you to continue building your MI knowledge and skills through reading, participating in MI training opportunities, watching videos, and practicing skills with coaching and accurate feedback.

## LEARN MORE

[\*Building Motivational Interviewing Skills: A Practitioner Workbook \(2nd Ed.\)\*, David Rosengren \[HTML\]](#)

[\*Introduction to Motivational Interviewing\*, Bill Matulich \[YouTube\]](#)

[\*Motivational Interviewing Network of Trainers \(MINT\)\*, MINT \[HTML\]](#)

[\*Motivational Interviewing: Helping People Change \(3rd Ed.\)\*, William Miller & Stephen Rollnick \[HTML\]](#)

[\*Motivational Interviewing Resources\*, Psychwire \[HTML\]](#)

[\*William Miller on Motivation Interviewing\*, SDS Psychotherapy Training \[YouTube\]](#)

[\*William Miller on the Righting Reflex\*, The Change Companies \[Vimeo\]](#)

## 8. Maintain Healthy Boundaries

Understanding the importance of maintaining healthy boundaries helps service providers deliver the best care possible, recognize *gray areas*, and avoid stress and misconduct. In human services, boundaries are guidelines for maintaining a positive and helpful relationship with participants. They serve as a container of sorts, where the service provider–participant relationship occurs. Boundaries help us to have a clear understanding of the limits and responsibilities of our role as a service provider.

The Nevada Board of Nursing describes boundaries as “The space between the professionals’ power and the [participant’s] vulnerability.” Boundaries set limits that create a safe connection centered on the participant’s needs. Boundaries are also the lines we draw between our work and personal lives. Boundaries are critical for self-care. They help us create space and time away from our professional roles and tasks to rest, relax, and recharge.

Boundaries are important because they protect both the service provider and the person we are serving. We hold boundaries to protect the therapeutic process and create a safe space for the relationship between the person served and the service provider. The professional relationship is one where you act on behalf of the participant, putting their interests ahead of your own. It is your responsibility to act in good faith. It’s not like a mutual friendship, and even minor boundary transgressions can send mixed messages. A boundary symbolizes the limits of a professional relationship.

Boundaries are critical for ethical practice and protecting participants from exploitation or harm. They help reduce anxiety on both the person served and the provider because they make roles, rules, and expectations clear. They help model healthy relationships and communication and protect the physical and emotional safety of both parties. Boundaries are vital for the well-being of human service providers who are at high risk for secondary traumatic stress and burn-out. They help to maintain our physical and emotional safety. They can also protect us in the event that a participant makes a false claim against us.



Some boundaries in our work represent ethical lines that we should never cross include the following:

- Don't engage in sexual behaviors with program participants
- Don't use drugs with them
- Don't benefit financially or exploit participants in any way
- Don't keep secrets with participants that you're not willing to tell your supervisor

These and other boundary violations are nonnegotiable.

Other boundaries we encounter in our work represent gray areas that are not always clear-cut. Knowing how to respond when facing areas or situations that lack clearly defined characteristics requires thoughtful discernment and consideration of the context, often in consultation with a supervisor. Examples of areas where we need to proceed with caution include the following:

- Disclosing personal information about yourself
- Engaging in physical contact such as hugs
- Frequently thinking about a participant outside of work
- Socializing with participants outside of work via chance meetings or belonging to the same group, organization, or faith community
- Going "above and beyond" for a participant
- Over-identifying with a participant's situation and thus losing objectivity
- Following one another or interacting on social media
- Being defensive or making excuses when someone comments on or questions your interactions with a participant

There are a range of strategies you can employ to maintain healthy boundaries. One important starting point is to slow down and listen to both your gut and head. If something feels "off" or not quite right, it's time to talk to your supervisor or a trusted colleague to get a second opinion. Working in isolation is often a factor in ethical violations. It's important to connect with your professional support network and ask those you trust to weigh in on sticky situations that involve a person you serve.

Other strategies for maintaining healthy boundaries:

- Examine your motivations
- Lean back on your agency policies and professional code of ethics and conduct
- Discuss the situation with a supervisor or colleague instead of filling the gaps by yourself if you are not consistently meeting a participant's needs
- Get support; talk to your supervisor, call your Employee Assistance Program, or seek therapy
- Prioritize self-care; find ways to nurture yourself and meet your personal needs in other areas of your life
- Take time away from your job to rejuvenate
- Explain boundaries and why they are important to program participants



## BOUNDARY QUESTIONS TO ASK YOURSELF

- Is this in the participant’s best interest?
- Whose needs are being served? Does this action benefit me rather than the participant?
- How would I feel telling a colleague or supervisor about this?
- Am I comfortable in documenting this decision or behavior in the participant’s file?
- How would this be viewed by the participant’s family or significant other?
- Does the participant mean something “special” to me?
- Am I taking advantage of the participant?
- What is the risk of exploitation (for me or the participant)?
- Will this have an impact on the service I am delivering?
- Am I treating this participant differently than other participants (e.g., appointment length, time of appointments, extent of personal disclosures)?
- Does this go against regulations, written Standards of Professional Conduct, or the Code of Ethics for the certifying group I belong to, etc.?

## Putting It into Practice: Some Final Words

Some of these ideas and approaches may feel new or different. We hope you will take time to absorb the information in this toolkit and reflect on how you might begin to incorporate it into your work. We recommend selecting an idea or approach that you feel naturally drawn toward to implement into your practice. Set yourself up for success by starting with a practice that is accessible to you and feels achievable. It can be challenging to do this work alone. Consider sharing the toolkit with a colleague and pairing up as implementation partners. You could work together or separately to incorporate different aspects of these practices into your work and meet regularly to share what you are learning, discuss the challenges you encounter, and support each other.

## Next Up

In Part 2 of the toolkit, we’ll dive into understanding the neurobiology of addiction, reviewing opioid use disorder treatment and recovery, navigating service systems, collaborating with community partners, understanding housing models, and supporting housing stability and recovery.



## Endnotes

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