Moving Forward Together

By Laura Prescott & Leah Harris

Introduction

Homelessness is traumatic. Like other traumatic experiences such as interpersonal violence, natural disaster, and wartime conflict, the impact of homelessness is devastating. Coupled with the loss of a place to call home is the loss of emotional comfort found in predictability and the ability to control decisions about one's life. These traumas result in disconnection from self and others, undermining self-efficacy, sense of safety, control, power, and choice. And yet, despite the staggering toll that homelessness takes on individuals, families, and our nation as a whole, there is much promise in the recovery of people with these experiences.

The Value of Recovery

What does it mean to recover from experiences of homelessness, trauma, psychiatric distress, and substance use? What is the relationship between consumer integration and recovery in the delivery of services to people who are homeless? While each person must define a personal process or journey of recovery, there are some themes commonly reported among people around the world: Hope, being believed, finding meaning in the experiences, giving back, and "recognition as a whole human being rather than being reduced to a label."

Ten Components of Recovery

- Hope
- Self direction
- Strengths base
- Person-centeredness
- Peer support
- Empowerment
- Respect
- Holistic
- Responsibility
- Non-linearity

In order to support people in reclaiming their lives, it is important to create environments that foster respect, break down hierarchies, and share power with those receiving services. This process requires a paradigm shift from a traditional service delivery approach to recovery-based approach. It begins with changing assumptions. Rather than seeing people as "sick," "diseased," or "disabled," it means seeing people as complex human beings with capabilities and strengths as well as struggles. Being recovery-oriented means believing that recovery can happen for everyone, no matter how vulnerable they appear to be at any given time. It means holding out hope for people who no longer can, because the research shows that people can and do recover (Harding et al., 1987, 1994; Huber, 1975; DeSisto et al., 1995) with and without intervention (de Girolamo, 1996). Agencies that create integrated environments where consumers are active partners send potent messages that recovery is possible to staff, people receiving services, and the community at large. Involving consumers at all levels honors recovery and provides strong, tangible evidence that healing is possible. People in recovery become living testimonies inspiring others and providing access to support. Their presence affirms possibilities and breaks down stereotypes that so often flourish in the absence of people with lived experience.

Over and over, consumers say, 'if they can do it, so can I!'
Testimony from provider agency

Integrating People Provides Hope and Improves the Quality of Services

With the integration of consumers into the fabric of homeless service planning, policy, and delivery, the resulting collaboration makes systems more sensitive and responsive, improving the quality of care (Consumer Practitioners in PATH-Funded Pro-

grams, 2006; Barrow et al., 2007; Van Tosh, 1993). It also fosters hope for those receiving services and those providing them. Moving Forward, Together presents a vision of strong partnerships with consumers at every organizational level.

"Having consumers work at the agency is of great value to us because it provides people (consumers and staff) with a sense of purpose, you can just see it, and it's infectious."

A major tension in the field of homelessness is balancing the scarcity of resources with the objective of fully integrating consumers in service delivery. The authors acknowledge that the standards this series sets are high, perhaps beyond the ability of some organizations and agencies that must operate from day-to-day in resource scarce environments. However, that by itself is no reason to aim for goals that are more modest; higher expectations yield higher outcomes for both individuals and organizations (Cotton, 1989; Good, 1987).

The Power of Language: Why Use the Term "Consumer"?

People who experience homelessness are not a homogenous group. They come from a broad cultural, racial, and linguistic spectrum, representing a diversity of genders, ages, abilities, health needs, and backgrounds. Many have co-occurring mental health and substance use disorders in addition to the impact of trauma. However, the common dominator among them is the grip of extreme poverty. The use of the term "consumer" is often in the context of mental health; some prefer other identifiers. "Survivor" refers to the fact that many individuals survived violence, psychiatric distress, homelessness, or the re-traumatizing effects of services.

Other common identifiers include:

- people in recovery
- people who are formerly homeless
- clients
- ex-patients (denoting time in psychiatric facilities)
- recipients
- users

Currently, there is no single term that captures all those experiences. In an effort to respect the varied ways people describe themselves, this series broadens the traditional use of the term "consumer" beyond its usual mental health connotation. In this series, the term "consumer" represents a person with past or present experiences of homelessness, who also may have histories of: substance use; psychiatric disability; and/or histories of trauma.

Early Support for Integration Efforts

Over the last thirty years, mental health and substance use organizations led the way in encouraging consumer integration in service development, delivery, and evaluation as part of an effort to create recovery-oriented environments that are person-centered and trauma-informed.

In 1996, the Health Care Centers Consolidations Act required Health Care for the Homeless grantees to develop governing bodies comprised by a consumer majority ("Implementing the CARE Act," 1998). Two Federal agencies under the U.S. Department of Health and Human services, The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) played an important role in supporting the evolution of consumer integration in concert with national trade associations such as the National Association of State Mental Health Program Directors (NASMHPD) (SAMHSA, 2003; NASMHPD, 1989). In its effort, the U. S. Department of Housing and Urban Development (HUD) incorporated people with experiences of homelessness into its Continuum of Care (CoC) planning process and as an integral part of Homeless Management Information System (HMIS) implementation (Barrow et al., 2007). These agencies recognize the benefits of actively involving consumers in all aspects of design, delivery, and evaluation of services.

First Steps in Moving Forward

While there is an increased recognition of the need for meaningful consumer involvement in the field of homelessness (Barrow et al., 2007), there remains a dearth of literature and practical guidance about how to achieve this involvement. During the background work for this series, the authors found people with experiences of homelessness involved in a variety of roles and activities in both paid and unpaid positions. Consumer positions generally fell into the following three categories (Mowbray and Moxley, 1997; Solomon and Draine, 2001; Salzer, 2002):

- Consumer-operated services (managed and operated by a majority of consumers)
- Consumer-partnership services (services delivered by consumers with control shared with non-consumers)
- Consumer volunteers and employees

This series' concern is with the latter two approaches to consumer-delivered services, specifically addressing the myriad roles people with experiences of homelessness play within agencies as partners

with non-consumers.

To encourage consumer integration in the field of homelessness, PATH developed a workgroup that surveyed forty-one states, gathering information about employing consumers in the delivery of services. In a 2006 report, the workgroup recommended future follow-up by contacting local PATH providers to determine the extent of consumer involvement in service provision, barriers encountered, and the strategies used to overcome them. In an attempt to build on prior efforts and continue this discussion, the authors spoke with representatives from fifty-one PATH provider agencies spanning thirty-two states and conducted a second round of more in-depth discussions with ten agencies that involve consumers in their programs in creative ways. Featured approaches include creating consumer-designated positions; involving people with experiences of homelessness in governance; providing accommodations such as flexible scheduling; and creating a recovery-oriented agency through internal training. These "Portraits of Commitment" descriptions are available on the PATH website.

References

Barrow, S., Tsemberis, S., McMullin, L., & Tripp, J. (2007, March). *Consumer integration and self-determination in homelessness research, policy, planning and services*. Paper presented at 2007 National Symposium on Homelessness Research, Washington, DC. From http://www.huduser.org/publications/pdf/p3.pdf

Consumer Practitioners in PATH-Funded Programs: Report of the Consumer Involvement Workgroup (2006). Retrieved September 5, 2007 from http://homeless.samhsa.gov/ResourceFiles/Documents/ConsumerWorkgroupReport_706.pdf

Cotton, K. (1989, November). Expectations and Student Outcomes. *NW Archives: School Improvement Research Series.* Retrieved August 2, 2008 from http://www.nwrel.org/scpd/sirs/4/cu7.html

Dailey, E. (2003). *Consumer advisory board manual for Health Care for the Homeless projects.* Nashville, TN: National Health Care for the Homeless Council. From http://www.nhchc.org/Publications/CA06E_CAB_Manual.pdf

DeSisto, M. J., Harding, C. M., McCormick, R. V., Ashikaga, T., & Brooks, G. W. (1995). The Maine and Vermont three-decade studies of serious mental illness. *British Journal of Psychiatry*, 167, 331–341.

Good, T. L. (1987). Two decades on teacher expectations: Findings and future directions. *Journal of Teacher Education*, 38, 32–47. Harding et al., 1987, 1994;

Huber, G., Gross, G., & Schuttler, R. (1975). Long-term follow-up study of schizophrenia. Acta *Psychiatrica Scandinavica*, 53, 49–57.

Implementing the CARE Act amendments of 2000. (2002, January). *HRSA Care Action: Providing HIV/AIDS Care in a Changing Environment*. Retrieved September 5, 2007 from http://hab.hrsa.gov/publications/january2002.htm

Mowbray, C. T. & Moxley, D. P. (1997). Futures for empowerment of consumer role innovation. In C. T. Mowbray, D. P. Moxley, C. A. Jasper, & L. L. Howell (Eds.), Consumers as providers in psychiatric rehabilitation (pp. 518–525). Columbia, MD: International Association of Psychosocial Rehabilitation Services.

National Association of State Mental Health Program Directors. (1989). *Position statement on consumer contributions to mental health service delivery systems*. Alexandria, VA: Author. Available at http://www.nasmhpd.org/general_files/position_statement/contribps.htm

Salzer, M., Mental Health Association of Southeastern Pennsylvania Best Practices Team. (2002). Consumer-delivered services as a best practice in mental health care delivery and the development of practice guidelines. *Psychiatric Rehabilitation Skills*, 6, 355–382.

Solomon P. & Draine, J. (2001). The state of knowledge of the effectiveness of consumer provided services. *Psychiatric Rehabilitation Journal* 25(1), 20–27.

Substance Abuse and Mental Health Services Administration. (2003). *Blueprint for change: Ending chronic homelessness for persons with serious mental illnesses and co-occurring substance use disorders* (DHHS Publication No. SMA-04-3870). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Van Tosh, L. (1993). *Working for a change: Employment of consumers/survivors in the design and provision of services for persons who are homeless and mentally disabled.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.