Session #4 Principles of TST – Part 2

INTRODUCTION

In this session, participants will continue their exploration of the skills involved in performing TST; in particular, the special skills and sensitivities needed to effectively interact with diverse patient populations. Participants will learn and practice strategies for preparing and educating patients for TST, including a review of frequently asked questions. The important impact of culture on the patient-provider relationship will be presented, with ways for participants to improve their cultural competence. This session will also address the complicated issues and health care barriers faced by patients who are homeless or use substances, and how TST technicians can respectfully and compassionately interact with these patients in accordance with local program policies.

MATERIALS SUPPLIED FOR THIS SESSION

- Outline for trainers
- Participant workbook (1 reproducible master copy)
- Masters for overhead transparencies and PowerPoint slides:
  - *Open-Ended Questions*
  - *Patient Education*
  - *FAQs*
  - *Why Is Culture Important?*
  - *Health Care Barriers for Homeless and Substance-using Patients*
  - *Review Questions*

MATERIALS YOU NEED TO SUPPLY

- Duplicate participant workbooks
- Poster paper, chalkboard, or dry-erase board
- Poster pens, chalk, or dry-erase markers
- Overhead projector or laptop and LCD projector

Material in this session is adapted from:

- *DOT Essentials: A Training Curriculum for TB Control Programs.* San Francisco, CA: Francis J. Curry National Tuberculosis Center; 2003.
- *Effective Tuberculosis Interviews Course, Part II: Targeting Special Populations.* Presented by the Francis J. Curry National Tuberculosis Center on June 26-28, 1995, in Stockton, California.
- *Self-Study Modules on Tuberculosis: Module 9: Patient Adherence to Tuberculosis Treatment,* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 1999.
- *Tuberculin Skin Testing: A Model for Trainers.* San Francisco, CA: Francis J. Curry National Tuberculosis Center; 2001.
- *Tuberculosis Outreach Worker's Course.* Presented by the Francis J. Curry National Tuberculosis Center on July 20-21, 2000, in San Francisco, California.

Session Outline for Trainers

35 min **Opening activities**

Session agenda

Review with participants. Your agenda may be customized with other items or additional details. Consider presenting the agenda on poster paper or displaying it on a chalk- or dry-erase board as a visual reference throughout the session.

- Pre-test
- Review of agenda and learning objectives
- Review of key concepts from Session 3
- Preparing and educating patients for TST
  - Skills for good communication, open-ended questions
  - Patient education
  - Frequently asked questions (FAQs)
- Working with culturally diverse populations
  - Definition of culture
  - Cultural universals and cultural identification
  - Developing cultural competence
- Working with patients with special challenges
  - Barriers to health care faced by homeless and substance-using patients
  - Community perceptions about patients who are homeless or use substances
  - Learning more about homelessness and substance use
  - Local program guidelines and resources
- Review questions or post-test
- Participant evaluation

Pre-test

Ask participants to complete the session pre-test on page 2 of their workbooks.

Learning objectives

Review with participants. Refer participants to page 1 of their workbooks.

Upon completion of this training session, participants will be able to:

1. Name at least two skills that contribute to good communication with patients.
2. Identify the most important information to relay to patients receiving TST.
3. Provide appropriate responses to the questions most frequently asked by patients receiving TST.
4. List five ways that people may culturally identify themselves.
5. State four ways to learn more about a specific culture and health beliefs.
6. Name at least three barriers to health care faced by patients who are homeless or use substances.
7. Identify at least two local community resources for patients who are homeless or use substances to address their non-TB-related needs.

Review of key concepts from Session 3

Review with participants the key concepts from the topics covered in Session 3. Consider organizing the discussion around the following questions.

1. What method of TST is used by TST technicians? What are the three main steps of this method?
2. What are the supplies needed to perform TST?
3. What are three ways to properly handle tuberculin?
4. What are four examples of "universal precautions"?
5. How do licensed health care providers determine which TST reactions are "positive" or "negative"?
6. What is a "false-negative reaction"? Name a circumstance under which this can occur.
7. What is BCG? How does it affect TST?

60 min I. **Preparing and educating patients for TST**

Discuss with participants.

An important step in administering TST is to prepare the patient for the procedure and to educate him/her about TST and tuberculosis. Good communication skills can help TST technicians to build the rapport needed for the patient to be open to receiving information and instructions.

A. **Skills that contribute to good communication**

Refer participants to page 3 of their workbooks. Consider brainstorming and recording participants' ideas first; then fill in missing items as needed.

1. Listen attentively and respectfully to the patient; use open, relaxed body language.
2. Assure patient of privacy and confidentiality.
3. Avoid being judgmental or accusatory and never show frustration.
4. Use simple, nonmedical terms.
5. Use the appropriate language level for the patient.
6. Limit the amount of information given.
7. Discuss the most important topics first and last.
8. Repeat important information.
9. Listen to feedback and questions from the patient.
10. Use concrete examples.
11. Provide patients with information in written words or pictures.
12. Ask open-ended questions.

B. **What is an open-ended question?**

Refer participants to page 4 of their workbooks. Discuss with participants, using overheads/PowerPoints: Open-Ended Questions.

1. A question that cannot be answered with a simple "yes" or "no."
2. Questions that begin with words and phrases such as:
   Who? What? When? Where? Why? How?
   Tell me about… Explain to me…

C. **Why are open-ended questions useful?**

Open-ended questions are useful because they are more engaging and can lead to more information than questions that ask for "yes" or "no" answers; they help the TST technician get a clearer and fuller understanding of the patient's understanding of TST and TB.

EXERCISE

What are some examples of open-ended questions that you might ask a patient to assess his/her knowledge or beliefs about TST and TB?

Brainstorm answers to this question and record the answers on a chalkboard, poster sheet, or overhead transparency. Examples:

- *When, if ever, have you received a TST?*
- *What do you remember about your previous TST?*
- *What have you been told about today's TST procedure?*
- *Tell me what you know about TB infection and TB disease.*
- *How do we know if a person has TB infection or disease?*
- *What questions do you have for me?*

D. **Patient education**

Refer participants to page 4 of their workbooks. Discuss with participants, using overheads/PowerPoints: Patient Education.

1. TST technicians are in a "frontline" position to educate patients about TST and TB. The purpose of TB patient information is to:

   a. Provide information
   b. Correct misinformation
   c. Help allay the patient's fears about TST or TB
   d. Help ensure the patient's cooperation with TST procedure and follow-up

2. How should the TST technician prepare the patient for TST?

   Review the following important elements that the TST technician should review with the patient. Under each item, discuss the details that are relevant for your local program.

   a. TST technician introduces self and health department
   b. Brief description of why TST is taking place
   c. Brief overview of steps involved in TST, including follow-up visit for measurement
   d. Explanation of consent form(s) and confidentiality policies
   e. Screening/medical evaluation questions
   f. Asking patient to share questions or concerns

3. Frequently Asked Questions (FAQs)
   Refer participants to page 5 of their workbooks. Discuss the questions and possible answers with participants, using overheads/PowerPoints: FAQs.

   The following is a list of questions frequently asked by patients receiving TST. Some of the questions cover topics that should be addressed by the TST technician when he/she prepares the patient for TST. Some questions are based on common misconceptions about TST and TB, and they provide a good opportunity for the TST technician to share correct information.

   a. What's going to happen today?
   b. Why am I getting tested for TB?
   c. How would I have gotten infected with TB? I don't share my coffee cup with anyone at work.
   d. Do I have TB?
   e. Will this shot give me TB? HIV?
   f. Can I give TB to my family (friends, co-workers, etc.)?
   g. Should my family be tested?
   h. Wouldn't I feel sick if I was infected? I feel fine.
   i. Since I had BCG as a child, won't my TST always be positive?
   j. Why do I have to come back on Thursday? Why can't I check the reaction myself and call you?
   k. Why isn't everyone in the factory (office, etc.) getting tested?
   l. If I have TB, can I die from it?
   m. Will this hurt?
   n. If I've had a reaction to a TB test in the past, is it OK to get another one?
   o. Can I have a band-aid in case it bleeds?
   p. I had a TB test last month at my doctor's—I don't need another one, do I?

   q. ____

   r. ____

Activity: ***Patient education role play***

Refer participants to the list of Frequently Asked Questions *on page 5 of their workbooks. Ask participants to divide into pairs. One person in each pair will act as the patient, one will act as the TST technician. The patient will choose a question from the list, and the TST technician will practice giving a respectful and informative response. Run through an example for your participants:*

(Patient) "Wouldn't I feel sick if I was infected? I feel fine."

(TST technician) "I'm glad to hear you're feeling fine. And that's why I'm here today: to place a skin test that will confirm whether or not you've been infected with the TB germ. Being infected is different than having active TB disease. With TB infection, there are often no symptoms at all. If you are infected, you can receive treatment to prevent active TB disease. When, if ever, have you had a TST before?"

Point out that in a "good" response, a patient is never told that he or she is "wrong." The correct information is presented respectfully and may be followed by an open-ended question by the TST technician to find out more about the patient.

After five minutes, ask the pairs to switch roles. After another five minutes has elapsed, reassemble into the large group and discuss the following questions:

1) Which patient questions were especially hard to respond to? Why?
2) Share some examples of responses that worked well with your "patient."

4. Patient education materials
   Display and discuss with participants the pamphlets, posters, information sheets, and other educational materials your program shares with TST recipients.

60 min II. **Working with culturally diverse populations**

Refer participants to page 7 of their workbooks.

A. **Why a session on cultural diversity?**

Discuss with participants, using overheads/PowerPoints: Why Is Culture Important?

1. TB affects a very diverse population.
2. U.S. statistics: approximately half of all new cases are among the foreign-born.
3. Local statistics *[Provide details about the cultural diversity of patients within your local jurisdiction.]*
4. "Diversity" refers not only to race or ethnicity. In many communities, a large number of patients are among groups with special challenges, such as the homeless and substance users. Each group has their subcultures, differing from the American "mainstream" (dominant) culture.
5. Health workers need skills to be able to communicate effectively with people from many different cultural backgrounds.
6. Health workers need to identify the many factors that affect culture and determine a group's values and rules.

B. **What is culture?**

Refer participants to page 7 of their workbooks. Review the definition with participants, and discuss the following points:

1. Is there anything you'd like to add to the definition?
2. Health workers need to understand how culture influences how a patient hears and responds to information and requests from health care providers.

Definition of culture

ADAPTED FROM: NOEL DAY, POLARIS INSTITUTE
Culture is a group's design for living. It is the group's assumptions about the world, other people, and the goals and meanings of life. It is the group's assumptions about what is right and what is wrong—and its beliefs about how to behave and how to expect other people to behave in all of life's situations. **Culture** is the integrated pattern of human behavior that includes thought, speech, action, and artifacts. It depends on the capacity of humans for learning and transmitting knowledge and values to succeeding generations. It takes into account the customary beliefs, social norms, and material traits of a racial, religious, or social group. We look at other people through our own cultural lens. This means we often make assumptions about people on the basis of one or two characteristics. These assumptions are often culturally specific and come along with judgments. Once we have made a judgment (positive or negative) about someone, it will show in the way we communicate with that person. If our view is negative, this can interfere with building rapport and/or trust. As health workers, we are often put into positions of power over our clients, which impacts individuals from different cultures differently. **Culture** gives you all of the answers—even when you don't know what the questions are!

C. **Cultural universals**

Refer participants to page 8 of their workbooks. Discuss with participants.

1. Certain human activities are **universal**; that is, they are a part of every culture. This does not mean, however, that they are practiced in the same way, have the same value or meaning, or are not subject to change by forces outside the culture. Everyone eats, sleeps, build shelters, mates, raises their young, celebrates, and passes on their beliefs and values to the next generations. Knowing and understanding that there are many rich and diverse customs for all of these activities will help you to become more culturally competent.

2. The following is a list of basic life practices performed by members of many cultures:

- age-grading
- art / theatre / drama / visual
- bodily adornment
- child rearing
- cooperative labor
- courtship / dating
- dancing
- death / dying
- education
- ethics
- etiquette
- family feasts / celebrations
- folklore
- food / food taboos / meal times
- funeral rites
- games
- gender roles
- gestures
- greetings
- hospitality / holidays
- housing
- hygiene / health / cleanliness
- joking
- kinship / relatives
- language / slang
- law / authority / punishment / prison terms
- literacy / aural
- marriage
- medicine / medical providers / healers
- mind-altering substances
- modesty / privacy about the body
- music /songs
- personal / family names
- pregnancy and labor
- pre-/post-natal care
- problem-solving
- property rights
- puberty customs
- religious beliefs / rituals
- sexual customs / roles / restrictions
- social organizations
- sports
- status differentiation / prestige / credibility
- trade / economics / money / barter
- visiting / socializing

Ask participants:

a. Can you think of any more?

b. Although all these items can influence the patient-provider relationship, which ones might have particular impact?

   [death/dying; hygiene/health/cleanliness; law/authority; medicine/medical providers; modesty/privacy about the body]

D. **Cultural identification**
Refer participants to page 9 of their workbooks.

Activity: *Cultural identification*

Explain that cultural competence begins with an awareness of the familial and cultural forces from our families and our cultures that shape our own identities. Cultural identification can be broken down into three layers or "dimensions."

Ask participants to select a total of 6-7 different items (of their own choice) from the primary, secondary, and third dimensions of culture and describe their own cultural identity on the worksheet on page 10. Remind them that this information will be shared with others in the group only on a voluntary basis.

When participants are finished writing, ask them to form groups of 2-3 participants. Ask them to share as many of their "cultural identifiers" as they are comfortable with in their small groups.

Primary dimension

The first way we can identify ourselves consists of individual characteristics that people are born with, and experiences that they have as infants and children. These are characteristics that we cannot change.

1. Age
2. Ethnicity/race
3. Gender
4. Language
5. Physical abilities and qualities
6. Sexual/affectional orientation
7. Childhood experiences and family factors
   (family religion, place of birth and household location, family social class, parents' occupations, etc.)

Secondary dimension

The second way we can identify ourselves consists of characteristics or experiences over which individuals may have some control or choice; however, the level of control or choice can vary widely for each characteristic.

1. Education
2. Geographic location
3. Income
4. Marital/relationship status/history
5. Military experience
6. Parental status/history
7. Religion
8. Work experience
9. Current social class/class status history
10. Political affiliation/perspective

Third dimension

The third way we can identify ourselves is through characteristics that are most unique among individuals and are not shared by all populations.

1. Experiences with immigration, exile, refugees, etc.
2. Lifestyle (e.g., gay culture, new age)
3. Degree of acculturation/assimilation
4. Degree of recovery
5. Recreational drug use
6. Health consciousness
7. Gender identification/change in gender

E. **Developing cultural competence**

1. **What is cultural competence?**
Refer participants to page 11 of their workbooks. Discuss with participants.

Similar to developing any set of skills, becoming culturally competent is a **process**. We can view this process along a continuum. On one end of the continuum, when cultural competency is completely lacking, individuals or institutions can hold attitudes or practice policies that are harmful to clients. Along the way, as individuals or institutions gain awareness and understanding about cultural dynamics, competence increases. Full cultural competence is achieved when individuals or institutions not only accept and respect cultural differences, but also continuously seek new knowledge and strive to improve their approaches with clients.

2. **How can health workers develop cultural competence?**
Brainstorm examples and record them on a chalkboard, poster sheet, or overhead transparency. When participants have no more ideas, fill in missing items as needed. Participants can record the responses on page 11 of their workbooks.

   a. Reading novels and stories about other cultures.
   b. Reading magazines, newspapers, or other periodicals produced by and for specific cultural communities.
   c. Exploring Internet sites that feature information about cultural competence.
   d. Attending cultural events (plays, music, dance, art exhibits, and festivals).
   e. Attending workshops on cultural awareness or on issues affecting particular cultural groups.
   f. Studying the histories of different cultural groups.
   g. Staying up-to-date on political events and the ways these affect different groups.
   h. Talking to friends and colleagues about their cultures and norms.
   i. Doing volunteer or paid work with people from a variety of communities and cultures.
   j. Seeking consultation from more experienced mentors or community leaders.
   k. If your health department staff is culturally diverse, consider this activity: during a staff meeting, ask each individual to identify major areas of concern for his/her culture as well as behaviors or activities that may be disrespectful to that culture.

[Note: Guidelines for using an interpreter will be covered in Session 6.]

60 min III. **Working with patients with special challenges**
Refer participants to page 12 of their workbooks. Introduce this section by discussing the following.

Patients who are homeless and/or use substances face barriers to health care that are complex and difficult to overcome. These barriers are often made worse by the negative perceptions that mainstream American society holds against the homeless and substance users. Instead of compassion, people often feel annoyance or anger against patients with these special challenges.

A. **What are special health care barriers for homeless and substance-using patients?**
Review with participants, using the overhead/PowerPoints: Health Care Barriers for Homeless and Substance-using Patients.

1. Lack of access to health care
2. Competing priorities (earning money, finding a place to sleep, acquiring substances)

3. Intoxication
4. Lack of stability; chaotic life circumstances
5. Distrust of authorities; legal issues
6. Denial
7. Blaming others for problems
8. Depression ("why bother?"); feeling overwhelmed by one's circumstances
9. ____
10. ____

B. **What are *my* barriers to working with homeless and/or substance-using patients?**

Explain to participants the importance of examining our own attitudes and assumptions about working with homeless and/or substance-using patients. Our own attitudes can serve as cultural biases. Some of our assumptions or attitudes might interfere with our ability to effectively interact with patients who face these special challenges.

Activity: *Discussion in pairs*

Refer participants to page 12 in their materials. Ask participants to divide into pairs and discuss the following questions with their partners. Remind them that this information will be shared with others in the larger group only on a voluntary basis.

It is difficult for me to work with people who are homeless because ___________

____

It is difficult for me to work with people who use substances because __________

____

After participants have discussed these questions in pairs, reconvene the larger group. Ask for volunteers to share some of their responses. Attitudes and assumptions should not be labeled as "right or wrong" or "appropriate or inappropriate." Instead, acknowledge that health care workers bring a variety of attitudes, assumptions, and personal experiences to their interactions with homeless and substance-using patients. This observation leads directly to the next discussion.

Special note: Issues raised and discussed in this exercise can be very sensitive. An individual with good facilitation skills is required to effectively conduct this exercise.

C. **Community perceptions of homelessness and substance use**
Refer participants to page 13 in their workbooks. Use the worksheet as the basis for a discussion about the various perspectives through which different segments of the community view persons who are homeless or use substances.

Read aloud the following statements. Ask participants to mark their agreement or disagreement for each item, using the following scale (which should be written and posted on a flipchart). Ask participants to be honest in their answers and let them know they will not be required to share their answers with others.

1	2	3	4	5
Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

1. People who use substances lack the willpower to stop. They have a character problem.

2. People who use illegal substances should stop because they are breaking the law.

3. Most people who are homeless wouldn't have to be if they were willing to work hard.

4. Many people are homeless because they are alcoholics or drug addicts.

5. Adults should have the legal right to use the drugs of their choice as long as they don't harm anyone else.

6. Many people are homeless because they have mental illness.

7. There are plenty of resources available to homeless people, but many homeless people are unwilling to utilize them.

8. There are plenty of resources available to people who use substances, but many substance users are unwilling to utilize them.

9. People who use substances have a chronic illness, not a moral weakness.

10. People who use substances are exhibiting "bad behavior" that was learned in their families or communities.

11. People who use substances have no concern for their health or welfare.

After you have read all the statements, ask participants to take a few moments to reflect on their answers and then discuss how these assumptions impact their ability to serve their patients well. Then, review each statement and ask for volunteers to share their responses.

Explain that no single perspective is necessarily right or wrong. The point of the discussion is not to debate the items, but to emphasize that homelessness and substance use are complicated challenges that will be perceived in very different ways by the patient and each individual and group with whom he/she interacts. ***No matter which perspective(s) a health care worker leans toward, the homeless or substance-using patient deserves the same respect, care, and dignity as any other patient.***

D. **Learning more about homelessness and substance use**

1. **Who are the homeless in the U.S.?**

   Refer participants to the fact sheet about homelessness in their workbooks (pages 14-16) and ask them to spend a few minutes reviewing the information; or, if you prefer, highlight the most important points as part of a verbal introduction to this topic.

2. **Definition of addiction**

   Refer participants to page 17 of their workbooks. Introduce the "Working Definition of Addiction."

   Ask if anyone has a strong attachment to coffee or chocolate. What are they like in the morning if they don't have their coffee? What happens when they don't get that chocolate bar in the afternoon? If they don't smoke their cigarettes? Stress the fact that many of us have strong attachments to various substances and we may be surprised to discover how bad we feel if we give them up even for a few days.

A working definition of addiction

Addiction is characterized by:

- A strong urge to use mood-altering drugs
- Loss of control over use of these drugs
- Continued use despite negative consequences
- Possible genetic disposition
- Family and social problems due to use
- Past attempts to stop or to control use
- Possibility of relapse after the addict stops using

Remind participants that not all users are addicted and many function socially, hold jobs, and have families.

Who are the homeless in the U.S.?

ADAPTED FROM: "WHO IS HOMELESS?" NCH FACT SHEET #3, PUBLISHED BY THE NATIONAL COALITION FOR THE HOMELESS, MAY 2004

AGE

In 2001, the U.S. Conference of Mayors' survey of homelessness in 27 cities found that children under the age of 18 accounted for 25.3% of the urban homeless population (U.S. Conference of Mayors, 2001). This same study found that unaccompanied minors comprised 4% of the urban homeless population. However, in other cities and especially in rural areas, the numbers of children experiencing homelessness are much higher. On a national level, approximately 39% of the homeless population is children (Urban Institute 2000). A 1987 Urban Institute study found that 51% of the homeless population was between the ages of 31 and 50 (Burt, 1989); other studies have found percentages of homeless persons aged 55 to 60 ranging from 2.5% to 19.4% (Institute of Medicine, 1988).

GENDER

Most studies show that single homeless adults are more likely to be male than female. In 2001, the U.S. Conference of Mayors' survey found that single men comprised 41% of the urban homeless population and single women 14% (U.S. Conference of Mayors, 2003).

FAMILIES

Families with children are among the fastest growing segments of the homeless population. In its 2003 survey of 25 American cities, the U.S. Conference of Mayors found that families comprised 40% of the homeless population, a definite increase from previous years (U.S. Conference of Mayors, 2003). On a national level, the numbers are higher: the Urban Institute found that children comprise approximately 39% of the homeless population (Urban Institute 2000). Research indicates that families, single mothers, and children make up the largest group of people who are homeless in rural areas (Vissing, 1996). As the number of families experiencing homelessness rises and the number of affordable housing units shrinks, families are subject to much longer stays in the shelter system. For instance, in the mid-1990s in New York, families stayed in a shelter an average of five months before moving on to permanent housing. Today, the average stay is nearly a year (Santos, 2002).

ETHNICITY

In its 2003 survey of 25 cities, the U.S. Conference of Mayors found that the homeless population was 49% African-American, 35% Caucasian, 13% Hispanic, 2% Native American, and 1% Asian (U.S. Conference of Mayors, 2003). Like the total U.S. population, the ethnic makeup of homeless populations varies according to geographic location. For example, people experiencing homelessness in rural areas are much more likely to be white; homelessness among Native Americans and migrant workers is also largely a rural phenomenon (U.S. Department of Agriculture, 1996).

VICTIMS OF DOMESTIC VIOLENCE

Battered women who live in poverty are often forced to choose between abusive relationships and homelessness. In a study of 777 homeless parents (the majority of whom were mothers) in ten U.S. cities, 22% said they had left their last place of residence because of domestic violence (Homes for the Homeless, 1998). In addition, 34% of cities surveyed by the U.S. Conference of Mayors identified domestic violence as a primary cause of homelessness (U.S. Conference of Mayors, 1998). Studying the entire country, though, reveals that the problem is even more serious. Nationally, approximately half of all women and children experiencing homelessness are fleeing domestic violence (Zorza, 1991; National Coalition Against Domestic Violence, 2001).

VETERANS

Research indicates that 40% of homeless men have served in the armed forces, as compared to 34% of the general adult male population (Rosenheck et al., 1996). In 2003, the U.S. Conference of Mayors' survey of 25 American cities found that 10% of the urban homeless population were veterans—however, this does not take gender into account (U.S. Conference of Mayors, 2001).

PERSONS WITH MENTAL ILLNESS

Approximately 23% of the single adult homeless population suffers from some form of severe and persistent mental illness (U.S. Conference of Mayors, 2003). It is estimated that only 5-7% of homeless persons with mental illness require institutionalization; most can live in the community with the appropriate supportive housing options (Federal Task Force on Homelessness and Severe Mental Illness, 1992).

PERSONS SUFFERING FROM ADDICTION DISORDERS

Surveys of homeless populations conducted during the 1980s found consistently high rates of addiction, particularly among single men; however, recent research has called the results of those studies into question (Koegel et al., 1996). Briefly put, the studies that produced high prevalence rates greatly over-represented long-term shelter users and single men, and used lifetime rather than current measures of addiction. While there is no generally accepted "magic number" with respect to the prevalence of addiction disorders among homeless adults, the U.S. Conference of Mayors' number was 30%, and the frequently cited figure of 65% is probably at least double the real rate for current addiction disorders among all single adults who are homeless in a year.

EMPLOYMENT

Declining wages have put housing out of reach for many workers: in every state, more than the minimum wage is required to afford a one- or two-bedroom apartment at Fair Market Rent (National Low Income Housing Coalition, 2001). In fact, in the median state a minimum-wage worker would have to work 89 hours each week to afford a two-bedroom apartment at 30% of his or her income, which is the federal definition of affordable housing (National Low Income Housing Coalition 2001). Thus, inadequate income leaves many people homeless. The U.S. Conference of Mayors' 2003 survey of 25 American cities found that 17% of the urban homeless population were employed (U.S. Conference of Mayors, 2003). In a number of cities not surveyed by the U.S. Conference of Mayors—as well as in many states—the percentage is even higher (National Coalition for the Homeless, 1997).

IMPLICATIONS

People who become homeless do not fit one general description. However, people experiencing homelessness do have certain shared basic needs, including affordable housing, adequate incomes, and health care. Some homeless people may need additional services such as mental health or drug treatment in order to remain securely housed. All of these needs must be met to prevent and to end homelessness.

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E. **Local guidelines for performing TST on patients who use substances**

Review with participants your program's guidelines for interacting with patients who are under the influence of substances. Explain the circumstances under which intoxicated patients may or may not participate in TST activities. For example, your program may allow TST participation for a person who exhibits signs of recent substance use, but is not currently intoxicated.

F. **Local resources for homeless and substance-using patients**

Refer participants to page 18 of their workbooks. Discuss the following.

Patients who face the special challenges of homelessness and/or substance use have a full range of needs: medical, social, economic, and psychological. Health care workers certainly cannot personally address all these competing needs, but can help communicate information about the patient's circumstances to other program staff. In turn, community resources can be identified to help the patient manage these issues. These resources can include: substance use treatment or rehabilitation centers; housing assistance organizations; HIV treatment programs; mental health programs; Veterans Administration facilities; harm reduction education; and job training.

Generate a list and describe the specific agencies, organizations, and other resources in your community that exist to help people who are homeless and/or use substances.

25 min **Closing activities**

Review questions or post-test

The following questions can be used for a group discussion to review the session's main points (use overheads/PowerPoint slides, Review Questions), *or they can be utilized as a post-test for participants (see page 19 in* Participant's Workbook.)

1. What are two skills that contribute to good communication with patients?
2. Name three important pieces of information to relay to patients receiving TST.
3. How would you respond to patients who make the following statements?
   a. I know I don't have TB, so I don't need the test.
   b. Why aren't the employees in the Payroll Department being tested, too?
   c. You're testing for TB?! Back home in India I knew many people who died of TB!!
4. What are five ways that people may culturally identify themselves?
5. What are three ways to learn more about a specific culture and health beliefs?
6. What are three barriers to health care that patients who are homeless or use substances may face?
7. Name two local community resources for patients who are homeless or use substances to address their non-TB-related needs.

Participant evaluation

Ask participants to share their feedback about this training session on the evaluation form (see page 20 in Participant's Workbook.)