From Their Perspective: The Connection between Life Stressors and Health Care Service Use Patterns of Homeless Frequent Users of the Emergency Department

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The perspective of homeless adults on their health care service utilization is not well studied. This article describes a study that used in-depth, semistructured interviews with 18 individuals to highlight the viewpoints of homeless people who are frequent users of the emergency department (ED) about the influence of life events on service utilization. Participants reported high levels of pain and comorbid psychiatric, substance use, and medical conditions. They also reported an identifiable pattern of health care utilization, often centered on a crisis event, influenced by high perceived medical needs, inability to cope after crisis, predisposing vulnerability from social determinants of health, and health care system factors. A social work case management intervention often led to a period of stability and use of ED alternatives. Modifiable targets for intervention at the health care system and local levels include improving trust and convenience of ED alternatives, enhancing consistency of care at ED-alternative sites, and educating those at risk of frequent ED use about community alternatives.

KEY WORDS: *case management; emergency department utilization; frequent users; homeless population*

Homeless patients have complex health care needs and difficulty accessing health services (G. Moore, Gerditz, Hepworth, & Manias, 2011). This can lead to increased use of acute care such as the emergency department (ED). Risk factors for frequent ED utilization among homeless patients include mental illness, substance use disorders, violence, social isolation, comorbidities, and chronic illnesses (Kushel, Perry, Bangsberg, Clark, & Moss, 2002; G. Moore et al., 2011). These patients often experience barriers to recovery after trauma or illness as they lack access to recommended over-the-counter medications, rest, and improved nutrition; one study found that only 4 percent of homeless ED frequent users were discharged with a plan that addressed their homelessness (Ku, Fields, Santana, Wasserman, & Borman, 2014). These barriers result in a higher likelihood of having repeat ED visits than those patients who are not homeless (Salhi, White, Pitts, & Wright, 2017; Tadros, Layman, Brewer, & Davis, 2016).

Reducing ED service use by frequent users benefits both patients themselves (Moskop, Sklar, Geideman, Schears, & Bookman, 2009) and the facilities from

which they receive care (Gill, 1994). ED frequent users are particularly vulnerable to poor health outcomes. In part, these patients experience fragmented care, leading to unnecessary tests and procedures (Gill, 1994). Moreover, frequent users require more continuous care because they often have several medical and psychological comorbidities, which increase the likelihood that an ED visit will lead to a hospitalization (Hansagi, Olsson, Sjöberg, Tomson, & Göransson, 2001; Schaulis & Snoey, 2001; Williams, 2001). Frequent use of the ED also affects facilities. EDs are a costly means of care—between two and five times the cost of primary care (Adams, 2013). Several previous studies have aimed to categorize frequent users' visits as "avoidable" versus "warranted" in an effort to redirect what are deemed avoidable visits to other care sites (Durand et al., 2011; Gill, 1994; Hsia, Friedman, & Niedzwiecki, 2016). Visits are deemed avoidable because they result either from patients seeking nonurgent care at the ED or, more often, patients seeking care for conditions that could have been prevented by primary care (Moskop et al., 2009). However, the structural and psychosocial barriers to

accessing primary care for many patients often renders the ED the only avenue to timely, effective care (Moskop et al., 2009).

Strategies to address individual-level factors influencing ED use among frequent users are fairly well studied (Althaus et al., 2011), yet it is not well understood why individuals become frequent users. In addition, few studies to date have focused in depth on patient perspectives. One previous study conducted qualitative interviews with homeless frequent ED users to identify influences on alcoholism (McCormack, Hoffman, Norman, Goldfrank, & Norman, 2015). Recent systematic reviews have called for studies to characterize the complex needs of homeless frequent users to guide evidence-based care guidelines (Salhi et al., 2017). Yet, much of the research to date has not focused on patient perspectives of their own service use. In this article we present the views of a group of homeless frequent users of the ED about their service use and the influence of current and past stressors on their patterns of health care utilization. We then assess barriers and facilitators to care and service access to gain insight into methods for improving services to homeless patients.

METHOD

Study Design

We conducted semistructured, in-depth qualitative interviews with homeless frequent users of the ED at a large, urban hospital and a corresponding medical record review. The university human subjects division approved the study.

Study Setting, Recruitment, and Procedures

Eighteen participants were identified by reference from the ED High User Case Management (HUCM) program at a large, urban hospital affiliated with an academic institution; the ED sees around 60,000 visits per year. The HUCM program offers short-term, intensive social work case management for patients with four or more ED visits in six months. Criteria for inclusion in the study included eligibility for or participation in the HUCM program, ability to speak English, ability to communicate verbally, and cognitive ability to consent. Participants were selected through purposive sampling and were given a \$25 gift card for participation. The interviews were conducted in person by two investigators. All interviews were audiotaped and

transcribed verbatim with signed consent. Additional participants were interviewed until three interviews were conducted with no new categories identified according to preliminary analysis and the interviewers believed that thematic saturation had been reached.

Measures

Qualitative Interview Guide. The interview guide was developed through several iterations by the lead investigator in collaboration with the lead social worker of the HUCM program, who has been a practicing social worker for 27 years and with the HUCM program since its inception in 2008. The five interview domains were (1) stressors or challenges faced, (2) medical service use patterns and decision-making process for seeking care, (3) impressions of interactions and communications with providers, (4) services needed or used, and (5) recommendations for how the health care system and HUCM could best meet patients' needs. Participants were allowed to speak freely and to raise their own topics during the process. Interviews ranged in duration from 30 minutes to two hours.

Medical Record Review. To better understand how themes elicited from interviews related to patients' medical needs, data were collected from the medical record with participant consent through a HIPAA waiver. Data were extracted for years 2015 and 2016 using the Microsoft Amalga platform. The following variables were extracted for each participant: age, gender, race, number and dates of ED visits and inpatient days, number of outpatient visits to the greater hospital network, self-reported pain from the Numeric Pain Rating Scale and triage status from the Emergency Severity Index (ESI) for each visit, and the International Classification of Diseases–10 (ICD–10) billing codes for each visit.

Data Analysis

Qualitative Analysis. Drawing on standard grounded theory methods, researchers performed inductive qualitative analysis on verbatim interview transcripts using three phases of coding. Phase 1 consisted of open coding to determine categories of topics; phase 2 consisted of axial coding to interconnect these categories; and phase 3 consisted of selective coding to build these categories into more representative domains. Any disputes in codes, categories, or themes were discussed until consensus was

reached. Dedoose (n.d.) analytic software was used to store and code data.

Analysis of Medical Record Data and Triangulation with Qualitative Interview Data. Basic descriptive statistics were generated for participants. To better understand the impact of the crisis event on ED use, ICD-10 billing codes were analyzed to determine how the most frequently reported chief concerns for ED visits by frequent users compared with the perceived chief concerns for visits by providers. Most visits contained multiple diagnoses. Primary billing diagnosis was used in analysis because this was determined to be most comparable with the reason for visiting the ED reported by the patient. Primary diagnoses that occurred in more than three patients are reported. In addition, self-reported pain ratings were analyzed descriptively. To further understand the severity of illness reported by participants, the ESI, a standardized assessment by health professionals, was examined for each visit. In addition, we used medical record data from visits to the study hospital’s ED for the 2015 and 2016 calendar years to contextualize the service use pattern identified in the qualitative interviews and search for further patterns.

RESULTS

Participants were mostly male (78 percent) and were racially and ethnically diverse (see Table 1). At the time of interview, there was variability in the

type of shelter where participants were staying. Ten participants (56 percent) were unsheltered or sleeping in an emergency shelter, many on a lottery basis. Three participants (17 percent) were living in temporary housing, including respite care and inpatient behavioral health centers. Five participants (28 percent) were in supported housing, including “wet” housing. Most (67 percent) had a primary care provider and had several ED visits (median 18) and inpatient days (median 26) during the 2016 calendar year.

The first major theme elicited from the interviews was an identifiable pattern of health care service utilization that centered on a crisis event and was affected by other life events (see Figure 1). First, a crisis event (often a physical injury, substance use relapse, or death of a loved one) occurred when the ability to cope and access to outpatient care were limited, which resulted in increased ED use. In many cases, intensive social work case management steadied socioeconomic instability, thereby reducing ED use and introducing a period of stability. A subsequent crisis moment *sometimes* recurred, and the pattern began again; without a subsequent crisis, the period of stability led to increased ability to cope and use of alternatives to the ED, such as outpatient and urgent care facilities. (See Table 2 for quotes illustrating these themes.)

The medical record data represent visit patterns at the study site in 2016. For most participants, this

Table 1: Participant Characteristics (N = 18)		
Characteristic	M (SD)	n (%)
Age	51.89 (9.5)	
Gender		
Female		4 (22)
Male		5 (78)
Race		
Black		4 (22)
Native Hawaiian		1 (6)
Native American		6 (33)
White		7 (39)
Primary care provider		
Yes		12 (67)
No		6 (33)
Median (Range)		
2016 encounters with health care system		
ED visits	18 (1–36) ^a	
Inpatient days	26 (0–97)	
Outpatient visits	7 (0–177)	
2015–2016 days in HUCM program	169 (54–377)	

Notes: ED = emergency department; HUCM = High User Case Management.
^aThe patient with one visit for 2016 was quickly affected by the program and had no ED visits after entrance into the program, exiting the program shortly after interview.

Figure 1: Description of Pattern of Emergency Department Use

Notes: Gray boxes indicate the process of health care utilization, whereas black boxes indicate the factors that affect this process. ED = emergency department; HUCM = High User Case Management.

represented the part of the cycle of frequent ED use, after the crisis event and before or during intensive engagement in the HUCM. The most common reasons for visits reported by participants and extracted from medical records are summarized in Table 3. Visits related to any kind of substance use accounted for 35 percent of all visits ($n = 103$) for 14 participants (78 percent). All patients experienced both psychiatric and medical comorbidities. Alerted by the common reports of pain, trauma, and mental illness in the interviews, we assessed these in the ICD-10 billing codes. “Pain” identified in the title of each ICD-10 billing code was found for 14 participants (78 percent), accounting for 18 percent of visits ($n = 54$). Trauma diagnoses were also common, potentially representing a recurrence of a crisis moment in the participants’ pattern of use. Eleven of the participants (61 percent) had traumatic injury diagnoses, accounting for 8 percent of visits ($n = 25$), and the most common was trauma to the head, which occurred in seven participants (39 percent) and accounted for 5 percent of visits ($n = 13$). Finally, mental illness unrelated to

substance use accounted for 7 percent of all visits ($n = 22$) in six participants (33 percent). No patterns by season or participant demographics were found.

Five Levels of Influence on Pattern of Health Care Utilization

Five domains contributed to a pattern of frequent ED use: perceived need and ability to cope, health care system factors, medical need, predisposing factors, and intervention.

Perceived Need and Ability to Cope. Most directly, participants explained that they presented to the ED because of the urgent need for immediate medical care. Participants had serious and complicated medical conditions for which new and concerning symptoms would often arise. In addition, participants had high levels of pain, which they felt required immediate intervention. More than half of the 295 visits had a corresponding reported perceived pain score ($n = 152$, 52 percent) (see Figure 2a). Many participants reported that their pain initiated and continued from the crisis moment, contributing to their frequent ED use; they suffered a traumatic injury, which led to chronic pain and influenced their perceived need for emergency intervention. Self-assessed severity of illness strongly affected perceived need for care. Patients viewed their conditions as urgent. One patient who felt dismissed by providers explained,

I understand because people have the perception of homeless people that they’re here for whatever reason or whatever. If I admit myself, I’m here for a serious reason. I’m usually coming in on an ambulance. Calling 911. On death’s doorstep.

In addition to patient self-assessment, all visits ($n = 295$) had a corresponding acuity assessed by health professionals based on the ESI scale (see Figure 2b). The most common assignment (64 percent of visits) was 3 (urgent).

The ability for a participant to cope after a crisis moment strongly influenced the participant’s perceived need, and thus her or his ED use. For one participant, a lack of shelter limited his ability to cope with his seizure condition; he attributed his worsening condition to medication that caused drowsiness:

You know, I’m fighting sleep and everything. And they’re telling me, OK, well, it’s bad to stay awake because it’s called sleep deprivation,

Table 2: Pattern of Health Care Service Utilization	
Phase	Illustrative Quote
Entire cycle	Well, I lost [my housing], you know? Because of what happened, goin' to jail and stuff. But I didn't care, you know? And then, I got hit by a car . . . and it broke my foot, but I had a concussion for two days and I was walking around and never went to the hospital. . . . Then finally I went to the hospital because I was awake again. And my foot was killin' me and it was huge, you know. So, I went to [another ED]—it was the closest place where I was at. And then on Monday I met [the case manager] and . . . the first thing that she says is: "There's an opening at the [low-income, sober support housing]. And are you interested?" I looked at her and I go, "What do you think? Yeah." And . . . and then she goes, "Well, I just have to ask, you know?" And I said, "How long is it gonna take?" She said, "Probably a couple weeks, you know." So I said, "Yeah, let's do it." You know? And it's like I'm getting my life back. My life has been . . . I mean, I've done a lot of things. And I've made a lot of money in my life. But that—that wasn't my goal. That, well, I don't even know why I even said that right now but, I mean, I've had really good jobs. Yeah, and I can get 'em again. You know, and so I'm feelin' really positive about things right now.
Crisis event	You know, 'cause this accident, it—you know, changed my life. I got hit by a car. I was jogging, yeah. . . . I was hit by two cars in a crosswalk and that's what started all this.
Health care utilization: increased ED use	And I don't want to go—I was going to [the ED] today. I was going to go back today because this hurts so bad. It's just so much pain. But I can't just keep going there. Twenty-seven times since January. Twenty-seven times I've been there.
Intervention stabilizes	Each and every time, you know I was having a hard time and then I got [my case manager]. I was lost, you know. Lost in my mind and they gave me a case manager. She helped me out. She helps me a lot.
Period of stability	When things were going good, I would go to yoga every day. And I'd stay at the [redacted] mission for \$5 a night. And it was—it's okay.

Note: ED = emergency department.

Table 3: International Classification of Diseases–10 Codes Occurring in More Than Three Participants		
ICD-10 Billing Code	Participants <i>n</i>	Visits <i>n</i> (%)
Alcohol-related disorders	10	91 (31)
Abdominal and pelvic pain	6	19 (6)
Other and unspecified soft tissue disorders, not elsewhere classified	6	8 (3)
Chest pain	5	14 (5)
Nausea and vomiting	5	7 (2)
Major depressive disorder, single episode	4	5 (2)

and it raises your risk even higher to have a seizure. And so they're giving me all these risk factors and they're like, this is maybe why you're continuing to keep having them.

However, the participant felt unsafe sleeping in a shelter or on the street, so he continued to deprive himself of sleep, affecting his perceived need for emergency medical care.

Health Care System Factors. Compounding factors, both at the individual and system levels, synergistically influenced ED use. Participants described the following specific system factors as influencing their health care utilization: proximity of the ED to their shelter or temporary housing, consistency of providers,

availability of clinics, reputation among peers, trust, comfort, unknown alternatives to ED, and case management availability and enrollment (see Table 4). When asked how they decided when and where to get care, participants often did not report a sense of making a decision to go to the ED instead of another health care facility. For them, it was not a decision but was viewed (a) as the only place to get their needs met; (b) as always open; and (c) recommended highly by peers, which led to trust and comfort in the ED setting. They were not aware of other options and had time to wait in the ED. Specifically, participants remarked on the continuity with ED providers compared with the inconsistency of providers in primary care clinics.

Medical Need. Medical need factors influencing ED use included current substance use, chronic illness, and mental health status. Fourteen participants discussed how their substance use affected their health and health care. Participants frequently discussed the penetrating impact their chronic illnesses had on their lives and health care use, and also the synergistic effects of stress and mental health. One patient with a history of heart attacks described the difficulty in discerning anxiety symptoms from cardiac distress symptoms.

When my mind starts racing and I can't concentrate, then it's time to just try—time to go

Figure 2: Pain and Acuity Reports from Patient Medical Records

Note: ED = emergency department.

Table 4: Health Care System Factors That Affect Pattern of Use

Phase	Illustrative Quote
Proximity	Usually I go [to an outpatient facility] for my cancer, but yesterday I was so sick I had to go to the closest hospital. So I went to [the ED].
Consistency of providers	<p>You know . . . when the doctors [in the ED] see me or the nurse sees me and they'll be like, "Oh, we seen you before." They come right on it. Because they start looking at things and they're like, OK, this has happened. And we have been dealing with you. So it's kind of like they'll know how to deal with me or whatever or just know to say, OK, we're just going to do this patient the same as we did this patient. They might not be able to do me this way, so they make sure that everything is intact so if something does happen, they're just already ready to go. Or they can put the IV in so they continuously put the medicine in my IV right away. They make sure everything is right, you know.</p> <p>I got a resident to be my doctor . . . We got along famously, you know? And . . . I thought he was great. And he really worked hard. I mean he really, really worked hard and he was really concerned and I know a lot about doctors . . . And then I had [a chronic] disease and I've probably seen about 200 doctors in my life, you know? And I've been to lots of hospitals and stuff. Anyway, [he] was great. But he graduated. Residents graduate and then they move on. [After knee surgery, the participant was struggling with pain control. Initially the resident was assisting in pain management. The participant followed up with a new physician and was not satisfied with the pain management plan. He then returned to the ED for care, where he regularly encountered continuity of providers who provided sufficient pain management.]</p>
Availability of appointments	I wish I could just get a provider, like, right now, so I can get a permanent one instead of having to wait, wait, wait.
Trust and comfort	It's better than any other hospital. I don't know. It's just—maybe since I've been here so many times that they all know me.
Unknown alternatives to the ED	I come to the hospital and it's fine. They help me. That's all I know.
Case management availability	[My case manager] . . . [has] always . . . been there when I needed her. And she has always thought things through . . . about how and looked ahead about, you know, what might be the next move sometimes. She's—she's just really good at what she does. I mean, I—I've seen a lot of case managers in my life. I've been going to mental health services for 26 years. You know? And I've always had case managers and . . . she's great.

Note: ED = emergency department.

to the hospital. Because then my mind—I have Afib and my heart will start complicating and I could have a heart attack or a stroke.

Other patients indicated that they came to the ED because of an urgent need, but also considered their time there as an opportunity to receive comprehensive care for chronic conditions.

[In this ED], for whatever shortcomings, at least you can get moved around, and you know it's hard for me to get around. [Being in this ED] has been a positive experience, and, you know, in being able to—to take care of these chronic things, along with whatever I bring in that day to the emergency room.

Predisposing Factors. Predisposing factors illustrate the social determinants of health—within which all other domains reside—and affect vulnerability to crisis events, as well as the degree to which a person can cope with a crisis when it occurs. Factors influencing participants' health care utilization included health beliefs and knowledge and social determinants, such as past trauma and abuse, age, race, gender, history of homelessness, employment, and prior incarceration. For example, one participant described how a miscommunication with a case manager while on parole led to re-incarceration. After his release, he was unable to access his social security funds, which rendered him unable to afford shelter. Because of his fear for safety and sanitary conditions in a shelter, he slept on the streets and did not properly care for his colostomy bag wound site. The wound became infected and he reported to the ED for care. These types of compounding destabilizing factors that lead to increased ED use were commonly reported by participants.

Intervention

Many participants highlighted the positive impact of intensive social work case management, specifically the HUCM program. These participants universally lauded their case managers' impact on their well-being through the organization of both their personal life and their health care. Most often, having one person to help organize all aspects of the participants' life offered a stability not found elsewhere. One quote illustrates the impact on health care utilization:

And so [my case manager] showed up real early to talk to the doctor. . . . That was good and so she was there when I got there and then she and I went and saw the doctor and she was in the room, too. We got everything squared away and the—the pain medication did start working . . . finally. And I was able to get a little bit of sleep that night. And then it's just gotten better and better.

The first four levels of influence—perceived need and ability to cope, health care system factors, medical need, and predisposing factors—often acted synergistically on participants' ED use until they were ultimately referred to the HUCM program. Through intensive case management, caseworkers acted on the social determinants in the participants' lives and on their behalf from within the health care system to ultimately reduce their ED use.

DISCUSSION

To our knowledge, the present study is the first to rely on in-depth interviews with homeless ED frequent users to elucidate influences on health care use. Furthermore, this study is one of only a handful of recent studies that relied on interviews with frequent ED user populations to understand care needs (Capp et al., 2016; Mautner et al., 2013; Poremski et al., 2016). Other previous studies that included both frequent and nonfrequent ED users have highlighted some factors associated with ED use that our study findings support, including fear and uncertainty about symptoms and difficulty accessing outpatient care (Hudgins & Rising, 2016; Rising et al., 2015). Another study highlighted the similarity of self-reported motives for ED visits between frequent and nonfrequent ED users; these findings are also in line with findings from the present study, including access, convenience, cost, quality, and perceived need for urgent care (Doran, Colucci, et al., 2014). Previously identified interventions to decrease ED use and increase use of outpatient care have included a focus on structural solutions such as insurance coverage and use of community health workers (Hudgins & Rising, 2016), increasing use of formal medical training models for providers to improve screening and understanding of appropriate variations in care and hospital admission decisions for homeless patients (Doran, Curry, et al., 2014; Salhi et al., 2017). Our findings add the perspective of frequent users who are also homeless, a particularly vulnerable patient population with intersecting challenges that make treatment and engagement in services particularly difficult.

Participants in our study reported a pattern of increased ED utilization, often initiated by a crisis event, in conjunction with predisposing risk factors, health care system factors, and individual-level vulnerabilities that limited coping strategies. For many participants, the crisis event involved a physical

trauma that led to intense pain and difficulty managing symptoms. Those factors, compounded by high levels of perceived medical need, co-occurring medical concerns, and limited resources to address these concerns in the community, proved to be an insurmountable combination of circumstances that pushed them into a pattern of frequent ED use. Participants did not view their health care utilization as a choice or a decision to be made, but rather viewed their use of the ED as a necessity. ED visits became a necessity to get needs met, particularly for what they viewed as urgent medical and pain management needs. Referral to community services at that point of care, before they have begun the pattern of frequent ED use, may be crucial to altering utilization patterns and improving care. ED providers might consider for all patients a brief psychosocial assessment that includes discussion of current life stressors, barriers to accessing health care, substance abuse services, mental health status, assessment of level of risk for homelessness, and plans for accessing stable housing if already homeless. This kind of assessment can lead to a more comprehensive care-and-discharge plan that includes referrals to case management programs or other community resources that meet the patients' specified needs. In addition, medical providers and others who refer patients to social workers in the ED might consider an automatic referral to social work for assistance with community linkage when a homeless patient with a predisposing instability presents after a crisis, as social workers can provide a thorough assessment of needs, crisis counseling, and concrete services (M. Moore et al., 2017, 2016).

The majority of the patients interviewed were experiencing abject poverty; lacked access to economic opportunities and stability; were food-insecure, and had no access to the basic recommendations of over-the-counter medications, rest, and improved nutrition. These limitations, along with difficulty affording transportation, lack of clean clothing, and inability to attend to personal hygiene, made clinical case management an ideal fit for improving these participants' circumstances (Moniz, 2010). Social work may act as a bridge to the community and to resolve the issues most frequently influencing the ability to access the services that clients need most. Through case management, clients experienced individualized care and accelerated access to emotional and basic needs support. Referral to such programs for vulnerable patients who are homeless is one actionable intervention; increasing resources to fund such

programs and research to evaluate effectiveness are also important. Targeting structural factors for intervention will be an important augmentation to the individual interventions being provided by case managers. Further research is needed to better predict which crisis events lead to frequent use in which patient populations. In addition, making community outpatient alternatives to the ED more convenient for homeless individuals to access, and then advertising these clinics at shelters and resource centers where homeless individuals spend their time, may divert patients to safer and less costly means of care. Creating close partnerships between EDs and community clinics might improve identification of unique local barriers to community clinic use and problematic referral and service patterns. Employing a respected community member and HUCM program graduate peers to champion the use of these clinics might also improve the reputation and trust of existing outpatient clinics. Other means to increase trust in outpatient care include continuity of providers and adequately addressing and managing chronic pain conditions.

Some individual- and system-level interventions have been suggested or piloted across the country with varying levels of success (Althaus et al., 2011). The key to successfully meeting the needs of homeless patients at risk for frequent ED use may be a more comprehensive approach that includes multiple levels of intervention, such as those suggested here. Homeless frequent users of the ED and those at risk for frequent ED use are a particularly vulnerable, marginalized group with poor health outcomes and high medical costs. Finding ways to best meet their needs in the most efficient manner is an important step toward improving their care and decreasing costs. Listening to the voices of homeless individuals in planning for those strategies is crucial to achieving these goals.

LIMITATIONS

Because data for the present study were collected at one hospital and many participants frequented several EDs in the area, the patterns of service use and targets for intervention may not be exhaustive or applicable in all settings. This study focused on frequent ED users who were homeless; other homeless patients were not included. The most unstable patients were either not referred or unable to complete an interview. These patients represent a unique perspective that may differ from participants who were

either not enrolled in the HUCM program or were unable to engage in the program, which is a requirement for enrollment in HUCM. Future studies can include diverse patients, including those who do not speak English. **HSW**

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RESILIENCE IN ACTION

An Information and Practice Guide

Roberta R. Greene and Nicole Dubus

Helping professionals are called to aid individuals and communities in times of tragedy or disaster. Effective intervention and treatment often hinge on augmenting the natural resilience of those affected by adverse situations. But what is resilience? How can practitioners recognize, foster, and celebrate resilience in the people that they serve?

Resilience in Action: An Information and Practice Guide examines the methods, practices, and protocols of the resilience ecological stress model (RESM). A metatheory grounded in ecological systems, RESM can be used to help individuals, families, and communities regain the ability to function after calamitous events. In this book, Roberta R. Greene and Nicole Dubus demonstrate how to apply RESM's framework with a variety of different service users, including those battling a chronic disease, navigating workplace violence, or coping with the aftereffects of an earthquake. The book also discusses how to take a resilient approach to work with refugees, adolescent students, military families, individuals belonging to minority groups, people with disabilities, and the elderly.

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