BECOMING COMPLEX-CAPABLE: THE IMPORTANCE OF HOPE AND STRATEGIES FOR WORKING WITH COMPLEX CLIENTS

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EXECUTIVE SUMMARY

Research Goals
Prepared with community partners from the Guelph Community Health Centre, this literature scan is aimed at (1) demonstrating why hope is critical in the treatment of individuals who possess complex needs through an investigation of the value of hope, and (2) pinpointing the best practices and strategies for inspiring hope in complex clients and welcoming them.

Methods
A literature scan was conducted to find relevant academic and grey literature resources relating to the role of hope, and the means through which hope could be inspired within complex clients.

Main Findings
It was found that hope is critical to life, so much so that it has been described as the *raison d'être* – main purpose – of human existence. Hope might empower clients to imagine an improved future as attainable, encouraging them to better manage symptoms, embrace life purpose, and increase societal involvement in hopes of making positive contributions to their communities. Findings have further suggested that the extent of hope found within an individual contributes to the prospects of following through on recommended treatments, and has been shown to improve self-regulation and decrease maladaptive consumption tendencies.

The literature identifies an abundance of techniques through which hope can be nurtured within clients. The most frequent of these recommendations are loosely based around developing strong staff-client relationships; increasing levels of hope within staff members, which is believed to transfer down to clients; pragmatically utilizing implicit and explicit strategies; creating a welcoming environment; developing autonomy in care; developing collaborative care; developing holistic, continuous care; recognizing spiritual hope; and managing unreasonable hope.
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INTRODUCTION

This literature scan has been completed in conjunction with the Guelph Community Health Centre and explores the role of hope in treating complex clients and the means through which such hope can be instilled within them.

The aims of this project are:

1. To determine why hope is important in the treatment of individuals with complex needs by examining the value of instilling hope within such clients; and,

2. To pinpoint the best practices and strategies for inspiring hope in complex clients and welcoming them.

This report has three main sections. The first section provides the contextual lens through which to understand the other two sections of the report by defining ‘complex clients’ and outlining various conceptualizations and understandings of hope that have been put forward.

The second section outlines the value of hope as described in the literature, explaining why it is perceived as important in treating clients with complex needs and which variant of hope is of most value.

The third section discusses a number of different strategies through which hope can be instilled and/or nurtured within clients.

The aim of the current literature scan is to present information that may assist staff from community based organizations in the provision of complex-capable services that inspire hope in individuals who enter their doors. This may be achieved through the direct provision of welcoming services and supports that meet an individual’s needs or by connecting those seeking support with partner organizations who are able to offer additional services.

METHODS

A number of search engines and library databases were used to find the most relevant academic and grey literature relating to the role of hope and the means through which hope may be inspired in complex clients.
Google Scholar, Primo (library databases including Springer, Wiley, Taylor & Francis Group, PsycARTICLES, Elsevier), and DeepDyve were used as the main search engines for this work. The search queries used included:

- “Recovery-Focused Work”
- “Recovery-Oriented Work”
- “Inspiring Hope” AND “Clinic” OR “Client” OR “Patient”
- “Welcoming Environment” AND “Clinic”
- “Strength Spaced Approach”
- “Complex Capable Services” AND “Hope” OR “Welcoming”
- “Co-Occurring Disorders” AND “Hope” OR “Welcoming”
- “Hope” AND “Clinic” OR “Client” OR “Patient”

WHO ARE COMPLEX CLIENTS AND WHAT IS HOPE?

Complex clients are individuals who possess multiple, unmet needs that include both health and social issues — whether physical, mental, emotional, or societal (Rankin & Regan, 2004). Individuals with co-occurring disorders of mental illness and substance misuse are commonly considered as complex clients (Cruce, Öjehagen, & Nordström, 2012). Individuals with schizophrenia, for instance, have been found to be two to five times more likely to experience harmful use of, or develop a dependency on, addictive substances than the general populace (Barnett, Werners, Secher, Hill, Brazil, Masson, Pernet, Kirkbride, Murray, Bullmore, & Jones, 2007). As such, these individuals require comprehensive, integrated care that meets these complex needs, and inspires hopeful, satisfying ways of life.

“Each individual with complex needs has a unique interaction between their health and social care needs and requires a personalised response from services.” (Rankin & Regan, 2004, P. 1)

Hope is of pivotal importance in treatment for complex clients, but there are a number of different means through which to conceptualize and understand hope. Prior to detailing the value of hope and the strategies through which to nurture it then, it is worth taking
the time to explore its multidimensional meaning so as to better contextualize the sections to follow.

**Measurable Hope?**

Menninger (1959) depicted hope as something that could be objectively studied and measured in individuals, and asserted that hope within individuals must not exceed or deplete below specific levels that staff members should be able to influence. In this respect, medical personnel were perceived as critical in governing the levels of hope clients possessed, as hope was — and still is, to an extent — perceived as a resource that can be transferred from one individual to another individual, especially so in staff-client relationships (Menninger, 1959).

Hope was thus perceived of as a sort of quality that had to be discovered in clients by staff members, and needed to be measured, transmitted, and exploited so as to ensure the survival of the clients in question, with the omission of information that might jeopardize hope considered permissible (Menninger, 1959; Lynch, 1965; DuFault & Martocchio, 1985; Herrestad, Biong, McCormack, Borg, & Karlsson, 2014).

**“Reasonable Hope”**

Over time, the perception of hope has shifted. Weingarten (2010) depicted one of the better-known contemporary forms of hope in her description of what she refers to as “reasonable hope.” This variant is relational and consists of a number of different practices aimed at maintaining a conceptualization within clients of the future as open, uncertain, and up to them (Weingarten, 2010).

> “Hope is an anticipation of a future that is good and is based upon: mutuality, a sense of personal competence, coping ability, psychological well-being, purpose and meaning in life as well as a sense of the possible.” (Miller, 2000, PP. 523-524)

In this respect, the development of personal goals by clients and the routes through which to attain them are critical. The hoping process is considered a means through which clients become equipped to “exist” once more (Weingarten, 2010; Herrestad et al., 2014). Hope is therefore perceived as a positive state of mind that motivates individuals, and is based on sentiments of personal agency and planning capacity (Snyder, 2002).
This perspective also perceives of hope as, in contrast to what Menninger (1959) asserted, a co-creational process. Weingarten (2010), for instance, argues in favour of abolishing the language of “instilling” or “inspiring” hope within clients in favour of “co-creating” hope, which refers to the belief that individuals do not give hope to other individuals, but instead provide conversational opportunities for individuals to strengthen personal hopes through sharing these hopes with others. This necessitates that staff members actively seek to create such conversational opportunities that will assist in the emergence of reasonable hope (Weingarten, 2010; Herrestad et al., 2014).

No Single Definition

With the multiple and competing conceptualizations of hope inherent within the literature — of which, only two have briefly been mentioned for contextual purposes only — the need to define one overriding definitional understanding of hope may not be required. Herrestad et al. (2014) assert that little is to be gained from the development of a universal definition or a framework through which to inspire hope, as conceptualizations of hope and the best means through which to instil them are ultimately dependent on the social practices and societal circumstances in each particular context. Instead, hope should be conceived of on an individual, case-by-case basis that critically examines what assumptions an individual has when making statements about hope, and considers the societal circumstances that allow or disallow space for the actions required for its realization (Herrestad et al., 2014).

THE VALUE OF HOPE

There are a plethora of studies that brand hope as an important factor in therapeutic effectiveness (Menninger, 1959; Lambert, 1992; Yalom, 1998; Cutcliffe & Grant, 2001; Hubble & Miller, 2004; Moore, 2005; Larsen, Edey, & Lemay, 2007). Indeed, it is asserted that hope is critical to life, so much so that Larsen et al. (2007) link this emphasis with the implication that “where there is life there must be hope” (P. 410). Hope is thus, as Marcel (1962) asserts, the raison d’être – main purpose – of human existence.

“Hopelessness can retard recovery or even hasten death, while mobilization of hope plays an important part in many forms of healing.” (Frank, 1973, P. 136)
It is theorized that hope might empower clients to imagine an improved future as attainable, encouraging them to better manage symptoms, embrace life purpose, and increase societal involvement in hopes of making positive contributions to their communities (Davidson & White, 2007; Sælør, Ness, Holgerson, & Davidson, 2014). Deegan (1988) articulated the importance of hope in coping with her schizophrenia well in explaining that “a tiny, fragile spark of hope appeared and promised that there could be something more than all of this darkness” (P. 14). This recollection alludes to the broader belief that hope is inherent within all individuals, the activation of which relies on the gradual revelation of seeds of hope that clients have always possessed (Larsen et al., 2007). Findings have suggested that the extent of hope found within an individual contributes to the prospects of following through on recommended treatments, and has been shown to improve self-regulation and decrease maladaptive consumption tendencies (MacInnis & De Mello, 2005; Perley, Winget, & Placci, 1971; Makarem, Smith, Mudambi, & Hunt, 2014).

Although hope is of critical importance in the healing of clients, it is important to note that hope levels cannot be maintained by oneself forever through the use of personal strategies (Cutcliffe & Grant, 2001). Consequently, external help of some kind is needed in order to nurture hope within clients.

While this external assistance can take a variety of different mediums — such as familial support or religious beliefs — the health care system has been identified as a crucial force in instilling hope given its regular interaction with clients. Health care staff must therefore take an active role in inspiring hope within their clients to ensure that beneficial impacts that have been demonstrated on treatment adherence, treatment commitment, and self-worth are realized.

It is critical not to underestimate the importance of the clients themselves in fostering hope. Indeed, one must be careful in the extent to which hope is depicted as an externally inspired phenomenon. Elliott and Olver (2002) explain that when clients perceive hope as an object bestowed upon them, clients no longer possess control over their own levels of hope and are thus dependent upon the “authority” of professionals rather than themselves. Although this sort of top-down, direct approach is sometimes required – as in the case of suicide risk, for instance – it runs the risk of affording an excessive amount of power to staff members who decide when feelings of hope are legitimate or not, which disempowers clients (Larsen et al., 2007). This seems
somewhat contradictory as hope entails, as described above, an imagined future that is unique to each individual and rests on his or her own agency.

The value of hope therefore lies in its “subjective” possession: it increases and decreases as clients’ perceptions change, with staff members complementing or hindering its growth through their actions (Larsen et al., 2007). Thus, hope is perceived as in need of protection by clients who constantly seek to protect personal hope from insensitive mistakes made by medicinal staff members, as demonstrated below. Instead, objects or events to be hopeful for are determined on an individual basis by clients and requires no legitimization from staff members.

“To hope was to undertake an active process of doing something. To hope introduced the chance that something positive or personally desirable was possible.” (Larsen et al., 2007, P. 409)

In addition, it is important to note that the value of hope can easily be diminished in a number of different ways, sometimes even implicitly. Given the fact that hope is not an everlasting, static state, and that it fluctuates along a hope-despair continuum, individuals who exhibit hopelessness due to the rise and predominance of despair could instill this in individuals surrounding them (Miller, 2007). This is problematic for clients seeking assistance as a correlation has been found between decreased levels of hope and reduced self-esteem and quality of life (Ritchie, 2001; Sullivan, 2003; Miller, 2007).

Further, Bland and Darlington (2002) have noted that despite the important role staff play as sources of hope, occasions sometimes emerge in which staff members serve as threats to the nurturance of hope, even if in indirect, subtle, and unintended manners. Moore (2005) offers an example of such an occasion. Ann, a competent businesswoman who was responsible for the technology department at a large firm, experienced a severe case of depression. During one of her appointments, Ann was speaking with a clinical staff member who was having difficulties sharpening pencils, so she offered to assist. After successfully completing the task, the staff member said, “Wow, you must have done a lot of pencil sharpening in your work,” in a tone and manner that was perceived as demeaning to Ann. This statement demeaned and belittled Ann as she felt as though the staff member in question perceived her as someone capable of doing only unskilled work, crushing the feelings of self-worth and hope she was trying to find at a critical point of time in her illness (Moore, 2005).
FOSTERING HOPE IN COMPLEX CLIENTS

The literature identifies an abundance of means through which hope can be nurtured within clients. The most frequent of these recommendations are discussed below.

Developing and Maintaining Strong Staff-Client Relationships

The most important variable in the cultivation of hope identified within the literature was the relationship staff members have with clients. As the primary point of contact with the health care system, staff members must develop strong and healthy relationships with clients in order to foster hopefulness within them.

Numerous studies exploring a range of individuals enduring different health issues — including individuals suffering from co-occurring disorders — have emphasized the importance of these relationships in inspiring hope (Miller, 1989; Herth, 1990; Cutcliffe & Grant, 2001; Svedberg, Jormfeldt, & Arvidsson, 2003; Alverson, Drake, Carpenter-Song, Chu, Ritsema, & Smith, 2007; Cruce et al., 2012).

For instance, Farran, Herth, & Popovish (1995) found that relationships coupled with a caring environment and continued connectedness with patients has nurtured hope in clients regardless of condition or situation. Cruce et al. (2012) found that clients often perceive staff members as friends that provide companionship for a number of different activities and opportunities to discuss topics unassociated with health care concerns, which prompts individuals to focus on other items beyond immediate health care concerns and motivates them to contemplate the future; a critical aspect of hope.

The importance of staff-client relationships described above is identified time and again throughout the literature. One participant from Cruce et al.’s (2012) study, which explored treatment for individuals experiencing co-occurring mental illness and substance misuse, exemplified the importance of this relationship well in describing it as a mother-son relationship:

She cared for him both with warmth and some degree of strictness, and listened to him when he was sad. She made him aware of his improvements in most life areas and looked for him when he withdrew. (Cruce et al., 2012, P. 666).

As alienated members of society, complex clients often feel stigmatized and isolated. Person-centred approaches counter such sentiments through emphasizing respect for these individuals, their self-determinative capabilities, their potential for personal growth,
the distinctiveness of each individual, and a need for understanding the conditions these individuals experience (Cutcliffe & Grant, 2001; Herrestad, Biong, McCormack, & Borg, 2014).

Listening and really attempting to understand clients’ diverse problems, feelings, and circumstances serve to confirm the humanity and dignity of these individuals. The importance of this attentive listening requires devoting adequate time and undivided attention to each client, which increases feelings of self-worth (Cruce et al., 2012).

Additionally, faced with significant personal and/or societal impediments, individuals might believe circumstances are too difficult to carry on. The provision of positive feedback to these individuals is critical in such moments, as these positive statements will provide the essential hope they are in need of and help inspire a determination to not give up (Cruce et al., 2012).

The following are some of the central techniques identified as most significant to the development of strong, friendly, and respectful relationships:

1. Affirm clients’ worth as human beings (Herth, 1990). Approach them, use non-verbal communication techniques that demonstrate attentive listening, offer therapeutic touch, and begin a conversation as a means to affirm dignity and worth (Herth, 1990). Demonstrate acceptance and understanding of the clients (Cutcliffe & Grant, 2001).
2. Show concern for clients and all aspects of their lives, both related and unrelated to whatever health care symptoms treatment is targeting (Cutcliffe & Grant, 2001; Cruce et al., 2012). Be sensitive to, and understanding of, clients’ predicaments.
3. Maintain continuous contact with the same clients and avoid passing clients off to other individuals (Cruce et al., 2012). Become familiar with the individual as a human being, rather than the individual’s symptoms or health care concerns.
4. Foster mutual honesty about health conditions, social relations, and personal lifestyles in the relationships between staff members and patients (Cruce et al., 2012).

Increase Levels Of Hope In Staff

Although staff can be important sources of hope for individuals, it is also recognized within the literature that it can be draining for staff members to continuously serve as
sole repositories of hope (Larsen et al., 2007). For instance, Freshwater and Robertson (2002) explained that being with clients that experienced despair was challenging for staff members as that despair could, at times, resonate with staff members’ own feelings. As such, scholars have emphasized the importance of increasing the levels of hope within staff members as a means to ensure this hope is passed on to clients in the regular interactions staff have with them (Moore, 2005; Tutton, Seers, & Langstaff, 2009).

“If the counselor fails to bring hope into the therapy environment, a key resource required by the client is not present and the client cannot replenish their depleted hope.” (Cutcliffe, 2004, P. 185).

There are a number of different strategies that can be utilized in an effort to nourish and sustain necessary levels of hope in staff members. Some of the most noteworthy of these tactics include:

1. **Workplace Cultural Shifts:** Changing the culture in which staff members work is seen as critical in inspiring hope within them. Making space for staff to observe and reflect upon the regular interactions they have with one another and the activities they perform enables staff to explore teamwork effectiveness, workload management, staff relationships, and overall time management (Herrestad et al., 2014). Exploring these aspects of their work enables staff members to develop more effective, person-centred workplaces that reduce stress and generate greater feelings of hopefulness in teamwork (Herrestad et al., 2014).

2. **Increased Client Awareness:** Increasing the personal knowledge staff members have of clients is perceived as a means of inspiring hope within clients as staff members will want the clients being cared for to pursue positive change due to new sentiments of connectedness (Herrestad et al., 2014). This practice involves looking beyond the symptoms that characterize the client and focusing on the characteristics that make him or her human, as well as the personal histories of these clients.

3. **Hope Retreats/Events:** In-depth training events dedicated to increasing the understanding staff members have of hope in the therapeutic process have also been seen as critical to the development of hope within staff, which energizes them around the importance of hope and the need to integrate related principles and practices within treatment (Moore, 2005).
Moore (2005) describes such a Hope Retreat and the activities attendees were encouraged to participate in, one of which involved the creation of personal hope kits. These hope kits served as an insurance policy of sorts that was to be on-hand and available at all times in case it was needed, and involved the collection of images and items of hope that were personally meaningful to them (Moore, 2005). Staff members were instructed to refer to their personal hope kits on days when hope levels felt diminished or challenged, and were encouraged to use this same strategy with the clients they served (Moore, 2005).

**Use Implicit & Explicit Based Strategies**

There is some debate among both scholars and practitioners about whether hope is to be inspired through implicit or explicit means.

Some assert that while hope needs to be intentionally incorporated within treatment programs, staff members should not explicitly mention hope to clients as this might be perceived as an imposition of staff members’ views of hope upon clients (Cutcliffe, 2004; Larsen et al., 2007). Forcing clients to view situations in particular ways and perceive of specific hopes in certain scenarios is considered a top-down approach that is disrespectful and counterproductive in treating complex clients. Explicitly mentioning hope in interactions with clients, from this perspective, might make them feel as though staff members are not listening nor allowing them to speak, and that hope is being coercively imposed upon them rather than nurtured collaboratively with them (Hanna, 2002). This practice will conflict with the ability of clients to feel a sense of ownership in their treatment and future, which is critical in the acquisition of hope. Some client-focused studies have supported this perspective, with clients expressing a belief in qualitative interviews that hope should be an implicit tactic in interactions with staff members (Larsen et al., 2007).

In contrast, some assert that there is value in mentioning and bringing up hope in explicit ways with clients, as this will ensure these individuals at least begin to give some thought to hope and the role it can have in the therapeutic process (Larsen et al., 2007).

There is thus a need for a pragmatic approach to the utilization of implicit and explicit means of hope inspiration. Throughout staff interactions with clients, implicit and explicit focuses on hope should be utilized, as depicted in the four strategies Larsen et al. (2007) describe:
1. **Staff Implicit/Client Implicit:** In this approach, hope is perceived as the gift of a desirable future. The development of hope is therefore linked to any practice that makes the future more tolerable, which can be accomplished through implicitly fostering hope within clients without explicitly mentioning it.

2. **Staff Explicit/Client Implicit:** In this approach, hope is perceived and integrated into treatment in an explicit manner as part of the therapeutic process. In such scenarios, staff members might ask for the client’s permission to speak about hope, to which the client can refuse or not answer with the expectation that staff members not bring up such a discussion.

3. **Staff Explicit/Client Explicit:** In this approach, both staff members and clients agree about the importance of hope in treatment, and negotiate the means through which this will be integrated into the therapeutic process. Such an approach might involve hope-focused questioning that is aimed at noticing hope, attaining evidence of hope, scaling hope, and imagining hope. Corresponding questions to each of these aims might include: “Who is someone you think of as being hopeful? … What is a hope that has come true? … How hopeful are you on a scale of one to ten? … What would a hopeful person do in this situation?” (PP. 411-412).

   This approach might also make use of a “hope collage,” in which clients take images from magazines and other graphical mediums and create a visual representation of the numerous elements reflective of their personal hope (Larsen et al., 2007). Besides the end product created, the process involved in the creation of these collages might even inspire hope as clients further contemplate a better future that becomes increasingly perceived as attainable (Larsen et al., 2007).

4. **Staff Implicit/Client Explicit:** In this approach, staff members might not be explicitly raising hope in interactions with clients, but clients might offer a series of hints indicating that there might be a potential desire for a discussion about hope. Staff members should capitalize on such statements and converse about hope with clients. Comments such as “The one hope is…” or “I hope that…” are common in interactions with clients, so staff members must determine when the use of the term hope is aimed at sparking a broader, more in-depth discussion about it and when it is used in a general sense.

Using these different approaches in a pragmatic way will help staff members embrace strategies that meet the needs of their clients, satisfy divergent perspectives of hope.
between clients and themselves, and recognize the importance of shifting and continuously adapting processes of inspiring hope (Larsen et al., 2007).

Create A Welcoming Environment

As previously mentioned, complex clients endure continuous stigmatization and marginalization within the communities in which they live. The health care systems serving these communities have been largely ineffective in combatting these feelings. This is due to a general lack of information available on effective treatment programs for clients suffering from co-occurring disorders, as well as systemic barriers that prevent holistic, comprehensive treatment (Minkoff & Cline, 2004).

Consequently, complex clients are perceived as “misfits” in their general communities and in health care systems in particular, as current regulations, funding frameworks, clinical certifications, and clinical credentials are not geared towards serving complex clients (Minkoff & Cline, 2004). This exclusion results in devastating blows to the hope these clients possess, making them feel “unwelcomed” in communities and health care facilities alike. This might lead these individuals to seek care from environments with fewer supports, such as temporary shelters (Minkoff & Cline, 2004).

There is thus an essential need to develop welcoming and accessible environments for complex clients so as to ensure these individuals feel hopeful about their future from the moment they enter health care facilities. Minkoff and Cline (2004) stress the importance of incorporating this emphasis on welcoming in written materials so as to ensure such practices are anchored within the health care system and ensure that staff members adhere to this important practice. This can be done through a number of simple tactics Minkoff and Cline (2004) describe such as:

1. Crafting a set of welcoming policies for all staff to abide by;

2. Writing and displaying a welcoming mission statement for clients to see upon entering;

3. Providing diverse informational materials for clients with a range of health challenges in the front foyer;

4. Conducting an orientation for staff members about the importance of welcoming clients, and how to accomplish this effectively; and,
5. Displaying aesthetically pleasing plants in the front foyer.

In addition, banners and posters displayed in prominent locations of the facilities should be written in a way that speaks to clients with co-occurring disorders rather than focusing on one disorder to the exclusion of others (Minkoff & Cline, 2004). This practice will hopefully inspire hope within the clients in question as it will seem as though the facility is specifically targeting them and understands what these individuals are experiencing.

There is also an emphasis on the provision of adequate training that will help staff members inspire hope. This training can range from general clientele satisfaction training to specific case-by-case training (Minkoff & Cline, 2004). For instance, Minkoff and Cline (2004) offer an illustrative example of a training module in which a client attends an appointment intoxicated and staff members must approach the client through the use of welcoming procedures they have been taught so as not to foster feelings of unwelcomeness that might diminish hope.

It is imperative that staff members have the ability to offer such welcoming services. Although adequate training can help staff members create a more welcoming, inclusive environment, this training will be of little value if staff members do not have the supporting policies needed to implement these practices (Minkoff & Cline, 2004). Contracts and policies must therefore provide staff members with the necessary flexibility to apply practices featured in welcoming training to their actual interaction with clients.

Develop Autonomy In Care

Autonomy and self-determination were identified as critical factors in inspiring hope. Clients value treatment programs that promote their own autonomous decision-making and autonomy in undertaking activities, strengthen their sense of self-worth and self-identification, and provide stability in day-to-day life (Cruce et al., 2012). These individuals want to limit the amount and frequency of contact they have with health care facilities and staff members over a gradual timeframe, and want to feel as though the steps they are taking as clients are fulfilling the requirements of treatment (Cruce et al., 2012). This relates to the importance of client ownership in the design and implementation of treatment, which is essential in building hope, as individuals will feel empowered to pursue positive change aimed at achieving a better future.
This sort of autonomy can be instilled within clients through a few different means. Treatment should first of all be individualized in accordance with each client’s needs and expectations, and it should develop self-confidence and independence within clients (Cruce et al., 2012). This might be accomplished through the provision of training regimes where self-help skills are built relating to occupational rehabilitation, housework, or road safety (Cruce et al., 2012).

**Develop Collaborative Care**

Although staff members have an important role to play in the inspiration of hope, it is also important that clients feel involved in and develop a sense of ownership of a treatment program (Larsen et al., 2007). This will ensure clients feel as though they are actively contributing to the pursuit of an improved future.

Treatment should therefore be designed through cooperation and collaboration between staff members and clients so that clients are involved in their own recovery process (Larsen et al., 2007; Cruce et al., 2012). In this respect, hope is fostered through shared construction between clients and staff members; an “experience co-created between individuals” (Larsen et al., 2007, P. 410).

This involves the development of conversational spaces in which staff members and clients collectively brainstorm client goals and actions that can be taken by the clients themselves to reach such goals (Herrestad et al., 2014). Having these conversations, it is theorized, will increase the likelihood that clients will realize whatever goals are hoped for as they will have had an active process in the determination of such goals (Herrestad et al., 2014).

**Develop Holistic, Continuous Care**

The development of comprehensive, continuous care that targets unique physical, mental, and emotional needs is also identified as critical in the nurturance of hope. The literature explains that clients have frequently complained about past treatment experiences in which the treatment offered focused on one disorder — substance misuse or mental illness — to the exclusion, and often the neglect, of the other (Cruce et al., 2012). This neglect diminishes hope within clients as these individuals feel as though staff members only care about one aspect of their situation, and that treatment programs are not designed for their complex, multifaceted problems.
In addition, clients have emphasized the need for continuous care that will provide them with the means to pursue gradual change rather than feel pressured to hasten recovery, which will decrease critical sentiments of ownership (Cruce et al., 2012). Likewise, treatment must not be ended too early, lest the client’s overriding stability become vulnerable (Cruce et al., 2012).

Recognize Spiritual Hope

As much as hope is rooted within the relationships clients have with staff members, it is also important to note the critical role spirituality and/or religion has in the hoping process.

“Hope is a movement of appetite aroused by the perception of what is agreeable, future, arduous, and possible of attainment.” — St. Thomas Aquinas

The quotation above offered by St. Thomas Aquinas implies that individuals must make an effort of some kind for hope to be fulfilled (Herrestad et al., 2014). For him, these efforts were to be directed towards God, as hope was perceived as a divinely ordained phenomenon (Herrestad et al., 2014). In this interpretation, prayers made to God are the most important action individuals can take for hope to be inspired and fulfilled within them.

The importance of faith is still a critical factor in fostering hope for some individuals, and is thus viewed as essential for the recovery of some clients (McDowell, Galanter, Goldfarb, & Lifshutz, 1996; Cruce et al., 2012). Spiritual and/or religious beliefs can offer a sense of meaning, for instance, for the suffering clients endure (Tutton et al., 2009). Despite this acknowledgement, staff members have been found to underestimate the importance of clients’ spirituality and/or religion and its importance for individuals’ recovery (McDowell et al., 1996).

It is therefore crucial that staff members recognize the positive role spirituality and/or religion can have in the nurturance of hope for some clients, and seek to provide the means through which this channel can be utilized. This entails providing the space for clients to find meaning in their lives outside of treatment through any spiritual and/or religious beliefs and practices they follow. For example, regular visits by officials from the diverse range of spiritualities and/or religions that clients believe in or designated areas in which clients could foster a connection to their beliefs might help inspire hope.
Manage Unreasonable Hope

It is critical that staff members not diminish a client’s hope, but it is also critical that staff members do not encourage false hope (Herrestad et al., 2014). Staff members must continually assess the extent to which a client’s hope might be realized in the foreseeable future, especially in scenarios where clients exhibit hopefulness for changes that have small probabilities of occurring (Herrestad et al., 2014).

In situations where it seems as though clients possess false hope, it is recommended that staff members affirm the positive role of this hoping process without confirming or disconfirming the prospects of whatever it is hoped for to be achieved (Herrestad et al., 2014). For instance, Taylor and Gideon (1982) wrote that:

“We would never take it upon ourselves to dash a patient’s hopes – that isn’t our role. But neither do we provide false hope – we won’t encourage the patient to shop around for still another hospital, another doctor, or some new unproven cure. If a patient expresses his faith in and hopes for an improbable outcome, we simply say: “We hope and pray you’re right.” (Taylor & Gideon, 1982, PP. 42-43).

CONCLUSIONS

This brief literature scan has outlined some important findings from the literature surrounding the role of hope in treating individuals with complex needs. It sought to determine:

1. Why hope is important in the treatment of individuals who possess complex needs through an investigation of the value of instilling hope within such clients; and,  

2. The best practices and strategies for inspiring hope in complex clients and welcoming them.

While the findings offer preliminary information that might be helpful and some initial steps that can be taken, it is important to note that this report constitutes a brief literature scan and not a comprehensive review of the literature. Most attention was directed to those sources deemed of most relevance and importance to the project and community partner, meaning other related sources which feature potentially beneficial tactics have not been included. We do however recommend the research cited here as a strong starting point for those wanting to learn more about the importance of instilling
hope in clients and gain insight into various evidence informed strategies to consider in the successful treatment of complex clients.
APPENDIX: STRATEGIES AT A GLANCE

The following table provides a brief synopsis of the main techniques medical facilities and staff can take to inspire hope within clients that possess complex needs.

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<tr>
<th>Thematic Topic</th>
<th>Practical Steps</th>
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<td>Develop Strong Staff-Client Relationships</td>
<td>Respect clients, their self-determinative capabilities, and their potential for personal growth.</td>
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<td>Be aware of the distinctiveness of each individual and attempt to understand the conditions experienced.</td>
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<td>Devote adequate time and undivided attention to each client.</td>
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<td>Provide positive feedback to clients as a means of inspiring a determination within them to not give up.</td>
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<td>Affirm clients’ worth as humans by approaching them, using non-verbal communication techniques that demonstrate attentive listening, and offering therapeutic touch.</td>
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<td>Demonstrate acceptance and understanding of the clients in question. Show concern for clients and all aspects of their lives, both related and unrelated to whatever health care symptoms treatment is targeting.</td>
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<td>Be sensitive to, and understanding of, clients’ predicaments.</td>
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<td>Maintain continuous contact with the same clients and avoid passing clients off to other individuals.</td>
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<td>Foster mutual honesty in the relationships between staff members and patients.</td>
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<td>Thematic Topic</td>
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| Increase Levels Of Hope Within Staff | Organize regular observation and reflection activities that focus on the interactions staff have and practices staff members perform to explore teamwork effectiveness, workload management, staff relationships, and overall time management. This will enable staff members to develop more effective, person-centred workplaces that reduce stress and generate greater feelings of hopefulness in teamwork.  
Increase the personal knowledge staff members have of clients so staff members will want the clients being cared for to pursue positive change due to new sentiments of connectedness.  
Provide in-depth training events dedicated to increasing the understanding staff members have of hope in the therapeutic process, which energizes them around the importance of hope and the need to integrate it within treatment.  
Conduct a workshop for staff members in which personal hope kits are constructed. These kits are meant to serve as an insurance policy of sorts and involve the collection of images and items of hope that are personally meaningful to staff members. Kits can be referred to when staff members feel that their hope levels are diminished or challenged. |
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| Use Implicit & Explicit Strategies | Use a pragmatic approach to the utilization of implicit and explicit means of hope inspiration. Implicitly foster hope within clients without explicitly mentioning it through attempting to introduce ideas and practices that make them perceive of the future as more tolerable. Ask for the client’s permission to speak about hope, to which the client can refuse or not answer with the expectation that an explicit discussion about hope be avoided. Discuss hope and its role in treatment with clients and, should they agree, negotiate the means through which discussions of hope will be integrated into the therapeutic process. Include hope-focused questioning that is aimed at noticing hope, attaining evidence of hope, scaling hope, and imagining hope. Corresponding questions to each of these aims might include:  
• “Who is someone you think of as being hopeful?”  
• “What is a hope that has come true?”  
• How hopeful are you on a scale of one to ten?”  
• “What would a hopeful person do in this situation?” Have clients construct “hope collages,” in which clients take images from magazines and other graphical mediums and create a visual representation of the numerous elements reflective of their personal hope. |
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| Create A Welcoming Environment   | Develop welcoming and accessible environments for complex clients so as to ensure these individuals feel hopeful about their future from the moment they enter health care facilities.  
Incorporate an emphasis on welcoming in written materials so as to ensure such practices are anchored within the health care system, which will help ensure staff members adhere to this important practice.  
Craft a welcoming set of policies for all staff to abide by.  
Write and display a welcoming mission statement for clients to see upon entering.  
Provide diverse informational materials for clients with a range of health complications in the front foyer.  
Conduct an orientation for staff members about the importance of welcoming clients, and how to accomplish this effectively.  
Display aesthetically pleasing plants in the front foyer. |
| Develop Autonomy In Care         | Provide individualized treatment in accordance with each client’s needs and expectations.  
Provide treatment that helps foster self-confidence and independence within clients.  
Provide training regimes where self-help skills are built relating to occupational rehabilitation, housework, or road safety for instance. |
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<td>Develop Collaborative Care</td>
<td>Design treatment through cooperation and collaboration between staff members and clients so that clients are involved in their own recovery process.</td>
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<td>Develop conversational spaces in which staff members and clients collectively brainstorm client goals, and the actions that can be taken by the clients themselves to attain them.</td>
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<td>Develop Holistic, Continuous Care</td>
<td>Provide continuous care that will afford clients the means through which to pursue gradual change, which will increase critical sentiments of ownership.</td>
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<td>Do not end care too soon as it might be perceived as abandonment.</td>
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<td>Recognize Spiritual Hope</td>
<td>Recognize the positive role spirituality/faith can have in the nurturance of hope for some clients.</td>
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<td>Arrange visits by, or appointments with, spiritual officials.</td>
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<td>Provide the space for clients to find meaning in their lives outside of treatment through any spiritual and/or religious beliefs and practices they follow</td>
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<td>Designate areas in which clients can foster a connection to their beliefs.</td>
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<td>Manage Unreasonable Hope</td>
<td>Assess the extent to which a client’s hope might be realized in the foreseeable future, especially in scenarios where clients exhibit hopefulness for changes that have small probabilities of occurring.</td>
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<td>If clients possess false hope, it is recommended that staff members affirm the positive role of this hoping process without confirming or disconfirming the prospects of whatever it is hoped for to be achieved (i.e. “We hope and pray that you’re right”).</td>
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REFERENCES


Cutcliffe, J., & Grant, G. (2001). “What are the Principles and Processes of Inspiring Hope in Cognitively Impaired Older Adults within a Continuing Care Environment?” *Journal of Psychiatric and Mental Health Nursing, 8*, 427-436.


