Best Practices in Homeless Services

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Training Objectives:
Participants will be able to:

- Identify the four elements of the mindset and heart-set of best practices
- Give two examples of responding in a trauma-informed manner
- Describe the three phases of Critical Time Intervention
- Describe the four processes of Motivational Interviewing
- Name three benefits of integrating peer support providers in homeless services
- Explain what it takes to successfully implement a best practice

9:00 Welcome and Opening
River of Resilience activity – values, strengths, and supports

9:30 Overview of Best Practices in Homeless Services
What they are and why they matter
The mindset and heart-set of best practices

10:00 From Housing Ready to Housing First
Housing First principles, practices, and outcomes
Tenancy support in permanent supportive housing

10:30 BREAK

10:45 Case Management Approaches in Homeless Services
History and models of case management
Critical Time Intervention – a time-limited approach

11:30 Trauma-Informed Care
The impact of trauma
Responding from a trauma-informed perspective

12:15 LUNCH

1:00 Enhancing Motivation to Change
Spirit, skills and processes of Motivational Interviewing
A guided MI conversation

2:15 BREAK

2:30 Integrating Peer Support Providers
Involving and integrating peers in service delivery
Principles and practices of recovery-oriented care

3:15 Caring for Self while Caring for Others
Why self-care matters
Sources of resilience and renewal

3:40 Implementing Best Practices
Why training is not enough
Steps for successful implementation of best practices

4:00 ADJOURN

The Mindset and Heart-set of Best Practices

"Best practices are done *for* or *with* people, not *on* or *to* them."
William R. Miller paraphrased

William R. Miller and Stephen Rollnick in Motivational Interviewing: Helping People Change (3rd edition) describe four elements of the mindset and heart-set of Motivational Interviewing: partnership, acceptance, compassion, and evocation. A convincing case can be made that these same elements reflect the core values of *all* best practices in homeless services – of what it truly means to care.

It is well known that the manner or spirit in which we provide care has a significant impact on people's receptivity to accepting the help being offered. This mindset and heart-set must be genuine and sincere; it cannot be fabricated. It is expressed through our body language, non-verbal facial expressions, tone of voice, attitudes, intentions, and how we use language to express ourselves. This mindset and heart-set is the essence of what people experience in our presence.

The elements of the mindset and heart-set of best practices are briefly described below:

PARTNERSHIP
Forming a collaborative working relationship with someone; letting go of the need to be the expert; showing genuine respect for the other person's life experience, hopes, and strengths; assuming that both of you have important expertise and ideas; "dancing rather than wrestling"

ACCEPTANCE
Meeting someone "where they're at" without judgment; believing in the person's inherent worth and potential; conveying empathy – seeking to understand where they're coming from; shining a light on the good things you see in them instead of focusing on what's wrong with them

COMPASSION
Coming alongside people in their suffering (e.g., homelessness, trauma, mental illness, addiction, grief, stigmatization, racial injustice, denial of rights); offering the gift of a safe, listening presence; being in solidarity with; acting *for* and *with* people

EVOCATION
Inviting or "calling forth" from people what they already possess – their hopes, values, desires and aspirations; learning what people are passionate about, what they already know and can do, what they want to learn, what's important to them, how they'd like their lives to be different, what changes they're willing to consider making, and more.

Adapted from Motivational Interviewing, *3rd edition by Miller & Rollnick, 2013*

Housing First

Housing First has been recognized as a promising practice by national researchers and policymakers. As a result, communities in many parts of the world are piloting projects that employ Housing First principles.

The National Alliance to End Homelessness (NAEH) defines the Housing First approach for addressing the chronic homelessness of disabled and vulnerable people as "a client-driven strategy that provides immediate access to an apartment without requiring initial participation in psychiatric treatment or treatment for sobriety."

Housing First is based on two core convictions:

1. Housing is a basic human right, not a reward for clinical success, and

2. Once the chaos of homelessness is eliminated from a person's life, clinical and social stabilization occur faster and are more enduring.

Housing First principles:

1. Move people into housing directly from streets and shelters without preconditions of treatment acceptance or compliance.

2. The provider is obligated to bring robust support services to the housing. These services are predicated on assertive engagement, not coercion.

3. Continued tenancy is not dependent on participation in services.

4. Units targeted to most disabled and vulnerable homeless members of the community.

5. Embraces harm reduction approach to addictions rather than mandating abstinence. At the same time, the provider must be prepared to support resident commitments to recovery.

6. Residents must have leases and tenant protections under the law.

7. Can be implemented as either a project-based or scattered site model.

Adapted from Downtown Emergency Service Center, Seattle, WA website www.desc.org

Critical Time Intervention Basics

Critical Time Intervention (CTI) is a specialized, time-limited case management intervention for the critical transition period from institutional to community care for people experiencing homelessness and mental illness. CTI was originally designed to help people transition from living in institutions (e.g. hospitals, jails, prisons) to community living, but now has broadened to include other types of transitions (e.g., from street to housing, or from one level of housing to another).

CTI is designed to bridge the gap between homeless specific services and community services. CTI prevents recurrent homelessness, residential instability and fragmented care by connecting the person to informal networks (e.g., family, shopkeeper at the corner bodega, friends) and to formal caregivers (e.g., case manager, psychiatrist). The goal is to help the various caregivers and other support people in the community connect with each other to form a network of care.

Principles of CTI

- A two-way street, with the client adjusting to community services and community resources adapting to individual needs for support
- Strives to have the client live in the least restrictive environment possible, but with the maximum amount of support
- Assesses clients along a continuum of needs
- Complements rather than duplicates existing service systems

Key Characteristics of CTI

- Time limited (approximately 9 months)
- Three phases with decreasing intensity of services over time
- Focus on only a few areas of treatment at a time
- Community-based model – outreach, assessment, monitoring and treatment – not office-based
- Small caseloads
- Harm reduction approach to behavioral change
- CTI team supervision by a CTI-trained MSW or Psychiatrist
- Early engagement with client
- Early linking to community
- No drop-outs: CTI intervention rarely shorter than 9 months

Phases of CTI

CTI is a nine-month intervention that begins on day of discharge from an institution or other setting. CTI ends approximately nine months later.

PRE-CTI

Prior to client's actual transition, an assessment is made of community links and client strengths.

PHASE 1: TRANSITION TO COMMUNITY

This phase begins on the day of discharge/transition. It is marked by intensive support and assessment of resources for the transfer of care to community providers. During this phase:

- CTI worker is there on day of discharge to help individual get settled and begin making community linkages.
- People in the community appreciate knowing the CTI worker will help them with some of the responsibilities in helping the client transition.
- Mediation and negotiation are critical skills for this phase.
- CTI worker makes a general plan with the client on what areas of treatment will be the focus during Phase 1 (This process begins in Pre-CTI phase.)
- CTI team members identify key providers who will help with services.
- Worker brings together community members.
- Most of this phase is spent on outreach.
- CTI worker does in vivo assessment of client's needs and skills.

PHASE 2: TRYOUT

Phase 2 focuses on trying out and adjusting support systems that were initiated in Phase 1. The goal is to strengthen connections between the client and supports in the community.

PHASE 3: TRANSITION OF CARE

In Phase 3, the focus is on transferring care from the CTI team to community resources for long-term support. The CTI team steps back to observe, anticipate pending problems, and to ensure the community supports are functioning well. In addition:

- Phase 3 focuses on the final transfer of care and includes a final transfer of care plan.
- Two weeks before the end of CTI, the worker and client have a wrap up meeting to get client's feedback and determine who he/she might call in case of need.
- Client begins to picture the future and see how far he/she has come.

THROUGHOUT THE PHASES OF CTI:

- Services decrease and responsibility is passed on to others. This is made clear all along the way.
- Client and community get in the habit of operating without CTI worker.

Trauma-Informed Care Basics

How can providers help care for people who have experienced trauma? In this article, we share best practices for trauma-informed care. These include understanding trauma and its effects, creating safe physical and emotional space, supporting consumer choice and control, and integrating trauma-informed care across service systems.

Some people experience very few traumatic events in their lives. For others, experiences of traumatic stress are chronic. Research and experience tell us that for people experiencing homelessness, rates of trauma are extraordinarily high. Many who enter the homeless service system have experienced violence, loss, and disruptions to important relationships from an early age.

Additionally, people who lack housing experience the loss of place, safety, stability, and community. These losses are also traumatic. They have a major impact on how people understand themselves, the world, and others. People who have experienced multiple traumas do not relate to the world in the same way as those who have not. They require services and responses that are uniquely sensitive to their needs.

What makes an experience traumatic?

- The experience involves a threat to one's physical or emotional well-being.
- It is overwhelming.
- It results in intense feelings of fear and lack of control.
- It leaves people feeling helpless.
- It changes the way a person understands themselves, the world and others.

Becoming Trauma-Informed

We know people can and do recover from trauma, and we want to provide services and environments that support healing. To be a "trauma-informed" provider is to root your care in an understanding of the impact of trauma and the specific needs of trauma survivors. We want to avoid causing additional harm to those we serve.

What does this mean in practical terms? How is this different than business as usual? Here are some concrete practices of trauma-informed care.

Understanding Trauma and its Impact

Educating providers on traumatic stress and its impact is essential. Trauma survivors, particularly those who have experienced multiple traumas, have developed a set of survival skills that helped them to manage past trauma. These survival strategies (like substance abuse, withdrawal, aggression, self-harm, etc.) make sense given what people have experienced. But they can be confusing and frustrating to others and often get in the way of current goals.

Without an understanding of trauma, providers may view those they serve in negative ways. Providers might describe behaviors as "manipulative," "oppositional," or "unmotivated." Yet these behaviors may be better understood as strategies to manage overwhelming feelings and situations. Trauma-informed training can help providers understand these responses and offer trauma-sensitive care.

Promoting Physical and Emotional Safety
Traumatic experiences often leave people feeling unsafe and distrustful of others. Creating a sense of physical and emotional safety is an essential first step to building effective helping relationships. Safe physical environments may include:

- Well-lit spaces
- Security systems; an ability for individuals to lock doors and windows
- Visible posting rights and other important information
- Culturally familiar signs and decorations
- Child-friendly spaces that include objects for self-soothing

Practices that help to create a safe emotional environment include:

- Providing consistent, respectful responses to individuals across the agency
- Asking people what does and does not work for them
- Being clear about how personal information is used
- Permitting people to engage in their own cultural and spiritual rituals
- Provide group activities that promote agency and community (e.g. movement, exercise, yoga, music, dancing, writing, visual arts)

Supporting Control and Choice
Situations that leave people feeling helpless, fearful, or out of control remind them of their past traumatic experiences and leave them feeling re-traumatized. Ways to help consumers regain a sense of control over their daily lives include:

- Teach emotional self-regulation skills such as altering breathing and heart rate
- Keep individuals well informed about all aspects of their care
- Provide opportunities for input into decisions about how a program is run
- Give people control over their own spaces and physical belongings
- Give advanced notice related to conducting room or apartment checks
- Collaborate in setting service goals
- Assist in ways that are respectful of and specific to cultural backgrounds
- Maintain an overall awareness of and respect for basic human rights and freedoms

Integrating Care Across Service Systems
Becoming trauma-informed means adopting a holistic view of care and recognizing the connections between housing, employment, mental and physical health, substance abuse, and trauma histories. Providing trauma-informed care means working with community partners in housing, education, child welfare, early intervention, and mental health. Partnerships enhance communication among providers, and help minimize consumers' experiences of conflicting goals and requirements, duplicated efforts, and or of feeling overwhelmed by systems of care. It helps build relationships and resources to provide the best quality of care possible.

Becoming trauma-informed means a transformation in the way that providers meet the needs of those they serve. The ideas above are only a beginning. Change happens as organizations and providers take these ideas, as well as their own, and use them to evaluate and adapt their approaches to care.

Adapted from *Trauma-Informed Care 101,* Homelessness Resource Center for Social Innovation
http://homeless.samhsa.gov/Resource/View.aspx?id=46857&g=ComResPosts&t=423

Complex Post Traumatic Stress Disorder (C-PTSD)

Complex Post Traumatic Stress Disorder (C-PTSD) is a condition that results from chronic or long-term exposure to emotional trauma over which a person has little or no control and from which there is little or no hope of escape, such as in cases of:

- Childhood/domestic emotional, physical or sexual abuse
- Repeated violations of personal boundaries
- Long-term objectification
- Exposure to gaslighting/mental abuse and false accusations
- Long-term exposure to inconsistent, push-pull, splitting or alternating raging and hoovering behaviors
- Long-term taking care of mentally ill or chronically sick family members
- Entrapment, kidnapping
- Slavery or enforced labor
- Long term imprisonment and torture
- Long term exposure to crisis conditions

When people have been trapped in a situation over which they had little or no control at the beginning, middle or end, they can carry an intense sense of dread even after that situation is removed. This is because they know how bad things can possibly be. And they know that it could possibly happen again. And they know that if it ever does happen again, it might be worse than before.

The degree of C-PTSD trauma cannot be defined purely in terms of the trauma that a person has experienced. It is important to understand that each person is different and has a different tolerance level to trauma. Therefore, what one person may be able to shake off, another person may not. Therefore more or less exposure to trauma does not necessarily make the C-PTSD any more or less severe.

C-PTSD sufferers may "stuff" or suppress their emotional reaction to traumatic events without resolution either because they believe each event by itself doesn't seem like such a big deal or because they see no satisfactory resolution opportunity available to them. This suppression of "emotional baggage" can continue for a long time either until a "last straw" event occurs, or a safer emotional environment emerges and the damn begins to break.

The "Complex" in Complex Post Traumatic Disorder describes how one layer after another of trauma can interact with one another. Sometimes, it is mistakenly assumed that the most recent traumatic event in a person's life is the one that brought them to their knees. However, just addressing that single most-recent event may possibly be an invalidating experience for the C-PTSD sufferer. Therefore, it is important to recognize that those who suffer from C-PTSD may be experiencing feelings from all their traumatic exposure, even as they try to address the most recent traumatic event.
This is what differentiates C-PTSD from the classic PTSD diagnosis - which typically describes an emotional response to a single or to a discrete number of traumatic events.

Difference between C-PTSD & PTSD
Although similar, Complex Post Traumatic Stress Disorder (C-PTSD) differs slightly from the more commonly understood & diagnosed condition Post Traumatic Stress Disorder (PTSD) in causes and symptoms. C-PTSD results more from chronic repetitive stress from which there is little chance of escape. PTSD can result from single events, or short-term exposure to extreme stress or trauma.

Therefore a soldier returning from intense battle may be likely to show PTSD symptoms, but a kidnapped prisoner of war who was held for several years may show additional symptoms of C-PTSD. Similarly, a child who witnesses a friend's death in an accident may exhibit some symptoms of PTSD but a child who grows up in an abusive home may exhibit the additional C-PTSD characteristics shown below:
C-PTSD

What it Feels Like
People who suffer from C-PTSD may feel un-centered and shaky, as if they are likely to have an embarrassing emotional breakdown or burst into tears at any moment. They may feel unloved or that nothing they can accomplish is ever going to be "good enough" for others.

People living with C-PTSD may feel compelled to get away from others and be by themselves, so that no one will witness what may come next. They may feel afraid to form close friendships to prevent possible loss should another catastrophe strike.

People experiencing C-PTSD may feel that everything is just about to go "out the window" and that they will not be able to handle even the simplest task. They may be too distracted by what is going on at home to focus on being successful at school or in the workplace.

Adapted from http://outofthefog.website/toolbox-1/2015/11/17/complex-post-traumatic-stress-disorder-c-ptsd

A Brief History of Motivational Interviewing

Motivational Interviewing (MI) is a way of talking with people about change related to things we often have mixed feelings about – exercise, diet, alcohol and other drug use, relationship issues, risky sexual behaviors, school and job related concerns, spiritual practices, certain attitudes, and other issues we face in our lives.

The MI approach grew out William R. Miller's work with problem drinkers. In the past, it was believed that people who drank too much were unable to see how their use was harming themselves and others. They were said to be in denial. Counselors and others who wanted to help would try to break through this denial by using "in-your-face" tactics such as confrontation and shame to try to convince people of their need to change. As you can imagine, this approach didn't work very well. None of us like it when other people think they know what's best for us or try to *get* us to change. We want to decide for ourselves how to live our lives.

In 1991, William R. Miller and Stephen Rollnick wrote a book titled *Motivational Interviewing: Preparing People to Change Addictive Behavior.* It explained how to talk with people about their alcohol and drug use in ways that respected their ability to decide for themselves whether they wanted to change. In the book, the authors described the spirit (core attitudes and beliefs) of this approach and the specific skills and strategies of MI.

A second edition, *Motivational Interviewing: Preparing People for Change*, was published in 2002. It further explained how MI works, the research behind it, and how to get better at using MI. It also described the spread of MI to other areas beyond substance use disorders including health care, mental health, corrections, and school settings.

A third edition, *Motivational Interviewing: Helping People Change,* 2013, expanded on the MI approach and included some new ideas such as the four processes of MI conversations: engaging, focusing, evoking, and planning.

MI is defined as **"a collaborative conversation style for strengthening a person's own motivation and commitment to change."** MI can also be described as "a way of helping people talk themselves into changing." This approach embodies "a mind-set and a heart-set" that includes partnership, acceptance, compassion, and evocation.

Motivational Interviewing is a guiding style that invites people to examine their own values and behaviors and come up with their own reasons to change. It doesn't try to convince people or argue with them. Instead, it draws out people's own hopes, experience, and wisdom about themselves including whether or not to change. As William R. Miller says, "You already have what you need, and together let's find it."

People who are used to confronting and giving advice will often feel like they're not "doing anything." But, as Miller and Rollnick point out, the proof is in the outcome. More aggressive strategies often push people away. MI, on the other hand, increases the odds that people will give change a chance

Motivational Interviewing: A Guided Conversation

Here is a general outline of how a model MI conversation might flow. In this case, drinking is the focus. Of course, real life conversations rarely play out in such a straightforward manner. Note that the spirit and core skills of MI are applied throughout the four processes of MI. As a general guideline, it is useful to follow a basic rhythm of asking an open question followed by one or more reflections, before asking another question.

ENGAGING
Provide a warm welcome; offer a beverage; exchange small talk; make sure the person feels safe; show that you care; get to know the person as a person; be hopeful

- "Hi. It's really good to see you. Would you like some juice or tea?" "How have things been going lately?" *(Respond with reflective statements)*

FOCUSING
Agree on what to talk about

- "What's on your mind?" "You mentioned several things. Where shall we start?" "Would it be all right if we took a closer look at you and drinking?" *(Reflect)*

EVOKING
Explore ambivalence

- "What does drinking do for you? What concerns, if any, do you have about it?"*(Reflect)*

Elicit change talk

- *DESIRE (want, wish, like)*
  "How would you like things to be different than they are now?" *(Reflect)*

- *REASONS (specific reasons for change)*
  "If you *were* to cut back or stop drinking, what are some reasons you might do that?" *(Reflect)*

- *ABILITY (can, could, able)*
  "How might you go about it in order to succeed?" *(Reflect)*

- *NEED (have to or important to - without stating specific reason)*
  "How important is it to you to make this change?" (use 0-10 scaling question) *(Reflect)*

- *TESTING THE WATER (readiness and confidence)*
  "How ready are you to make this change?" "How confident are you to make this change?" (or use 0-10 scaling question) *(Reflect)*

PLANNING

- *COMMITMENT (will, plan to, intend to, going to, willing, ready, etc.)*
  "What do you think you will do next?" "What is your plan?" "How can I help you with that?" *(Reflect)*

MI Self-Appraisal

In facilitating a conversation to help strengthen the person's own motivation and commitment to change, I...	*0- not at all*					*5- extremely well*
1. Provided a **safe, welcoming** presence with my words and actions. *Example:*	0	1	2	3	4	5
2. Engaged with and showed **genuine interest** in the person, e.g., what she or he enjoys, needs, values. *Example:*	0	1	2	3	4	5
3. Found out and clarified what the person wanted to **focus** on currently. *Example:*	0	1	2	3	4	5
4. Helped explore **both sides of the person's dilemma**, e.g., what's working and what's not; upsides and downsides. *Example:*	0	1	2	3	4	5
5. Avoided trying to **"fix"** the problem or *get* the person to change by advising, confronting, warning, or teaching. *Example:*	0	1	2	3	4	5
6. Elicited what might be some possible **reasons** to change, *if* the person were to decide to change. *Example:*	0	1	2	3	4	5
7. Learned about **possible ways** that he or she might go about making this change. *Example:*	0	1	2	3	4	5
8. Asked **how important** it is at this time for the person to make this change. *Example:*	0	1	2	3	4	5
9. Asked **how confident** she or he feels to be *able* to make this change. *Example:*	0	1	2	3	4	5
10. Inquired about **what steps**, if any, the person might take next. *Example:*	0	1	2	3	4	5
11. Asked permission before providing **information or suggestions.** *Example:*	0	1	2	3	4	5
12. Used the **core skills** of MI (open questions, affirmations, reflective listening, summaries) throughout the conversation.	0	1	2	3	4	5
13. Consistently demonstrated the **spirit** of MI:						
> Partnership	0	1	2	3	4	5
> Acceptance	0	1	2	3	4	5
> Compassion	0	1	2	3	4	5
> Evocation	0	1	2	3	4	5

Developed by Ken Kraybill based on Miller, W.R. & Rollnick, S., Motivational Interviewing: Helping People Change, 2013

Peer Support Providers

Peer support providers are people with a personal experience of recovery from mental health, substance use, or trauma conditions who receive specialized training and supervision to guide and support others who are experiencing similar mental health, substance use or trauma issues toward increased wellness. The term peer supporter is an umbrella for many different peer support titles and roles, such as peer advocate, peer counselor, peer coach, peer mentor, peer educator, peer support group leader, peer wellness coach, recovery coach, recovery support specialist, and many more.

In general, a peer supporter is an individual who has made a personal commitment to his or her own recovery, has maintained that recovery over a period of time, has taken special training to work with others, and is willing to share what he or she has learned about recovery in an inspirational way.

In many states, there is an official certification process (training and test) to become a qualified "peer specialist." Not all states certify peer support providers, but most organizations require peer support providers (who are employed) to complete training that is specific to the expected responsibilities of the job (or volunteer work). Often, a peer supporter has extra incentive to stay well because he or she is a role model for others.

Those who provide authentic peer support believe in recovery and work to promote the values that:

- Recovery is a choice.
- Recovery is unique to the individual.
- Recovery is a journey, not a destination.
- Self-directed recovery is possible for everyone, with or without professional help

A peer support provider is caring and compassionate for what a person is experiencing. If the peer support provider has been through similar challenges, he or she may offer ideas or wisdom gained through his or her personal experiences to inspire hope, support personal responsibility, promote understanding, offer education, and promote self-advocacy and self-determination.

Strengths that peer providers add to the workplace include:

- Personal experience with whole health recovery that includes addressing wellness of both mind and body
- Insight into the experience of internalized stigma and how to combat it
- Compassion and commitment to helping others, rooted in a sense of gratitude
- Can take away the "you do not know what it's like" excuse
- Experience of moving from hopelessness to hope
- In a unique position to develop a relationship of trust, which is especially helpful in working with people in trauma recovery
- A developed skill in monitoring their illness and self-managing their lives holistically

From International Association of Peer Supporters https://inaops.org/definition-peer-specialist/ and SAMHSA-HRSA Center for Integrated Health Solutions http://www.integration.samhsa.gov/workforce/team-members/peer-providers#General

Recovery-Oriented Practices

What is recovery?

Recovery is a process of growth and change through which people improve their health and wellness, live a self-directed life, and strive to reach their full potential. People in recovery say that the process of recovery is about finding new meaning, purpose, and possibility in life. For many people, recovery means:

- No longer defining oneself by the experience of mental illness
- Being a full participant in the community with valued roles such as worker, parent, student, neighbor, friend, artist, tenant, lover, and citizen
- Running one's own life and making one's own decisions
- Having a rich network of personal and social supports outside of the mental health system
- Celebrating newfound strength and skills gained from living with, and recovering from, mental illness
- Having hope and optimism for the future

A Model: Person-Centered Recovery Planning

For individuals receiving behavioral health services, a person-centered approach means that they have choices in the services and supports they use. It also means that they are active partners in selecting their recovery support team and in inviting family members and other natural supports (such as employers, tutors, neighbors) to be involved. Further, it means realizing that, or being helped to realize that, they have the power to change their lives and can partner with their recovery team in doing so.

For providers, Person-Centered Recovery Planning (PCRP) means partnering with people receiving services to help them achieve goals that are personally meaningful to them, even when such goals extend beyond those areas traditionally addressed by clinical care. Such goals may include returning to work, finishing school, making friends, having a girlfriend or boyfriend, learning a new skill, or developing a hobby.

PCRP is informed by many sources, particularly the experiences of people (providers and people in recovery) who have struggled with the limitations of traditional models of care and have called for radical changes toward more person-centered planning approaches.

Limitations of traditional models of service planning

Some of the limitations of these traditional models identified in research and clinical experience include the following:

- Power is allocated largely (or only) to the service provider to develop treatment goals
- People receiving services are not commonly encouraged to take an active or self-directed role which fosters both short-term disengagement and long-term despair and dependency

- Service agencies focus on systemically defined outcomes (e.g., hospitalization rates) and are held less accountable for other outcomes that hold real value for those they serve (e.g., employment, relationships, community activities)
- Success is most often determined by system standards and is gauged on narrowly defined goals such as treatment compliance or symptom reduction
- Services are typically fragmented and disconnected from other important parts of a person's life.

How is a Person-Centered Care Plan developed and evaluated?

The creation of a person-centered plan can be organized into several logical steps that follow in order and include, *in collaboration with the person receiving services*:

- Conducting a strength-based assessment
- Formulating an integrated understanding of the individual
- Prioritizing areas to be addressed
- Setting recovery goals and a vision for the future
- Identifying barriers to address as well as strengths to draw on
- Creating short-term objectives that help to overcome barriers
- Describing interventions or activities reflecting a range of evidence-based and emerging practices
- Determining action steps by the person served, as well as any involved natural supporters, in an effort to activate the recovery network
- Evaluating progress and outcomes (includes evaluating discharge/transition criteria)

Excerpted from the Recovery Roadmap (in progress) based on the work of Janis Tondora, Psy.D. & Rebecca Miller, Ph.D., Yale Program for Recovery and Community Health

Finding Resiliency and Renewal in Our Work

"In the event that oxygen masks may be needed, place the mask over your own face before assisting others."

Providing care to people experiencing trauma, displacement, and various forms of oppression involves working under demanding circumstances, bearing witness to tremendous human suffering, and wrestling with a multitude of agonizing and thorny issues on a daily basis. At the same time, we have the privilege of becoming partners in extraordinary relationships, marveling at the resiliency of the human spirit, and laying claim to small but significant victories. Such is the nature of this work that it can drain and inspire us all at once.

Despite the rewards inherent in the work, it inevitably exacts a personal toll. By listening to others' stories and providing a sense of deep caring, we walk a difficult path. Yet we do so willingly, knowing that first we must "enter into" another's suffering before we can offer hope and healing. As Henri Nouwen notes, it is interesting that the word *care* finds its roots in the Gothic "kara" which means, "lament, mourning, to express sorrow."

Caring can become burdensome causing us to experience signs and symptoms of what the literature variously calls compassion fatigue, secondary traumatic stress, or vicarious traumatization. The impact is compounded by the frustrations of trying to provide help in the face of multiple barriers to care including inadequate resources and structural supports for people. To feel weighed down by these circumstances is not unusual or pathological. It is, in fact, a quite normal response.

In part, the "treatment of choice" for diminishing the negative effects of this stress is to seek resiliency and renewal through the practice of healthy self-care. Self-care is most effective when approached with forethought, not as afterthought. In the same manner that we provide care for others, we must care for ourselves by first acknowledging and assessing the realities of our condition, creating a realistic plan of care, and acting upon it. Though many providers practice self-care in creative and effective ways, we all sometimes lose our sense of balance, and fail to provide the necessary care for ourselves with the same resoluteness that we offer care to others.

To better understand what self-care is, here are three things it is *not:*

1) Self-care is *not* an "emergency response plan" to be activated when stress becomes overwhelming. Instead, healthy self-care is an intentional way of living by which our values, attitudes, and actions are integrated into our day-to-day routines. The need for "emergency care" should be an exception to usual practice.

2) Self-care is *not* about acting selfishly. Instead, healthy self-care is about being a worthy steward of the self – body, mind and spirit – with which we've been entrusted. It is foolhardy to think we can be providers of care to others without being the recipients of proper nurture and sustenance ourselves.

3) Self-care is *not* about doing more, or adding more tasks to an already overflowing "to do" list. Instead, healthy self-care is as much about "letting go" as it is about taking action. It has to do with taking time to be a human *being* as well as a human *doing*. It is about letting go of frenzied schedules, meaningless activities, unhealthy behaviors, and detrimental attitudes such as worry, guilt, being judgmental or unforgiving.

The following A, B, C's of self-care can provide a useful guide in reflecting upon the status of your own practices and attitudes.

AWARENESS – Self-care begins in stillness. By quieting our busy lives and entering into a space of solitude, we can develop an awareness of our own true needs, and then act accordingly. This is the contemplative way of the desert, rather than the constant activity of the city. Thomas Merton suggests that the busyness of our lives can be a form of "violence" that robs us of inner wisdom. Too often we act first without true understanding and then wonder why we feel more burdened, and not relieved. Parker Palmer in *Let Your Life Speak* suggests reflecting on the following question: "Is the life I am living the same as the life that wants to live in me?"

BALANCE – Self-care is a balancing act. It includes balancing action and mindfulness. Balance guides decisions about embracing or relinquishing certain activities, behaviors, or attitudes. It also informs the degree to which we give attention to the physical, emotional, psychological, spiritual, and social aspects of our being or, in other words, how much time we spend working, playing, and resting. I once heard it suggested that a helpful prescription for balanced daily living includes eight hours of work, eight hours of play, and eight hours of rest!

CONNECTION – Healthy self-care cannot take place solely within oneself. It involves being connected in meaningful ways with others and to something larger. We are decidedly interdependent and social beings. We grow and thrive through our connections that occur in friendships, family, social groups, nature, recreational activities, spiritual practices, therapy, and myriad other ways. Often times, our most renewing connections can be found right in our midst in the workplace, with co-workers and with the individuals to whom we provide care.

There is no formula of course for self-care. Each of our "self-care plans" will be unique and change over time. We must listen well to our own bodies, hearts and minds, as well as to the counsel of trusted friends, as we seek resiliency and renewal in our lives and work.

Fasten your seatbelts and enjoy the ride!

Ken Kraybill

Self-Assessment Tool: Self-Care

How often do you do the following? (Rate, using the scale below):

5 = Frequently
4 = Sometimes
3 = Rarely
2 = Never
1 = It never even occurred to me

Physical Self Care

- ☐ Eat regularly (e.g. breakfast & lunch)
- ☐ Eat healthfully
- ☐ Exercise, or go to the gym
- ☐ Lift weights
- ☐ Practice martial arts
- ☐ Get regular medical care for prevention
- ☐ Get medical care when needed
- ☐ Take time off when you're sick
- ☐ Get massages or other body work
- ☐ Do physical activity that is fun for you
- ☐ Take time to be sexual
- ☐ Get enough sleep
- ☐ Wear clothes you like
- ☐ Take vacations
- ☐ Take day trips, or mini-vacations
- ☐ Get away from stressful technology such as pagers, faxes, telephones, e-mail
- ☐ Other:

Psychological Self Care

- ☐ Make time for self-reflection
- ☐ Go to see a psychotherapist or counselor for yourself
- ☐ Write in a journal
- ☐ Read literature unrelated to work
- ☐ Do something at which you are a beginner
- ☐ Take a step to decrease stress in your life
- ☐ Notice your inner experience - your dreams, thoughts, imagery, feelings
- ☐ Let others know different aspects of you
- ☐ Engage your intelligence in a new area - go to an art museum, performance, sports event, exhibit, or other cultural event
- ☐ Practice receiving from others
- ☐ Be curious
- ☐ Say no to extra responsibilities sometimes
- ☐ Spend time outdoors
- ☐ Other:

Emotional Self Care

- ☐ Spend time with others whose company you enjoy
- ☐ Stay in contact with important people in your life
- ☐ Treat yourself kindly (supportive inner dialogue or self-talk)
- ☐ Feel proud of yourself
- ☐ Reread favorite books, review favorite movies
- ☐ Seek out comforting activities, objects, people, relationships, places
- ☐ Allow yourself to cry
- ☐ Find things that make you laugh
- ☐ Express your outrage in a constructive way
- ☐ Play with children
- ☐ Other:

Spiritual Self Care

- ☐ Make time for prayer, meditation, reflection
- ☐ Spend time in nature
- ☐ Participate in a spiritual gathering, community or group
- ☐ Be open to inspiration
- ☐ Cherish your optimism and hope
- ☐ Be aware of nontangible (nonmaterial) aspects of life
- ☐ Be open to mystery, to not knowing
- ☐ Identify what is meaningful to you and notice its place in your life
- ☐ Sing
- ☐ Express gratitude
- ☐ Celebrate milestones with rituals that are meaningful to you
- ☐ Remember and memorialize loved ones who have died
- ☐ Nurture others
- ☐ Contribute to or participate in causes you believe in
- ☐ Read inspirational literature
- ☐ Listen to inspiring music
- ☐ Other:

Workplace/Professional Self Care

- ☐ Take time to eat lunch
- ☐ Take time to chat with co-workers
- ☐ Make time to complete tasks
- ☐ Identity projects or tasks that are exciting, growth-promoting, and rewarding
- ☐ Set limits with clients and colleagues
- ☐ Balance your caseload so no one day is "too much!"
- ☐ Arrange your workspace so it is comfortable and comforting
- ☐ Get regular supervision or consultation
- ☐ Negotiate for your needs
- ☐ Have a peer support group
- ☐ Other:

Adapted from Saakvitne, Pearlman, and Traumatic Stress Institute Staff, *Transforming the Pain: A Workbook on Vicarious Traumatization, 1996.*

This work…

exhilarating
and exhausting

drives me up a wall
and opens doors I never imagined

lays bare a wide range of emotions
yet leaves me feeling numb beyond belief

provides tremendous satisfaction
and leaves me feeling profoundly helpless

evokes genuine empathy
and provokes a fearsome intolerance within me

puts me in touch with deep suffering
and points me toward greater wholeness

brings me face to face with many poverties
and enriches me encounter by encounter

renews my hope
and leaves me grasping for faith

enables me to envision a future
but with no ability to control it

breaks me apart emotionally
and breaks me open spiritually

leaves me wounded
and heals me

Ken Kraybill