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TRAINING MANUAL
FOR

PERSON-CENTERED, STRENGTHS-BASED CASE MANAGEMENT.

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INTRODUCTION

This manual is designed to assist professionals who work directly with citizens of Kansas who experience substance abuse and/or chemical dependency. This includes case managers, substance abuse counselors, mental health therapists, and department of corrections personnel. The purpose of the manual is to provide knowledge and skills that will promote efficient and effective organization and delivery of both residential and community-based treatment/services. There is a growing body of empirical evidence that Person Centered case management is an essential component of successful recovery. The approach may generate desirable outcomes for those we help and also promote safer communities for all citizens.

In the fist module we examine key concepts related to the **purpose** of our work. The importance of assisting people to achieve social as well as cognitive and behavioral outcomes is emphasized. We are a challenged to re-consider the meaning of key concepts such as motivation, problem, change, and independence within the context of a Strengths-Based, Person-Centered perspective. In this section we also see how current federal policy, as reflected in the mission and goals of the Substance Abuse and Mental Health Service Administration supports the Person-Centered, Strengths-Based Case Management Project in Kansas and many other states such as Oklahoma, Nebraska, and Maryland.

In the second module we examine a framework designed to assist us in integrating the prevailing disease/medical model of alcoholism with a Strengths Perspective. Many initially see these two paradigms as being separate and mutually exclusive. The module will help us to see that both the biological and the social are essential for providers to address and they strive to assist people in choosing and sustaining recovery.

In the third module we re-consider the concepts of **motivation, problem,** and **change**. The key points are that there is no such thing as being “unmotivated”. Definitions suggest that all people are motivated. Our challenge becomes to build a relationship and to influence them to channel their inherent motivation in ways that are healthier for them

and for the community. We will reconsider the problems based model of treatment. It is suggested that unless the person we are working with truly sees their drinking behavior as being a problem, as it relates to serving as a barrier to personal goal attainment, they are not likely to modify their behavior. Finally, we shift from a focus on "change" to teaching people about growth and transformation. We re-affirm our awareness that we as counselors and case managers do not have the power to change anyone but ourselves. The concept of influence within a trusting relationship becomes the primary focus of our efforts. These factors are integrated into a more holistic contextual view of human behavior and decision-making.

In the fourth module the process of assessing the strengths of people and of communities will be illustrated. It is upon these strengths that the Personal Wellness/Recovery Plan will be built. We will have a chance to work with two assessments and the treatment plan which serve as the primary indicators of fidelity to the approach. These fidelity measures will assist practitioners, supervisors, administrators, and program evaluators to assess the degree to which the approach is being implemented in day to day practice. This process evaluation is critical if we are to ultimately assess the degree to which strengths-based, person-centered practice is effective in helping people to achieve and sustain sobriety and to achieve and sustain social goals such as employment, healthy parenting, and socially acceptable behavior in the community.

In the final model we look ahead to next steps and how to sustain the momentum of this philosophy in Kansas. We will examine some of the barriers that have been identified by those who have attended the early rounds of training and have some experience trying to implement the approach in their programs. Efforts that have served to address and remove these barriers in Kansas and in other states will be reviewed.

In each module there are ***focused learning activities***. These reflections are designed to help us become more aware of the values and beliefs we currently hold, and how these may be transformed through our learning.

MODULE I: ***Why Do We do What We do? The Ultimate Purpose of Our Work.***

Most of us would agree that if people have a clear understanding of what their purpose is they will do a better job. Our purpose is what we ultimately hope to achieve through our efforts. Another way to think about this is the notion of ***outcomes.*** Over the years I have asked substance abuse counselors around the nation "What do you see as the ultimate outcome of your work with people?" The vast majority of these providers respond initially by saying something like "to help clients attain sobriety." This, of course, is a very important factor related to recovery. In the Strengths-Based, Person-Centered approach, however, this outcome is not enough. Sobriety is viewed as a ***means*** not an end in and of itself. They key question becomes "What are the social, spiritual, psychological, physical, and behavioral payoffs, benefits, and personal rewards, for making the decision to abstain from using alcohol and other illicit mind altering chemical substances?" The assumption in this perspective is that if the payoffs for choosing sobriety do not outweigh the perceived payoffs for using a substance the person will most likely revert to using again. Therefore, our work with people expands from a narrow notion of "treatment" which is often psycho-educational in nature. More and more we are discovering that it is crucial to attend to factors in the person's environment which are directly related to their thoughts, feelings and ultimately to their behavior. Consider the following statement of purpose and the related contrasts:

THE PURPOSE OF HELPING IN THE STRENGTHS MODEL

TO WORK WITH INDIVIDUALS AND FAMILIES, (SERVICE PARTICIPANTS), WITHIN THE CONTEXT OF A COLLABORATIVE, MUTUALLY ENRICHING AND RESPECTFUL PARTNERSHIP, TO IDENTIFY, SECURE, AND SUSTAIN THE RANGE OF RESOURCES, BOTH EXTERNAL AND INTERNAL, NEEDED TO LIVE IN A NORMALLY INTERDEPENDENT MANNER IN THE COMMUNITY.

KEY CONTRASTS INHERENT IN THIS STATEMENT

Helping another human being vs. "treating" a patient or client

Viewing people as active participants in the process vs. passive, dependent, compliant service recipients.

Blending stakeholder agendas, compromise, negotiation vs. unilateral prescription of Tx plan.
Power with another vs. power over another. Power sharing.

The constant challenge of sustaining gains vs. notion of just maintenance or palliative care.

Focus on resources, "supplies" vs. focus on provision of formally constituted services.

Initial focus on the social, the person's external desires and needs vs. an initial focus on the internal or "intra-psychic" desires and needs, with the realization that these two realities constantly interact in dynamic formulation.

Outcomes are identified in terms of observable, measurable behaviors and achievements involved in living life each day vs. in terms of abstract constructs such as self-actualization, self-sufficiency, self-esteem, etc.

Emphasis on interdependence and responsibilities of citizenship vs. independence and patient's rights.

Emphasis on creative individualized efforts designed to promote permanent loving family interactions, and honor the principle of "best interests of the child."

Learning Reflection:

1. What are the concepts, words, phrases that capture your interest and attention in this statement of purpose? Expand on your thoughts and feelings related to the concepts which illicit this reaction.

2. How might practice look different if we embraced the concepts of “mutually enriching” and “collaborative partnership” in our daily work with people?

3. What would be the implications if we focused our work on community-based outcomes as much as we focus on cognitive and psycho-dynamic outcomes?

4. Identify all of the aspects of your life that support the belief that you are interdependent?

In Strengths-Based, Person-Centered practice the ultimate goal is measured by the extent to which the person we are working with engages in behaviors that is to be ***normally interdependent***. This basically means that people engage in behaviors that are acceptable and tolerable in the community. It has been suggested that laws are nothing more than codified social norms. Society makes laws to influence the kind of behaviors which people generally believe is "appropriate" "desirable" and "essentially good." For example, going into a bar when a person is 21 years old is considered normally interdependent. Having a few drinks and breaking a cue stick over someone's head in a fit of anger is not normally interdependent. In this perspective, being in the bar is not problematic in and of itself. We move the standard from merely being in the bar to the behavior the person engages in while they are in the bar or after they have left.

Learning Reflection:

1. Most providers and parole/probation officers contend that "staying out of bars" should be a required condition of every person's plan. Why do you believe this is?

2. Mark, a 25 yr. old person you are working with who has 30 days of sobriety tells you he went to a bar to watch the Chiefs with three friends who have been sober for several years. They drank diet coke, played several games of pool, had a great time, and he drove the others home after the game. What do you say to him?

Ultimately then, we need to continuously examine means and ends. In this approach all types and forms of "treatment" which includes the methodology we refer to as case management are considered means. The outcome or "end" upon which our work will be evaluated is the extent to which each service participant makes decisions (as measured behaviorally) that promote their own personal goals that are socially acceptable (legal) and which also contribute to the safety and well-being of others. We need to assist people in achieving and sustaining personal goals (employment, family relationships, meaningful leisure, etc.) that mean more to them then using a substance. In other words, the potential costs in terms of personal loss now outweigh the potential gains of engaging in use of illicit chemical substances.

If we want service participants to replace their beliefs about "independence" with "normal interdependence" we must provide them with other concepts that replace the meaning they have ascribed to this term. I have found that both "freedom" and "autonomy" serve this purpose. Freedom to do what one wishes, to make their own choice between alternatives is a very powerful motivator. Autonomy is a sociological term that suggests personal accountability. Each person has the power to makes their own decisions (even in the midst of strong cravings) and each person is accountable for their decisions. We are striving to assist people in becoming less "self" centered and to become more aware of their connection and consideration of others.

Armed with this expanded sense of purpose we now examine the six principles that serve to guide and direct individualized, creative, personal wellness and recovery plans.

Key Concepts from Module I.

Purpose of person-centered, strengths-based case management
Normal Interdependence
Mutually enriching, collaborative relationship
Community based social outcomes
Assessing means and ends

MODULE II: Integrating a Medical/Biological Perspective with a Person-Centered, Strengths-Based Perspective.

As professionals we are guided and directed by a set of beliefs regarding human behavior in the social environment. It is fairly well established that there is a biological component to addictive behavior. It is becoming increasing recognized, however, that human biology, including brain functions, is affected by environmental factors. The initial tendency is to place the Disease Model and the Strengths Model as mutually exclusive polar opposites. A person-centered philosophy, however, helps us to see that these perspectives may co-exist to help us more fully understand and intervene in the complex phenomenon we have come to know as addiction or chemical dependency.

Learning Activity (may be done individually or in a small group)

Take some time to review the statements below each heading. Reflect upon how ell each statement rings true in your experience.

Read the statement at the bottom of the page. This statement attempts to bridge the gap between the disease/medical model and the strengths model. Share with each other the extent to which you believe this statement. Give examples of how this philosophy may have been true in your life or in the life of someone you know well or have worked with in the past.

How Do providers Understand and respond to Substance Abuse and Chemical Dependency Behaviors? Reconciling an Illness/Disease Centered Perspective with a Person-Centered Strengths Perspective.

ILLNESS PERSPECTIVE	**STRENGTHS PERSPECTIVE**
The problematic behavior (drinking) is a symptom of the illness. The person is not able to control his drinking due to the nature of the disease which is rooted in neurobiology. It is only though total abstinence that one is able to cope effectively with this illness, as it is a life-long affliction.	The decision to drink or not to drink is a constant choice. There is a personal desire that is related to the decision to use a substance. One's brain chemistry is not a choice. The key is to discover what the Addictive behavior means to each unique person, placing the behavior in a social context.
When a person suffers from the co-existing disorders of substance abuse and mental illness there may be a difference of opinion regarding what to focus on first. Conventional wisdom suggests treating both simultaneously.	When a person struggles with mental illness and substance abuse the focus in on the person, not the problems/illnesses. The stated social outcomes, desires, aspirations of the person drive the helping activities.
Key concepts include limit setting, boundaries, confrontation, stripping away defenses, enabling as a n unhealthy process, abstinence as goal of treatment.	key concepts include collaboration, power sharing, mutuality, social/behavioral outcomes (may precede authentic cognitive changes) harm reduction, recovery.

Premise to Bridge the Gap

For people to modify their use of substances they must come to a point in their lives where they want to change or realize that they need to change in order to achieve and/or sustain something that holds more meaning and value for them than does the substance. People have the power to choose recovery. The capacity to make and act on choices that promote wellness in an inherent strength in all people.

Learning Reflection.

1. Identify all of the possible reasons why people consciously choose to make decisions to continue using or to discontinue using alcohol or other drugs.

2. Why is it that you believe some people never get to the point where they decide to live a drug-free life?

In the following module we elaborate on three concepts that are essential to our work. It is suggested that we re-think our notions of these concepts in order to move closer to strengths-based, person-centered practice.

Key Concepts of Module II.
Disease Perspective
Strengths Perspective
Conscious Choice

MODULE III. Re-Thinking the Concepts of Motivation, Problem, and Change.

A Broader Contextual and Behavioral Definition of Motivation.

How many of you have ever been to a meeting where staff is discussing a person they are working with in treatment and someone says "well, the problem with him is that he is unmotivated." In this scenario, it is apparent that the person does not truly want to stop drinking, nor do they believe they need to. Consider the following more strengths-based definition of motivation:

Channeling energy in order to achieve something that a person desires… wants…or believes that they need.

In a person-centered, strengths-based perspective the person's behavior is not judged and determined by the professional. In this perspective, all people, as long as they are still breathing, are viewed as being motivated by something. Our challenge is to gain a deeper understanding of what the behavior means to each unique individual. Our task is to help people see that the "illness" or "disease" is influencing decisions they are making (i.e.: cravings, shakiness, physical and/or psychological discomfort) but the disease is not making the decision for them. If people want to feel relief, to feel calmer, to be happier, etc. there are alternative means to achieve these ends. When we gain this broader view of motivation we are better equipped to suggest alternatives which are healthier and we also begin to intervene more in peoples' social world to help them gain things in their lives which are important to them and they do not want to lose.

Later we examine assessment tools that shift the focus from the problem or illness to the person and the social context. These tools help us to gain a fuller and deeper understanding of what people desire in all aspects of their being these desires become the fuel which will hopefully channel peoples' energy to become motivated to choose recovery each day. Being abstinent and sober becomes firmly defined as a "need" that is

directly related to some other outcome that the individual truly wants, with little or no ambivalence.

Wants and desires in our lives are different from needs. Strengths-based practice suggests that needs only have meaning in relation to the goals and aspirations that people have. In this approach to practice it becomes important to try to get a deeper sense for "why" people decide to use. Some have argued that counselors should not ask "why" because many people do not know, or the question will be perceived as being judgmental. I have found that people often **do** have a sense for why they decide to use, and in fact, this awareness if often a pre-requisite for their decision to make other choices regarding substances. As a judge once said, "if young people believe they have nothing to lose, why should we expect them to make different decisions"? As case managers and counselors our goal then is summed up as follows: **to nurture a trusting relationship and to attempt to influence people to make healthier decisions for themselves and for others in the community.**

Learning Activity:

Take a moment to consider the relationships and possessions that you have in your life. Consider the things you truly desire to achieve and maintain. Reflect on how these factors help you to prioritize what you "need" to do tomorrow.

Think about a behavior you are currently engaging in that may not be exactly healthy for you (smoking, eating too much fried food, etc.).

Re-Thinking the Problem-Solving Model

Most people in the helping profession at some point have been exposed to the problem solving model. It was the practitioners' job, through use of assessment skills, to identify and/or diagnose the "problem" and then deliver a treatment package designed to ameliorate the problem. If people go along with our impressions of the problem and participate willingly in treatment they are viewed as "compliant". If, however they do not agree with the professionals' view that they have a "problem" they are seen as non-compliant, resistive, manipulative, and in denial. If, for example, a person who was referred for substance abuse treatment after a DUI states that drinking was not the problem but the pressure that they experience being unemployed and homeless was the problem what would you think? What would you say? Many would view this as an attempt to manipulate and they would not assist the person with finding a job or a home until they had achieved at least 90 or more days of sobriety. To do otherwise would be construed as "enabling."

In the person-centered, strengths-based approach we attempt to tap in to what the person is saying they want and agree to work with them on achieving it. While we work on these social goals we also work on the recognition that sobriety will most probably be related to whether or not they achieve and are able to sustain their stated goals. Even though a person may state that he "wants" to be sober our task is to help him see that in order to achieve is goals he "needs" to be sober. Thus, the ambivalence of wanting to be sober and wanting to drink is shifted to a different level.

The third key concept to re-think is the notion of change. Many of us have learned that our role is to be "change agents." This is a bit of a contradiction. On one hand, we know that we do not have the power to change anyone but ourselves. Yet, we make "change" the focus of our efforts (i.e.: assessing what stage of change a person is in). Person-

centered practice shifts the focus from the provider assessing their level of "change" to the persons decision-making and behavior related to short term goals (needs) they have agreed to on the wellness and recovery plan (next module).

In this approach we recognize that although we do not have the power to change someone, we do have the **power to influence** them. And, we know that this capacity to influence is directly related to the strengths and trust that has been patiently nurtured and developed in the relationship. We have all heard and probably used the old adage "change is scary". But have we ever thought deeply about why this is so? I think it is because change suggests that things are different, not like they were before, and there is often a sense of permanence and even loss associated with change.

Many have found the notion of transformation to be a healthier and less frightening way to view their lives. The belief is that all people and even nature are constantly adapting and transforming. This is a natural process, not one that is imposed from within or without. Transformation is a process that is open to and affected by many factors, not caused by one factor. Many people who are in recovery have benefited from this more fluid view of wellness and recovery, not as a "change" or end, but as a part of an on-going process of discernment and decision-making…truly one moment and often on second at a time.

So how do we incorporate skills and tools to help us gain this fuller and deeper understanding of each persons' motivation, hopes, dreams, aspirations and meaning that will serve to guide, direct, and fuel their own transformation? In the next model we examine tools that will assist us in this effort.

MODULE IV: THE PERSON-CENTERED STRENGTHS ASSESSMENT AND PERSONAL WELLNESS/RECOVERY PLAN.

In this module we examine three tools that serve as the primary fidelity indicators regarding the faithful implementation of Person-Centered, Strengths-Based case management and counseling. You will have the opportunity to learn more about these tools by applying them to your own life. These tools are The Person-Centered Strengths Assessment, The Strengths Assessment for Substance Abuse, and the Person Wellness/Recovery Plan. The first two forms provide the data that will direct the individualized treatment plan. The third form documents the action taken by the service participant that is needed to achieve health, wellness, and on-going sobriety and recovery.

A critical aspect of this approach is the process of inviting the person we are working with to identify their goals, desires, and aspirations in seven life areas (domains). In a medical model of practice the professional identifies what the person needs to learn and do in order to attain the goal of abstinence. In the Person-Centered, Strengths-Based model, the person provides the assessment information that will lead to the formulation of goals that are important and meaningful for her. Without movement toward such social goals, the goal of sobriety is not anchored in a social/relational context.

Given the current system, it is necessary to complete a number of intake protocols such as the Addiction severity Index and the KCPC. These are designed to document the scope of the problem and to justify and legitimize treatment. The goal is to begin the conversation with the person in a manner that replicates the person-centered strengths assessment. After you have engaged the person in an exchange that focuses on their own goals and social circumstances you may then move to gathering this problems oriented information. Begin with a focus on the person not the problem. Research on the engagement stage of work has suggested that people are more willing to share meaningful and relevant

information when they get the sense that the counselor/case manager values and respects them as a unique individual and not just as “another case”. It is suggested that after this initial conversation with the service participant, you show him the assessment and invite him to work on it between individual or group meetings. You may then review the information at your next meeting. It is important to view the inclusion of information as an on-going process not as a stage in the process that is completed. As the relationship grows we know that people will tend to share more information that will influence the direction of our helping efforts.

Learning Activity

Find a quiet location where you can go by yourself and review the questions on the following assessment. Take your time. When a life domain or question seems to create an interest or emotional reaction I invite you to write down the information just as you would if you were a service participant. Try to stay with the process for at least 40 minutes. As adults we learn best by doing. This exercise will help you to gain a fuller understanding of the strengths assessment process. It will also help us to gain deeper empathy for what people we are working with are thinking and feeling when we ask them to work on these tools. When you return from the exercise there will be a series of questions to consider.

PERSON-CENTERED STRENGTHS ASSESSMENT

Participant_____Case Manager_____date:_____

Housing/ A Sense of "Home": Where are you living now?

What do you like about your current living situation?

What things don't you like about where you are living now?

For now, do you want to remain where you are, or would you like to move?

Describe the housing situation you have had in the past that has been the most satisfying for you.

Transportation/getting around: What are all the different ways you get to where you want or need to go?

Would you like to expand your transportation options?

What are some of the ways you have used in the past to get from place to place?

If you could travel anywhere in the world, where would you go? Why?

Financial/Insurance: What are your current sources of income, and how much money do you have each month to work with?

What are your monthly financial obligations?

Do you have a guardian, conservator, or payee to help you with your finances?

What do you want to happen regarding your financial situation?

What was the most satisfying time in your life regarding your financial circumstances?

Vocational/Educational: Are you employed full or part time currently? If so describe where you work and
What you do at your job.

What does your job mean to you? If you do not have a job now, would you like to get one? Describe why you would or would not like to get a job at this time.

What activities are you currently involved in where you use your gifts and talents to help others?

What kinds of things do you do that make you happy, and give you a sense of joy and personal satisfaction?

If you could design the perfect job for yourself what would it be? Indoors or outdoors? Night or day? Travel or no travel? Alone or with others? Where there is smoking or no smoking? Where it is quiet or noisy?

What was the most satisfying job you ever had?

Is it harder for you to **get** a job, or harder for you to **keep** a job? Why do you think this is so?

Are you currently taking classes that will lead to a degree or taking classes to expand your knowledge and skills?

What would you like to learn more about?

How far did you go in school? What was your experience with formal education?

What are your thoughts and feelings about returning to school to finish a degree, learn new skills, or take a course for the sheer joy of learning new things?

Do you like to teach others to do things? Would you like to be a coach or mentor for someone who needs some specialized assistance?

Social Supports, Intimacy, Spirituality: Describe your family.
What are the ways that members of your family provide social and emotional support for you, and help to make you feel happy and good about yourself?

Is there anything about your relationships with family that make you feel angry or upset?

What would you like to see happen regarding your relationships with family?

Where do you like to hang out and spend time? Why do you like it there?

What do you do when you feel lonely? Do you have a friend that you can call to talk to or do things with? If not, would you like to make such a friend?

Do you have the desire to be close to another in an intimate way? Would you like to have this type of relationship?

What meaning, if any, does spirituality play in your life? If this area in important to you, how do you experience and express your spiritual self?

What are your thoughts and feelings about nature?

Do you have a pet?

If not, would you like one? (if so, describe)

Have you ever had a pet? (elaborate)

Health: How would you describe your health these days?

Is being in good health important to you? Why or why not?

What kinds of things do you do to take care of your health?

What are your patterns regarding smoking? Using alcohol? Using caffeine? What effect do these drugs have on your health?

What prescription medications are you currently taking? How do these medications help you?

How do you know when you're not doing too well? What is most calming and helpful for you during these times?

What limitations do you experience as a result of health circumstances?

What do you want and believe that you need in the area of health?

Leisure time, Talents, Skills: What are the activities that you enjoy and give you a sense of satisfaction,
peace, accomplishment, and personal fulfillment?

Would you like the opportunity to engage more frequently in these activities?

What are the skills, abilities, and talents that you possess? These may be tangible skills such as playing a musical instrument, writing poetry, dancing, singing, painting, etc. or intangible gifts such as sense of humor, compassion for others, kindness, etc.

What are the sources of pride in your life?

Are there things you used to do regularly that gave you a sense of joy that you have not done in recent years?

Which of these activities would you consider re-discovering at this time in your life?

Prioritizing: After thinking about all of these areas of your life, what are the two personal **DESIRES** that are most meaningful for you at this time?

**** The response to this question is the key…this will serve as the Motivational Statement, the on-going long term goal that serves to continue to fuel the decision to remain substance free. This is the goal that is re-stated on the top of the Personal Wellness/Recovery Plan.***

Now that you have had a chance to work on your own strengths assessment consider the following questions:

1. How is this assessment different from other assessments that you are familiar with?

2. What insights were generated through this activity?

3. Note the temporal sequence of the questions…the focus first is on the here-and-now, the present. Then the questions focus on the future, not future needs, but rather, future WANTS.

4. Do you see how this process first partializes areas of the person's life and then the last question pushes the person to "prioritize" the desires that are most important to them.

Remember that each person must make the connection between their decisions to abstain from substances and a "payoff" or gain that becomes more important to them than the payoff from substance use. A tool that helps us to learn more about the motivation to **choose to use** is now examined.

The **Strengths-Based, Person-Centered Assessment Relating to the Decision to use Substances** is designed to gain more individualized information about the role of substances in a person's life. It focuses on the perceived benefits or rewards which tend to sustain the behavior. It is suggested that unless we understand what the behavior means to someone in a more positive way, it will be more difficult to influence him to make alternative, drug-free choices which help him to accomplish the same ends.

Again we turn to an experiential learning activity to help us more fully understand this process.

Learning Activity

Go to the assessment on the next page. Consider a behavior you are currently involved in that you may know on some level is not healthy for you. Others may have also suggested that you modify or even stop this particular behavior. In my life it is smoking cigars. Yours might be smoking cigarettes, eating a lot of chocolate, drinking a lot of coffee, not exercising enough, drinking a lot of soda, etc. using this behavior as the focus, read the questions of the assessment and insert this behavior when the form uses terms related to drinking. We will then consider discussion questions to promote your learning after you have completed the exercise.

STRENGTHS-BASED, PERSON-CENTERED ASSESSMENT RELATING TO DECISION TO USE SUBSTANCES.

Participant:_____I.D._____

Date:_____ Primary Counselor/Therapist/CM_____

Gender ___M ___F D.O.B. _____ Years since initial diagnosis_____

Number of previous admissions for substance abuse treatment_____ highest grade

completed in school____ previous involvement with criminal justice system __Y__N

Current involvement with criminal justice system___Y ___N

In your own words, describe the circumstances leading to your being here at this time.
(use back if necessary)

What is your drug of choice? What is it about this substance that most appeals to you?

When you reflect upon your use of substances, what are the things that motivate you to decide to use?

Describe your patterns of use…for example, what time of day, alone or with others, at a bar, home, or somewhere in the community, etc.

What happens to your mood and behavior when you use?

Why have you decided not to stop using before now?

What are the things that you do in your life that help you to feel good about yourself and happy that do not involve use of substances?

What would you stand to gain if you decide to stop using?

What do you stand to lose if you stop drinking?

Who are the most important people in your life?

What are the three most important material possessions in your life?

What are the things you are most afraid will happen if you stop using?

What are the things you are most afraid will happen if you continue to use?

What are the three things that are most important for someone to know about you in order to better assist you in getting what you want and need in your life.

What are the three barriers or obstacles that must be overcome for you to achieve you goal of daily sobriety?

Please add any other information that you believe is important in better understanding you and your situation.

In a small work group share you responses to the following questions.

1. How did you experience this exercise?

2. What insights regarding change were generated or reinforced?

3. What are the implications of these insights for you daily practice with people and your response to decisions they continue to make?

4. Why have you decided at this point not to modify or change this behavior?

5. What would it take to influence you to make other, possible healthier decisions regarding the role of this substance in your life?

We see through these assessment exercises people tend to engage is behaviors related to food, tobacco, sugar, caffeine, etc. that become ritualized and a part of a pattern. These patterns are very difficult to change, especially when we see on some level that there is a payoff for engaging in the behaviors. Once the insight and increased awareness of the role these substances play in our lives takes place, and there is also concern that there

may be some immediate undesirable consequences to the continued use of these substances, we are at a place where the decision to change may be strengthened.

The data we have gathered from these personalized assessments now may be used to guide and direct individualized treatment efforts. The Personal Wellness/Recovery Plan is now reviewed. This tool is where we work with the person to document their long-term **motivational goal,** their **mid-range concrete goal**, and the **short term,** day to day goals which reflect what each person NEEDS to do if they are serious about taking charge of their lives and turning it in another direction.

In pilot projects in a residential treatment facility in Kansas the service participants shared information on these assessments quite readily.

The Personal Wellness/Recovery Plan

The Personal Wellness/recovery plan is the tools used to document the person's stated goals and their willingness to complete the short term goals that have been discussed and developed in collaboration with their counselor and/or case manager. The tool is designed to be an on-going, organic document which captures the shifts, modifications, and fluid nature of the helping process. It is not designed to be a "cookie cutter" plan that is developed by the professional and then shared with the person as a prescription. There are certain goals that are required to be stated by certain funding and certification entities. This plan is designed to demonstrate how each individual is moving in his or her own way to accomplish such general goals such as sobriety, abstinence, understanding and working the twelve steps, etc.

Turn now to the Personal Wellness/Recovery Plan on the next page.

PERSON-CENTERED/COMMUNITY BASED WELLNESS/RECOVERY PLAN

Participant: John Smith Counselor/CM Joan Smith Date April 5,2005

Participant's Aspiration: (motivation…may be concrete or abstract):

I want to be clean and sober, I want to be a good parent to my kids and a good husband, I want to live and take better care of myself, I want to be a better person and be closer to God.

Intermediate Concrete Goal Related to Aspiration: (three to six months)

I will complete the program, I will have updated my resume and received three letters of reference from old employers, I will have made amends to those I have hurt and I will have made all arrangements so that I will have a job when I am discharged.

Short-Term Goals: (What NEEDS to get done to accomplish above?)

Goal/Task/Objective	Target Date/ Date Achieved
1. Contact 3 former employers and ask them to send ref. let.	5/6/05
2. Write letter to kids and review with counselor	5/6/05
3. Continue to record information on Strengths Assessments and share in group	5/6/05
4. Walk for twenty minutes tonight	5/5/05
5.	
6.	
7.	
8.	
9.	
10.	

Participant **Provider** **Recovery Support Person**

Use back for progress notes

Learning Activity

In your group consider the following questions:

1. What do you notice about the Personal Wellness/Recovery Plan?

2. What is similar to or different from the plans you are currently developing with service participants?

3. Why are the target date and date accomplished important in this process?

SUMMARY

In this module we have examined the key forms of documentation involved in person-centered, Strengths-Based case management and substance abuse counseling. We have seen how it is critical to have the person identify the desires, aspirations and goals in each of several interrelated life domains. We may need to spend some time helping people to resolve any ambivalence they experience regarding what they truly and honestly want to achieve or maintain in each of these areas. If we are to help someone recognize that they NEED to make different decisions regarding the use and/or abuse of substances in their lives they need to clearly see how these decisions are necessary to accomplish their own ends, not someone else's.

The top line of the personal Wellness/Recovery Plan identifies what I call the "Motivational Statement." Every participant should be invited to write their own dream, vision, aspiration, desire on this top line. It is suggested that you counsel the person to identify the "payoffs" for choosing sobriety each day rather than simply stating "I want to be sober." In this model choosing to be sober each day, each hour, each minute, is always related to some other personal outcome which holds meaning and value for the person,

such as “being healthy so I can be with my children”, “getting my child back from foster care”; and “getting and keeping a job so I can take care of my family”.

I invite you to take some time and write your own personal wellness/recovery plan. What would your motivational statement look like? What do you hope to achieve three to six months from now that help you to see and feel that you are succeeding in moving toward your long-term goal? What do you need to do tomorrow (short-term goals) if you are serious about achieving what you stated on the top line? As we apply this approach in our own lives we come to see even more clearly that the accountability lies with no-one other than ourselves. If we do not follow through, or change our mind, we hopefully will gain more understanding and empathy for others who are engaged in the challenging process of transforming their lives for the better.

In the final module we examine initial results and barriers to the integration of this approach. If this model of practice is to continue to emerge funders, administrators, policymakers, and providers will need to continue to evaluate the process of providing services and treatment (efficiency) and to evaluate the social outcomes experienced by those we strive to help (effectiveness).

MODULE IV: WHAT HAVE WE LEARNED? BARRIERS AND NEXT STEPS

In this final section we review what we have learned thus far in our process of implementing and evaluating the Person-Centered, Strengths-Based approach to practice in Kansas. These findings were generated during a one-year evaluation at the Addictions Treatment center in Girard, Kansas. We also have anecdotal data regarding the feedback from several hundred counselors and case managers throughout Kansas who attended two days of training and one-follow-up day of training in 2005. We close with a consideration of barriers that have been identified that will demand our attention in the years to come.

We learned that service participants generally respond positively to the Person-Centered, Strengths-Based approach. Participants readily completed the Strengths Assessments and Personal Wellness/Recovery Plans. They often included information on these forms that was recorded nowhere else in their records.

It appears that more work needs to be done translating the information gathered on these assessments to the individualized personal wellness/recovery plan. Often times the tools did not include a motivational statement that was written by the service participant. The short terms goals often did not specify a target date and were more “on-going.”

Based on the data gathered from the self-assessments and personal wellness plans, the service participants perceive a wide range of factors that they believe are important for their continued recovery. It is clear that these factors are related to the decision to choose sobriety each and every day. These include, having a good job that pays a decent and fair wage, getting more education and training, having friends and family who are understanding, encouraging and supportive, having the strengths that comes from a higher power, taking care of their physical and mental health, and being able to engage in

a range of activities that are enjoyable and have special meaning for them. These are the social outcomes which must be identified early in the treatment process and focused upon while the person is receiving care. This means that we need critically re-consider scripted, linear, pre-determined psycho-educational groups and their effectiveness in generating truly individualized plans of recovery.

Barriers to implementing Person-Centered, Strengths-Based treatment were identified on multiple levels. Many providers who had many years of experience with their own recovery and who were invested in the disease model experienced some difficulty in expanding their focus. As one counselor shared with me "boy, you are really asking us to get out of our comfort zone…and I don't know how comfortable I am with that!" This lead to a very good discussion of how this is exactly what we try to do in our work with others in our program. There were also agency barriers. The current policy regarding the number of problem based assessments that must be completed and the standards related to certification, what must be addressed in treatment, and fee generation, all were identified as systemic barriers that must be addressed. As people were re-assured that these issues were being addressed at the state level there was less reluctance to move in this direction.

The perspective of the people we work with may also serve as a barrier. Many people who have been in the treatment system expect us to work in a certain way. They have become comfortable on some level with the way substance abuse programs have been set up. Moving in a Person-centered, Strengths-Based direction requires more accountability for the person to begin right from the start by developing and completing short term goals related to what they need in the community. It may take some time to "re-socialize" folks

who have been in the system for some time. With service participants who are receiving care for the first time, however, this initiative represents a wonderful opportunity to beginning to re-shape and re-cast how we provide more comprehensive and community based treatment.

So given what we have learned, it begs a question…where do we go from here? Given SAMHSA's directive for states to continue to develop "integrated" continuum of services it will be important for us to continue to provide cross training experience for providers from corrections, mental health, social welfare, as well as addictions/substance abuse. Although each system will provide different and unique services, they must all be contributing the social/behavioral outcomes identified by the service participant. If they are not integrated we may continue to work at cross purposes, which is ultimately ineffective and more costly.

We must continue to become practitioners who constantly evaluate their treatment efforts. What is the evidence that we are making a difference? To what extent is the participant working on social/behavioral outcomes that will serve to fuel the commitment to sobriety? How are we making known to our colleagues and policy makers to methods and approaches that have proven to be effective?

This is an exciting and challenging time to be in the field of addictions. We will be challenged to adapt our efforts to accommodate shrinking budgets and increasing demand. This will not be possible if current paradigms of service delivery are not critically re-examined, re-formatted, and rigorously evaluated. Our hope is that the material presented in this manual will be useful for you as you meet these challenges.