

# Establishing Person-Centered, Housing-Focused Goals and Building Motivation for Goal Achievement

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Brenda Earle, DMHAS

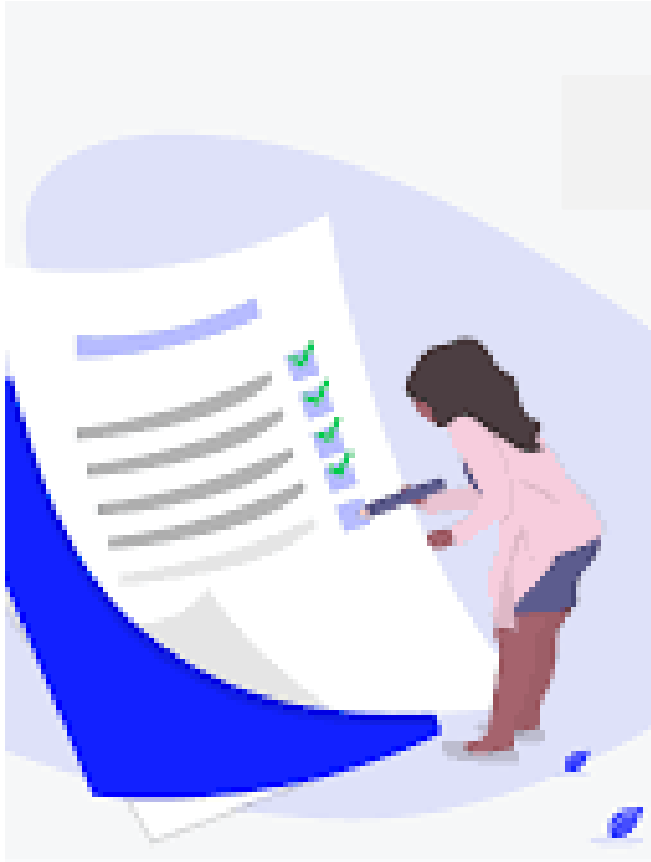
Andrea White, Housing Innovations

Lauren Pareti, Housing Innovations



# Agenda

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- Needs Assessment
- Service Planning
- Motivation Building
- Monitoring Items related to today's topics
- Next Steps



# Ice Breaker

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GIVE AN EXAMPLE OF WHEN A PARTICIPANT IN YOUR PROGRAM WAS HELPFUL TO OTHERS, COULD BE OTHER PARTICIPANTS, YOU OR FAMILY AND FRIENDS

What do  
you **NEED**?

HOW CAN I HELP?

A close-up photograph of a person's hand, palm up, reaching out towards the text 'HOW CAN I HELP?' written on a chalkboard. The hand is positioned in the lower left corner of the image, with the fingers slightly curled. The background is a dark, textured surface, likely a chalkboard, with the text written in white chalk.

# Needs Assessment

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# Assessment

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- Is a process not an event.
- Requires trust that offering information will lead to needed services/resources.
- Information unfolds over time:
  - As the client experiences challenges and progress, the assessment will deepen.
  - Use information about how each person lives, their dreams, their connections, and how they look when they are thriving and when they are struggling to build the assessment.



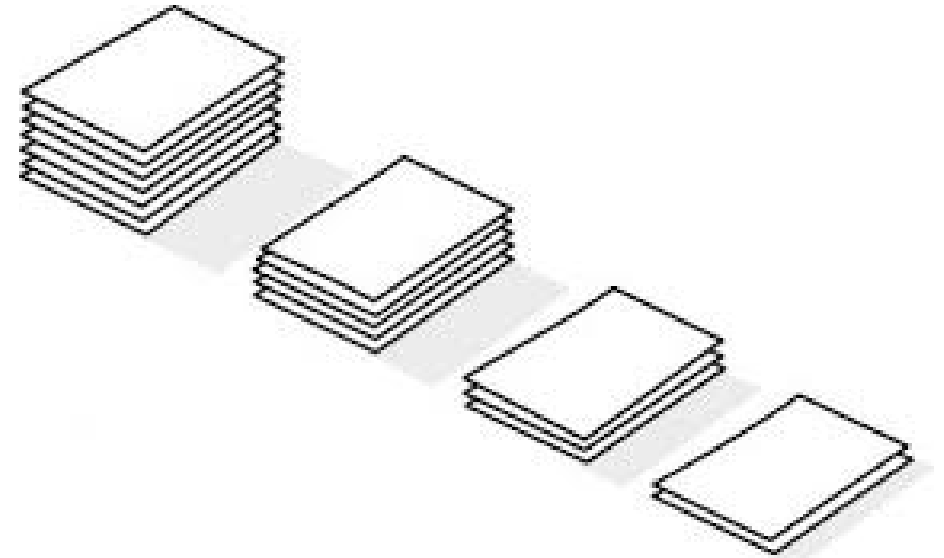
# Brief Assessment - Required

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Included in the PATH Assessment and Service Plan Template:



Sample PATH  
Assessment Service P



# Deeper Dive Assessment Domains

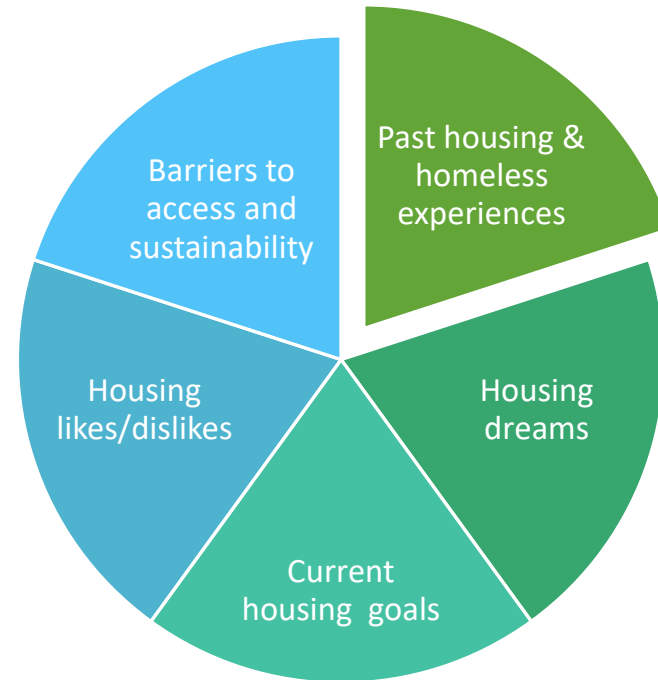
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- Housing and Homelessness History and Information
- Life Skills
- Employment and Education
- Health
- Mental Health, Substance Use
- Trauma

- Financial Resources and Obligations
- Legal Involvement
- Services Resources
- Natural Supports
- Interests and Hobbies
- Strengths and Barriers to Accessing resources
- Summary



# Housing and Homeless History & Preferences



Tool to explore housing preferences and options:



Housing preferences Worksheet



# Financial Needs/Requirements

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- Deposits
  - First and Last
  - Security
  - Utility deposit
- Moving costs
- Furnishings

Upfront cash needs



- Utility costs
- Rent
- Formal/Informal Debt
- Other living expenses

Ongoing cash requirements



# Financial Resources & Obligations

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What you say: Let's do a budget!

What the client hears:

Let me tell you how to spend your money.



# Another approach

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Tell me about how much money you need to live comfortably in housing.

Let's talk about how much you have now and how we can work together on getting what you need.



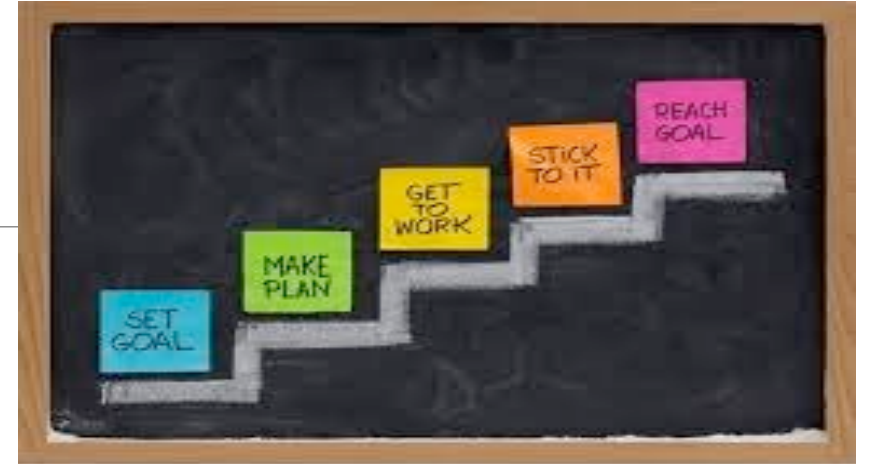
# Service Planning

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# Plan Overview

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- Guides and provides structure for the work.
- Focused on what matters to the client.
- Makes progress manageable by breaking out small steps.
- Requires on-going assessment - Informed by discussions with client, team, informal supports & community resources.
- Evolves over time.
- Builds hope and a sense of accomplishment as objectives are achieved.



# Developing a Service Plan

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Limit the areas of  
intervention

Focus on the most  
pressing needs that  
impact housing access  
& retention

Relate all  
interventions to long  
term goals

Usually not a linear  
process

Help people move  
away from crisis-  
driven lives

# Getting Started

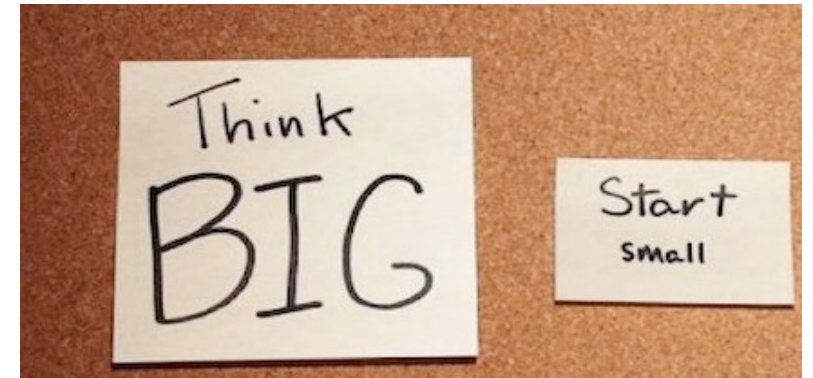
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## Begin with basic needs:

- ✓ Safety, food, pain relief, transportation, money

## Focus on basic needs:

- ✓ Develops trust
- ✓ Provides opportunity to define roles
- ✓ Allows client to talk about experiences
- ✓ Sets tone & structure for future work



STAGES OF CHANGE		
Stage	Relationship to Problem Behavior	Staff Tasks
Pre-Contemplation	No awareness of problem	Ask q's/ raise awareness of obstacles to goals
Contemplation	Aware of problem & considering change	Pros & cons of changing/not
Preparation	Making plans for how/when to change	Options: strategies, supports & services
Action	Changing behavior	Support/relapse prevention
Maintenance	Change sustained for 3-6 months	New goals
Relapse	Return to problem behavior	Assess stage and intervene



# Progressing

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- Progress to more complicated tasks:
  - ✓ Housing, family, connections to services, employment
- Connect short-term work to dreams and aspirations.

**“Your dream doesn’t have  
an expiration date.  
Take a deep breath  
and try again.”**

~ Kathy Witten

PersonalExcellence.co

# Goal Setting Strategies

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What does the client want from life?

- Identify values
- Clarify what is important.
- Let people dream– *What does your ideal future look like?*
- Identify what is negotiable/non-negotiable– *What do you have now? What would you accept?*
- See options available as steps toward a larger goal.



# Decisional Balance Sheet

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PROS AND CONS OF KEEPING DRINKING THE SAME

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PROS AND CONS OF REDUCING DRINKING OR DRINKING DIFFERENTLY

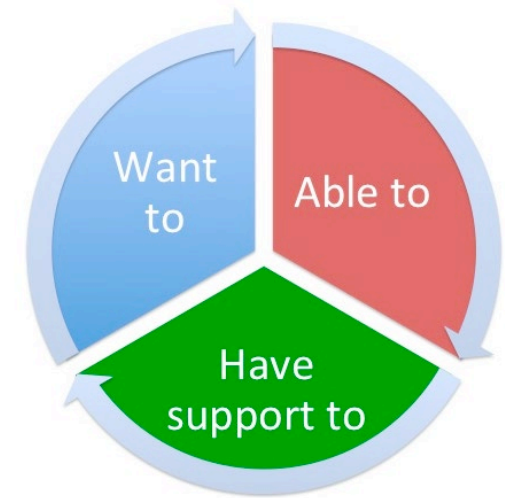
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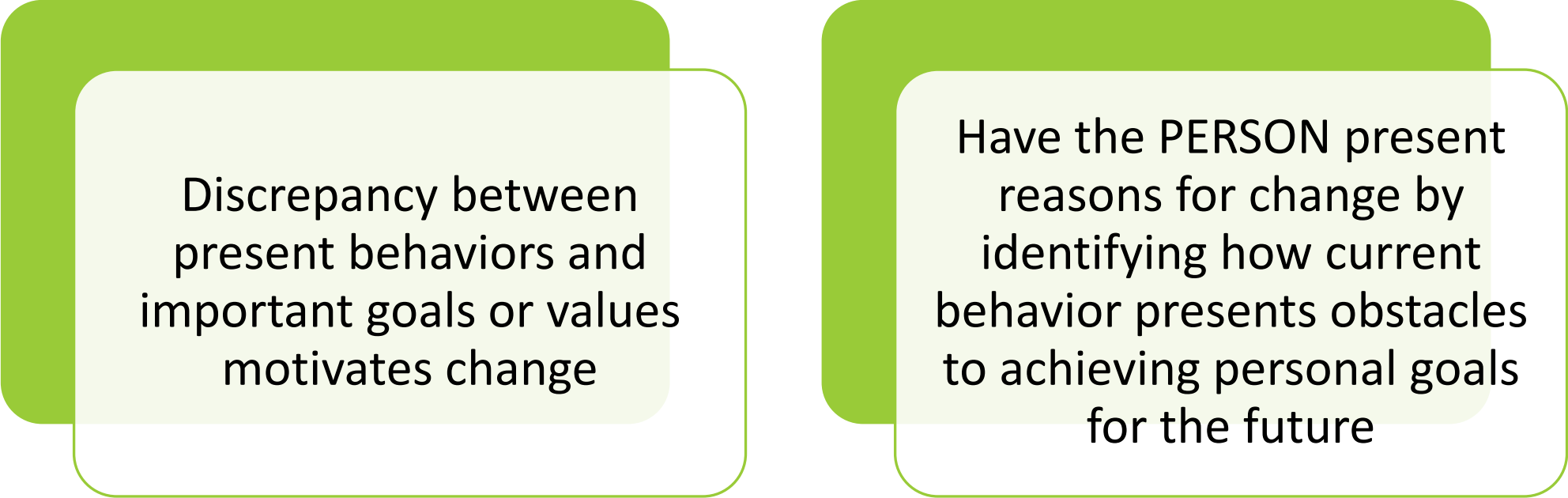
# “I have no goals. I just want to use.”

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Factors that impede goal identification:

- Homelessness limits ability to think long-term.
- Crisis requires focus on survival.
- Loss of control over one's life makes change difficult.
- Past failure makes people feel unprepared.
- Psychiatric symptoms & substance use can disrupt cognitive abilities.





Discrepancy between  
present behaviors and  
important goals or values  
motivates change

Have the PERSON present  
reasons for change by  
identifying how current  
behavior presents obstacles  
to achieving personal goals  
for the future

You've told me that getting a place is the most important thing to you. The housing of choice requires a disability form? Do you want to look at other housing options? Is there a way to get the form completed that you might accept?

# Creating a Platform for Change: Hope, Meaning and Confidence

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## HOPE

- How can you change if you don't think it is possible?

## MEANING

- How can you change if you don't think it is important?

## CONFIDENCE

- How can you change if you don't think you can do it?

# Surfacing goals

Start with immediate needs & build.

Questions that can help:

- *What would make you more comfortable right now?*
- *What would help to make your life better next week? Next month?*
- *How would you like your life to be different 6 months from now?*
- *How much money do you need to live comfortably in housing?*
- *What do you dream your life could be like?*





# Beware of compliance goals

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If you ask about a 12 year old's goals, it's unlikely they will say:

- Take my meds as prescribed.
- Keep all of my appointments.
- Drink/smoke/use drugs less.
- Stick to a budget.



# Evaluating & Updating the Plan

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At least every 6 months:

- Document steps achieved.
- Achievements build **CONFIDENCE** and **COMPETENCE**.
- Identify barriers.
- Identify adjustments needed to supports.
- Re-assess priorities.
- Clarify preferences.
- Refresh goals.



# Case Studies

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BREAK OUT DISCUSSIONS



What's is each person looking for?

What do you hear that might help this person move towards housing?

What do you see as the barriers?

What are the options?

What is the plan?

- Where do you start?
- What is the timeframe?



# Peter

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Peter has been living in an encampment off and on for years. He used to have a wife, children, and house. He was injured on the job and started to take pain pills. That went downhill quickly. His family went and so did the house. He says he was done with them - too much work.

Peter manages the encampment, he maintains order, assigns tasks and make everyone keep it clean. He helps the guys get benefits and then takes a small cut. He has no benefits himself. He says he wants housing. He also says he is worried about how his guys would survive. He says he wants peace and quiet, but he gives orders and watches everything. He tried a hotel and did ok. He made friends with the hotel staff and was helpful. They confronted him about the people he moved into his room, and he blew up. After all he did; he could not believe they were being such jerks. He left breaking the front door as he went.

# Arnold

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Arnold has lived on the street and in shelters. He lives in an encampment but always stays a distance away from others. He often hollers and has jerky movements that scare people. He has been hospitalized - he says locked up - several times. He is scared this will happen again. The guys at the encampment tolerate the yelling and watch out for him. He gives them his check. They give him food and cigarettes. He goes to the shelters sometimes when it is really cold. As soon as they talk to him about doctors and medication he is gone. He also got beat up a couple of times there. He says the food is terrible.

Arnold is afraid you are really trying to capture him. He is wary. He does like the water, food and clothes you bring. He even came in and took a shower once.



# Suzy

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You finally got Suzy to go to a hotel. She wouldn't go to a shelter but agreed to the hotel. She had been living with a group of guys for protection. She did some general caretaking, helping when they were sick, some cooking and cleaning. She also provided sex to them - sometimes to make money.

At first, she loved being in the hotel. She loved the shower and having a toilet. She even liked the microwave. She helped the other people with laundry and the microwave. She complained of being lonely and often went back to see her guys. She moved one man in, which is against the rules. Now she is spending most of her time in the encampment. She still sneaks people into the hotel. The other residents are beginning to avoid her, which is upsetting. She is thinking of just moving back to the encampment.

# Monitoring - Assessment & Service Planning

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If case management resources are insufficient to enable assessment & service planning with all enrolled participants:

- Propose a case management targeting strategy via the outreach plan.
- REMINDER: Updated Outreach Plans due to DMHAS 8/31/20.





# Monitoring - Assessment & Service Planning (2)

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- Use of template is required for all enrolled or targeted clients, as approved in Outreach Plan.
- Initial service plan within 30 days of participant enrollment
- Assessments and service plans updated at least every 6 months
- Signed by the client, outreach worker and supervisor
- Goals must be client-driven, specific and measurable, and plans must indicate who is responsible for indicated action steps and when those action steps will occur.





# Monitoring – Motivation Building

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- Staff helps participants gain control of their own lives, define their personal values, preferences, and visions for the future, and establish meaningful individual short and long-term goals? (Primary source: Service Plan)
- Staff helps participants to develop discrepancy between their personal goals or values and their current behavior? (Primary sources : Discussions with Staff and Case Notes)
- Staff adjusts to participant resistance rather than opposing it directly? (Primary sources: Discussions with Staff and Case Notes)
- Staff helps participants to build confidence, self-efficacy and hope that the things they want out of life are attainable? (Primary sources: Discussions with Staff and Case Notes)



# Next Steps

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# Tools

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[Outreach Plan Template](#)

[Sample Outreach Plan](#)

[Assessment & Service Plan](#)

[Housing Target Tracking Tool](#)

[Consumer Survey](#)

# Upcoming Webinars

AUGUST 6<sup>TH</sup> - CREATING  
EXPECTATIONS IN  
HOUSING

# Contact Info

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Brenda Earle

[Brenda.Earle@ct.gov](mailto:Brenda.Earle@ct.gov)

Andrea White

[awhite@housinginnovations.us](mailto:awhite@housinginnovations.us)

Lauren Pareti

[lpareti@housinginnovations.us](mailto:lpareti@housinginnovations.us)

Shannon Quinn-Sheeran

[shannon@housinginnovations.us](mailto:shannon@housinginnovations.us)

