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Introduce Yourself

- This method is used by **Courageous Conversations®** in their workshops.
- It comes from a **Māori** tradition. It encourages us to go deeper into reflecting on and sharing who we are as human beings.
- Share **three stories about yourself**. Please share what comes up in the moment or what feels most important; you don't need to include all details.

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Introduce Yourself

1. **Place:** What is a place that has shaped you? That could be where you grew up, where you live now, or any other place that has meaning for you. It could be your own story, the story of your ancestors, and/or the story of people who lived on the land.
2. **Name:** Who named you, and why did they name you? What is the journey you have been on with your name? Your name is part of your origin story and situates you in the context of your family, community, and world.
3. **Intention:** What are you willing to take responsibility for? What are you willing to receive today? What are you willing to give?

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Person-First Language

How to put the person first in conversations about supports

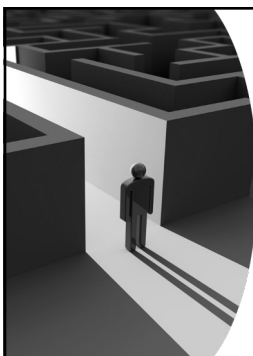
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Why person-first language?

- Way to emphasize the person as more than a diagnosis
- Assists in maintaining a respectful environment
- Eliminates stereotypes
- Reflects good manners not political correctness
- Puts the person before the before the disability
- Describes what a person has and not who a person is
- A person's self image is tied to the words used about them
- Person-first language was coined by people who said and still believe "We are not our disabilities"

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Impacts of not using person-first language

- Fosters pity and low expectations
- Perpetuates negative stereotypes and reflects prejudice
- Devalues and disrespects people as individuals
- Limits the person's identity
- Defines the person by their diagnosis
- Robs the person of the opportunity to define themselves
- Increases bias, stigma, and shame

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Examples of diagnosis- or deficit-first language vs. person-first language

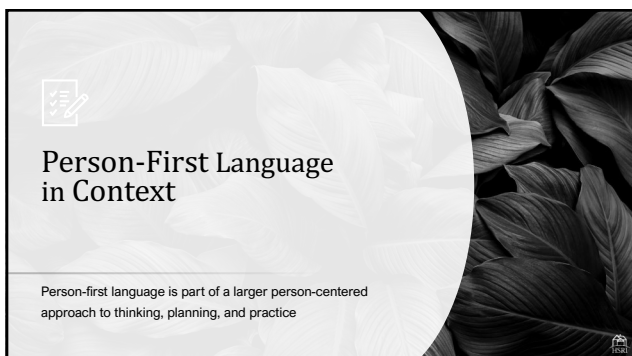
Diagnosis or Deficit-First	Person-First
Addict	Person with a substance use disorder, person in recovery
High (or low)-functioning	Has a spectrum of different capabilities
They are ADHD or hyperactive	They are working with ADHD or hyperactivity
Frequent flyer	Uses our services when they need to
People are suicidal or having suicidal ideation	People impacted by suicide or experiencing thoughts of suicide
She committed suicide	Death by suicide, killed themselves
He is severely mentally ill	He has a mental health diagnosis
Suffers with, suffers from	Person with, who has a diagnosis of
Non-compliant	Chooses not to because ...

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Reframe problems/symptoms into needs

Instead of this:	Try this:
Those with serious mental illness	They need supports to navigate their emotional wellness and mental health
She is manic/ has mania	Describe what that means or looks like for the person
They have behavioral problems	They need behavioral supports or could benefit from emotional navigation strategies
He has reading problems	He needs individual support with reading
She isolates and withdraws	She could benefit from more friends and genuine supports
They have anger issues/ always fight/ are aggressive	They need a safe space for physical release when ignited with intense emotions

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Person-First Language in Context

Person-first language is part of a larger person-centered approach to thinking, planning, and practice


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Person-centered approaches include person-centered thinking, planning, and practice




Person-centered thinking

- A foundational principle requiring consistency in language, values, and actions
- The person and their loved ones are experts in their own lives
- Equal emphasis on quality of life, well-being, and informed choice



Person-centered planning

- A methodology that involves learning about a person's preferences and interests for a desired life and the supports (paid and unpaid) to achieve it
- Directed by the person, supported by others selected by the person



Person-centered practices

- Alignment of services and systems to ensure the person has access to the full benefits of community living
- Service delivery that facilitates the achievement of the person's desired outcomes

NCAPPS National Center on Advancing Person-Centered Practices and Systems

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How do we think about person-centered practices and systems?

Negative perspectives on illness and disability has led to a 'SYSTEMS focus.'

- Limitations define the person
- Focus is on "services" that people become eligible for, based on the extent of their "impairment"
- Overemphasis on problems
- Supports are driven by the needs of the system (structure, forms, professional rules, and boundaries)

Person-centered approaches draw from human rights approaches to health and wellbeing.

- Recognize person's unique capabilities and contributions
- Identify strengths and preferences
- Recognize the challenges of illness and disability in planning for a future life and identify supports

A person-centered system of support builds capacity of each person based on who they are.

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What helps and what hinders?

Findings from a interviews with 115 people who use publicly funded behavioral health services in nine states, including Texas

Helps

- Seeing self as a whole, complete person
- Gaining knowledge and becoming educated
- Dignity of risk and the freedom to fail
- Individualized service planning
- Optimistic staff
- Full commitment to lived experience voice on personal and system levels

Hinders

- Negative beliefs and attitudes
- Invalidation and a lack of information
- Labeling
- Lack of meaningful involvement in treatment planning
- Pessimistic staff
- Lack of lived experience voice on personal and system levels

O'Brien, S. J., Darnoff, J. M., Ridgway, P., Dorman, D. H., & Ralph, R. O. (2002). *Mental Health Recovery: What Helps and What Hinders?* A National Research Project for the Development of Recovery-Oriented System Performance Indicators. <https://www.recovery.org/sites/default/files/MSIP20020615021020.pdf>

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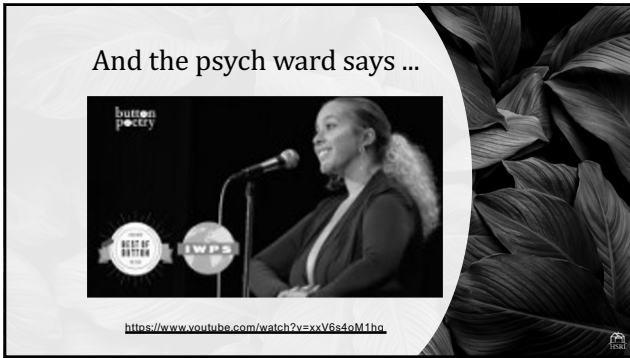
An alternative to the medical model has evolved from a better understanding of trauma and recovery

Medical model	Trauma/recovery model
Assumes mental health problems are result of chemical imbalances or otherwise biologically based	Assumes that mental health problems are complex and not fully understood; environmental, cultural, social, developmental, and other factors are major contributors
What's wrong with you?	What happened to you?
Focus is on illness, deficits	Focus is on wellness, strengths
Emphasis is on the brain	Emphasis is on the person
Psychiatric diagnosis is essential	Psychiatric diagnoses are unreliable, unscientific, potentially hurtful, and unnecessary
Recovery means symptom reduction	Recovery means a full life
Behaviors viewed as deviant	Behaviors are viewed as coping attempts
Medications are central	Medication is not seen as more important than psychosocial and other supports
People are encouraged to comply with treatment interventions	People are empowered to take charge of their own recovery
The helper is the expert and the client is dependent on the helpers expertise	The person is the expert and the helper is a coach

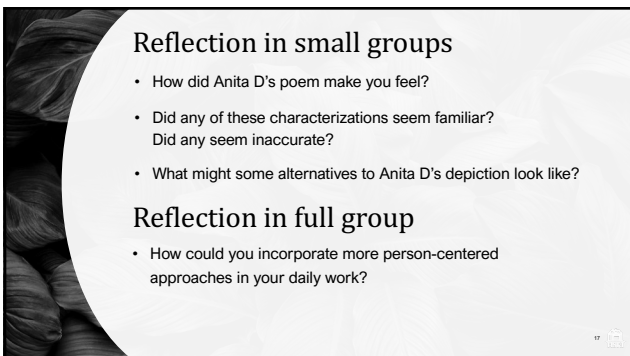
Adapted from the July NCAAPS webinar "The Three Legs of the Stool: A Framework for Person-Centered Community Mental Health Services"

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