Hospital Diversions and Alternatives in Crisis Response

Laurie Curtis: Hello everyone and welcome to this recovery to practice webinar. I'm delighted, this is Laurie Curtis, and I am your host today.

Today we're focusing on hospital diversion and recovery and alternatives in recovery response. After some housekeeping and a short overview of recovery to practice, we will begin the presentation. On behalf of Substance Abuse and Mental Health Services Administration or SAMHSA we would like to welcome you all to thank you for joining us today.

At this very moment, we have over 250 participants signing on today and we expect that number will grow as we get going.

I also want to thank our presenters today, Lisa St. George and Dr. Karen Chaney, for sharing their knowledge and experience with us today and we'll introduce them in just a moment. At the end of the session you will be able to download a certificate of attendance that you can use to apply for continuing education credits for your professional association; and we have some good news, the webinar has been preapproved for continuing education from NAADAC, the addiction professional association. To qualify for these continuing education hours you must attend the full webinar, complete a brief quiz and a webinar evaluation. There will be more information at the end of our webinar.

At the completion of the webinar today an opportunity to provide feedback will automatically open on your screen, so please take a few moments to let us know what you thought of today's webinar and provide us with feedback, it means a great deal.

Finally, if you have registered for the webinar you will be emailed a link to view the archive recording. This link will also be available on the recovery to practice website where you will find links to past recovery to practice webinars.

This webinar series is hosted by SAMHSA recovery to practice. The overarching goal of this initiative is to improve the knowledge, and ability of the behavioral health workforce to use recovery to practices every day.

But what do we mean by recovery oriented practices? In 2011, SAMHSA released a released a working definition of recovery and a set of guiding principles that incorporate aspects of recovery from both substance use and mental health conditions. SAMHSA's working definition of recovery in behavioral health is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The 10 principles of recovery shown on this slide, along with four major dimensions of recovery: home, health, purpose, and community, form a solid foundation for developing recovery oriented lives and for building recovery oriented services and systems that are necessary to support them.

SAMSHA’s Recovery to Practice initiative helps you turn these principles into workforce practices. Recovery to practice offers a set of discipline-based curricula to promote the understanding and uptake of recovery principles and practice developed by these six professional disciplines for educating their membership about recovery in behavioral health. These materials are available and adaptable for use by other disciplines and organizations seeking to build the recovery oriented workforce. Links to these curricula can be found at the SAMSHA’s RTP (or Recovery to Practice) website. And you’ll see on the bottom of each slide the link to that website.

Recovery to practice is expanding its discipline focus to embrace multidisciplinary services in integrated settings. Those of us who work in behavioral health or integrated healthcare organizations have opportunities every day to promote wellness and recovery with the people that we serve. We can powerfully communicate hope for recovery and the value of self-care and wellness just in how we approach our work. Recovery to Practice can help you strengthen your recovery oriented practice through free webinars, newsletters, training, and technical assistance opportunities.

Many of us recognize that with crisis comes opportunity for growth. All too often however, individuals and their families who face mental health crisis experience fear, disempowerment and even trauma. Today's presentation is the last of a three-part series that examines a number of ways to integrate recovery oriented approaches into responses to support alternatives…support services to help individuals in these crucial periods. I want to introduce our speakers for today.

Lisa St. George is the director of recovery practice at RI international and the director of RI consulting. With over 30 years of work experience, social work experience, Lisa is an expert in developing recovery focused systems and strong peer support workforces that provide mental health addiction and integrated care. She has provided leadership and startup of many recovery programs in Arizona, California, and New Zealand helping to transform systems of care to have a strong recovery focus and vision while working within existing process and procedures. Wherever she goes, Lisa brings unending belief in the coherent -- inherent courage, wisdom, and strength that people in recovery needs. Over the years, Miss. St. George has authored multiple books, articles, and trainings with a recovery focus. As a person with lived experience of recovery, she brings a unique blend of expertise to go work.

Dr. Karen Cheney is the executive director of consulting services and chief medical officer for RI international. Previously, Doctor Cheney served as the chief medical officer for Terros Behavioral Health or she supervised medical providers and managed clinical programs. From 2011 until 2013, she served as medical director for Magellan Health Services in Arizona, additional previous experience includes serving as medical director at Terros Men’s Behavioral Health, staff psychiatrist and medical director for Value Options, and as a consulting psychiatrist for Chandler Hope and Sundance Holistic Treatment Center. In her current role, Dr. Chaney is deepening the organization's existing routes in recovery training, while overseeing expansion of key areas including zero

suicide, next-generation crisis systems, integrated care, and behavioral health leadership. And with that I will turn over to our presenters please join me in welcoming Dr. Cheney and Lisa St. George.

Karen Chaney: Thank you so much Laurie. And hi Lisa and hello to everyone who is on this webinar.

What you will be seeing, after we get to our next slide please, what you will be seeing here is a tour, a sort of tour of our recovery response center. I will discuss with you what the vision is a how this works and why it needs the recovery to practice initiative. We also, in reviewing this I realize that we are using the 10 guiding principles of SAMSHA, so let's talk a little bit about this particular RRC, this is our Peoria, Arizona RRC and as you can see it is quite lovely and we're very proud of it, and as we talk I will show you more of the RRC. Next please.

We not only have this site in Arizona but we have other sites all over, the Peoria Arizona is our flagship, we're opening an RRC in Wilmington, we have one in Ellendale, Delaware we have two in Durham and Henderson, North Carolina, Riverside in Palm Springs California, and five in Lakewood, Washington. We also have a freestanding living room which we will discuss later, in New Zealand in the city of Pukekohe, and I hope I said that right. Next please.

So we are a different kind of crisis center, and why we are, is because recovery is first and foremost for us there. We make use of a step-down type of a program and it sounds strange but it actually reduces hospitalization and it allows folks to come in to our program and not be hospitalized. We have a very high level of peer support providers and you will hear this throughout this talk about the peer support throughout our system. We also help folks get just-in-time medication. This means that if they are running out of medication and they haven't seen their doctor and they don't have an appointment for a few days, we will bridge their medications after an assessment and discussion with their medical provider as well as their team. And we also recognize the social connectedness is a part of wellness and recovery and this is part of what we instill as folks are coming in and being discharged. And our peer-support coaches do this quite well. Next.

We use interdisciplinary team. We know the people in crisis need effective care, and they need folks to support them. With that in mind, we know that every member of the team is important and has a voice. That includes our peer support folks, our medical providers, our nursing technical assistance, and we also know that medication helps but it is most effective with a dose of kindness and hope. And what we do here is in this interdisciplinary team -- is we let them know the recovery is possible. Our peer support coaches let them know that on an hourly basis if necessary.

Right now, we have a poll and we would like to have you participate in this, the question is, what barriers exist in your services system and accessing medication? And if you would just fill this out and we will take a look at it in just a few minutes. Next.

O.K. so now we start the tour of our RRC or Recovery Response Center. This is our lobby and as you can see it is quite lovely, we welcome walk-ins, we also have a peer support provided right as a person walks in, so that they can be assisting anyone who is coming in for assessment. We have 24/7 availability for assessment and assistance, and we help with the refills and the prescriptions as I spoke about that before. We do this because we're trying to avert a crisis and relapse as well as decreasing the ED visits, so we're helping them get their medications in the moment with the consent of their outpatient providers.

We make sure also that if they need to be admitted after the assessment we do that but they do not have to be admitted from the lobby into the rest of the program. Let's look at the poll. And it looks like the barrier that is really quite high at 63.2%, and it's a long wait time to see a prescriber. I think that does not surprise me, this is one reason why in the lobby, we also to those refills so that we can make sure that people have their medications.

Lisa St. George: Yeah, this is exactly what I have heard from a lot of people that we have served over the years. It is consistent with what we know and understand.

Karen Chaney: Alright. And again, as folks come into the lobby, we really do listen to what they need and we tried to do that throughout their stay. Or just in the lobby. Next slide please.

From the lobby, we go to the retreat. This is an observation unit; the length of stay can be 24 hours and our length of stay averages 22 hours. It is a secure area for evaluation and for stabilization of the folks that come in. There are individual rooms and communal areas so the person who comes in and maybe agitated, they want to be in an individual room, and stay calm. Others want to be part of the milieu and can be in the communal area. We serve snacks during this time, and peer support plays an important role. Again, you will hear me say that throughout this talk, because peer support is something that we rely on quite a bit.

The, it's important to also note we have about 25 recliners were folks can be seated comfortably or they can even sleep in them. We also have a police entrance where there is a nurse and a peer support that are there when folks come in and they help to calm individuals and also educate them about their admission. Next.

Lisa St. George: It is just as important to note, right at the entry at the entrance a peer support is present to offer their support, and help people understand where they are and relates to them about the experience of being there are so people can feel safe.

Karen Chaney: Great, thank you Lisa. Our next stop is the living room. So if someone is in the retreat or has been petitioned or has more need of having more time at our facility, they will go into the living room. And it is a warm and welcoming environment. It uses healing spaces and let me tell you what that means. Basically, as you can see, it is bright, beautiful, calm, open, and there are beautiful soothing colors and so the

environment just speaks of their being calm and working on their treatment. The length of stay can be up to five days, however, our averages about 2.4 days. The living room again is staffed by peer support workers again a very important part of the treatment for these folks. Also, we have about sixteen beds for those people who are in the living room. Next.

Lisa St. George: I should note that the individuals that stay in the living room have a room with a bathroom connected to it and there is typically one person sometimes two in the room but most of the time one person. And it helps for their sleep and their well-being and their comfort.

Karen Chaney: It is a very accommodating environment for folks who are having a crisis.

The next stop is the peer-run respite. Now when I say this is peer-run, I mean completely peer run. It is a step down from the living room or folks can just bring themselves to the respite and they can be there for a little while. What happens is that sometimes in the process of discharge we're working on community resources as well as housing etc., when this is going on, the peer coaches assist them in doing many of these things but they may not be – may not have them ready at this time. So basically they go to the respite, and they can stay for about 30 days, and we're kind flexible on that, the number of days, we have about 10 beds and the peers are mentoring all the time through groups and one-on-one meetings we also need to understand that folks are there and they can leave to go to a job and leave to go to appointments, and return that day. So, we have peers throughout our observation, our inpatients and now our peer run respite which is obviously outpatient. Next.

More about our recovery response center, our team members who are identified as peer support roles work alongside team members who may or may not have lived experience of recovery. Basically we have peer review -- peer coaches working with the teams and there may be other peers on the team, but we really don't ever know and basically they have been trained to help with the team and also help the individual. It is also important to know that there are nurses and physicians and other staff that may have a personal experience with living with a mental health concern and are in recovery. We look at that as being, this is part of recovery is getting back into the workforce. We also have a career ladder for all team members, including our peer coaches. Next please.

O.K. What are our team contributions? Everyone has a contribution to make to the well-being of individuals that we serve. All team members provide warmth and kindness and belief in individual's ability to recover. When we do shift to change, we value everyone's opinion and everyone's interpretation of what has gone on during the day, with the person that they have been overseeing. Basically, when they are speaking about those things, that have been important to our individuals that has been helped, we feel it is important that all of that is shared every team member is responsible for the creation and maintenance of the healing spaces and it's also important to realize we have this multidisciplinary approach, a team effort, all sending a message of hope. Next Please.

So let's talk about what the alternative -- that are offered by the RRC. First of all, we offer an alternative to the emergency department use for psychiatric crisis events. Often times, our site patients are sitting in the ER and they are not being treated for the psychiatric illness, and they are waiting on that to happen and they are waiting on a bed so bringing them to the RRC really avoids all of that. We also act as an assessment center for petitions, and I'll describe that in a minute, and we offered supportive environment that may assist individuals to avoid an inpatient hospitalization. We also use the best practice philosophy of no force first. So let me tell you what that means.

That means that we use therapeutic options which is evidence-based, and it is relational driven and how we do that is that we try to de-escalate folks verbally we utilize folks that they may have established a bond with on their team, and we move them to a quiet place so they can de-escalate mostly on their own but with some help. If that fails, basically, we can bring them to a seclusion room which we do very, very infrequently, the only time that we ever have used restraints is when there was someone who was a danger to themselves or to others and when the safety of the milieu was questioned. In that case, we will use restraints if we have to, but we pride ourselves on being no force first.

The other thing that I would like, would want to talk with you about is our petitioning process in Arizona. The RRC acts as an assistant center for this and a person has to demonstrate a danger to self, to others, or being persistently gravely disabled. This must be documented in an order, in order to have the individual picked up by the police to be evaluated by our medical provider. The police bring in the individual, the provider will review the document and do an assessment for approximately 3 days if needed, to determine if this person needs any further treatment and if they are willing to take treatment at the time.

Basically, that would entail going to court, and being placed in an inpatient hospital at the time. Going to court means that if a judge agrees, then this person would be on court order for 365 days. What we do is, we try to stabilize the individual after the assessment, in the living room and many times because of the treatment that they get and the time that they can spend, the petition is dropped. It is important for you to realize too that we do not deny service, what we do is we redirected. Instead of going to the ED or to the hospital, or even being petitioned, if we can, we will take care of that individual in our system. Next please.

We have to develop community relationships as I am sure you all have to do in certain instances, and our community relationships are important to us. We work with our external stakeholders and hold them as a part of our recovery response center. We work closely with law enforcement to help them understand that they can bring anyone to us, anytime and we will serve that person. Every time we serve an individual who was brought in by the police, that individual is not being taken to jail. We feel that's a very important aspect in treating mental illness. We have developed a work relationship with hospitals and clinical teams, mobile crisis teams, in order to help folks to get out of the ED so they can go on to having

treatment. We create a welcoming atmosphere for parents and for loved ones to visit and we have flexible hours for visiting. In doing this, we also give families resources along with linking their loved ones to a provider and other community resources. In doing this, we work at giving families hope as well. Next.

Lisa St. George: I think the visits are so important because they keep people connected to their life outside, to their families, and we really think that's important because in setting when people come in we do not Terros Behavioral Health want them to experience isolation by being disconnected to the people that are important in their lives, so we do not want that when people are out of a treatment center and we do not want people to have that experience in the treatment center.

Karen Chaney: And this is part of the social connectedness, if we have someone who is isolated in a hospital let's say, oftentimes families have a difficult time getting in and finding out what is going on, and in our case we really do value that family relationship or whatever support system they have. And then once they are out in the community, they have maintained that support system, and probably will be making other choices as far as support people. So it is very, very important.

O.K. Thank you Lisa. The RRC and its value. Well we talked about the version and this is our Peoria site, we divert about 200 individuals each month from hospitals and EDs to our treatment center and basically that's a lower level of care and yet we're taking care of them and using what we need to assist them. People are brought to the RRC by police approximately 70% of them. And 30% are brought in by mobile crisis teams, families or by self-referrals. The Peoria site also sees 5,000 unique individuals each year. Again, we should be very clear that we're not denying services, we are redirecting them to our treatment center and getting folks out of the hospital – not out of the hospital, out of the ED and perhaps decreased hospitalization which is often very traumatic for individuals in crisis. So…Oh I'm sorry go ahead.

Lisa St. George: Sorry. And also, every time someone will come to the RRC especially when brought by the police, it's a time when they did not go to jail instead.

Karen Chaney: Correct. From the lobby to linkages to community resources, treatments and services are available to all of those who need it. Next please.

So, besides having some value in what we talked about, we have an even higher value we think in the average length of stay in comparison of the retreat to the emergency department and living room to hospital. Our retreat, again, is about 22 hours and that is an observation unit. In the emergency department, it is variable but research has shown that it is approximately 6.8 to 34 hours in the emergency room waiting on a bed and/or being seen by psychiatric professional. In the living room, we have 2.4 length of stay which can go to five if it's needed, in the hospital the difference is 7 to 14 days. So, you can see inpatient hospitalization is much longer where as in the living room were ready to

help the person and do it on an individual basis as well as discharge them to community services, their team, whoever needs to be involved.

You may say, it says here that the average for an emergency department is more than 12 hours. The reason that we have high-value is, and we can change the next slide, is that in cost analysis the RRC cost about one third of an ED visit so we feel that it's very important and it is very important to have our EDs ready for those who have medical problems and we need to be able to take care of our psychiatric patients who have problems.

In that one third, that is value added, we also on the return visits within the same month are only at 5%, and because we have peers who assist our folks follow-up in ED visits has decreased within the first 30 days. Another reason the peer support so important. Next.

O.K. We also divert court petitions when it's necessary, when we can basically, about 65% to 70% of petitions are dropped at the Peoria site, thus they are not sent to the hospital for court, they are not court ordered for a year, and it gives them the ability to continue on in the community and to be able to be treated by the outpatient team. Dropping a petition and any other treatment recommendations are the result of a whole team input, but a medical provider does determine after assessment what should be done with the petition. Next.

Outcomes. Now outcomes you hear this, this the buzzword all over the place anymore, everyone wants to pay for a good outcome, and you can’t blame them for that, but what we have found in our other RRC is a significant reduction in hospital and ED visits. Our RRC in Delaware had a 50% reduction in ED use. It also had a hospitalization rate reduced from 48% down to 10% and, in Washington because of our peer supporters who is a great deal with individuals who are discharged, we have reduced hospitalizations by 79% from 202 individuals per year down to 40 individuals per year. Those are really terrific outcomes.

In summary, what do we know? We know that our system assists folks in crisis, they assist in helping families and individuals with mental illness work their way through the healthcare system, which is sometimes very cumbersome, we help with diverging from the ED to a crisis recovery center rather than sitting in the ED waiting for a bed, to open or even for someone to see them. We also found it decreases hospitalization which can be very traumatic for folks and it is the highest level of care and we would rather not have to use that if possible.

We also know that peer coaches assist those we treat and this has decreased recidivism, ED visits and unnecessary hospitalizations. So with that I will hand it over to Lisa so she can let you know all about our support coaches. Thank you.

Lisa St. George: Thanks a lot, Karen. Peer support is a great addition to any multidisciplinary team. They can provide— next slide-- empathy, and support, and help people take back their power and understand that they have a part to play in their care. They use their journey as a tool for hope. In fact, we think that one of the most important roles not just for

peers but for all people who serve individuals with mental health challenges, is to create a feeling of hope in them that things can change and get better. As people work as peer support specialists, their recovery also improves. Next slide.

It is important when we bring peers on to our… in multidisciplinary teams that they are trained well. RI international has provided peer training for over 15 years. At any given time, about two thirds of our staff are peer support in identified peer roles. They are really important members of our team. With our training, they have trained over 7000 peer support workers across the US and abroad since 2000. Our training thoroughly covers SAMSHA competencies for trainings and meets those competencies. Next slide.

The training consists of 80 hours of class interaction, over a 10 day period of time, we look at conflict resolution, trauma informed care, communication substance use, emotional intelligence, we help people to understand what we mean when we talk about recovery and what's possible for people, we also have documentation and partnering with the other people that you're going to be working with. And how to do that well.

It provides certification in multiple states and countries and it is currently the Veterans Administration's preferred training option. We have trained veterans for many years, but acquiring this particular opportunity to serve our veterans has been really, really an important part of our work. RI's Recovery Response Center has worked with peer support specialist since 2003, and we started with a one peer support in the lobby greeting people, and now we have peers throughout that entire system in every location. Next slide.

So we have a poll now. And you'll see it at the bottom of the screen. We would like you to fill that in if you could. We see a lot of people are answering they do not have any support in their crisis services. I see very few that think people with lived experience cannot handle the stress of crisis work and that is great. Because what our experience has told us is that peers are very strong people, they've been through a lot in their life and once they understand how to use that effectively, all that skill and knowledge they have gained through the years, they make really good workers.

Karen Chaney: And I think it is really important, Lisa, to let folks know that although they go through this peer training they don't necessarily have to work for RI international, or at the RRC, they can get jobs wherever they would like to.

Lisa St. George: Yes. There are a lot of peers in lots states doing great work. We also see that a proportion of you have fully integrated teams with many peers working alongside non-peers. That is also great. And that lots of systems have peers available in support roles.

I see one that says we have one or two peers working the crisis service center. It's been our experience that we need a larger group of peers in all of the workplaces so they can support the team in bigger ways and

work with more people and be the example of recovery within your team because through the participation, recovery will begin to happen for your team members in other words, they will begin to understand and believe in the possibility of recovery not just for the peers on their team, but for everyone that they serve. And by recovery I mean everybody can lead a full life in spite of the challenges that face them, they can learn how to work through those challenges.

Laurie Curtis: Lisa this is Laurie. I'm interrupting just to let you know you have about 10 minutes if you want to leave any time for a lot of questions.

Lisa St. George: So, let's change to the next slide. From the moment people are admitted during every phase of their admittance, from the very beginning, they had a peer that is working with them. And it will change with shifts and whatnot, but there will be peers around them all the time. Next slide.

When peers work with someone and they're making their plans to exit the Recovery Response Center, they can follow up with them in the community and go to all kinds of appointments with them that might be scary at first and offer support. They can go to people's homes they can help them connect in the community, teach them how to ride the bus, all kinds of things. Help them get social services that are needed that probably gained a huge understanding of during their time that they might have needed to use those services. Next slide.

Throughout our organization, peers do all kinds of services, they run the psychosocial rehab groups, in our recovery response centers they check acuity levels and vital signs, all of our peers in all of our organizations document and sign the health care records, and our peers go right up from a starting position all the way up into the highest levels of leadership in our company. Next slide.

We employ peer support and work with them in the development of their employment skills, we want them to work with people and help them to see themselves as becoming employees, we want them to strengthen the involvement of their opportunities in the community, and what we see is a lot of peers come into this work and other people who want to go into the work are doing it because they want to give back. They want that sense of belonging that comes from work. Next slide.

So essentially the peers support specialist become a reflection of recovery for the people that they are serving. I like to call them living breathing hope. What we are learning is that… next slide… is that peer support has been a great value in our crisis response centers. They support people to learn and understand that self-management is possible, that they can increase their skills around their personal wellness, they offer support to individuals either advocating for them or helping them to feel supported so they can advocate for themselves. They look at wellness activities, when they go out and work with people in the community that might include a walk around the block, healthy eating

habits, and all kinds of things. Karen mentioned that it reduces emergency department use and hospital use. Let’s go to the next slide.

When workforce development, all the team members that we hire regardless of their role, goes through a new hire orientation getting the foundational skills of the work that they're going to do. In addition to that, our peer team members have 80 hours of training that we provide, and that training aligns with the core competencies. Let’s go to the next slide.

We have other tools that organizations and peer supporters can use once they have completed peer employment training or if they are bringing peers onto their team. And they include supervising a peer workforce, keeping the recovery skills alive which is a supervision tool where there are 52 modules that can support people in supervision throughout the year. One per week. And some others that are listed here and they are important because they are continuing education for peer specialists. We think their education has to be continuous and we’re learning peers need to grow in their work as peer supporters not morphing into other roles through other training, that do not focus on the role. Next slide.

We teach team members how to respond to people and with people who are highly distressed. People who have used the RRC are able to share their personal story sometimes with our team, and sometimes people come back just to explain to the team that they have been served by, how much better they are doing or how things are working for them. Every team member gets one hour of supervision for every 40 hours that they work and we feel that's important and it helps them to stay connected to the focus on recovery.

We value each team member and the unique aspects that they bring to the job. If you want to, let's go to the next slide. Get started right now with your peers and your company. So, their presence is felt by the rest of the team. Leadership will demonstrate that it values both peer support and recovery philosophy, and change the environment to reduce barriers and we want to make sure that nurses bubbles go away, that sitting behind desks doesn't happen so much so that people feel like they are being connected with by individuals that are serving them when they are in the setting. Some of the other things you can do is use that… next slide… great language, that is not focused on what is wrong, but is focused on hope and possibilities. So, we encourage words like when you are better, once you are home, what are your plans. And we ask people continuously what do you need and how can we help, and when we’re ready to listen to them deeply, and really state in connection with them and believe in the possibility of recovery for each and every person. Thank you.

Karen Chaney: Laurie, your mic is not on. We can’t hear you.

Laurie Curtis: Sorry, O.K. can you hear me now?

Karen Chaney: Yes, yes.

Laurie Curtis: You missed my whole wonderful intro. My apologies. I was saying, for those of you who could not read my lips, that it was a

delightful presentation and you stimulated a great deal of conversations both in the chat and a number of questions have come in. We had a few minutes for questions. Let me focus on the one that seems to be the most common theme. At least initially. I will put this towards you to start Doctor Cheney, and Lisa you may want to add on this, and that is funding. People are impressed with what you are doing they want to know where it is all around the country do you have one in my area, but how are these programs being funded?

Karen Chaney: Well, I'm sorry my computer just shut down here. Funding is quite different but usually in the places that we are, we are funded by an organization which is covering all the mental health for certain counties or for the state, and that is how we are funded.

Lisa St. George: And what is interesting to note is that a lot of the peers are in roles where they can build Medicaid and will usually bill peer support if the state has that as something that is billable in Medicaid or they bill psycho social rehab codes.

Karen Chaney: So everyone is able to bill and most of our folks are Medicaid although not all of them.

Laurie Curtis: All the peers on your workforce are paid, it is a paid workforce it is not a volunteer workforce?

Karen Chaney: Correct.

Lisa St. George: Yeah.

Laurie Curtis: That's very, very helpful. Another series of questions came in and I will that the two of you decide who can best field this, but that is talking about how are you working with individuals who have substance use disorders? How does that play into your services and how you work with that in particular if it fits a primary substance use, and also related to that, people who have physical health problems. And how are you connecting and helping people connect with services in the community around physical health problems. These other populations. Who would like to pick that up?

Karen Chaney: Lisa do you want to answer the one on substance abuse?

Lisa St. George: Yeah so we…a lot of the people that come to see us a lot of them have substance abuse as their primary reason for coming to us. So, we are very used to working with people in their early detox process and supporting them until they are able to exit or if they need further care, move into a higher level of care. But we treated people in our recovery response centers for years that have substance abuse challenges, the two, mental health and substance use, goes hand-in-hand.

Karen Chaney: And often, to piggy back off that, if they have -- going to be at risk for detox, we do utilize hospitalization until the detox is

over. We don't want to -- we want to do the appropriate level of care, if they are detoxing from alcohol use and that sort of thing.

Lisa St. George: We care for people who have physical health challenges of course, but in their assessment when they come in and the nurse is looking at them while the peer support is supporting, if they are having a health challenge that would put them at risk if they came in the RRC because they need higher levels of care, then we will insure they get what they need and send them to a nearby hospital.

Laurie Curtis: Following up on that, would you expand a little bit on how you are coordinating with community services and some of that linkage area go through peers but also through some of the professionals in your team?

Karen Chaney: Let me start and I'm going to let you finish it Lisa. Many of the folks that come in let's say to the Peoria RRC are part of the seriously mentally ill population were provided with medical providers and teams and case management and that sort of thing, so oftentimes, actually all the time, we coordinate with their team and let them know what's going on and we also collaborate on what needs to be done or we think needs to be done, we do doc to docs, and all that and it is just standard of care. Once they leave, and if they need additional community resources, we make sure this happens and we make sure we let the team know what we see as being needed. We listen, and Lisa brought this up before, part of the treatment plan or all of the treatment plan is based on what the needs of the individual are and those needs that is in the treatment plan and so we basically share that with those folks in outpatient who take care of them on a regular basis. Lisa?

Lisa St. George: Yeah, if they have never been in the system and there is a person who might be benefiting from being in the public mental health system, we can help them to know how to enter and get the right support to walk them through that. In addition, we are in constant contact with the committee partners on where there are beds, what else needs to happen, how can we support this person and we in sure they have connections made before they leave the RRC and we're there to help them follow up.

Karen Chaney: At times, some folks come in and they have not been designated as seriously mentally ill and we help with the evaluation of this person and the assessment for that designation if it is needed.

Lisa St. George: There's a person who wrote a note down below, I want to mention because it's an important question about language, when we have people who come in who do not speak English, if we do not have a staff member that speaks their language we have language line and we access in every way we can to work with them in the language of their choice.

Laurie Curtis: Going along with the accommodations to different people and different needs, people are technology you are doing phenomenal work with peer supporter the crisis and crisis alternative arena. The question

comes up, what are you doing if anything around family to family? Because it's not just individuals coming in who are impacted by mental health crisis, it is everyone around them including family members, can you talk about what your thoughts are or what is going on in your services in that arena?

Karen Chaney: Lisa I'm going to give that one to you because you did well in that.

Lisa St. George: We have two trainings that we have developed specifically for family members to help them learn how to be working within the systems themselves and to increase the understanding of recovery and to help them feel included in the whole process. In our recovery response centers, the parents can come to any meeting the family member can come to any meeting, with the individual, and their team at the response center and I want to mention the open visitation so family members do not feel pushed aside, and they feel included as part of the process if the person says that's okay. Because the person is the one who is driving their care.

Karen Chaney: One other addition is in the outpatient system, many of the providers have family mentors so they will assist with the families and with the individual in whatever way is necessary.

Laurie Curtis: I may be opening a whole can of worms here at the end, but there's a lot of amount of interest and appreciation for no force first. And a lot of questions about how that really works on the ground. In terms of actual use of restraint, the kinds of circumstances under which that might happen, what is that really look like and feel like?

Lisa St. George: Can I take this to begin with?

Karen Chaney: Sure.

Lisa St. George: In the beginning, when we started looking at changing our philosophy from one that was very comfortable with restraint to one that was going for zero restraint, before, if a participant knocked on than this -- knocked on the window once or twice and came back and did it again, they might be restraint, and there is this Sentinel kind of way of seeing the staff had of watching people and monitoring the behavior. We started to shift that and we realized a zero restraint is not really -- cannot really occur because sometimes we need to help people keep himself safe and we need to keep the environment and the other people that are being served by us safe but it is the last thing we go for. And we will try to help them feel calm and a participant can be very angry and start throwing chairs around and everybody was asked to go to their rooms, and she stood with the person and she moved the coffee and the tea away so that would not be a danger and she said I understand because I have been there. Then immediately coming from that peer support place, the person broke down crying, and they felt that kind of support coming from someone who understands.

Laurie Curtis: Doctor Cheney we have 29 seconds for you to add to that.

Karen Chaney: It is a lofty goal to say no restraint and no seclusion, as Lisa said I don't think that… it probably is not real we train everyone in therapeutic options and in the past it was CPI so they understand what can be done in order to assist these people and basically, we talk about verbal escalation and utilizing folks that are important to that person so we really work at not using seclusion or restraint but if it has to be, we do.

Laurie Curtis: Wonderful. Thank you so much both of you for this phenomenal and exceptionally rich webinar. I want to extend my personal thanks and the thanks of SAMSHA as well as all the participants on the webinar today for your comments and your forthright consideration of these issues.

For further information, a lot of people have asked how do we get in touch with you. Please see the email and the website information here on this slide. Feel free to contact the presenters we also invite your comments at recovery to practice.

One of the things -- this is the last of the winter webinar series we're in the process of planning the spring webinars and we are excited about that so stay tuned for your emails for what the webinars will be. Will also be releasing the spring recovery to practice newsletter in March and following that newsletter released we will have webinar to explore the content in the newsletter this newsletter will be focused on readiness and recovery transportation and organizations so we are actively putting that together right now.

In the meantime, please check the recovery to practice website for updates and archives this webinar will be archived and uploaded to the website for the power points

Please provide a feedback on the slide that will come up as you begin to close off, however, if you're interested in receiving NAADAC continuing education hours for this webinar click on this link, see NAADAC CEH, you will be directed to a page that will give evaluation and a quiz and the certificate if you're not interested, you can download your certificate of participation here now, on the bottom.

Please take the time to complete the evaluation and on behalf of SAMSHA I want to thank you very much for participating in today’s webinar. We look forward to seeing you in the spring. This concludes today’s webinar. Have a good afternoon.