# Recovery-Oriented Crisis Services: Applying Principles of Open Dialogue and Peer Support

Elizabeth Whitney: Good afternoon everyone, and welcome to today's recovery to practice webinar titled "Recover-oriented Crisis Services: Applying Principles of Open Dialogue and Peer Support". My name is Elizabeth Whitney and I will be your host for today. After a short overview of recovery to practice, we will begin today's presentation. On behalf of Substance Abuse and Mental Health Administration and the recovery to practice team we would like to welcome you and thank you for joining us today. We already have almost 250 members in the audience, so welcome. I would also like to thank our presenters, Dr. Chris Gordon and Keith Scott, for sharing their knowledge and experience with us today.

A couple of details. At the end of the session, you will be able to download a certificate of attendance that you can use for applying for continuing education credits for your professional organization. And this webinar has been preapproved for continuing education hours from NAADAC the Addiction Professional Association. To qualify for these continuing education hours, you must attend the full webinar, complete a brief quiz and the webinar evaluation. More information on this will be giving to you at the end of today's webinar. At the completion of our webinar, you'll be given an opportunity for feedback, and we would really value you taking advantage of that and providing your feedback.

Finally, if you registered for the webinar, you will be emailed a link to view the archived recording. This link will also be available on the RTP website where you will find links to past RTP webinars as well. This series is hosted by Samson's Recovery to Practice. The overarching goal of this initiative this to improve the knowledge and ability of the behavioral health workforce use recovery oriented practices everyday. But what do we mean when we talk about recovery oriented practices? In 2011 SAMHSA released a working definition of recovery, and a set of guiding principles incorporating recovery in both substance abuse and mental health conditions. SAMHSA's working definition of recovery and 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." Four major dimensions of recovery: Home, Health, Community, Purpose, form a solid foundation for developing recovery oriented lives, and forming recovery oriented system necessary to support them. SAMHSA's Recovery to Practice initiatives help you to turn these principles into workforce priorities. Recovery to Practice offers a set of discipline based curricula to promote understanding in uptake of recovery principles and practices. Developed by these six professional disciplines for educating their membership about recovery and behavioral health, these materials are adaptable for use by other disciplines and organizations seeking resources to build a recovery oriented workforce. Links to these curricula are available at the RTP website. And RTP is expanding disciplined focus to embrace multidisciplinary services and integrated settings. Those of us who work in behavioral health or integrated health organizations, have opportunities every day to promote

wellness and recovery. We can powerfully communicate hope for recovery and the value of self-recovery just in how you approach your work.

RTP can help you strengthen your recovery oriented practice through free webinars, newsletters and training and technical assistance opportunities. Many of us recognize that with crisis comes opportunity for growth but all too often, however, individuals their families who face a mental health crisis experience fear, disempowerment and even trauma. Today's presentation, part of a three-part series, that examines a number of ways to integrate recovery oriented approaches into responsive support services to help individuals in this crucial period. I will now introduce our speakers for today.

Chris Gordon has been a psychiatrist, medical director, and senior administrator for Advocates Incorporated for the past 19 years. He is responsible for all clinical programs, including residential services, outpatient emergency services and employment services. He is deeply involved in working with people who are dealing with psychiatric illness and those who are in advanced recovery. Chris works with NAMI and other family and consumer organizations. Chris is also an associate professor of psychiatry at Harvard Medical School where he teaches residents in psychiatry and training at McLean Massachusetts Mental Hospital.

Keith Scott is the vice president of peer support and self-advocacy at Advocates where he has been a vital contributor and leader since 1989. Keith was originally hired for his psychiatric lived experience and has been a lifelong user of psychiatric services both voluntary and involuntarily. He has worked in a variety of positions, as a direct care councilor, a program manager, and prior to his current role as the director of recovery in peer support. Keith is passionate about the rights of individuals with mental health diagnosis, and has worked to create systems that support the autonomy of people, amplify their voices, and advocate for their rights and provide access to information and resources, particularly those resources available outside the mental health care system. I'm thankful to have you both, and with that I will now turn the presentation over to you.

Chris Gordon: Thank you very much Elizabeth. Keith and I are really thrilled to be here today and we really appreciate everybody coming on and participating in this webinar with us about recovery oriented crisis services. Keith and I and our colleagues and many of the people we support have been working for many years trying to make our services more recovery oriented. Keith and I want to emphasize from the very beginning that for us, this is a journey, not a destination. We know we have a lot further to go before we will have the kind of recovery oriented services to which we aspire. But we would like to highlight in this webinar about crisis services, two elements of our work that have been particularly important. The first is, to appreciate the immense value of having a robust peer specialist team. Having this team under Keith's leadership has shifted our work in so many ways toward a more recovery oriented orientation. And this has touched every element of our company, and we want to highlight is the role of peers in a crisis services today. The other element of our work that we'd like to highlight today is the way we have been trying over the last five or six years to adapt elements of

open dialogue into all of our clinical services including crisis services. And we'll go into more detail about what open dialogue is in the body of the webinar, but very briefly, open dialogue is a mode of working with people in emotional or mental health crisis developed in Tornia, Finland over the last 25 years. Which is predicated on the idea that when we are in a severe or emotional mental health crisis, it is best to receive help rapidly and in the least pathologizing, most comfortable setting possible. And to include in dealing with the crisis our family or other people whom we choose whom we would find to be helpful resources. The other thing about open dialogue that is very important is that the help that's offered does not begin with a prior assumption that a medical or psychiatric model is the best paradigm to which to view the problem. And instead, really attempts to meet the person and his or her network where they are.

With that introduction let me just say that the crisis services that we aspire to are services that are welcoming, respectful, helpful, accessible, and safe. The touchstone for us would be that these would be crisis services but the people who receive services themselves would themselves endorse and recommend the services to others. And finally, that the crisis services that we envision would reduce, mitigate or ideally eliminate completely the real risks people experience when they turn to professionals for help in a mental health crisis. And as we'll discuss in this webinar, these risks are very real. We also want to invite you to participate in this webinar by completing a poll, which I think will be up on the screen shortly, in which we ask your opinion about what you think the main obstacles are to crises oriented – to recovery oriented crisis services. And with that, let me turn to my colleague, Keith.

Keith Scott: Thank you Chris. So I will briefly talk about the agency we work for. I want to thank everybody for participating today, and thank you Elizabeth. Advocates is a full service private non-profit human service agency that has been providing residential, outreach, outpatient, and emergency services for 40 years now. This is our 40th anniversary this year. We have worked really hard particularly in the last 20 years to make our agency and services and supports as recovery oriented as possible to minimize the use of coercion and force in our services and to maximize support for people's autonomy -- for their right to live a life they choose, and of their own design. And of course that's our aspiration right? We are nowhere near that goal. The reality is we still exercise some use of force and coercion under certain circumstances, regrettably. We still serve people who have guardianships, who have conservators, who have representative payees -- people who control their money. We have people who are being medicated every day by our staff. Sometimes when they don't really want to be. So we understand we are not where we want to be, but this is about the journey. So that is what we are here to talk about. The journey that we're on, and I'm assuming the journey of everybody who is participating in the webinar today, and I'm hopeful that some of the things that we have to say will be of use to you.

Chris Gordon: Thank you, Keith. I would like to now talk a little bit about the obstacles to providing recovery oriented crisis services in

conventional settings. Because for many people the place they turn and the only place that may be available in a mental health or emotional crisis is a hospital emergency room. Hospital emergency rooms can really be pretty difficult places to receive recovery oriented care. Part of the reason for this is that the paradigm from which emergency medical personnel are proceeding is that there is a high premium on identifying serious or life-threatening conditions and making an extremely rapid, accurate diagnoses and then intervening promptly on the basis of that diagnosis. And if we go to an emergency room with a possible stroke or heart attack, that is exactly what we want.

However, if we are in an emotional crisis, a mental health crisis of some kind, and we turn to an emergency room, this paradigm may be very ill-suited to our needs. Anyone who has got to a hospital emergency room can probably attest to the fact that that is an environment that is often difficult to provide recovery oriented services in or find recovery oriented services in. The whole atmosphere can be quite unwelcoming. The welcoming staff, or the admitting staff may really overlook the perspective of the person seeking care especially if the person is known to have a psychiatric history. The admitting or registering person may jump to unwarranted conclusions about the nature of the problem or what is being sought. And the ER personnel may unwittingly use methods both to figure out what's wrong and to try to intervene that can actually be substantially complicate the problem rather than help. In fact, some of the, as we will see, some of the experiences in ordinary emergency rooms can be traumatizing. Particularly, if as is so very often the case, people have had previous bad experiences in these settings. Then the experience can be traumatizing and re-traumatizing. I would like to turn back over to Keith to talk about the nature of problems for which people come for care.

Keith Scott: So we think about crisis…I believe there are many different ways that a person can experience a crisis, and there are paths to recovery. I think, crisis is something that can feel overwhelming in the moment, it is either something which has been building for a while that sort of boils over into a crisis or sometimes it’s very extemporaneous where something could happen in a person’s life and there is a sense of immediacy to the crisis. And you know, it’s certainly true that sometimes a crisis can be dangerous for the person, particularly if they don’t have adequate support in place. It can be dangerous for family members, friends, neighbors. That is very important to pay attention to.

I think, you know, as Elizabeth said in the opening you know, I think we try to approach this with the view that I learned about through training with Sherry Mead in Intentional Peer Support, that crisis should be viewed as a real opportunity, as an opportunity for growth for the person, as an opportunity to develop some skills about how to manage what they are experiencing in a way that is effective for them, in growth, in confidence, in the ability to manage future crisis should they occur. I think, not only do we want to approach the crisis with the sense that this is an opportunity, I think we also have the obligation to approach the person in crisis with a sense of hope about a resolution that will be satisfactory for the person and help enhance ultimately the quality of their life. It's not just something to survive but it is something they

can certainly build on and can add to their skill set with dealing with future crisis events. I think, we want to look at it as a story the person has to tell, and ask the person to tell the story. We want to avoid making assumptions the person is experiencing. And I think we want to view it in a holistic context. Even though the origin of the crisis might be in an interpersonal relationship for example, or in a social relationship, or familial relationship. Or it could be medical in nature, or biological in nature, or potentially psychological or emotional, or even religious or spiritual. It doesn't exist on one of those planes separate from the others. It occurs in the context of all of these aspects of who the person is. We really want to approach it in that way. The solutions for people sort of involved out of an understanding that this is not just happening in one part of their life.

So the next question is, what do we need in a crisis, what does a person need in a crisis? I think there are definitely helpful attitudes and approaches that we want to be considering. Most significantly among them is perhaps the role of culture, values, the role of religious and spiritual beliefs, economic status, those kinds of things. An approach that is trauma informed that understands this is a very gradual situation and we don't want to do anything as Chris was mentioning in a context providing support for someone in a crisis that will do additional harm, that will make matters worse. So we want to pay close attention to that. You know I think we want to be asking the person what happened. We want to avoid defaulting to a clinical lens and assuming what the person is experiencing is just a set of symptoms that have been exacerbated by a refusal to take medication, for example. Really ask the person what they are experiencing and what it is meaning to them in the moment.

I think we want to consider what kind of support we can offer the person, what would be helpful in terms of support whether that's family support, friends, peer support that's based on shared lived experience and the sense of mutuality. I think we want to help the person to feel safe and I think when we do that we can ask them what made them feel safe in the past, what can we do to replicate that. We want to offer comfort and compassion and be mindful of being transparent about what's happening. One of the scariest things when you're in crisis is sort of this sense of loss of control. You don't know what's happening, you don't know who's talking about you, what kind of decisions are being made about you. Toward that end I think we would want to focus on making sure the person is included in conversations about what is happening to them and what their options might be, what people are thinking. And obviously to be involved in any planning moving forward.

Finally, I think, you know, we want to be patient. Sometimes crisis resolves itself in the course of time. If we can be patient and not rush to judgment and not do anything that will exacerbate the subject or harm the person additionally, sometimes things start to resolve themselves. If we can, you know on top of being patient, if we can provide space and meaningful options to give them including things like additional staffing support, peer support either through friends our community peer support or through a professional peer specialist who work through a provider, if we can consider respite options, if available, including peer run respites, then I think we are doing what we can to assist the person

experiencing the crisis in a way that is recovery oriented and really focused on, again, supporting that person's autonomy.

I won't go into too much detail about the recovery principles. I know Elizabeth showed the slide with the principles and domains in the beginning of the presentations, but just to mention a couple of things. Again I think hope is exceedingly important, I think us as professionals supporting people through crisis and approaching the person with a hopeful attitude in our hearth that this can be resolved in a way to ultimately add to the person's abilities to be resilient, to be strong and to deal with crisis down the road. I think, again, approaching this with the idea crisis occurs in a holistic context and that culture, values, and beliefs are vital to the process or recovering through a crisis. I think we also need to be mindful and sensitive to issues related to prejudice, discrimination, and oppression.

Many people specially those who've had multiple experiences in the mental health system, have experienced the loss of control, the loss of civil/human rights. It can sort of lay the ground work for a person's interpretation of what help is when they are having a crisis. I think again, we want to do everything we can to not reinforce that idea and to be trauma focused and trauma sensitive. I think we want to pay attention to the balance between the responsibility of care that we have as providers and professionals in supporting a person through a crisis with the need for and the right of the person to continue to make choices about their life. As many choices as are possible given the context of what is happening to them.

Finally, relationships. The value of peer support where it is available to people is in the relationship that's built on a shared with experience, connection through that, mutuality, and honest communication. And so those are the things we want to pay close attention to when thinking about how recovery principles influence the work we do when someone's in a crisis.

Chris Gordon: Thank you Keith. I think the audience can probably see why I feel like I died and went to heaven. To have a colleague like Keith and to have the certified peer specialist team as partners in my work. I want to speak just briefly about some common missteps that I think professionals particularly make in the delivery of crisis services to people who are in emotional or mental health crisis. The main one is simply not listening. Not taking the time to see the person as a unique individual in a unique situation, and to really appreciate the dilemma the person is. And instead, under the pressure of time, under the pressure of the emergency room perhaps, there is a tendency to draw unwarranted conclusions, to make unwarranted assumptions, to offer unhelpful, unwelcome, and sometimes downright hurtful speculations about diagnostic ideas. These have in common the toxicity of the clinical gaze in which the person feels treated more like an object then as a human being and full partner.

Another element of this is phenomenon is that, under the pressure to figure out what's wrong, sometimes we fail to take note of and to appreciate the strengths and coping capacities of the person. And of

course a very common one to which we can all relate is when any of us go to the ER, pretty much the first thing that happens is even if we were brought there by friends and family we get ushered into the bowels of the ER while our support system waits in the waiting room. So separating people from their critical supports. I have already eluded to this on the previous slide.

Sometimes the language that psychiatric and medical professionals use is truly ugly and really downright harmful especially if this is arising in the absence of a real relationship in which both people know what they are talking about and there is a feel for the sensibilities of each person. This is even more true in the tendency in emergency services for the treating personnel to feel like they must do something. This may be because of the obvious distress of the person who's come for care, or the distress of the people who brought the person for care, or it may be from the distress of the caregiver himself or herself: I simply can't stand it, I feel like I have to do something. And unfortunately, this sometimes this leads us to use treatments that are strong, powerful, sometimes very toxic and to implement treatment in the absence of a real relationship with the person which would be necessary for authentic, informed consent. Now I'd like to turn back to Keith to talk about the role of peer specialists in the emergency service.

Keith Scott: Thanks Chris. I glanced down at some of the results of the poll question and I'm not sure if it has continued to change, but I noticed two popular responses had to do with the culture of the ER as an impediment to recovery approach to crisis care and a lack of training of ER staff, as well. And I would absolutely agree with that. It's one of the things that we focused on when going about creating a plan to provide peer support in psychiatric settings particularly in emergency rooms. You know one of the things we want to do right up front is to try to engage the staff of the ER, whether that's the nursing staff a doctor, or administrative staff.

To have a conversation about the value peer support could bring to their ER setting, the value for them as a professional having to deal with a lot of crises all at the same time, and the value to the person who is in the ER in crisis. We also want to give them an opportunity to talk about their concerns and allay as many of those as we could put them up front. Part of the way we do that is we have a conversation about what the roles of the peer specialist is specifically in providing support in the ER, and what it's not. What they as staff in the ER, which is kind of their setting where they work, can expect from us and what they shouldn't expect. We also want to educate the peer specialist providing that support about ER policies, and ER culture, both the formal culture and also the informal culture. What's the role of nursing, what's the role of security while they are there? What can they expect when they are there? Just so there are as few surprises as possible. We want to be really clear with the peer specialist working in these settings that they are a guest and we want them to be really focused on trying to, while they are there, to build relationships with the other professionals there. So that this can be a developing, ongoing sort of relationship. That's the context in which these services and supports can be best delivered and most effective.

We really want to be clear about identifying an ongoing process for us to continue to talk about how's it going, to debrief incidents which were potentially problematic. Have a system for sorting out and solving problems as they arise. And again, at the end of the day, much like the connection to the people we are supporting who might be in crisis, we are really focused on building relationships, relationships, relationships. Because that is what sustains these types of initiatives. Without that we have found that it's very easy for peer specialists working in these settings to get marginalized, demoralized, and no longer want to provide those services. As well as the ER staff feeling like it's not something they want to invest in. For the individual who is being supported in the psychiatric setting or ER, you know, we are really focused on providing that support which is based on shared experience and mutuality. We want to be with the person in crisis.

We want to spend a lot of our time listening. We want to provide that person with access to information about things like how this process sort of unfolds, what they can expect, how long it might take, we want to provide advocacy for that person to understand what their rights are under these particular circumstances, or what their rights are should they be sections, should they be committed to the hospital. We want to help the person wherever possible, participate in all discussion about their care and treatments while in crisis, consistent with the idea of "nothing about us without us." And then we want to pay attention to the simple things like helping that person feel as comfortable as possible. Given they are in an emergency room, they are probably separated from family and friends. If they are thirsty, give them a drink. If they are cold, give them an extra blanket.

Obviously we want to pay attention to the rules of the ER so as not to violate those, but really focus on the person being as comfortable as possible. We want to make a connection. It's hard to do in a short amount of time, it's a little bit easier now that people are boarding in the ERs for longer periods of time but given the relatively short amount of time we have to connect with the person, we really want to try to connect with the person. And finally, we want to check in with the person if they would like some follow up from us, a hospital visit, a phone call when they get home, for us to stop by and see how they are doing.

Chris Gordon: Thanks Keith. I'd like to turn now to a few comments about Open Dialogue, but before I do I want to make one fast comment about what Keith was saying. I think that idea of building real relationships with emergency room personnel is absolutely critical. And I realized listening to Keith that my own comments about the emergency room personnel were kind of snarky and that really doesn't help matters. It's far better for us to go down the path that Keith is talking about of building real relationships and showing people how these services can actually enhance their work and what they are striving for too.

Here's just a few words about open dialogue. As I mentioned in the introduction, open dialogue is a mode of working with people that was developed in Tornio, Finland. A method of working with people in mental health crisis, that emphasizes the idea that when we are in a severe crisis, what we need is to get help fast in the least pathologizing

setting possible and to have access to our loved ones, not to be isolated from them, and to have an opportunity to speak openly about what all the options are, and what we want to have happen and what we don't want to have happen. That is basically what open dialogue is all about.

In Tornio, Finland, where this process developed, if a person is in psychiatric crisis or mental health crisis and called their team, the team is immediately embodied that will travel to the person's home, if possible, and involve the family or other natural supports. As we practice open dialogue, the person at the center of concern gets veto power over who they want and don't want at the meeting. But the idea is to be flexible about the support, to have the person at the center of concern, and then to promote a dialogue among that group about what is going on and what would be helpful and what would be unhelpful. The clinical team assumes responsibility for providing whatever is necessary, whatever emerges from that meeting, and to provide that for whatever frequency and whatever length is necessary but not a minute more. Because there is a desire to help people in crisis restore capacity to engage in living, and then kind of get out of the way so that people are not drawn into a chronic engagement with the mental health system.

The other critical element of open dialogue is what is known as tolerating uncertainty. That is, the open dialogue team wants to approach the person in crisis without any preconceived ideas about how best to understand what is going on. We don't begin with an idea that this is necessarily a crisis best understood psychiatrically or medically. That means moving slowly to diagnose, if safe to do so. And only using diagnostic categories or medical paradigms if it emerges they are helpful or necessary.

The last element is what I like to call gentle psychopharmacology. Which means, as Keith points out, many times, crises resolve on their own if we don't freeze them and make them worse. For that reason, there's a premium on open dialogue to not move too fast in making diagnoses and also not to offer treatment so we can see how things may evolve naturally.

The meetings with the person or network can involve whomever the person prefers, and these meetings can occur wherever it's convenient to do it. It could be in the ER or the person's home. When we provide services to people on a long-term basis, we like to convene meetings when things are going well, in order to plan for future crisis should one arise, as part of a wellness or crisis plan. But the setting is really optimal where people are most comfortable and it is least pathologizing.

And just a couple of words about what happens in these meetings. They are pretty unstructured and open ended. And the clinicians follow the lead of the family and network as the problem is explored. As Keith mentioned, it's more of a narrative explanation. There is more emphasis on stories and what has happened. Less emphasis on what is wrong. There is something very important about the conduct of the clinicians I would like to emphasize. And that is what I am calling total clinical transparency. In an open dialogue meeting, there is always more than one clinician present. And the clinicians make an agreement with the person and network that the clinicians will make no substantial decisions about the person

except in the presence of the person and the network. And included in that is that the clinicians will engage in conversations about the options including sometimes strenuous disagreements, in front of the person and family. And then invite the person and family to respond or comment.

This does not mean that the decisions are necessarily made on a purely democratic basis. At times, the situation becomes so dangerous that we have to act unilaterally, so that it might be necessary to commit someone to a hospital. But even in that circumstance, the decision is made openly, transparently and with opportunity for people to comment. Lastly, there is an emphasis on modest goals and helping people to, what the Finns calls, restoring their grip on life. And then, as I say, getting out of the way so that people are not drawn into chronicity. And now we'd like to, oh no, I have one more slide sorry…

We have three programs that involve the open dialogue model. One is called the collaborative pathway, which is designed to identify and serve people with early episode psychosis in hopes of avoiding chronicity. The second is a program called Open Dialogue in Community Based Flexible Supports, which is the program we offer for people who are engaged with the Department of Mental Health. The third is the program I am going to turn it back to Keith to talk about, which is a very exciting partnership between our crisis team and our peer specialist team.

Keith Scott: Thanks Chris. So we do two basic things. We have had peer specialists who have worked with crisis clinicians, and we've been very fortunate here that we operate the psychiatric emergency services for a large geographical area, so the crisis clinicians we partner with are also employees of our agency. But even still, it was important to have an understanding of each other's roles, expectations of how we would be working together, an understanding of each other's code of ethics in the course of work.

And we really want to focus on how best to use the time. We tried to use down time to have ongoing conversations with those crisis clinicians and teams of clinicians. To have those hard conversations about the things Chris mentioned a little bit earlier. Things like diagnostic language, sort of attitudes of chronicity, and the impact of force and coercion, those kinds of things. And as much as possible, we want to be working with the crisis clinicians proactively to prevent crisis or mitigate crisis. As much as possible, and that involves getting out into the community sooner before the crisis occurs. Or involves planning with people how they want to be treated in a crisis. And we use Wrap planning or other kinds of crisis planning models to help people do that. We are also focused on keeping and reviewing data so that we know how those relationships are going and what kind of impact they are having on people in terms of their ability to remain in the community, stay at home, continue working, continue with school, as opposed to ending up in the hospital.

There is this one great pilot which we have been working on for about the last 7 months, involves embedding a crisis clinician, and experienced crisis clinician, someone who knows the community based flexible based

support system, which is basically our residential system, who has worked as a residential councilor, who worked as a program manager, and who is now a crisis clinician. We pair that person with an experienced peer specialist, somebody who has also worked in hospital settings as a peer specialist, who has worked in the community as a peer specialist. They go out together and are fully mobile, not tied to an office. They respond to crisis and do evaluations. They can also do that proactive work I talked about earlier. The idea is to offer as much support and service as far upstream so that we can avoid crisis, if at all possible. This has been quite amazing for us. It has helped keep a number of the people who were high users of our services out of the emergency room, out of the hospital. It's reduced our use of force. 7 months in we are very optimistic about this for the future.

Chris Gordon: Thanks Keith. You know it's worth mentioning that Paul and Abby spend a lot of time in the community went there isn't crisis. And, therefore, a person is seen by either of them when they are in crisis, they are seeing a familiar face, they are seeing someone they know, and you just can't overstate how helpful that is as opposed to being in crisis already and then going and meeting with strangers. So we would like to offer a few simple ideas in closing, and then talk a little about our other efforts to become more recovery oriented and then look forward to some dialogue with you. Some simple ideas to reiterate are, that the tone of crisis services needs to be on un-crisis like, it needs to be friendly, what I like to call neighborly, warm. We need to convey to people that we are glad that they have come, that we feel they have come to the right place.

It has to be unhurried. It really has to be almost like offering a person a cup of tea. Let's take some take time, breath. It really helps to not separate people from their loved ones and their support. And to listen attentively with an open heart and open mind to whatever those resources have to suggest. Keith has already talked about the importance of offering simple supports. You know all of us can relate to that you know. If we are stressed out and someone offers us a warm drink or a warm blanket, it says a great deal. From my point of view as a psychiatrist, I can't say enough about ceding control in every way that is possible to do. Give people as many choices as you can, about as many things as you can. Prescribe information and choices over the prescription of treatments.

The other thing to repeat something I said a little bit earlier, is to really notice and appreciate everyone's strengths. Notice what people are doing to cope. If we walk a mile in the shoes the people that we are serving, we can't help but be awed by their accomplishments in surviving and coping as well as they do. It really helps to ask what has helped in the past. And to illicit and honor their ideas no matter what they may be. And as I said before to imagine modest goals. Lastly, if you have not already developed a robust peer specialist team, I can't urge you strongly enough to do so. Let me turn, for the last words, over to Keith.

Keith Scott: This will be tough to pull off in three minutes, but many things we have done to become a more recovery oriented agency we have done over the last 20 years, we continue to do.

Initially, we started to bring Dr. Patricia Deegan to work with us so that we could become a more recovery oriented agency. She spent about 5 years with us helping us develop some performance standards for people to work in direct service roles, to work in ways that support and nurture recovery, and that helps to supervise our staff in ways that further our goal of becoming more recovery oriented.

We began shortly thereafter training all of our staff and using intentional care performance standards. We began to evaluate the impact it was having. We started using the tool called recovery enhancement environment measure, which we administered twice, to see how people felt we were doing becoming more recovery oriented.

We then began to focus on perspective of people we were serving to see how they felt we were doing as an organization to become more recovery oriented. Then we began to focus more on the perspective of the people we are serving to see how they felt about their own recovery process. We began to use two tools, one was milestones of recovery measure and another one called the mental health recovery measure to get their perspective. In addition, we sort of partnered with organizations in the community that are run by people with lived experience and staffed by people with lived experience like the Transformation Center, and Empower and the National Empowerment Center.

We brought in many speakers who are leaders around the world in alternative perspectives to this thing that we call mental illness and in alternative treatments. Bruce Levine, David Cohen, and Rufus May, Robert Whitaker, and we continue to train our staff, particularly our peer specialists, in skills that allow them to reinforce for people that recovery is possible. It happens all the time in 1 billion different ways. Our staff were trained in intentional peer support, in vocational peer support, in wellness recovery action planning, things of that nature.

Under Chris’s leadership, of course we brought Open Dialogue into the organization which has been amazingly transformative. It really conveys this idea that people at the center of concern should have as much control as possible and should not be isolated from family, from their friends, from their colleagues at work or at school. Then what we want people to make meaning of their experience. Ultimately, when people are able to make meaning of their experience, they are then able to manage. And as Chris said, the goal is to have them deflect off the mental health system rather than become stuck in it forever.

And then finally, internally, we decided we wanted to promote the idea of disclosure for the purpose of providing that hope and that example that people do recover and do move on with their lives. We have a group called the promoting the culture of respect group, where our employees can come and talk about the challenges of disclosing and get support for disclosing. Again for the purposes of conveying this message: many people

deal with these challenges and move forward with their lives. Thank you for your time.

Chris Gordon: Thanks for being here. We turn it back over to you, Elizabeth.

Elizabeth Whitney: So let me start again, just saying that you've done a really beautiful, eloquent job conveying and talking about the principles of recovery oriented care that so many of us aspire to. In such a way of really helping us understand how to bring it to day to day practice. I have notes all over my note page here of some of the really lovely things that you've talked about in terms of… Keith talked about a sense of hope and resolution, not just surviving crisis. And the idea that solutions will involve if we stick with people and take time. Chris, you used the phrase of prescribing information and choices over treatment. Really some very evocative and practical, and now lots of questions.

To start, Keith here is a question for you. Someone was asking how long did it take you to develop a good working relationship with ER personnel? Is that ongoing? Because there are changes in staffing and what not. What advice do you have with others who are working with that?

Keith Scott: Yes, absolutely it is an ongoing process. We have no illusions about sort of where we are, and you are correct I think ER staff changes. And depending on when we are there, sometimes problems come up. We then set a meeting to sit down and try to resolve. The goal is to hang in there. It can be really challenging both for the peer specialist in there trying to do their job, support the person in crisis, advocating for the person to have as many rights as possible, while keeping in mind the ER staff who have their own set of rules and culture. My advice it to continue to hang in there. Engage and build relationships where you can. When we were talking about that little pilot program has done wonders with relationships in one emergency room. They have noticed people who were there frequently are not there as frequently. So that has paved the way for to be able to support other people there more effectively.

Elizabeth Whitney: That's fantastic. Thank you that really describes it and it really is a relationship based work which parallels everywhere. Someone was asking how can they learn more about the crisis clinicians and peer work? That pilot that you have described?

Keith Scott: I think you are going to share with folks my email address at the end. If they would like, they can email me. I am happy to share information about what we have done with some preliminary data. I can give folks my number and they can give me a call and speak with me if they so choose.

Elizabeth Whitney: Great, thank you. I imagine you may get some calls. That's mice thank you.

Chris this is a question for you, going specifically to when you were talking about Open Dialogue and you were talking about the way you are

using Open Dialogue principles that the person at the center of concern has veto power about who's involved. How do you work with support people who might be with someone? Let's say someone came to the ER or crisis center and the person says they don't want them involved. How do you handle that and work with the support person?

Chris Gordon: That's a tough one. That's a tough one. We may be in a position in an emergency where we absolutely must know what the support person has to tell us. To the greatest extent possible, we would try to honor the request of the person at the center of concern. As you know Keith was saying before, even when we can't honor the preferences of the person at the center of concern, we have principles for how to think about that. One is to be completely honest and transparent about it. Not to try and put any spin on the ball. And having acknowledged that is the position we are in.

For example, if the decision is that based on our assessment we feel a person must be hospitalized involuntarily, it may be a small comfort, but it may be something to ask the person about the hospital preference or one you would prefer to avoid, is there someone they may want to speak to or have us speak to. Anything to extend the realm of choice. That might be the case too, I really feel like I need to speak to the support person to hear what they say, I promise to tell you what they tell me or better yet they can come in to speak in front of you. But I won't give any information without your permission. That might be an example.

Elizabeth Whitney: That is a lovely example, and I imagine what happens in the heat of acute crisis can change as things calm down and different choices can be made.

Chris Gordon: Absolutely. Keith made the point that most of the time crises resolve on their own. Much of the mischief is trying to make decisions too fast. If we have someone in the ER is having a lot of difficulty…If it is possible to take a couple of hours and get some sleep and look at the situation the next day, it often looks radically better.

Elizabeth Whitney: We have just a couple of minutes, I'm going to shift the questions a tiny bit. Chris, this is more personal to you but I think it is a lovey question. As a medically trained psychiatrist, what made you focus on recovery oriented care?

Chris Gordon: Well you know I am a bit of a small breed because I am a really happy psychiatrist. I absolutely love being a psychiatrist at Advocates. I feel like it allows me to be the doctor I wanted to be when I went to medical school. I get to use all of my medical skills and think about biology, psychology, social and spiritual factors. You know to me being a doctor is about helping people who are suffering. This is the best setting I have ever had for being the kind of doctor I want to be.

Keith Scott: If I could just interject something Elizabeth. One of the things that is so impressive about Chris and his support of this at this organization has been in effect he sends a new psychiatrist and interns

to the peer specialist team meetings, even having them spend an entire day shadowing peer specialists. I think we communicate how important we view that resource in the organization and to orient new psychiatrists on how we work here at Advocates.

Chris Gordon: I really appreciate that Keith. You know, it's pretty simple that if you think what you would want for someone you deeply loved, this is the care I would want for someone I deeply loved or for myself.

Elizabeth Whitney: That is a perfect principal to end on and reflect on. I can't thank you enough and you both have modeled the collaborative care approach that you are talking about.

Chris Gordon: Thank you for having us.

Keith Scott: Thank you Elizabeth.

Elizabeth Whitney: Here are the email addresses if someone wants to communicate more about their presentation. We also invite you to email us with comments or questions. We are excited about the final webinar which will be next Tuesday, February 2. It will be on hospital diversion and alternatives in crisis response. Please join us if you can. If you can't join us, check our website where we will have these webinars archived. So thank you so much. If you are interested in receiving the NAADAC continuing education hours, click on this link here on your screen. You will be directed to a page to complete an evaluation for your certificate. If you are not interested, or do not need the hours, you can download a certificate in the downloads pod on this screen. Please also complete feedback opportunity that will automatically load at the end of the webinar. On behalf of SAMHSA, thank you for attending we really do appreciate your time. Have a wonderful afternoon.