Good afternoon everyone and welcome to today's Recovery to Practice webinar, titled, Supporting Recovery in Acute and Emergency Settings. My name is Elizabeth Whitney, and I will be your host today. After a short overview of Recovery to Practice, we'll begin today's presentation. On behalf of the Substance Abuse and Mental Health Services Administration and the Recovery to Practice team, we'd like to welcome you all and thank you for joining us today. We have over 140 people in the audience already and we expect that that number would grow. I'd also like to thank our presenters, Thomas Joyce and Bryan Bailey for sharing their knowledge and experience with us today.

A few details. At the end of this session you will be able to download a certificate of attendance that you can use to apply for continuing education credits with your professional association. And we have good news for you, this webinar and all of the webinars in Recovery to Practice Winter Webinar series have been preapproved for continuing education hours from NAADAC, the Addiction Professionals Association. To qualify for these continuing education hours, you must attend the full webinar, complete a brief quiz and the webinar survey. More information on this at the end of today's webinar. At the completion of our webinar today, an opportunity to provide feedback will automatically open on your screen, and please take a few minutes to provide us with your feedback, we really value it. Finally, if you've registered for the webinar, you will be emailed a link to view the archived recording, and this link will also be available on the Recovery to Practice website where you will also find links to past Recovery to Practice webinars.

This webinar series is hosted by SAMHSA's Recovery to Practice. The overarching goal of this initiative is to improve the knowledge and the ability of the behavior health workforce to use recover oriented practices every day. But what do we mean by recovery-oriented practices? In 2011, SAMHSA released the working definition of recovery and a set of guiding principles that incorporate aspects 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 ten principles of recovery shown on this slide, along with the 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 necessary to support them. SAMHSA'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 understanding and 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 SAMHSA's Recovery to Practice website.

And Recovery to Practice is now expanding its discipline focus to embrace multidisciplinary services in integrated settings. Those of us who work in behavioral health or integrated health organizations have opportunities every day to promote wellness in recovery. 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, and training and technical assistance opportunities. And we're thrilled that so many of you are new to Recovery to Practice are here today to learn more about us. We hope that you will join us for the entire Recovery to Practice Winter Webinar series, exploring recovery-oriented practices in crisis and emergency services. And we'll provide more information about what's coming up at the end of today's webinar. Many of us recognize that with crisis comes opportunity for growth. All too often however, individuals and their families who face a mental health crisis experience fear, disempowerment and sometimes even trauma. This three-part webinar series today and for the next two Tuesdays will examine a number of ways to integrate recovery-oriented approaches in to response and support services that help individuals

experiencing mental health crisis. It will present models and approaches that exemplify the value of the recovery orientation in these crucial periods.

So with that I would like to introduce our speakers for today. Thomas Joyce is the associate director of recovery support services at The Providence Center's Anchor Recovery Community Centers. A licensed chemical dependency professional in the state of Rhode Island, he has worked in the substance abuse field in both residential and outpatient treatment since 2006, specializing in peer-to-peer recovery support services, opiate substance use disorders and adolescent substance abuse. A person in long-term recovery himself, he is an advocate in both the recovery and homeless communities. Thomas is associated with the Governor's Task Force on Drug Overdose, the Rhode Island Drug Overdose Prevention and Rescue Coalition, the mayor's Substance Abuse Prevention Council, Coventry Substance Abuse Task Force, and is a board member of the Rhode Island Community for Addiction Recovery Efforts.

Bryan Bailey is an assistant service manager of psychiatric services at Parkland Health and Hospital System in Dallas. He received his bachelor of science and nursing from the University of Texas at Arlington and currently finishing his masters of science and nursing at Walden University. Brian currently has over 12 years in healthcare in both hospital administration and nursing with his last few years spent in emergency psychiatric nursing. Before coming to Parkland Health and Hospital System, Bryan worked with Green Oaks Hospital which is part of Hospital Corporation of America and was also with Baylor, Scott and White. In addition, Bryan is a member of the American Psychiatric Nurses Association and is an active voice for Recovery to Practice with his peers.

Welcome to you both, thank you so much for being here. Tom, you can begin.

Okay. Good afternoon, everyone. As Elizabeth said – actually thank you Elizabeth for that great introduction. My name is Tom Joyce, I'm the Associate Director of Recovery Support Services at the Providence Center in Anchor Recovery Community Centers. And as Elizabeth said, I'm also a person in long-term recovery myself. Today I'm going to be talking about a unique program that we have here at Anchor Recovery which is our AnchorED Program, which provides recovery coaching in the emergency room settings. The agenda today is we're going to have an overview of the recovery coach's roe in the emergency room departments, some of the program operations such as the scheduling, how we use some communication devices, documentation and some of the supervision requirements. We're going to go through some – an overview of the referral process for recovery support and treatment and probably go over some of the data that we've collected in our first year of operation, actually and we're in the middle of our second year as we speak right now.

So a little background. AnchorED was launched in an attempt to reduce the overdose epidemic that was hitting Rhode Island in 2014. The founder of Anchor Recovery Community Center is a gentleman named Jim Gillen, who is a true hero in the recovery community on a national level, and Jim was actually at the Behavioral Health Department of Rhode Island speaking of what kind of plan of action could actually happen to reduce – not really to stop what was going on, but to minimize some of the damage that was happening and through a conversation with Rebecca Boss who works with the Behavioral Health Department and Jim they decided to use some of the recovery coaching that was happening at the Anchor Recovery Community Center and use them in the emergency room setting. What would be the effect – what would happen? And at that point in time AnchorED was launched.

What we do. AnchorED actually utilizes peer-to-peer recovery supports in an emergency room setting. The time when someone overdoses is medically risky but it also presents a unique opportunity at that point in time for that person to engage in some type of support. Peer-to-peer recover support is recovery coaches in recovery themselves who share themselves at that point in time and that point in crisis to get a relationship with the person who just recovered from an overdose and try to engage them in some type of recovery supports. Prior to this, overdose patients -- overdose recoveries, I'm sorry, in most of the

emergency rooms in Rhode Island, you know, part of the process was they would get medically stabilized and they were discharged with really minimal resource or any type of information that was going on and they were not routinely referred to treatment or recovery support services. So, you know, AnchorED was created really out of a recognition that this was a lost opportunity for an intervention and to actually engage in that person at that point in time. You know, as it says, sometimes it takes a tragedy to introduce change and the AnchorED program is a prime example of really, you know, recovery-oriented program that's put to action that seems to be very, very – well it's effective and we'll go through some of the data as we go on. The AnchorED program under it's initiative, the recovery coaches are certified in the state of Rhode Island and we'll go through that as the presentation goes on. But the recovery coaches are on-call on a 24/7 basis. When the first year of operation, due to our funding, the AnchorED program was only in operation from Friday night at 8:00 p.m. to Monday morning at 8:00 a.m. through some of the data that we worked on with the hospitals, that seemed to be the high utilization times that we put into action. As of September of this year, AnchorED we went 24/7, we are now in nine hospitals in the state of Rhode Island, including Hasbro which is our children's hospital and women and infant which is basically prenatal care. We're also – we have agreements right now, pending signing for the other three hospitals in Rhode Island, so hopefully within 30 days we'll be in all 12 hospitals in the state of Rhode Island. I have to say my recovery coaches are probably the most dedicated and passionate people that I have ever came in contact with. You know, they're on-call for 24/7, they're on 12 hour shifts and they've never failed to rise to occasion.

So certified peer recovery specialists, what they do is they meet with the patient after two hours of being in the emergency room. Due to regulations if someone survives an opiate overdose in Rhode Island they are going to be held in the emergency room for four hours. Usually after the second hour we will get the call, our coach will go in and basically engage, I mean the first thing they do is they fill out the documentation, which we'll get as the presentation goes on. But at the point in time, the most important thing the coach does is form a relationship and bond. You know, I like to say, the recovery coaches who work in the AnchorED program, they're actually the human touch in the emergency room at that time of crisis. They're an empathetic ear, they're compassionate, they're empathetic and they have a unique ability to bond by sharing themselves with that person at that time to engage and let them know that there is hope. That, you know, that you can recover, not just recover, that you can recover well.

At the same point in time, the coaches will ask what's their pathway to recovery, you know what are they looking to do. If they're looking to get into treatment, we will actually assist with the hospital to do referrals to treatment, whether it be residential, detox, or recovery housing. At that point in time too, all of our coaches go through training, they are actually trained trainers in naloxone. So before anyone leaves the hospital they are trained with how to administer Narcan. Some of the hospitals have worked with us to supply kits, if not, we will give them the information where they can get naloxone. Rhode Island is unique, we have a doctor called Jodee Rich who actually wrote a blanket prescription for the state of Rhode Island, so any Rhode Island resident can go to the local Walgreens, go in and say they want naloxone and actually they will be provided a kit based on that point in time. Also, at the same time the recovery coaches also will engage with the family if that's what the person wants at the time. We provide supports to the family and we'll give them some information on some support groups or train them in naloxone at the same time. And then we keep in contact with them. After the patient is discharged and the coach is there the coach will actually follow them through, they will be in constant contact with them for the next couple of days until that information comes back to us at Anchor Recovery Community Center, if they want to continue to engage in recovery approach services, at that point in time, they will actually get assigned a new coach and we will stay with them throughout their whole length of recovery, their whole pathway.

So, as I said before, the hours after an overdose are – you know, it's medically risky, but at that point in time there is a unique opportunity to connect with those suffering from a substance abuse disorder. You know, what we've found is that by just utilizing some simple skills of motivational interviewing, but actually

just sharing your own story with that person at the time, let them know that you've been there, there is almost that instant bond that happens and you know we can provide a little bit of education at the same time. And you know we said, as what we say, in Rhode Island, we – it's step – substance use disorders is a condition but recovery is possible. And what we do at that point in time, you know, that recovery coach actually sells a little bit of glimmer of hope to that person, to let them know that they can recover and someone is actually caring for them.

So, how do we engage? To be honest it's the story itself. You know, when the coaches go in and share a little bit of themselves, there's an instant bond that goes on. They listen and they're present to answer any questions that the person might have. You know, sometimes people just survived an overdose, you know they're not really too sure what the resources are out there. And I think just starting a conversation with that person and letting them know what the options are is important. Because a lot of them just think it's just one option, you know, it's tough to go to detox. What the coaches do is they share their own story, they share their own pathway to recovery. And let the person know that whatever their pathway is going to be, we're going to support them no matter what it could entail. We're not, you know, we don't really say you have to go to one place or the other, we will make a quick assessment and we will actually let them know what our opinion is, but really that person's pathway to recovery is what they have to create themselves and what's going to work for them at that point in time. At the same time, if they want to talk to the family, we actually go out and talk with the family, let them know a little bit about what the person is going through based on our own experience and actually give them a little education on substance use disorders in general. I think at that point in time the family, again it's a unique opportunity to engage with the family and speak with them a little bit and let them know what's going and let them know what the options are. Because I know from our experience is that sometimes the family members don't really have the information that's out there, they've done some research but I think it takes a point in time to let someone know that you know based on their own experience, these are the options that we have. I think the more options we can give to a person and family that are in that crisis at the time, the better off they can make an educated decision of what's going to work for them.

So there is a little bit of a difference when it comes to recovery coaching in our state, Rhode Island we call them peer recovery specialists. We're non-clinical, we're people in long term recovery who – our biggest strength and our biggest tool is our own experience and our own life experience. So we aren't clinical, so you know part of being in the peer world is that there's no power differential, which separates us from your counselor or merely your sponsor in a 12-step fellowship. You know, a counselor, as it states here, primary preparations are academic studies and ongoing training and supervision. Our coaches do based on our program here at Anchor, you know there is some training that they have, but they do have ongoing supervision, so there is some similarities. Where a 12-step sponsor will basically be a person in – a person in recover and that's their experience, you know there is a power differential there. Recovery Coach, I said, it's their main tool is their shared experience. And a counselor will have a treatment plan, which is usually agency treatment approach where a sponsor is there, anybody in the 12-step fellowship knows the 12 steps are the basis of the existence. What we do in the recovery community is that we use a recovery plan, this is made from – we actually partner up with the recovery at the time, they make their own plan, they create it, they own it and take responsibility for it. And it's something that's reviewed constantly with them to engage where they are in their recovery and how they're improving or what we can do to assist them. I think the biggest differential here is self-disclosure. IN the clinical field and being a clinician myself, it was always used very sparingly to disclose that I was in recovery myself and what my pathway was. A sponsor uses it often. The recovery coach uses it often, but we don't really worry about the paths, we self-disclose and use it to benefit the person. So actually what we tend to concentrate on is our recovery today and where we are moving forward in what we do to keep our own recovery in check. We really don't go into the past that much; we usually go from this point forward.

Location of services, you know most clinicians will meet in the office and the sponsor is in the community. In recovery coaching we can do both, we will meet you anywhere you need. You know one of the great

things about the recovery community is that, you know, we truly do meet the person where they're at literally, where it would be. We just started a new program here at Anchor that complements our AnchorED program which is we send a street outreach team that's kind of supporting the AnchorED program, so we actually have a team of recovery coaches out there doing some almost like homeless outreach, but street outreach and coordinating and bringing recovery support services to communities or populations that weren't necessarily engaged at that point in time. So another thing that's a little bit different too, is that, you know, based in the clinical world the length of treatment is usually based on insurance or the length of services there. The sponsor and 12-step fellowship is always open ended. A recovery coach is the same way. You know as a recovery coach will stay with you for the whole length of your recovery no matter what it be. We just started at Anchor working with some insurance companies but that's usually as long as a person wants to engage with us, we will stay engaged with them for the whole length of their recovery, as long as they want us.

So we talked a little bit about how recovery coaches can complement the recovery process and how this is applied to the ER. So what we found is that, I love the right compliment because it's exactly what we do in the emergency room setting. We provide a unique resource based on our own experience about what could work and what could not. Also the recovery coaches – I always put the challenge out in Rhode Island that I think my recovery coaches have the biggest toolbox of referral sources in the state, just by the sure volume and the relationships that we've built. We have, we know who we're calling, we know the person who's going to pick up the phone, and based on the relationship and our referrals it works very, very well with us. Sometimes in the emergency room setting the timing is – it's critical, you have a short window where that person is going to engage and actually engage in treatment at that point in time.

So let's just talk a little bit about the spectrums of attitudes. This is very important in our recovery coach academics and its treating people as either objects, recipients or resources. And treating people as objects is what we know is best for them and we disregard what their wants and needs are. This happens quite often, and people when they're first starting off and first disclose that they have a substance use disorders, a lot of times this can come from the family where based on you have a substance use disorder, that they know what's best for you. And that doesn't really work best for the person that's recovering at that point in time. Treating people as recipients, this happens, it happens to be in my own experience too is where you're invited in the process, and this happens usually in after-care planning, is that you're involved in the process but the outcome is already done there. Many times when based on my own experience in treatment, where I've been brought into an office and they say, "We're going to go through your after-care plans, Tommy." And I say, "Okay, this is where I think would be a good idea." And they'd be like, "Oh, no we've already discussed this and this is where you're going to go." At that point in time, I had mixed feelings about who had my best interest at that time. In the recovery community, specifically with recovery coaching we try to avoid that at all costs. What we do is we treat people as resources. I think there is one expert in the room when you are dealing with someone who just recovered from an opioid overdose and that is the person themselves. There is a respect that's given to them that's asking them what they can do. Because more than likely they've been through the system, they know what's going to work for them, they know where they're going, where they want to go and they have a good idea as to what's going to work for them. We found that by treating people as resources, they have an honest approach to where they want to go. As I was saying, you know, someone from long-term recovery, at one point in time I couldn't really – I couldn't hide from the mirror, I knew exactly what was going on and I knew exactly what needed to be happening in my life at that point in time, based on my experience. So by treating people as resources, we use that as one, a relationship builder; but also to find out exactly utilizing a resource that really has the most expertise in that person's life at the time.

So I'd like to speak a little bit about, and these questions always come up when we talk about the ED program, is you know, what is different in recovery coaching in the emergency room setting in compared to in our recovery center? So all the ED coaches, they go through a 30-hour recovery coaching academy but they're also trained specifically, for anywhere from a six- to eight-hour course, depending on people

involved and how many people we have in that session, specifically how to work in the ER. So in the ethics and boundaries part of it is the same rules apply working in the emergency room as it were at the agency, you know we do hold the coaches, even though we're non-clinical, that we look at, you know, 42 CFR which is, you know, confidentiality with the HIPAA laws. We're always respectful of the ER staff. But we're always afraid – always that it's not to be afraid for help. So we know we're visitors, we know we're visiting, we're on a volunteer basis in the emergency room and we know our limits.

But I have to go back because actually I get a little ahead of myself. So we're going to go back to a poll. We actually have a poll that's going to be taken right now and we are going to discuss some of the things based on your experience, of what happens in the emergency room setting. I do have to apologize, I got a little ahead of myself. What's happening in your – from your experience or in the emergency room departments? What are some of your follow-up after discharge and after-care planning? So I'm seeing here, they've offered peer-support in some. So I'm seeing here too is I think a good percentage is the person is expected to make self-referrals from a list provided, that happens quite often. Or they're meeting with the clinician, which I think is great. So ER staff is giving an after-care plan with treatment expectations to that person, which I think is great too but I'm seeing a lot here that the majority of the practices is that the person is expected to make a self-referral from a list provided. This could be varied for a person who just really survived an overdose. AT that point in time, based on their own fear and not knowing the people on the list. We found that through self referrals, the person might make the call, but they're not going to be as honest. I think just like anything else, my recovery coaches have experience with some of the facilities they're referring to, so we found that by actually assisting them in that referral process we can give our opinions and let them give a little insight of what the treatment center they're going to is actually involved with. You know, we can let them know it's going to be a detox, we can let them know what the facility is like. We can give them a little outlook of what it looks like inside, actually what the facilities are and some of the things of that nature. So, but it's interesting though because we found that in Rhode Island that a large percentage was doing the same thing as the self-referrals from a list provided, but we found two, that from the self-referrals the follow-up wasn't there. That actually the people weren't really following up with some of that, some of the referrals that were being made.

So part of our training with – the additional training we do for the recovery coach academy and for the AnchorED is that we have a very – very aware of self-care. What's happening in emergency room departments is a little bit different, as I've said before, then what happens in the community center. So you know, we have some people who have – some of our coaches are in long-term recovery and actually experienced overdose themselves, or they had a family member or friend. So we're very – supervision plays a big key in to keeping our coaches healthy because if they're not taking care of themselves, they're not going to be able to take care of the people they go to see in the emergency rooms. So there's a real, you know, we're very strong advocates of self-care to make sure that coaches are taking care of themselves first. And realize how they're feeling after they meet with the person who recovered. So I think that it's very important because, you know, a good example of that, we had one coach who actually was there and she – it was a couple weeks afterwards, but she kept returning back to one person that she met with and through some supervision that we increased, you know, she's doing okay and we gave her a little break from the ED program which is well needed.

So part of the AnchorED procedures. We're going to go through some of the training, the orientation, data and documentation, as well as the supervision piece. I've probably touched on a lot of these so far. But we'll go through them with a little bit more detail. So, was going to go back, excuse me. So every certified peer recovery specialist in the state of Rhode Island goes through a 30-hour, 30-our training and then go through additional training with an AnchorED to work in that program, but they also do 500 hours of volunteer work to get their certification. At that point in time they go through an orientation to the ED which is our expanded training that they go. And part of that training to is the documentation and some of the stuff that we'll be providing in the emergency room. What's most important is the supervision piece.

So the supervision piece, it's mandatory they meet twice a month, one of those is in a group setting. So and we also meet individually and they also check in before and after every shift.

So how it works, so it's pretty – it's a very simple program. The coaches will actually will go in, they will identify themselves at the beginning of every shift into the emergency room, at that point in time they introduce themselves to the charge nurse, and then they will be on call for 12-hour shifts. when a call does come in he – it comes into our answering service that will go to the coordinator, to myself and everything else, who will actually let the coach know that there's a call. And they will actually present to the emergency room within 30 minutes. At that point in time, they will check in and they will begin and engage with that person who just recovered. So it's a very simple concept. You know, once we get the call, we put them right in, we make sure the coach is there, and then actually we begin the engagement process and we will be there for the referral process and we stay with the person until they are discharged from the emergency room.

So I would like to go over some data. So it's – you know, in our first year of operation we saw 230 survivors of an overdose in the emergency room setting. So out of that 193 survivors, or 83% -- 83% engaged in recovery supports after discharge. So that was within 30 days they either went to treatment, met with a recovery coach, or a telephone recovery support. We're very fortunate that our AnchorED program is sent to the Anchor Recovery Community Center which is – you know; we see 250 people daily through that center so we have a place for them to go. Only 36 survivors decline support. But what I thought was best – the best data that we took out of this was that we only saw 12 more once. So these are the frequent fliers that were going in multiple times throughout the emergency rooms, and we only saw 12, which is, you know, 5% we're only seeing more than once. Which I thought was an amazing statistic. So we always, you know, go through multiple recovery support paths, whether it be, you know, clinical treatment or, telephone recovery support, which a lot of people enjoy which is somebody calls them once a week, recovery housing, or recovery coaching.

So impact on ED staff and operations. What we found, which I thought was very impressive that we slowly but surely by people sharing themselves, and treating people with compassion, and being empathetic in the emergency room, we changed the setting in the emergency room, we changed the atmosphere. We found that a lot of the times, the emergency room staff were a little more engaging with the people they saw multiple times, realizing that there was hope for them and there actually is some help. Which is something when the program was created we really didn't see that happening. But slowly but surely we changed the atmosphere in the emergency room just by one person sharing their experience with another. Which I feel like was amazing. Which I think if there is one thing I have to give credit for is that my coaches are, as I said before, the most dedicated and passionate people I've met. And what they've done in the emergency rooms in changing that environment to somebody, it's nothing short of amazing.

So right now I would like to introduce my partner in crime for today, and my co-presenter, Mr. Bryan Bailey. So Bryan can take over.

Thanks Tom, I appreciate it. So My name is Bryan Bailey, I'm an assistant service manager at Parkland Hospital, as Elizabeth and Tom have said. And I'm going to talk to you all today about some of the things that we did with recovery-oriented care and how it has affected change with our patients in order to achieve better outcomes. But also the secondary effect that we've had has helped achieve better care to our patients by the way that we communicate, listening to our patients and their needs, determining what it is that they're wanting to happen and us not telling them what we want to happen.

So the first slide here. How do we get recovery-oriented care for individuals who come to the hospital for acute emergency issues started with our frontline staff? The RTP approach which rolled out to Parkland psychiatric services back in 2014 by our director Celeste Johnson. She not only helped develop the criteria and the curriculum with the American Psychiatric Nurses Association as part of her doctorial

capstone. But she was also one of the first trained facilitators, so we like to refer to her as our Florence Nightingale of RTP. So she was the one who rolled it out here at Parkland back in 2014, soon after our psychiatric service line clinical educator was one of – was trained as well as the facilitator. And we were able to incorporate the training into our new employee orientation with then all of our newly hired psychiatric service line staff. Additionally, we had current employees cycling through that training as well.

I see there's a question already popping in about how the program is funded and Celeste is actually on the call today, she can grab your name Diane and let you know how we've funded that program. Also we were able to identify that a lot of our training was best done when we involved our peer navigators. Having them there, providing their insight and their feedback during training provided a different level of understanding for our staff that was secondary to none. In addition to that we obviously take time every day to reach out informally to our staff on the units and train them into recovering oriented care. Currently we're teaching about trauma, triggers, responses, calming strategies, the importance of peer support, helping others feel safe, inspiring hope and impacting of our behavior and communication on others. We're challenging our staff daily to be more flexible and to meet our individuals where they are, rather than focusing on nursing tasks, that's one of the biggest things that we do. Additionally, we are challenging the long-held belief and traditional practices by encouraging staff to focus more on anticipating and meeting needs of our patients, presenting – bringing escalation, early intervention, and obviously using non-physical de-escalation techniques when we can. Due to this training that I will tell everybody we have seen a very nice decrease in our restraints and seclusion rates, I don't have those statistics for you, but I hope to get them in the nots when we get them out. Another interesting point is that our emergency department which is the entry point for all of our patients here at Parkland, is currently implementing recovery-oriented care training to their new and existing staff. We believe incorporating this education in the emergency department will positively affect how we care for patients from the moment they step foot in our emergency department and hopefully will be carried throughout their entire visit with us. And eventually we're hoping to see this become a hospital wide initiative as we know mental illness and recovery can be on any floor and in any unit.

So, you see a person in extreme distress that's coming to our hospital and seeking assistance and is greeted with by our friendly triage nurse here on the left. I'd like to take a chat poll, if any of you chuckled at that cartoon, I'm sure you've all seen it before. I'm sure a few of you did and that's okay. That's the reality that we're facing here at probably any hospital. A change in the perception before a person even walks in the door is our goal. Now let's stick to the picture to the right, you're walking on to an old in-patient psychiatric unit and this is what you're greeted with, the danger, high risk, risk for elopement. Again, we can take a quick chat poll if anybody wants to chat in there. I don't think that that's a very welcoming environment when you're trying to come into a hospital unit. It suggests that we might be going somewhere other than an inpatient psychiatric unit. So we recognize some of our environmental opportunities as well, and attempted to make positive changes so individuals felt more welcome. And I'm going to show you all of the changes that we made here shortly.

So the first component we looked at was our verbal communication. This is an area where we made changes and I think it is probably one of the most obvious for anyone familiar with recovery-oriented care, RTP, reminding staff and peers that these are individuals coping and dealing with their condition and are not defined by their condition. So a lot of the people who are nursing have heard the comments of, "Oh the borderline is back," or, "She requires too much attention. All she wants is this or that." It's not very therapeutic at all and more importantly it's not recovery-oriented at all. We orient and gauge all of our new psychiatric services employees to recovery-oriented care. For many of the staff this is their first time they are hearing this message and many times I hear from staff, that it changes the patient-caregiver message dynamically. Asking what can I do for you? Or, how can we help you this visit? Opens up a dialogue and makes our patients and individuals feel more validated. We aren't here to judge or criticize their life choices. We're here to meet them in recovery right where they are. It's their decision as far as where they want to go or what they want to achieve every visit they come to us for.

The next are obviously is non-verbal communication. I'm sure this is not unfamiliar to any of you all either. Non-verbal communication speaks volumes. Many situations can be eliminated or escalated by not even saying a word, we see this a lot in our psychiatric ED. This is extremely true also in recovery-oriented care when we give it to individuals. We aren't asking our nursed to give up hugs to everybody but we are often asking them to, you know, do the simplest things like sit next to the patient at their level and meet them eye-to-eye. The actions that they – their non-verbal actions are excellent, compliment the use of verbal communication and most everyone is already aware that – and we already discussed that part, so.

So here is some of the environmental changes that we've made on our unit. We're going to pull up a poll here in just a second. We changed our environment. The original door you see it on the left, it's the danger, high elopement, list for, you know closed unit. The picture on the right, I think you can agree with the lighter door and with the signs removed, the danger signs coming off the doors, it seems like a much more inviting environment. I think there's going to – we're going to pull up a poll, I just wanted to see if you could use some words that describe how you might have felt coming through the doors on the left, prior than coming to the doors on the right. I think, Michael, we have to identify the unit as a psychiatric unit. I think that might be – Celeste might be able to pop in there and reply as to why we had to keep the psychiatric in-patient unit sign on there. So, yeah I think it does too. I think so Patrick, I have to agree with you, it looks a lot better, it's certainly a step in the right direction and much more comfortable.

So here are some more photos about the in-patient psych unit, we created open spaces, used bright colors, artwork, more comfortable home-like furniture. One of my favorite additions is we have a rocking chair, it's on that left picture between, like sort of on the couches right there. We have rocking chairs so the people who like to pace, can rock back and forth which kind of gives them some comfort. Also our psychiatric emergency department includes private consultation rooms, including an exam room. We moved into this brand-new facility, it's state of the art, in August of 2015. All of our units are psyche safe now, our inpatient and our psyche ED. And they offer a lot of different features that we weren't able to offer at our old facility. Our inpatient floors offer private rooms with flatscreen TVs. On the top floor of our 17 floor hospital is just very nice, the views are amazing. Our day room has a refreshment bar, a snack fridge and two flatscreen televisions, we also offer two recreation rooms where we do arts and crafts and group therapy. Our management has really gone to great lengths to make these environments pleasant and comforting while continuing to maintain safety.

The next slide is our psychiatric emergency department, which also underwent some environmental changes. We included some more comfortable recliners in addition of two flatscreen TVs. We also doubled in size, but only went up in census two patients from 18 to 20. So we gave them twice as much room to move around in while not having to stack people up on top of one another. We also added a comfort cart that our mental health techs push around the unit offering snacks several times during their shifts. It's made a huge impression on patients because they don't have to ask for snacks. They have the opportunity to proactively meet their needs, which is really, really great.

And then my favorite part of our program here at Parkland is our peer navigators which kind of brings us back to what it was that Tom does with the Anchors in Rhode Island. Of all the points the incorporation of peer navigation is our proudest. It was launched in May 2014. We employ five full-time peer recovery specialists, known as peer navigators who are in recovery from their own struggles with substance abuse or mental disorders. To assist patients diagnosed with these conditions. Today all of them have completed state certification. The Parkland program also includes a clinical pharmacist and a social worker. And Parkland's main and psychiatric emergency departments our peer navigators meet with patients who have been identified with possible mental health or substance problems while they are waiting to be seen by clinicians. In addition to helping patients feel more at ease by offering support, and sharing their stories of recovery our navigators provide information about peer recovering navigation programs at Parkland. Once the patient enrolls in the program and is discharged from the hospital the navigators will call them weekly providing them recovery support, referrals to pharmacists for medication,

or to the social worker for housing, transportation challenges and other social issues. They also provide information about other available community resources. Our peer navigators also lead, or co-lead recovery support groups in our psychiatric inpatient twice a week, which is really, really great.

So that's all I have. If there are any questions for me, I'm going to give it back to Elizabeth.

That's super. Thank you so much Bryan and Tom. Your presentations were great. You both spoke, I thought, I think really movingly about what as tom is saying kind of a group of – small group of dedicated and compassionate people, the changes that you can make both in the lives of people who are using services, but also in the systems that you're working in, the cultures within which you're working and how critically important that is as well as really honoring the unique and personal pathways for each person in achieving and kind of following their own recovery path.

Um hm.

Tom there are a few questions that we have. So I'm going to try to get through some of them. I'm hoping that Tom is here, with us even though his camera isn't on.

I'm here.

Great.

I'm going to start with you because there are a couple of just very practical questions. One is whether recovery coaches as part of your program are paid, is that a paid position?

Yes, we're very fortunate we're part of the Providence Center which is a community mental health organization in Rhode Island. So yeah, the AnchorED specifically is funded through the state of Rhode Island group behavior health through the Block Grant, the SAMHSA Block Grant. So the way the funding goes and sort of the pay for the coaches. To be on call they get paid $75 stipend to be on call for 12 hours. Every time they get a call to the emergency room, they get paid a $50 stipend. So they're per diem recovery coaches, but that is how they are pay goes by stipend. But at Anchor Recovery Center we do employ full-time and part-time recovery coaches.

That's great. Thank you. And does Anchor have any programs outside of Rhode Island at this point?

Not yet.

Okay.

It's almost on a daily basis, I am working with another community. Just this morning I was talking with somebody from New Jersey who was looking to do a similar program like AnchorED. And we're always, you know, always have phone calls around the country to try to help people out to get either centers going or programs.

Yeah, I'm sure that's true. And we'll be hearing about some other interesting peer programs later in this series as well. Another question that I'm going to start with you Tom, but that Bryan a different version of it for your organization. It has to do with disciplines working together. So there were a number of questions about how other disciplines kind of fit in with the programs that you are discussing. And I want to put that in this – in terms of this it's kind of as you – so Tom as you started to create the AnchorED program, how did the other ED staff – did they have concerns? What were the concerns? How did you address them? And ultimately, how do the disciplines work together. Because it could be argued that some of the roles of the recovery coach are playing would be roles that would be typically held by a different employee, a social worker, a discharge nurse, something like. So how did you negotiate all of that.

Well I think a lot of it was a lot of time spent talking to find out what would work in the emergency room. So I know some of it HIPAA was a main concern. Immunizations, were a concern. So part of being with the Providence Center, we're also part of Care New England which is a hospital group in Rhode Island. So all the coaches get fully immunized, we train them with HIPAA. We went through the paperwork that the coaches would be using. And we went through the training. So it was slow at first, but as the coaches went in and as we started working the relationship, you know the hospitals realized the values of the peers, and in the training that we put into them. But some of the barriers were exactly that, the interaction that we were complementing not replacing services, and mostly it was based on the HIPAA regulations and confidentiality.

Hm.

So we worked with them. And I think the main hurdle really was the immunizations in the emergency room. So that took the longest to get done, but we put all of our coaches through the full immunizations for hospitals and it's been going famously.

So it sounds like just being clear that it's not that you're – the recovery coaches replaced other staff, but that they're complimenting other staff. Which I think is what you were talking about before.

Exactly, where we want to be in intrusive, in the emergency room. We don't want to hamper anybody. We don't want to be a distraction but at the same time we want to make sure we're complimenting the services and giving the support that's needed.

Mmmhmm. So Bryan, you talked about peer navigators in the ER, same question to you. How did they integrate into the work in the ER? How are they?

Yeah, I wasn't here for the integration as far as back in 2014. However, I can speak to the fact that today, I mean, the peer navigators come through and meet with the nursing staff or the treatment team, which is the clinician, a social worker and a nurse and identify the patients that are most need of the services and then they meet with those patients, as soon as they – I mean they're on staff. So those are paid positions as well for us, they're here, I believe 24 hours a day. Celeste can correct me if that's wrong. But I believe we do have them here 24 hours a day. So someone is able to meet with them wherever they are, whenever they're here.

Great fabulous.

Yeah.

Some of the questions that are coming in about our – how can we do what you're doing in our community? So you're making a real impact and a real impression in the work that you're doing. I'd like to put to you Bryan a question about, you know, we know part of helping people change their practices is kind of winning over hearts and minds.

Yeah.

And what advice, what ideas do you have from the experience that you and Celeste have had at Parkland Hospital for what other people could do? You know, in an ER setting or somewhere else?

I think from the jumping point is really engaging nurses and clinical staff to change the way that – I mean the way that they've been taught. It's just engaging them in a new way to approach patients from like I was speaking on my presentation about the verbal and the nonverbal communication as is this understanding that people are not their diagnosis. You know, I think that's something that we're all working very hard to change, but you know we have to fight years of mindset, which has been probably the most difficult, is you know, that oh they're here again, oh they're here again, but they're here again for

a reason, and that's what we're here to do the work that we do to provide support and encouragement in recovery, not to judge. So that's probably the –

Yeah, so changing behaviors and –

Yeah, behaviors –

It sounds like, yeah.

Absolutely.

Tom do you have any thoughts on that? Of how you change hearts and minds for people who are used to thinking in a certain way?

I think anytime that you have a conversation – any time you change the language so to say, I think using you know, the term substance use disorder and not addiction. You know we stayed away from the terminology of clean, dirty, those – I think any time you change the language, you change the conversation. And any time you change the conversation that's where the magic happens. So I think it's just being role modeling, for one and then advocating for that population also. You never missing a chance to educate somebody, you know these are conditions that are treatable, that people recover, and reduce the stigma that's attached to them. You know we found that in working in AnchorED, you know, there is some stigma in emergency rooms. And by changing the conversations and role modeling, you know, the environment is changing. And I think what's happening specifically, I can speak from experience in Rhode Island that you know the more the conversations they're having about this overdose epidemic, the more compassion people are having towards what's happening out there and then realizing that it's not just a – it's not a number, it's actually someone's son, you know, someone's husband, someone's family member, or someone's friend that's suffering.

Absolutely. Absolutely.

Sounds like that comment resonates with you Bryan about –

It does, I agree.

Yeah.

Specializing care is what it's all about.

Mmmhmmm. Mmmhmm.

And I think parity is with it too. You know and we say it all the time here in Rhode Island that if this is any other medical disorder, you know, there would be a national emergency that would be out there.

Sure.

And we're looking at it now that it should be treated like any other medical disorder that's out there, there shouldn't be anything else – you know they should get the same treatment. You know, they should get the same access to treatment, same medications. And really the same treatment, not as in medical treatment, but treatment by individuals.

(Inaudible – multiple speakers) The way we regard them. Exactly Tom, I agree. It's the way that we regard the patients, is probably the most important thing. And if was – you know, if depression or any other afflictions are equated to congestive heart failure, we'd all have a much different way that we would treat them and react to them, as opposed to it being a mental stigma that we have still attached to psychiatric disorders.

Exactly. And we use the example all the time when we give, if I was a diabetic and I went and told my doctor I just ate a candy bar, he wouldn't refuse me treatment. But unfortunately with substance abuse disorder, that doesn't happen as much as it used to, but it is changing which is a positive.

Right.

I think what both of you are modeling and to bring it back to Recovery to Practice as well, is that we need to then help people, help practitioners understand kind of what to replace that with. And how can we think differently, what's the language we can engage in that's different? What are the behaviors that will help us have a different outcome and to engage with people differently? And you've both shown that really beautifully. I'm going to ask one more question, Tom and perhaps the both of you, but it's about whether you've been able to have – you know whether you attended to the cultural composition of who's on your recovery coaching team, or at Parkland the navigator team so that it matches the people who you're seeing?

It's a little bit difficult with the AnchorED because we – when we get the first initial call, we just get really bare basics. So, but when they do come back to the
Anchor Recovery Center, you know, we're fortunate we have a wide variety of diverse coaches that we do try to match the recoveree up to the coach that we think would be best fit. Whether it be, you know, by gender, age, you know whatever they feel comfortable with. But we always ask the person too as a resource, what kind of coach do you feel comfortable with. And they will let us know and we do everything we can to make sure they're comfortable with that.

And I would say the same thing with us. Like I said, we have five full-time peer navigators and I think we – it's a very diverse group of individuals to meet the patient population that we see here at Parkland. That's obviously very important. We have a large Spanish speaking population, so you know, obviously we have access to that kind of the peer navigators as well as the language lines we use, and the technology that we use to be able to communicate with all of our patient population.

Thank you so much. I have a feeling that we could continue this conversation for a long time, given the number of questions and comments that are coming in. But in the interest of time, I think I will thank you so much for the presentations that you've been able to give us today.

So I would like to give you a special thank you and if anyone has other questions that they would like to get in touch with Tom or Bryan here, use the information, we'd also love to invite you to email us at Recovery to Practice, you can email us at the address here. We're excited about some of the webinars coming up. On January 26th, next week we'll be talking about recovery-oriented community focus responses to behavioral health crisis. And on February 22nd, Hospital Diversion and Alternatives in Crisis Response. Both very rich discussions are planned. Please join us as soon as you can. Remember if you can't join us the webinars will be recorded and made available. So check the Recovery to Practice website for updates and archives of our past webinars.

If you're interested in the NAADAC continuing education hours, please click on the NAADAC link here on this slide, where you'll be directed to the page with the evaluation and a quiz to complete in order to receive your certificate. If you're not interested in receiving the NAADAC CE H's and do wish to participate in the quiz, you may download a certificate of participation in the materials download box near the bottom of your screen. And complete the feedback opportunity that will load automatically on your screen following this webinar. And as I said, please do provide us feedback, it's very helpful to us in developing future webinars.

So on behalf of SAMHSA I would like to thank you for taking time out of your day to attend today's webinar. We know you have busy lives and jobs and we really appreciate your interest and your time. And this concludes our call for today. Have a great afternoon.

Thank you.

Thank you.