Creating Environments of Hope and Wellness: Recovery in Hospital Settings

Laurie Curtis: Hi everybody, and good afternoon. I want to welcome you to today's Recovery To Practice online seminar. This is the first webinar of our winter webinar series. Today we are focusing on creating environments of cold and wellness recovery in hospital settings. My name is Laurie Curtis, and I am the Recovery To Practice project director. I will be your host for today's webinar. We will begin today's presentation after some brief housekeeping and a short review of what Recovery To Practice is. On behalf of the substance abuse and mental health services administration, otherwise known as SAMHSA, and the Recovery To Practice team, we would like to welcome you to all and thank you for joining us today. At this point we have over 165 participants in the webinar and we expect this audience to grow as we go along. I would like to thank our presenters for today, Peggy Swarbrick and Teresa Miskimen, for sharing your knowledge and experience. We look forward to their presentations very much. First let's review the page layout so you get the most you can from the features of this webinar. You have three options for communicating with us today. If you have any technical problems during the webinar, please let us know using the question box in the lower left corner of your screen. A support technician will help you very quickly.

This box can also be used for questions at any time that you like to raise with our presenters. We'll be asking the presenters your questions during the question and answer session at the end of the presentation. We also have a participant chat box that you can use for general comments and discussions with other participants. If you would like to zoom in on the presentation you can make the slide larger with the full screen button that is in the upper right corner of the PowerPoint slide that you see on your screen. To exit from this full screen view just press the escape key on the keyboard and that will allow you to toggle back and forth. The full screen view will also take away all these boxes if you find them to be a distraction for you. You can come back to the boxes when you want to open a question or post a question or ask a comment. This webinar is being broadcast by your computer speakers. Make sure your computer speakers are not muted. Adjust the volume for your own comfort. If you do not have computer speakers or your sound is not working well, please let us know in the question box and we may have an option for you. At the end of the session today you will be able to download a certificate of attendance that you can use to apply for continuing education credits for your professional association. You'll also have an opportunity to provide us with feedback on today's webinar. We have some good news for you. This webinar, and all of the webinars in the winter webinar series, have been approved for continuing education hours from NAADAC which is the Addiction Professionals Association. To qualify for these continuing education hours, you must complete the full webinar. You must complete a brief quiz and an evaluation at the end of the webinar. We will give you more information about that at the end of today's presentation. Finally, if you are registered for the webinar, a link to the archives version of the recording will be emailed to you. You can check the Recovery To Practice website for the archives of this and other wonderful Recovery To Practice

webinars. In addition to the recordings you will find there are slides and any materials related to the presentation.

This webinar series is hosted by SAMHSA's Recovery To Practice initiative. The overarching goal of this initiative is to improve the knowledge and ability of the behavioral health workforce use recovery oriented practices every day. What do we mean by that? What do we mean by recovery oriented practices? In 2011 SAMHSA released a working definition of recovery and a set of guiding principles that incorporate aspects of recovery of both substance use 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." With this definition and these 10 principles that encompass that definition along with four major dimensions of recovery: home, health, purpose, and community, all form a solid foundation for developing recovery oriented lives and for building recovery oriented services and systems that support recovered oriented lives. SAMHSA's Recovery To Practice initiative helps you turn these principles into everyday practice.

Recovery To Practice also offers a set of discipline-based curricula to promote the understanding and uptake of recovering principles and practices. Developed by these six professional disciplines, for educating their own membership about recovery and behavioral health. These materials are available and adaptable for use by other disciplines and organizations seeking resources to build recovery oriented workforces. The link to these materials and resources are available at the SAMHSA Recovery To Practice website. Please note at the bottom of each slide you will see the link or address for the Recovery To Practice website. If you don't catch it on one, you'll be able to catch it on others.

Recovery To Practice, however, is also moving beyond its initial disciplined focus to embrace multidisciplinary surfaces and integrated practice settings. Those of us who work in behavioral health or integrated healthcare organizations have opportunities every day to promote wellness and recovery. We powerfully communicate hope for recovery in the value of selfcare and wellness in just how we approach our work. Recovery To Practice can help to strengthen these practices through our free webinars newsletters and training and technical assistance opportunities. We hope they will join us for the entire recovery practices and crisis and emergency services. We will provide more information about what is coming up at the end of today's webinar. Today we're going to explore the ideas and themes raised in the newsletter, Recovery To Practice newsletter, that came out last December entitled *Incorporating Recovery Orientation in Hospital Settings*. Much of the materials for today's presentation were initially developed for state psychiatric hospitals, and focuses on longer term inpatient settings. We will consider not only how these concepts can bring focus on recovery and wellness to those settings but also how they can be applied and adapted for work in other inpatient acute settings. I would now like to introduce our presenters for today.

Peggy Swarbrick is a member of the Recovery To Practice committee. She has worked at the collaborative support programs of New Jersey for 18 years and is an associate professor at Rutgers University. Peggy is involved in research, training and consulting activities in the area of wellness and health promotion, employment services, and the role of peer support, a worker in strategies for enhancing recovery to participation in valued occupation. Her 2009 article in the *Occupational Therapy in Mental Health Journal,* a wellness and recovery model for state psychiatric hospitals, will form a portion of the foundation of her presentation today. Dr. Teresa Miskimen is the vice president for the medical services at Rutgers University behavior health care, otherwise known as UBHC. This is New Jersey's largest provider of behavioral health care services. Certified as a psychiatrist by the American Board of Psychiatry and Neurology, she is also a professor at the Department of psychiatry at Rutgers' Robert Wood Johnson medical school and a distinguished fellow in the American Psychiatric Association. She works at regional and national levels including most recently serving as the New Jersey representative to the assembly at APA. She divides her time between clinical practice, administration, teaching and clinical research. More comprehensive biographies of our presenters can be found in the download materials box which is displayed now. We welcome both you Peggy and Teresa and Peggy you may begin.

Peggy Swarbrick: Thank you very much Laurie. I am excited to be here to talk to you about a topic that is near and dear to my heart, which is creating environments of hope and wellness in inpatient settings. I'm going to talk today a lot about some ideas that are built from my experience and the experience of others doing this work. Long before we had the guiding principles and recovery definitions, many people have been doing work to bring recovery and wellness alive in settings and we're excited to be here today to talk about my experiences as well as trying to encourage you to think about building on your own experiences while building on what you're doing already to be able to bring the ideas to your work. One thing we want to know is that recovery oriented support in hospitals is possible. We do know this. There are a lot of daily opportunities we can look at in some of the experiences I've had in inpatient long-term, short-term and even forensic settings where we have been successful. I will also link you to other resources that will show some of the evidence that we've made this work. I'm going to talk about thinking about the interactions we have had with one another and the people we care about in these settings and the need to create the opportunities.

Creating change and moving to these ideas to put them into practice can be challenging. If we use these guiding principles of recovery, there are some concrete steps hopefully you will hear about that you can put into your own work. I started this work in my own personal recovery many years ago, thinking about and doing wellness for myself. I was very fortunate to have a career moving into occupational therapy. There were no peer provider roles in those days. What happened for me was the work I brought into my occupational therapy practice and then I was really even in those days challenges existed. It was not easy to bring in a different way of thinking. I found when I kept my

attitude focused, when I remembered why I was doing the work and gathered myself with other like-minded people that embrace the attitude recovery and wellness, we could see a change. I think that is something you're probably are doing or continue to do.

We will talk about the wellness framework, some strategies to think about how to put this in all types of environments. I'm going to give you an example of a program we were successful with as community health providers reaching into a hospital to bring in a program that was run by people in recovery that impacted staff development. We will have more presentations around some other things to hear how the role of psychiatrist and multiple disciplinary teams and how university behavioral health is doing some exciting things that shows this is possible.

Everyone who knows me will know that this is something I even wear on my T-shirt. If you can't see it right now I'll stand up. It is the wellness wheel. I wear my wellness wheel because this is what I think is so important. The lens of wellness. Thinking about our recovery from that multidimensional area and keeping our eye on the wellness for the person we serve, for our self and for our environment. Thinking clearly about this wellness model that can and has. Where I developed this model was a personal journey. I was able to transform it into my work in early in the 1980s in a state psychiatric hospital. I'm going to talk to you about things we have done and has continued. A lot of what we know is we need to keep focused holistic healing on our self. We're in an emotional crisis, we're in a traumatizing situation. Keeping our folks on our strength, thinking of ourselves, from the 8 dimensions we all have strengths we can build on. As providers or planners and a variety of other people who may be on the presentation today, you can too keep the lens of wellness. Thinking about service planning and thinking about the environment in which you are offering services or evaluating services. Keeping the focus on wellness and most important having the dialogue with the people we serve. In discharge planning or planning we do for the treatment in the inpatient setting, we want to help people to remember their strengths and look at areas where they may have challenges, but then help them focus on strengths to overcome those challenges. We can think about helping people to view themselves from this lens. It will transform their vision of themselves, and how they move forward in the recovery. Those of us who are providers or administrators we will see better outcomes and we'll feel good about the work, helping people move forward in their recovery. Don't just focus on the emotional challenge the person brought in. Remember that they have valuable role, they have a spiritual side, social financial environment, they need a place to go and live that will sustain their recovery. All of these things are important. When we think about the wellness framework and the dimensions we keep that in the focus of our treatment planning. We need to remember that people have valued roles and we want to help them look at the strengths and help them remain in the roles or reconnect with those roles. We're working on helping people see the recovery and help use the model of wellness to help support the recovery planning and goals. Wellness is about empowerment. Just as recovery is. Helping the person and their supporters to take on the personal responsibility, to make the steps. As providers or people designing and delivering the services, we want to educate, guide and support rather than

being able to shame and blame people for what has happened. We want to shift that focus to educating, guiding and support them. To help them learn the skills and regain the knowledge that can help them in their path to recovery.

We want to remember that the motivation for change is not fear but a good health and personal control. Those are very important and significant factors in the recovery for people. Next we're going to talk briefly about some of the ways we can think about the dimensions. There are some examples of things that have happened in practice. A further discussion of this is in one of the papers that will be available to you. I cannot go over all of them but some of these are here and you can go back to it.

Physical wellness. It's a hospital. We do not want to throw the medical model off the door. The medical model prevails in a hospital but it is the greatest opportunity to get back to that physiological balance. An important sleep rest cycle is very important. When we want to help people to think about the routine inhabit for sleep because it is important for people's recovery. Getting people involved in balanced exercise and daily activity routines is a great opportunity to help people in the hospital setting. Education groups help people understand stress management strategies and the routine of the unit being something that can be important. We can help people become more aware of monitoring themselves if they are medication. Keeping track of weight, keeping track of blood pressure, blood sugar etc. Things that can be tracked, need to be tracked. Physical wellness strategies are a great opportunity as well as helping people to start to think about the habits and routines they want to create. They may not want to get up at 6 AM like it is at the hospital, but help them establish that a sleep and wake routine will help support the recovery journey when they leave the hospital.

Spiritual. This is the one that in the 80s and 90s I did not put in the dimensional model because they probably would have given me Haldol or Thorazine or some other medications thinking I'm talking about people's spirituality. Yes, we were talking about this and it was a strength of people's recovery. Helping to look at their spiritual side, thinking about the activities that connect with their values and beliefs, and then to help them engaged with those activities. Then to connect them with those activities in the hospital or connect them to the chaplain service for those individuals that that's a preference. Not being afraid to talk about these things but to help people. Tai chi and yoga help some people with their spiritual balance. Yoga has helped me a lot in that area. Having those activities available for people to be exposed and educated on are tools to help in the recovery.

Emotional is an area that we have a lot of opportunity to focus on. Instead of anger management people liked wellness groups. We had a host of topics around helping people with things around journaling, creative arts therapy, wellness collages, helping people to express themselves and help

them express the anger and frustration and deal with stressors in an open and constructive way that can help them find the balance in other areas. One thing I did not mention when we looked back at the wellness wheel is you focus on one area. You may only focus on one area, but it influences the other areas. That's what we find with wellness, that you may have some imbalances in some areas, but we will focus on their strengths and focus on the emotional well-being and it will influence the other areas of wellness and support our recovery. We want to think about social wellness. This is important. This is where social interaction between staff, in person served, and the respectful communication. Having more and more peer provider roles that are identified that can be a positive role model, that is something I will talk to you about in a minute how we did the recovery network project. The hiring and recruiting and retaining people in positions is a very strong role modeling effect. Both indirect service and administrative role opportunities. Helping people to think about and connect to the family or family of choice or their supporters, don't cut those people off. Those people are going to be very important as people are planning to leave and moving on in recovery, and hopefully continuing the recovery and feeling well in the community. The social wellness has a lot of opportunities for things to happen there. Occupational wellness and helping to look at people strength's and making sure we are documenting and using them in the planning we are doing. Making sure we think about people's occupational roles and linking them back to those and helping them to think about leaving the hospital in getting connected back to the things that provide purpose and meaning to them, that are part of their occupation side. Again, it is very important to think about those supporters that relate to people and involving family as much as possible.

We also want to think about when people are in the hospital, involving them. They may have been caretakers of other people. Getting people involved in the planning routines planning a programming. One of the articles you will see invited people -- we tried to get people involved in telling us what they wanted. In a lot of the wellness programing I developed over the years is all based on the framework of what people were telling us and using their strength and involving them as much as possible. Then we have the intellectual strategy. Keeping people available with educational materials that is related to their needs helps people keep that brain power going, and helps them educate themselves on things that are important for their own recovery that will continue. When I thought about doing this presentation a colleague of mine who came up to me and reminded me he attended my occupational therapy group many years ago, and how he hated being in the hospital but he was very impressed that I made sure I brought him the daily news, and I engaged them. He said that made his life bearable in that facility and he got a little bit out of the groups too. He said that was an important thing. Knowing to have materials available and things available to connect with people and keep them unconnected and growing. He has not been back at that hospital since 1991. There are plenty opportunities to keep the environment and working spaces free of clutter and debris. Helping to create music that is calming and soothing that is connected to the person. Being aware of the noise stimulation. I also highlighted that in one of the articles. We track that kind of music he had, the noise pollution we had, and could implement a lot of positive things by monitoring that and making sure it was supporting people's

recovery. I have a lot more to talk about. Dimensions is my favorite thing. We have given you a lot of resources around programming have given you some workbooks we have created that are free.

I want to briefly mention a project we have called the recovery network. This is back in the mid-two thousands when recovery definition was coming around. I met with -- I worked at a collaborative support program of New Jersey community agency and met with some of the state's hospitals. First it was the CEO of the forensic hospital and he said "I want you to run a program bringing peers and let's help inspire hope for the people being served and the staff." We worked with the rehabilitation – specifically the OT staff initially but we spread it out to the rest of the hospital. We had the people in recovery going in as consultants. I helped develop a curriculum and did some supervising and mentoring. They went in and ran those groups of the forensic hospital and eventual the other state hospital. It was a great success. We would have anywhere from 10 to 13 people in the program. We had medical security officers who were in the program, the attended. We adapted it for the different settings. Some were longer or shorter term. We were able to adapt it a bit. The idea was to seek culture and change through educating the staff. It really was a great opportunity for people in recovery to come back and tell their story, share ideas, and we really had some good success. We were a consultant at the hospital. We were able to role model the recovery journey and show evidence that is possible to get out of the hospital stay out and show those examples. It was important. We eventually started doing training at this hospital. Which is very helpful. We were part of the training team.

What happened was people really learned a lot. The staff could see someone really move out, because when they see someone before them not doing well they think everyone is not doing well. They can see people well living in the community. It was a real hope. We talk about them creating an environment of hope. This was helpful. We had one of the articles to show we had 769 people who participated and had favorable feedback around the benefits of being part of this program. A lot of the evolving of the curriculum was based on their feedback as well. We had some positive outcomes. We talked about the wellness model being a way to frame your service planning or environment or program. The recovery network is evidence that you can do this. We can go into the hospitals. It is a nice community hospital collaboration. The other piece to this is we want to do this for the programming for the person served. It is important as we see in Recovery To Practice that we need staff development. Staff need more skills, knowledge and support to create this positive change. In our recovery network, we had peers going into some of the hospitals and where trainers. We trained in one hospital all staff in that setting. That was a positive experience. Not only just the clinical staff but the housekeepers and foodservice people. To get the training and see this and learn about the program but learn about training around recovery and wellness. They implemented this into the new employee orientation. We encouraged them. I have worked a lot about staff wellness. You cannot promote wellness for people in treatment planning if staff are not aware or attending to their own wellness needs.

I also have an article I can direct you to that highlighted staff and wellness focus. The Recovery To Practice curriculum is an excellent resource for staff development and training that we hope you have taken advantage of all will take advantage of that can help make this movement towards creating an environment of hope recovery in inpatient and other settings.

I'm very excited to talk about this. I could go on forever but I do want to look at a poll we have where we wanted to see what type of focus you guys are doing. We can see in your work setting which component of wellness you would like to promote more of. What are the areas you think of wellness you would like to promote more of? We can direct you to resources or we would like to know what you think. Take a few minutes then we'll introduce you to our next presenter who will give you exciting news on other things happening in New Jersey. Emotional wellness seems like something people would like to promote more of. Social wellness. It looks like emotional wellness is one that people, of course people need, when we get to the hospital emotional well-being it is an area. There are a lot of different areas for wellness. We hope through this presentation you get some more ideas. I would like to turn it over to my colleague Teresa. Thank you very much.

Teresa Miskimen: Thank you, Peggy. It is a pleasure for me to be here today. I have to mention, having worked with Peggy over the years she is an inspiration. From hearing her presentation, it is loud and clear that the road she has paid for us in New Jersey we have taken to task. Here at University Behavioral Health Care, we use a lot of the principles that she has been researching. Please read her articles. They are incredible in terms of focusing your attention. Let me start off with what is the focus of attention from my presentation today. I did see the poll was more social and emotional, but I do want to bring back to the wellness portion of the wheel. As a psychiatrist, someone who has been trained in medical services that remains the focus. I will be talking about the evidence-based rationale concerning the integration of physical health and in inpatient behavioral health settings. I will proceed to discuss the multidisciplinary approach in recovery oriented care. What is the goal of the whole process of integrating physical and mental health? That would be via a holistic coordinator approach. We must make sure that treatment outcomes improve. So, in the long run, people afflicted with mental illness come for help and not only an inpatient setting but in an outpatient setting have better wellness in terms of their physical care. Why should behavioral healthcare teams be concerned at all by this holistic healthcare integrative approach? Because as evidence in clinical practice comorbidity of medical and psychiatric conditions is the rule rather than the exception. I wanted to bring your attention to this slide because it does point out several areas. The main thing is the individual diagnosed with serious mental illness such as bipolar disorder, schizophrenia, major depressive disorder and psychosis in general, are at higher risk for medical problems such as high blood pressure, heart disease and diabetes. An average person diagnosed with serious mental illness do die prematurely and sometimes up to 25 to 30 years younger than the general population. Which means our clients are afflicted with serious mental illness are dying in the prime of their life, between 40-55.

The lack of fulfillment on someone's life if you are dying at a time in which you are in the best years to be productive, giving to the community, into your family and yourself. Premature death due to medical problems alone do account for more deaths than suicide. That is why integration of care becomes critical.

Having said that, I think that for psychiatric and behavioral healthcare services, we have a leg up on integration. That is what we are dealing with daily. Psychiatric care is delivered in a multidisciplinary team. This model addresses head on the problem of fragmentation of care. Let me talk a little more about this because it is seen in the medical field and when we silo some of the treatment interventions that we give out. Several years back I read an editorial column by Kurt Strange. This was in the annals of family medicine. The issue of fragmentation was clearly elucidated. I like how Kurt put in the actual what is this fragmentation and how is it described. What he was talking about was that of all the things that are affecting our healthcare delivery the fragmentation issue is a critically underappreciated problem. Fragmentation is when your focus and acting on the part without appreciation of the whole. For instance, in the medical field if you are cardiologists you will only talk about the heart with the clients in front of you. You seldom ask about depression and social issues, wellness issues, you just go by do you have chest pain yes or no do you have an EKG? Is the same for psychiatrist until recently. We were just concerned about the psychiatric problems at this point. I'm not even going to weigh you or follow-up with your blood pressure or any of that because we were dealing with the silo mentality. Thank goodness, the has changed. That is the whole integration of care. In behavior health and psychiatry, the issue of addressing with the patient is coming in for a be a multidisciplinary team approach is the way to go. It talks about the integration. What is the makeup of the multidisciplinary team? I think your traditional members: social workers, nursing staff, psychiatrists, occupational therapist, care coordinators, but I also want to point out that as Peggy said what is the next step and how can we improve the quality. We need to think freely outside that box. What other nontraditional team members can we bring into the fold? Let me tell you something we have done in acute inpatient care. We've brought in a nutritionist. Several years back we noticed as we focused our attention to wellness and body mass we noticed there was an average weight gained when people were hospitalized. Even though this is an acute care setting by the end of the hospital stay unfortunately there was an average gain. Sometimes three or 4 pounds.

We decided to address this twofold. First where's the problem? We had to increase the physical activity. We then started working with some of the TV and Wii to improve and increase the activity in the unit. If the patient was not a danger to their self or others they would be able to go outside of the unit. They would have the opportunity if they wish to increase their activity. In addition to that, we brought in a nutritionist. The nutritionist sits with us during team meetings. They come in to talk to the clients as they are hospitalized. They are providing information on diet and what to do if they want to decrease weight. We are not an eating disorder hospital, so most of our patients were gaining weight secondary to a sedentary life. Things like that do help.

I also want to point out to the continuity of care. This is also part of the importance of a multidisciplinary team approach. What you want is regardless of where the patient is in the continuum of care whether they are an outpatient, inpatient, impartial, or in the nursing care that there is a continuity. I did put up information that you will be able to download on the types of continuity of care. It is included in your resources and literature review. They talked about information management and relational. I wanted to briefly discuss these. Informational is what is contained in the chart. As a multidisciplinary team member, it is crucial that each one of us that each one of us makes sure that all the information we are obtaining from the clients is clearly documented specifically for the initial evaluation as patients are leaving the unit. We do send information to the next level of care. That will include the initial evaluation and a discharge summary. That continuity of care is crucial as you are referring the patient outside the inpatient unit. The next level of care provider will have the information of what the patient prefers. Is there an advance directive? Is the person having difficulty in their social milieu? Does a person need housing? Then you go on to the management continuity of care which is crucial in chronic care. Please remember that serious and persistent illness is a chronic illness. That you are doing a comprehensive treatment plan so you will share this with other providers. Including primary care providers, social workers, psychologist, clinicians. So, that is part of the management of continuity. Lastly, the relational continuity of care and the role of psychiatrist and behavioral healthcare professionals which is crucial because our clients are coming to us first. Our continuity of care should always include are you also following up your physical wellness with a family physician are a primary care provider? What other things are you doing? We are the hub of that care. Moving on with the role of the psychiatrist.

Laurie Curtis: This is Laurie I just want to be mindful of the time. So, we have adequate time for questions and answers at the end.

Teresa Miskimen: Thank you. The role of the psychiatrists, especially at UBHC, is we need to set the tone to integrate that physical and mental health setting to follow the practice standards and minimize any metabolic effect of psychotropic medications. We counsel on lifestyle choices and bringing us right into the workforce development. For psychiatry and not only for psychiatrists but also social workers we need to remember that we do need a diverse psychiatric workforce and workforce in general for the multidisciplinary team. I want to make sure you are aware of that the SAMHSA website has a lot of information about what constitutes a diverse workforce including cultural and other aspects such as gender inside of practice.

I also want to bring your attention to what SAMHSA have done for psychiatrist. We are trying to incorporate this wellness and the wheel of wellness and the lance of wellness into everything we do. To that effect in conjunction with SAMHSA, the Emergency Psychiatric Association, and the community psychiatrists have created a whole project on implementing a set of training materials so psychiatrist can also contribute to bringing the recovery oriented practice into mainstream of professional practice. Over the next several years this will become critical for us. Also, I want to bring to your attention what you can you do now? You have listened to all the wonderful things that can be done in wellness and I am encouraging you to act at this point. I will share some of our projects in the past 5 years so

hopefully you will be inspired. Just like that Betty Swarbrick inspired me to do some of the projects we have done. You will be able to see some of the projects we have done. We always participate in the wellness week. Wellness week is something that we use from the wellness materials. You can download them. There are posters and activities that have been crucial for us to make sure not only our patient but our staff members know this is all about wellness. The animal New Jersey behavioral animal health quality improvement fair. This is a statewide initiative. We all come together once a year and have a fair in which we have our best projects. UBHC we did the fifth annual, and I have to bring this up, we did win the cup. We won with this wonderful Q initiative to step in to better health in which we focus on a partial care setting. How is it that our clients will be able to incorporate walking, just clear walking, into not only their programmatic daily activities but for after as they left. We are currently going to publish on this project. All in all, patients did improve their wellness. They had weight loss and overall patient satisfaction was recorded as increased. There are many ways you can do this. You can do newsletters, flu shots, health promotion. For my final slide, I want to give you a slide that inspires me. This is from Joe Parks. The director from Missouri Institute of Mental Health. It is a medical fact that once your dead of a heart attack you cannot recover from schizophrenia. I believe what we will do now is pass it to Laurie for question and answers. Thank you very much.

Laurie Curtis: Thank you both those were wonderful presentations. You have inspired a lot of chat. People have been going back and forth on a number of things. There have certainly been some questions that have come up. Let me start with the most important one. This is directed to Peggy. A lot of people want to know how to get the T-shirt.

Peggy Swarbrick: Okay, the T-shirt we have it through the agency. They can contact me. We order them periodically when we do the conference. We usually sell them at the conference. They can get my email. We mostly do it for the conference. It is a popular T-shirt. We don't have any right now but as we gear up for the next conference I will let people know.

Laurie Curtis: Will you say what conference?

Peggy Swarbrick: Collaborative Support Programs of New Jersey operates an annual wellness conference. We have been doing that since 2003. We have 450-500 people come. We have people in recovery, care providers, psychiatrist, medical directors, people and service providers and people from the state. It's an eclectic group. It will be happening in 2016. Check on our website to know more about when that is.

Laurie Curtis: The website would be the collaborative support programs of New Jersey?

Peggy Swarbrick: Yes.

Laurie Curtis: The first question that has come in is directed to Peggy. One of the things that was happening in the chat while you were talking was an inspired conversation around the issue of spirituality. The degree to which individuals feel they can respond and support spirituality as part of recovery and wellness. Certainly, those who are working in more state types of settings. Could you have talked to that a little bit? What is the viability of supporting people in individual spiritual exploration in hospital settings?

Peggy Swarbrick: Initially I did not put it in the program description early on but later one we did and had no problems. You have staff who are often squeamish about it. The biggest thing we tell staff

is don't push your spirituality on people. The idea is to help people know what spirituality means to them and how it supports their recovery. Having that kind of dialogue and approach is the way to go. It is helping people to explore it and offering connections to things that is possible. But denying it creates a whole set of challenges. Spirituality as we know is part of the dimensions. If you look at the way we have asked the questions about it, you can see it is nondenominational. It looks at some people could use religious strategy to help them with their spiritual connection. But don't cut people off from that. It becomes a real dialogue for people. I have not had any problems in hospitals doing it. Where you get problems with it is when people get dogmatic about what they view as spirituality. Keep an openness to the definition of it, and that is the way we have approached it with success.

Laurie Curtis: I would like to address the next question to Dr. Miskimen and Peggy may want to weigh in. Who advocates for individuals and hospitals to receive these kinds of services? How do we get that going?

Teresa Miskimen: Part of that multidisciplinary team approach is the fact that we're all advocates for individuals who are receiving treatment in our facilities. The main thing is it must go from the top down. Wellness is something that does not just occur at the local level. It must be part of the framework of the strategy of the organization. That this is something that is part of the culture of the organization. How do you get this going? For us its starts with our CEO, who is a strong advocate for our clients. After that we created wellness groups and had staff managers that were interested in participating in the wellness week over the last 15 years what started as basically we should be taking care of the whole patient it has just branched out into doing wellness trackers. The initiatives we provide information. Not only for outpatient but the inpatient. If in your organization there is nothing that talks about wellness and recovery and you are participating in this online seminar how to start it off, the easiest way I think would be to go to a person you think is in the administration that would be a champion. Bring an idea, start with something basic. SAMHSA already has all the information about wellness week and make sure you download the information and do it every year. You will be amazed at how that networking will expand. We have seen in the last 15 years where we started off very localized and now it is throughout the whole organization. I hope that helps.

Laurie Curtis: It does. Thank you very much. In the interest of time we need to close off the question and answers. We have a couple of other questions we would love to ask but we only barred people for an hour today. What I would like to do is to point out if you would like to follow up with Peggy or Teresa please feel free to contact them at their email address on the slide. You can also contact us at Recovery To Practice. Our address is on the slide.

Coming up soon. Next Tuesday and for the next three Tuesdays at the same time we will be having additional webinars focusing around recovery oriented practices in crisis and crisis response. Please join us next Tuesday for a discussion of recovery and acute care in emergency setting. Following that the community focus responses to behavioral health crises and we will close with a discussion on hospital diversion and alternatives for crisis response. Please register and join us for as many as you can.

We would also like to remind you if you are interested in receiving the NAADAC CEH hours you can click on the link on your slide. Just click it right off the PowerPoint. That will take you to a page that will allow you to provide an evaluation as well as complete the quiz and your certificate will come up as you have completed that. If you are not interested in the hours but you are interested in the certificate of participation you need to download it from the download material pod in the lower right-hand

corner of your screen. Print it out and there you have it. Immediately following this webinar, those of you who are not going for the hours will have a form pop up on your screen that will provide feedback to us on the webinar. We appreciate you completing that. The information you share is very important. With that I would like to thank everybody for sharing time with us today. We hope to see you within the next couple of weeks for future webinars. Thank you to our speakers for an exciting webinar. We appreciate your time. Good afternoon and we will see you next week. >> [Event Concluded]