Shared Decision Making: A Process, Not a Program

Laurie Curtis: Hello everyone and thank you for joining us for this Recovery to Practice webinar this afternoon. On behalf of the Substance Abuse and Mental Health Administration and the Recovery to Practice team we would like to welcome you all and thank you for joining us. We have over 70 people joining us today and we know that number will grow as we begin to move forward into the webinar. My name is Laurie Curtis and I'm your host for this afternoon. After some brief housekeeping and a short review of Recovery to Practice we will begin today's presentation. At the bottom of your screen you will see a download materials box where you can access our presenters' bios as well as a PDF of the presentation slides we will be using today. This webinar has been preapproved for continuing education credits through NAADAC the addiction professional association. To qualify for these continuing education units you must attend the full webinar, complete a short quiz at the end of the webinar, and complete an evaluation of the webinar. More information about this at the end of today's webinar. Finally, if you are registered as an attendee, you will be emailed a link to view the archived recording. This link will be also available at SAMHSA's Recovery to Practice website. This webinar series is hosted by SAMHSA Recovery to Practice initiative. The overall goal is to the knowledge and ability of the behavioral health workforce to use recovery oriented practices every day.

Understanding what recovery means is critical to our and their success. SAMHSA's working definition of recovery 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. Recovery to Practice offers a set of discipline-based curricula to promote the understanding and uptake of recovery principles and practices. Developed by six professional disciplines for educating their own membership about recovery and behavior health. These materials are available and adaptable for use by other disciplines and organizations seeking recovery resources to build their workforce.

Recovery to Practice can help you strengthen your recovery oriented practice through these free webinars, newsletters, training, and technical assistance. Check out the recovery to practice website regularly for new opportunities. This particular webinar today will explore and expand perspectives on what is shared decision-making, and what is a shared decision-making process, and provide strategies that can - and provide strategies and examples of how it can be adopted by a variety of practitioners in diverse practice situations. I would now like to introduce our speakers for today.

Our first speaker is Jacquelyn Pettis, an advisor and trainer with the Recovery to Practice project. In her current position as manager of wellness and recovery she provides leadership for wellness and recovery at Beacon Health Options in Maryland. It is the nation's largest independent behavioral health company. Prior to that, she led Baltimore's Behavioral Mental Health Systems the core service agency and local mental health authority for Baltimore.

Our second speaker for this afternoon is Melody Riefer, a senior program manager at Advocates for Human Potential. Miss Riefer provides consultation to behavioral health authorities on many aspects of recovery oriented system. During her more than 30-year career, Ms. Riefer has worked as a practitioner, manager, educator, and consultant.

>>Sound breaks off for a long time<<

Jacquelyn Pettis: Hello?

Laurie Curtis: Hi, Jackie. Please feel free to go ahead.

Jacquelyn Pettis: Okay, I could not hear. Hello everyone, good afternoon. I am going to start out looking at the overview of shared decision-making. One second. Shared decision-making is an interpersonal and independent process. Here it says it is a process, and it is a partnership between at least two people. And for the sake of our discussion today, that is the healthcare provider as well as the person that's in treatment. It is a collaboration in making decisions about treatment. Together people work on building a consensus and relies on medical evidence and experience on the person's expertise, preferences for clinical and not clinical staff. And the specific unique characteristics of the person in treatment.

Key components of shared decision-making -- Key components of shared decision-making are listed here. Information, education, responsibility, values, preferences, and respect. A balance between the perspectives can influence the decision making. Mutual information and mutual respect for the responsibility for decisions once they are made and treatment focuses on what matters most to the person. We can involve a family and other natural support, of course with consent. Some barriers to implementing shared decision making – one second -- some barriers to implementing shared decision making is perceived time constraints. A healthcare provider's use regarding which people want people want to participate in shared decision-making, which people should engage in shared decision-making, and who are capable. There's a belief that shared decision-making only applies to physicians and others who prescribe medications. But we know that is not necessarily the case. There is also a lack of training as seen as a barrier by providers, and also the person in treatment lacks information and skills to participate in shared decision-making in a meaningful way. The lack of training also for the advocates to prescribe how people prepare for the process.

POLL: We have a poll here and we're going to ask what do you think is the greatest barrier to implementing shared decision-making. You can see a poll at the bottom of the slide. You can take a quick vote, and see where audience thinks about that. And it looks like the polling, although still changing, are saying time constraints. It looks like people online are saying time constraints are the biggest barriers which is consistent to what we often hear from people field. So, it looks like time constraints. Okay, next slide.

Perceived time constraints is the most frequently cited barrier to implementing any change in clinical practice. So that is really not a surprise that we have these findings, but then combine these results with several randomized trials providing us with such strong evidence that more time is required to engage in shared decision-making than it is to engage in any change in clinical practice. It is important to emphasize this when talking to staff and trying to encourage people to participate in shared decision-making, and also what has been found to be helpful is the early identification of champions within the organization. People who believe in shared decision-making and the effect of medicine, the improvement in outcomes and care and, as I mentioned before training is important and teaching both the provider and the people receiving services how to communicate in a different way to help them to implement shared decision-making. And you need to create time for dialogue and routine information up front that can save a lot of time. We also note that – we also not that the use of technology is an important way to save on time constraints. Technology, smart phone, electronic records, electronic medical records are ways that people overcome some of the barriers to shared decision-making.

Another -- Other examples include providing real-time training and coaching. People need ongoing support when you're are implementing change whether it be shared decision-making or other types of change in clinical practice. There are several decision-making aids -- There are several decision-making aids that people use to promote and engage in shared decision-making and to create dialogue, provide relevant educational information, provide relevant shared decision tools, collect – I'm sorry. Provide training and real time coaching that are discussing advantages for staff and person and know that there are improved relationships when people are involved in the decisions that are made in the clinical treatment. So, there are several –they're several different things we can do. And, most people are familiar with that decision aids because there are many that are out there and available. And as I mentioned making technology a friend. Smartphones are used a lot.

So, here's a list of "whos" -- when people think about who is involved in shared decision-making, we have listed here a variety of team members. And also, we recognize that shared decision-making occurs in a variety of health services and peer run programs. But who do you think is missing from this list? We have several team members here, but I'm thinking about who is missing? Well the obvious person who is missing is, you can't do shared decision-making without the person who is receiving treatment. They must be present and an equal member of the team, and being effectively engaged in the treatment process.

I want to share just some of my personal experience with shared decision-making. One of the things that's important to me in preparing for any health appointments of any kind, is to prepare a type of questions that are ready. Some of the questions that I have here is: is the treatment necessary? What are the costs involved? Will insurance pay for things and what recommendations made? What impact will it have on my life personally? And we will sometimes talk about with these options, what are some risks and benefits. And what we have to do, what I do with my providers, is I try to be as transparent as possible. And sometimes

looking at things, as with the example of medication it says here, what is the science behind some of the recommendations. Just simply looking at is there evidence for the recommendations that are being made? Sometimes there may be a better sense of security.

The other thing is having tools and support. And I think one of the tools they use most for myself is my cell phone. I use my cell phone to set up reminders. I use my cell phone to follow up on notes of what we've discussed in the appointments, things I need to explore and get more information about. I asked for input and get a lot of support from my friends and family. Some people use tracking forms. And I have used them in the past. I used personally a Journal that again helps me follow up on some of the things that we've talked about in the appointment with my healthcare providers. And of course, peer support is very important. People that can understand and relate to the specific healthcare issue that I am dealing with at different times. And that, I think that is critical. And again, the decision aids can be as simple as having a pro and con list of what some of the recommendations are those that are being made. Or they can be real complex and use web-based decision aids. There are number available, and you can search online and find others that will fit you and how you engage in shared decision-making.

The other thing for me in the shared decision-making with my provider and I am pleased to say that it has really been effective and it has changed my whole outcome when it relates to treatment and advocating for myself. I spend a lot of time preparing in advance because we know that in order to get the best out of the appointment it is necessary that I make the best use of my time, and best use of the time of the provider. We engage in honest dialogue. It is not a conversation where I am telling the person what it is - what I want them to do only. We really do have a conversation and a relationship. I think shared decision-making is based on relationships. There is no pressure to expect recommendations and there are times when I have disagreed with what my healthcare provider is recommending. And that is okay. What we've done in the situations is we negotiate what the options are. I am fully aware and responsible for whatever choice that I make on whether we agree or disagree. That is what's nice about shared decision-making we each accept responsibility, the entire team. I usually leave the office feeling that there is respect for me and for my particular decisions that I made and also that I have respected my physician and other healthcare providers. Now I'm going to turn the presentation over to Melody.

Melody Riefer: Hey, thank you, Jackie. I sure appreciate your knowledge and information. In particular, I appreciate your weaving in information about your personal use of shared decision-making processes. I want to begin by telling you that one of the things that I have encountered when learning about using and teaching about shared decision-making, I think it is helpful to start with, where is it we begin in our normal process with our care providers? So, I imagine, what if these appointments were on the telephone instead of in person? And I imagined they are being - there being a lot of silence and a lot of information that that we think we are sharing actually stays in her head. That it's though bubbles, if you will. And so, I could be sitting in the appointment and having these concerns thinking that the medicine is causing me to gain too much

weight. Or I'm having a hard time waking up in the morning. I don't know how to workaround this grogginess. Or, might sex drive is zero and it's negatively affecting my relationship. But these are just thoughts in my head and my provider, for as much as I know, is sitting over in their chair thinking I guess things are going okay because you're not hearing voices. And you know, oh, I don't want this person to work because they think it's too stressful. Or, oh my gosh I've got so many people to still see today, I'm running behind! And these are all these thoughts that are happening in the appointment and they get in the way of our ability to do any shared decision-making because it's just thought bubbles. And so, one of the things we can do with shared decision-making is his move from thoughts to actually speaking with one another.

We think we all ready do shared decision-making. I had a nurse practitioner literally say to me: "I do shared decision-making, I care so much about the people that I work with and that I see. So, I make a decision and I share it". And, she didn't hear how weird that was.

That is not what shared decision-making is. So, I think this visual, if you're in a place you can see the screen points out some very important things we need to consider for shared decision-making. And that is there is some common factors that are influenced by a person's perception of their level of involvement. And, the person's trust and the person's clinician or care provider and then the person's preferences for the level of involvement that they want to have. And, all of this feed into the person's comfort level with shared decision-making. And, so, it's important that we give that some thought. But we can't stop there because this very same process is happening for the clinician or the care provider. So, the clinician has their perception of involvement feeding into the shared decision-making. And their trust in the person feeding into shared decision-making as well as their preference for involvement by their - a preference for what their level of involvement should be, or their preference for what the level of involvement for the person they are serving should be.

But this is happening on both sides of the process. And all too often, when we are looking at training or implementations, we only address one part of the dynamic, one part of the pair for who is influencing the shared decision-making. So, there are some great training resources around shared decision-making that we have a responsibility, I think, to make sure that people have access to. And, I'm a big proponent for having all information available to everyone. So even though some of the information you find will say okay, this is geared toward the prescriber, or this is geared toward a case manager, or this is geared toward paid staff. And, here is a brochure for a person receiving services. I think that everybody should have access to all the same information. That is one of the reasons why Recovery to Practice is such an important initiative in the way that it brings together people and disciplines and across educates folks as they are pursuing recovery oriented services.

So, this is labeled the five core components to decision-making to be facilitated by the clinician. And, this facilitation is that whoever the provider is in the moment for identifying a shared decision-making process, that they have some responsibility to take this on and to really

help jumpstart the process. I fear that in trying to provide recovery oriented services, and in trying to be person centered, that that has led some providers to believe that they should set back and be hands off and kind of let a process go on organically. I really think that there is a mutuality in the responsibility for recovery. If there is something that I know as a provider that I can share with somebody to help them move this toward being more recovery oriented, than that is going to be helpful. And I want to leave room for the person to teach me. And, it's really this co-teaching co-learning relationship development that is really foundational for shared decision-making.

So, let's look at these core components. If I'm trying to be of assistance to someone, and I am trying to nurture an environment where shared decision-making can happen, I'm going to say, and I'm going to be thinking, I am going to seek an agreement on the decision to be made. That might not be where we start, but it means that that is where we're trying to get to. It doesn't even have to be an agreement on everything. Even though for instance in a relationship I might agree, you know so -- a real-life example: last night we were talking about dinner and we couldn't agree on how to get it done couple we could agree that we wanted Chinese food. And so, that place of agreement helped us leverage a next step. That was shared decision-making. If we had stayed in the place about just talking about what we disagreed on, like how to get it done, and that difference, it would not help us move forward. But if what we were pursuing was where can we land on an agreement and help move forward from there, then we can really get some momentum. A second core component is providing information and access to decision-making. Someone mentioned in the chat earlier about MEDLINEplus. MEDLINEplus is actually not a decision aid but it is a place that provides information. And it's a place that has some level of integrity because it's not based on advertisement. Whereas, some medical information sites that you go to are - the way they're business model, if you will, is to take advertisements. Sometimes you cannot differentiate between the information that you are seeking from the ad.

So, as a clinician or someone partnering with another in making a shared decision, I want to make sure I'm providing reliable and vetted information or at least making sure it's available and also making sure people have access to the decision aids. There's a whole Institute, an international organization that oversees and defines what constitutes a decision aid. And so, it's not just simply saying here let me help you with the decision, but it is – like let's explore all this sides of the issue. Let's make sure that someone has had access to reliable information and let's give time and space for exploring the person's ideas, concerns, expectations, and values. That component of really giving some way to what someone values and what their preferences are is an absolutely critical part to shared decision-making. Unfortunately, it is one that is frequently swept under the rug. What I feel about the medicine I take, or what I believe about a particular intervention that I want or do not want, does not seem to influence the process too much. In shared decision-making, we are saying: as we adopt this practice as a universal practice for our services, we will take into consideration, we do care about what you feel and what you think.

Another important part of shared decision-making is capturing the decision are the decisional leaning. So, the idea of capturing the decision is not just doing a note for billing purpose but it really is saying at this point, at this particular crossroad we decided as a team or as a pair to go in this direction. And, part of the capturing is so that we can then go back and review the decision to see if it actually worked the way we hoped it would work.

So, in order to review something, you have to kind of remember that you did it. You have to move it up to a conscious level. So, shared decisions are not accidental. And you cannot go back and say - that was the shared decision because there would be a lack of intentionality with that. And so, being intentional, marking the decision and evening having a plan for how you are going to review it to see if it works.

So, when I see my doctor, and we're talking about medication to help manage my diabetes, every single time part of that decision is based on how long are we going to try this medicine, what do we hope it will do, and when will we review its benefits? And, my doctor knows that I'm going to be involved in this, that it's not going to be just waiting for a test to come back. But that it really is more of a process for both of us. And so, he can share with me what he has learned from other people, I can share with him what it's like for me and we both teach and we both learned.

That's a bunch of information. But all of the steps really are important. W<And we are making some inroads into having some people who provide behavioral health services become aware of what it means to do quality shared decision-making. But there are also factors that influence the person's participation. So, if I am a service recipient, how I interact during the shared decision-making process really is going to influence how that goes. Do I have the confidence to speak up? Do I have experience with speaking up? Some of us have received services where we have been encouraged to not speak. And I'm using the word encouraged kind of as a polite term. But where our silence has been preferred over our speaking up and so, to change that behavior to move into a - an environment where speaking up is not only allowed but it is expected is a really big change. In doing so, though, there are some vulnerabilities that are created.

If I talk, then I become more vulnerable around how people are going to see me. And what their perception of me will be. Will they think I'm not smart? That I don't know enough about my diagnosis? Or about my history? Will I receive or will I give this information about mental illness or addiction? If I'm working with someone who is not an expert, or somebody who is working outside of the realm of their expertise than that creates a vulnerability for me. And so, I don't want to take medical advice from someone who doesn't know about medicine. I don't want to take housing advice from someone who is always had information and resources provided to them. There's something about being able to rely on somebody having walked through certain paths that makes this an important process.

My previous treatment experiences also influenced how I'm going to be involved with shared decision-making. If I've always been told what to

do, or if I'm angry because of the way I have been treated and so I am not engaged in - I don’t want to do shared decision-making. I'm not going to share - this is my decision!

In doing so, I kind of limit my access to reliable information. The other thing that is a vulnerability as limitations that are put on us by external forces so poverty, ongoing health problems.

Lack of education or access to educational resources. Lack of transportation. All of those things that are external of our will, that are external of our desires, are still going to really limit what we can say yes to or no to when it comes to shared decision-making.

So, then having limited support, or limited relationships. If I'm alone in this but the shared decision is due more social things with people - that's not really helpful because I need some stuff before I can go to that shared decision - before – before I'm a piece of that. How to make friends, where to reach people if I’m poor and don't have a ride. How do I interact with folks? We have to really appreciate the place where someone is emotionally and physically and socially when we are working together to find points of consensus and ways to move toward a next step. There are influences for the care provider’s participation. I spent a good number of years in my recent past being responsible for training psychiatrists and other care providers in using shared decision-making in their practice.

Some people were - this is fantastic! I remember this one psychiatrists in Pennsylvania was saying, I am so thrilled with this tool! I’ve felt these things; I have had them floating around my head. I know that relationship is important but shared decision-making gives me this structure and vehicle for doing so much better in my practice. And you know, I'm thinking that makes me a good trainer because she got it! Then there were other people in the room with her who were like- am I going to see a need for this or I have to go, I have an appointment. Folks who were just not engaged. People have different responses based on who they are and that supersedes what they are. Whether they are a nurse, psychiatrist, or residential provider. That is just their title, but who they are influences how they respond to shared decision-making.

So, do they have communication skills? Active listener? You would not know it by the way I'm talking today but I can actually be a good listener. Given the way webinars work, I have to talk a lot. But I learned so much when I’m sitting back and listening to someone or with someone. Using language that people understand, we have to throw away our technical jargon or our professional jargon. It is not helpful and it gets in the way. But, some providers feel much more comfortable when they are speaking with authority or using big words. We are positioning ourselves as equals. I can't say enough about how important that is in any human relationship. That being able to take turns as to who is the teacher and is the learner. We all are coming from the same place, providing an array of choices, sharing your story about how you became an expert is as important as sharing your story about how you have reached your point of recovery.

Believing in your principles and working your principles. In 12-step vernacular, that's you have to walk the walk and not just talk the talk. So, that is being person centered and strength-based and embracing resiliency and being open and honest and all of that is so critically important. So, we have the person who influences shared decision-making, we have the provider who influences the shared decision-making, and we also have other things that influence it. So the system influences it. And, that's about the mental health system but the community at large. Do you have enough staff? Do you have enough time? And, so much of this is driven by people who are not thinking about shared decision-making. They are thinking about resource allocation. And, somehow the two have to spend some time together. And know that an investment up front in establishing a good relationship is going to get you further much faster.

So, making room for shared decision-making to happen. And, then having the societal and cultural factors be considered. If a person grew up in a culture where it was a sign of respect to not interrupt or share your opinion with an expert, then that needs to be addressed and the definition for the relationship needs to be expanded so that you are responding to the person's cultural orientation but also inviting a different type of relationship. And there would be a gazillion examples of where culture influences this. But those are things to consider as we move toward shared decision making spare shared decision-making.

And then finally, I just want to wrap up saying shared decision-making is not about medication, or about who is involved in the decision, but it really is about making and involving yourself in shared decision-making across the system and across relationships. Is not reserved to the med clinic. It's not reserved for a peer relationship. It happens with all of those relationships and in all of the settings. So, I hope that information is helpful for you and I want to turn this over now to Laurie who will guide us through an opportunity for some questions and discussion.

Laurie Curtis: Hi everybody. Thank you, Melody, and Jackie so much for those presentations. I think I know a lot about shared decision-making in behavioral health. Then when I listen to you guys, I realize I have a lot to learn, too. That's wonderful. So, thank you both for taking the time with us this afternoon.

We do have a couple of questions and I would like to share them with you. I'm not sure who I should ask this this particular question up first. So I'm going to toss it out and whoever feels they have the best answer toss it out. So that is – there is a question about shared decision-making and peer providers and how peer providers can get some training and then integrate shared decision-making into the work they do with individuals. I mean, is this even the job of your providers? How does it work with peers? And, where can people get trained?

Jacquelyn Pettis: Melody, I could take this question.

Melody Riefer: Sure Jackie.

Jacquelyn Pettis: I think that training is available and can be available through the employer. Those programs that have begun to recognize the value of peer support when providing training for other members of other team members that are involved in treatment teams. It is important to recognize this, as Melody said and pointed out throughout this particular webinar, is that everyone is involved and has an opportunity to participate in developing a relationship, so certainly the role of peer support staff in working with the person is just as important to those relationships starting to be developed, and within those relationships there are opportunities to engage in and support the person in shared decision-making. They are advocating with the person's permissions back to other members of the team. But I think it's the training that's traditionally been offered to members of the team, it is important to point out that peers need the same - not the same thing, but peer need training as well. They need training with skills as we talked about earlier in learning how to communicate and communication behaviors that support shared decision-making.

Melody Riefer: I agree with everything Jackie said. I would add one more thought and that is I think that certification programs for peer providers need to incorporate a module on shared decision-making so that as people are looking at how they interact with folks and provide services that are respectful of the peer relationship, that they also know how shared decision-making can happen in that and where people are already certified think it's a great post-training topic, and of course with Recovery to Practice resources and Brass Tax resources, both of which can be accessed by the SAMHSA website, there are some really great recordings of webinars and resources. So even if you are a provider that is slow on the uptake you can take on some of that responsibility and find the information that is available.

Laurie Curtis: Thank you, Melody, for adding that. And I want to point out that next week's webinar which will be the last in this series will also take a look at some of the ways that peer programs themselves are embracing and using shared decision-making within their own services and ways that they can help people in a somewhat formal way but in a structured way to prepare for meetings with physicians and things like that. So that is this coming up and we will be able to dig in at that.

I have another question and that is: the topic of this webinar is that it is a process not a program. And yet, a lot of shared decision-making is somewhat program focused. And that's the same in healthcare as it is in behavioral healthcare. When I had a health incident, I went to the shared decision-making center. They mailed to me booklet decision aids. I had appointments with different types of physicians and a coach to help me make a decision. I mean there was a structured program. When we deconstruct from that with specific tools and specific processes, we began to get fuzzy and confused. Could you, perhaps Melody, elaborate on what is the difference between shared decision-making as we are presenting it here and something like really good quality person-centered care. Is it the same thing? Is it new? Is it different? Can you help me?

Melody Riefer: I hope so. The way that I think that it is different is that there are some that say milestones that one follows in shared decision-making that takes it a step beyond just a principle or theory and moves it towards a process. But a process is not the same as a program. So, a process can be applied in lots of environments. And in lots of situations. So, the process of shared decision-making can take place in education as much as it can take place in the business world, as much as it can take place in behavioral health. And that is the process I think in really simple ways defining the decision point, exploring the factors that influence what you need to make the decisions. So, whether it's more information or time or research or sharing opinions, because shared decision-making does not happen in a vacuum. I can't do shared decision-making myself because I would be dishonest. I know, and I think most of us would. It involves that another person who helps us think more broadly. And then weighing that with how it sits in our life. So that's the first part, the weighing, the decision, and how it sits in our life. Then there's the agreement, what are we going to try whether it's longtime our short time and then the assessment and keeping on again. So, it's a cycle that moves forwards with lots of different decision points coming up. But I can do it anywhere with anyone. I have taken shared decision-making into my personal relationship, into my home. So that then I would think this would be a good attempt at this process. And it's helpful.

Laurie Curtis: I'm going to expand on that. We have a very interesting question that has come in. Maybe Jackie you want to share your thoughts on it first. Then we will let Melody respond at as well. And that is, how does shared decision-making work in settings where people are receiving involuntary treatment?

Jacquelyn Pettis: Well, I think even in inpatient settings where people are receiving involuntary treatment there are always opportunities - they don't have to be large opportunities - but there's always opportunities in that relationship where a person should be given the opportunity to participate in the decisions that are made about them. So, if there has been an involuntary commitment and a person is advocating for what it's going to take for them to be discharge in that relationship with their healthcare providers, there are opportunities to ask the person what they think they need to do in preparing them to go before - if it's the judge or the body of people that are having the authority to make that happen. It's important to ask the person and help them see, guide them. They do have some say – they may have been involuntary committed, but everyone's goal is to help a person get back into the community with their lives. So people who are a member of that particular treatment team and family with consent and people that the person trust can help that person identify and encourage that person to identify where they can make some decisions, where there are opportunities to make a decision. I don't know if that is clear but I will let Melody pick it up from here.

Melody Riefer: Yeah, that was, that was great Jackie. I think that whether you agree or not with involuntary commitment, the goal for those of us who believe in recovery is greater autonomy. And –and so, pulling in shared decision-making at every opportunity like Jackie said, helps to

move toward obtaining that goal. Because a decision was taken away, or several decisions were taken away, doesn't mean all decision-making capacity was taken away. So, I think it's even more important that people - care providers and folks in services receive shared decision-making.

Laurie Curtis: Thank you, I think those are both really rich comments. And I'm going to throw in an addition to that, if I may with both of your permissions. And that is, I think part of this is about the parameters. Sometimes there are parameters for any decision. There are things we can do there are things that we can't do. And we need to make decisions within those parameters. I think in a lot of settings that as clinicians, particularly, we need to be very clear on what the parameters are. There might be something I want that simply is not available. Or it may be entirely inappropriate for my situation, for example taking an aspirin for my appendicitis. I mean there are just things that – there are parameters here and understanding and working within those. And I think part of what you are saying is how do we use shared decision-making within the parameters that are available. There are certainly constricting parameters in involuntary care.

Melody Riefer: Absolutely. I think that's part of the information gathering section of shared decision-making. It's that where you explore and identify what the parameters are.

Laurie Curtis: Alright, and at this point, I'm going to close off this rich conversation. I want to invite everybody to be sure to join us for the next webinar, next Tuesday, sometime time same place. I would like to also let you know that both Jackie and Melody are available to talk to if you would like to follow up with any conversation or ask them specific questions. They are both exceedingly knowledgeable.

I would also like to let you know that we have coming up our next following webinar. But after that in September, early October, we will be doing a webinar on psychiatric advanced directives. We are really excited about that. We have a wonderful lineup of presenters. This will be the same topic as the next Recovery to Practice newsletter which you should put in your mailboxes and early September, September 7. Also on the theme of psychiatric advanced directives. So, these two will go hand-in-hand and we think they're wonderful and exciting. We encourage you to register when that announcement comes up.

I would also like to let you know that you can, if you're interested in NAADAC continuing educational hours please click the link here where you will be going directly to a page with a brief quiz and evaluation of this webinar. Completing those you will receive your certificate. If you do not need NAADAC CEU's, you can still download a certificate in the materials box near the bottom of your screen. Also, please be sure to answer the feedback question that will load at the end of the webinar. We really appreciate your feedback they provide. They are important to us and we take them very seriously. On behalf of SAMHSA, I would like to thank you for taking time out of your day to attend today's webinar. This concludes our call. Please have a great afternoon. Thank you.