Building Recovery-Oriented Systems

Good afternoon, everyone, and welcome to today's Recovery to Practice webinar. Today's session is titled, "Building Recovery-Oriented Support Systems." Today we're going to depart a little bit from the format that we have used to date in the Recovery to Practice webinars. We'll have a brief presentation and then a moderated panel discussion. We expect and hope to have considerable time for your questions this session.

My name is Laurie Curtis, and I'm the Project Director for SAMHSA's Recovery to Practice Initiative. I'll be moderating today's webinar. I'll briefly review some housekeeping tips and provide a very short overview of Recovery to Practice.

But first, I'd like to acknowledge our webinar participants. At this point, we have nearly 170 participants joined on to this call; and we would like to welcome each and every one of you and thank you for your participation.

I'd also like to personally thank our presenters: Mary Jansen, Steve Onken, Patrick Sullivan, and Melody Riefer for taking the time today to share their knowledge and experience.

Let's review the page layout for the housekeeping so that you, on the audience side, get the most out of our webinar features. You have three options for communicating with us.

First, if you have any technical difficulties during the webinar, please enter your question in the "Technical Support" chat that is on the lower left side of your screen; and a support technician will quickly help you.

There is also a "Question and Answer" box that is just below the PowerPoint slides. You can enter there any questions you have for any one of our presenters. If you have a specific question for a specific presenter, please include that in your question so that we can direct your question to the person you would like to answer it. We'll raise as many questions as we can during the discussion.

You may also use the "Chat" box for general comments and discussion with other participants; but please, do keep your chat relevant to the presentation.

If you would like to zoom in on the slides that we're sharing today, you can make them larger with the "Full Screen" button at the upper right corner of the display pod. You see that way up above to the right of the slide. To exit full screen, just press the "Escape" button on your keyboard; and this will allow you to view the presentation without all the pods and the clutter that you see on your screens.

You can download a PDF of today's presentation, as well as additional resource materials and a Certificate of Attendance from the "Download Materials" box at the bottom of your screen.

This webinar is being broadcast via your computer, so please make sure that your speakers are unmuted and that you adjust your volume for your comfort. If you do not have computer speakers or your sound is not working, please e-mail us in the "Chat" box; and we have an option for you.

We've also posted an evaluation link to the webinar links below. Please take a few moments to complete that evaluation because your feedback really does help us learn from today's presentation and do better in future presentations.

This webinar series is hosted by SAMHSA's Recovery to Practice Initiative, a workforce development initiative with an overarching goal to improve the knowledge and skill of the behavioral health workforce and to integrate the concepts of recovery-oriented practice into everyday practices by all staff.

So why is recovery important?

Ron Manderscheid described recovery as one of the most powerful words in our behavioral health language because it creates real lives, promotes hope, and it can open doors to enlightened and dramatic care reforms. The general concept of recovery has been recognized for hundreds of years, but is now transforming mental health and substance use landscape in ways almost unimaginable a decade or so ago. People with lived experience of recovery have certainly fostered this vision, and SAMHSA has made this vision a reality for many.

Recovery is not a journey alone. Other people…peers, family, friends, practitioners, and supportive communities…are fellow travelers. In 2011, SAMHSA released a working definition and set of guiding principles that incorporate aspects of recovery from both substance use and mental health disorders. The four major dimensions…home, health, purpose, and community…and these 10 components of recovery form a structure and a foundation for developing recovery-oriented lives and for building recovery-oriented services and systems, one of our topics for today. SAMHSA has initiated the Recovery to Practice initiative to incorporate these principles into the behavioral health workforce.

The initial phase of Recovery to Practice was launched in 2011 and focused on six professional disciplines…and you can see them here…to create discipline-based curricula to promote understanding and uptake of recovery principles and practices. Each discipline used language and frameworks relevant to their membership, and developed ways to integrate the curricula into their professional development activities and certification procedures. You will find links to each of those association websites in the "Webinar Links" below on the lower right-hand side of your screen.

The second phase of the Recovery to Practice Initiative focuses on multidisciplinary and integrated services and settings to push these concepts and resources out to more diverse audiences and settings. This webinar series is designed to open up the curricula and the information to a much broader audience.

I would like to now introduce our speakers for today.

Our first speaker today will be Mary Jansen. Mary directs the Bayview Behavioral Consulting, Incorporated in Vancouver, British Columbia, where she advises agencies and health authorities about rehabilitation and recovery services. She has authored many organizational publications on rehabilitation and recovery. and was instrumental in developing the American Psychological Association's Recovery to Practice curriculum.

We're also pleased to have a very distinguished national panel of responders on today's webinar.

First, we have Patrick Sullivan, who is a Professor at the Indiana University of Social Work. While earning a Ph.D. at the University of Kansas, he helped developed the strengths model of social work practice. Pat served as a Steering Committee member for the SAMHSA Council on Social Work Education Recovery to Practice Initiative among other national taskforces and committees.

Steve Onken is the MSW Director in the Department of Social Work at the University of Northern Iowa. He has been extensively involved with workforce, program, and community development activities to advance recovery-based, trauma-informed, and community development activities across the lifespan. Like Pat, he has served on many behavioral health-related national taskforces and committees, and was a member of the Recovery to Practice process.

Melody Riefer is a Senior Program Associate at Advocates for Human Potential; and she has over 30 years' experience in mental health services, having worked in inpatient settings and in psychosocial rehabilitation programs and as the Director of Training for Pat Deegan & Associates. She has also served as the Inaugural Director for the Office of Consumer Affairs in the state of Oklahoma.

So with me, please welcome all of our presenters today. Thank you all very much.

Mary, you can begin.

Okay, thanks so much, Laurie.

I want to add my welcome to everybody who has joined us for this webinar…so welcome to everybody.

What you'll see on the screen is just a quick overview of what we're going to cover on today's webinar. First of all, we're going to talk about some suggestions for moving to a system that is focused on helping people recover and regain a satisfying and productive life. Next, we're going to talk about some of the many challenges involved in changing mental health systems. Third, we're going to focus on the essential elements for ensuring that the changes that we *are* able to put in place become sustainable.

I think the first question is: Why is change so important? Isn't the system okay as it is? We've all worked really hard to try to get a mental health system in place, and we're all doing the best we can to provide the services that we all believe are important. So why do we need to change the system anyway? What's wrong with it?

I think there are a few things I want to say about this to answer that question. The first is that lots and lots of people, as most of you know, have a serious mental health disorder. In fact, one in four adult Americans has a mental health disorder, substance use disorder, or both.

Secondly, on average, adults with serious mental illnesses are known to die *much* earlier than people without serious mental illnesses. Why is this?

There are several reasons, but one chief among them is that the health and mental health systems are not there to meet their needs. So that's certainly a reason why we have what you see on your slide there as an ethical responsibility to change mental health systems to ensure that people are receiving the services that they want *and* that they need.

One thing I like to do when people ask why do we need to change the system is to read a quote from Mike Hogan who, at the time he wrote this sentence that I'm going to read, was the Commissioner of Mental Health in Ohio. What he said is…and I quote…"Most people with schizophrenia get no or virtually no care." Little of the care that *is* delivered is consistent with best evidence, and people with schizophrenia are overrepresented in most of life's worst circumstances. Many are incarcerated; many are homeless; they are often disabled; and they are dying early, as we said. This, from Michael Hogan, was published in the January 2010 issue of *Schizophrenia Bulletin.*

Going on, what does system change require?

The very first thing that's required is a fundamental shift in thinking. To change the mental health system to a recovery-oriented system really does require a paradigm shift. It means changing the organizational culture of the system.

Why is this difficult?

Well, it is difficult because all too often our health and mental health systems are really not recovery-oriented. *One* of the essences of a recovery-oriented system is that it is consumer and family driven. All too often, mental health systems are driven by *us*, by the providers. After all, we've been trained. Most of us are trained mental health providers, and systems are set up so that we provide services; and the people that we are there to help accept those services. But a recovery-oriented system is one that is really driven by the individual that we are there to serve.

We're not going to talk much about trauma in this particular webinar. We did talk about that a bit in the interventions webinar, so we're not going to spend a lot of time on that. But it is important to remember that most individuals with serious mental illnesses either were abused and suffered the effects of trauma prior to developing symptoms; and, unfortunately and sadly, all too often many continue to be abused and traumatized, often by the mental health system itself. So one of the things that we need to do is to remember that one of our foci should be on helping people recover from the traumatic effects of serious mental illness.

We are really there in a recovery-oriented system to help people achieve the potential that they have. But accomplishing this kind of work really often requires transformational change, and sustaining that change has proven to be exceptionally difficult. We all know how challenging and difficult it is for *us* to accept change. It's difficult for everybody, and changing a *system* to be recovery-oriented is really exceptionally difficult.

So what are some of the challenges?

First of all, it's important that we provide staff with the kind of training, education, and tools necessary to be successful in providing the kinds of services that have been proven to be effective. Aligning available resources to help support new approaches to service delivery is also very challenging. And why is that? Because most providers are really concerned about delivering the best services they can and believe that the services that they're currently providing are the best that can be offered.

Most mental health providers are fully engaged in the system and truly believe that we're doing the best we can, so asking people to change that is really quite something. We're asking people to stop doing what they *believe* to be the best thing and the right thing and maybe to start doing something else. So that right there, in and of itself, is a big change.

Another challenge is getting commitment from leadership. As you all know, many, many of the people who are *leading* mental health services are often not trained to be mental health service providers. Oftentimes, they have never worked with people with severe mental illness. They really don't understand what's involved in a recovery-oriented system. And sometimes, sadly, they're all too concerned about budgetary implications. So getting commitment from leadership is absolutely critical.

Finally, I don't want to say that this is more important than anything else because every single aspect of getting change in place is important. But one of the things that we need to do right from the get-go is to be able to have a data collection system in place because if we can't monitor the progress that we're making and find out whether the people that we're serving are satisfied, we'll never be able to sustain the kinds of changes that we're hoping to put in place.

I'm going to talk about a couple of key components that are really critical for implementing a recovery-oriented system of care. The first one that is absolutely key to the concept of recovery is that the individual with the illness is in the driver's seat. This is very different from the way that *most* of us have

been trained. So this really is a key part of that paradigm shift that I was talking about. It involves a completely different way of working with people. The balance of power is shifted. No longer are we, the provider, the one who is the decision maker; instead it involves a partnership between us, the people that we're serving, and that person's support system…the people that individual wants to have involved.

So it really is not business as usual anymore, and sometimes this is more difficult for some kinds of providers than for other providers. But this is another reason why having peer support as part of your system is really essential.

Another key component that I want to stress is conducting the right kind of assessment. What you see up on your screen is a comparison between a traditional clinical assessment and the stress of strength-based assessment, which is really what a recovery-focused assessment is all about.

In a traditional clinical assessment, the focus really is on getting a diagnosis. How are we going to label this person? Identifying the difficulties that the individual has had…what are the problematic symptoms and behaviors? You can already tell that a traditional clinical assessment all too often focuses on the negative aspects of the individual and his or her life. So, again, what are the barriers that his person faces to success?

If we look at the other block…the block on the right-hand side of your screen, you'll see some things that are critical to a strengths-based assessment. First of all, a strengths-based assessment focused on strengths…not on deficits. What we're aiming to do is to gather information about the skills and the resources not only that are needed but that the person has at hand to help him or her achieve the recovery goals that he or she has set.

It is also an assessment that focuses on the individual's family stories, their cultural background. What is their emphasis on spirituality? What are the things that are important to this person in his or her life?

And what about the knowledge that this person has?

We all too often overlook the fact that the people that we're working with have a *huge* amount of knowledge. This is knowledge that they have gained from the adversities they've faced, from the experiences that they've had; and this is a critical part of the information that we need to use to help them look at themselves and that we need to have at hand.

So let's go on now to what's involved in change. One of the things is that making change does really involve a realignment of available resources. It would be wonderful if we could suggest change and then be able to secure as much money as we need in order to accomplish those changes. That is, sadly, rarely the case. So what we often need to do is realign the resources that we have. This is something that follows from commitment. We can only realign resources if we have the commitment of everybody involved…from the top leadership all the way down to our colleagues, the people that we're working with, *and* the families and support systems of those individuals.

All of this is to take place in a recovery-oriented environment; and that means, as I said before, a true partnership between the people that need our help, the families and support systems of those individuals, *and* ourselves. It really does need to be a partnership where we're all listening to one another and all working together toward the goals that the individual has identified.

Part of this does involve believing that the people that we're serving can actually identify the services that they want in order to meet their goals and that they can choose those services. Again, this is where the partnership comes into play.

Next we'll go on to some of the components of change…what actually is involved in changing the system. We've already talked about involving clients, families, staff, leaders. I haven't mentioned politicians; but I think it's important that we ensure that our political leaders are also part of the process because, after all, it's the political leaders that keep our systems in place and that provide the funding for the services that our clients need to have.

Another component…I'll sort of go from down on the right-hand side here…another component is it's important that change be put in place as a total package and not in dribs and drabs, not piecemeal.

Another component is that this is going to be a long-term process. We're not going to be able to implement change overnight and sustain that change. But because it is a long-term process, there's actually a benefit, an upside, to this. That is that we can get the data collection systems in place that we need, that we really desperately need…I'm going to come back to this and why it's so important later on. But we're going to be needing to collect baseline data; and the fact that it is a long-term process will allow us to get these systems in place and begin collecting the all-important, crucial data.

You've got about four minutes.

Oh, okay. I'm looking to see where we are in terms of the slides. I'll go pretty quickly here.

Okay.

We need to be sure that we're hiring the right kinds of staff; and we also need to be sure that we have appropriate, ongoing supervision mechanisms in place with the kinds of supervisors that can provide that supervision.

We talked about resources. We need to be sure that we have appropriate and comprehensive services. There up at the top, again, you see that all important data collection. So we'll go on here.

So what's involved?

I mentioned the interventions webinar from last week. I'm not going to go through all these services, but that webinar focused on the three categories of services that you see on your screen. These really do provide a comprehensive system to help people meet their goals and their needs. There's a little statement there at the bottom that says "striving for fidelity." In light of the time, I won't belabor that. We talked about that quite a bit on the interventions webinar as well, but let's just say that we need to do the *best* we can when we're providing evidence-based and promising practices to stay as close to the way that those services were designed and researched; and if we don't do that, we're not really providing those services. It's important that we're honest with the clients that we're working with. As I said, I won't belabor that.

I said I would come back to data collection, so let me do that now. In order to sustain the changes that we're able to put in place, it is *absolutely* necessary to be able to have information to support those changes when inevitable challenges come our way; and those challenges *will* come. There is no question. They will come from leadership changes. We all know in the mental health and other healthcare systems leaders change frequently; and when a new person comes on board, what is the first thing that person wants to do? They want to put their stamp on whatever is being provided. And how do they do that? Well, they want a change.

So a lot of the changes that *we* might have been successful in getting implemented are then under threat. One of the ways we can protect those services is by having data. So it's really important…I mentioned baseline data previously…it's really important that we collect data on where our clients are before the change and how they're moving along and where they might be after the change. If we can gather economic data, for instance, on rehospitalization, service utilization, that's also critically important. Why? Because budget drives decisions.

So gathering data about outcomes, about economic returns, but also about how the individuals who are receiving the services feel about those services, that's also critically important. We need to know if they're satisfied and whether they're pleased with the system that we've put in place.

I've already talked about some of the things on this slide, so I won't belabor this. My time is going to be up very quickly. So sustainability is really critical, and we will *not* be able to sustain the changes without data to do that. As you see on this slide, the job isn't finished when services are put in place. I talked about leadership changes. We've talked about budget. So we need to have processes in place that will transcend leadership changes.

This is *my* last slide, and I just wanted to say one of the things when I give a presentation like this I'm often asked is, "Well, I'm not a person in power; I'm not a leader. But I really do see the need to make some changes. Can you tell me how to do that?"

I put six things up here that you can do easily. The first is to speak to your supervisor just about *one* program that you can use as a pilot. Choose a program that you might manage and that you can measure and change easily. Talk it up with your colleagues, with clients, with family members. Design simple pre and post evaluation measures, outcomes, satisfaction, staff perceptions, and economic impact if possible. Present the results honestly, and be prepared to tweak your services depending on what the results tell you. Use the results to make change permanent.

I'll stop there. Let me just say that the information *I've* presented is from the curriculum that was developed for the Recovery to Practice Initiative by the American Psychological Association. The website where you can avail yourself of the full curriculum and all of the PowerPoints and all of the tools that go with it, that's up on your screen. That's it for me. Thank you, everybody, for listening.

Mary, thank you for that wonderful presentation. I think you've laid a really solid foundation for our panel discussion.

Just for folks in the audience, we do not have a lot of PowerPoints from our remaining discussants; so we will just be talking, and we have each of them on the screen here.

Patrick, I'm going to start with you. What kinds of changes may be needed in specific academic course content in the overall curricula for professional schools in order to help people entering our field be prepared for recovery-oriented and integrated care worlds?

[No response]

Patrick, I think you're on mute. Patrick, are you with us?

[No response]

All right, I think what we'll do is circle back to Pat.

Steve, with your permission, I'm going to jump ahead to you. One of the things that you have done has been to work in correctional facilities and try to build a place of healing in a women's prison. How do you do that? What elements make that possible?

Okay, so one thing that was *really* critically important in our situation was the vision of the leadership. We had an amazing warden, Mark Patterson. He was native Hawaiian. He had a vision of creating a pu'uhonua, which is a Hawaiian concept of sanctuary. So that pulled in a cultural component. That was

really, really important. He also passionately involved the community; so we had many, many community partners.

The way we went about doing it and some ways of reaching more of the political leadership and the business leadership and the scientific community was to use the trauma-informed care framework to get to a healing community. We were, in essence, promoting recovery; but the framework that really helped us do that because we could bring in hard science, like neurobiology and epigenetics, was through the trauma lens.

The other piece that was really, really important was a working group that involved all the key players…community, staff, the inmate population themselves were a part of this group. The first task we did was articulate a set of guiding values in terms of what we were going to do. There's no new information there. Probably one unique value was that we also wanted to use storytelling as a way of capturing the process that we were undergoing because so much knowledge is translated and passed on through storytelling. So we had those elements involved.

I've attached handouts for our participants to look at. There's a briefing from SAMHSA that really goes through the story more clearly than I can. I've also attached what is a technology transfer framework to look at because that became really, really important for us to use. We wanted to hit on nine essential ways of embedding our efforts at transformation in terms of creating a place of healing and a place of safety and recovery.

Multiple exposures was one of them; so we trained in different ways, in different formats, different speakers, different opportunities…everybody from the warden on down to the groundskeeper. We actively dealt with resistance. If you don't have in particular middle management leadership aboard, you're not going to get very far. So we would literally reach out to those most resistant and find out what was going on, hear what they had to say, involve them, incorporate their input.

The women themselves, the inmates, were really critical. They led a lot of our initiative. They totally revamped our assessment process. They basically threw it out and said, "You assess us when we first get here, which is the least opportune time to do that because we don't trust you. We've just lost our families. We've been just locked up; sometimes we're coming off of drugs. It makes no sense." We replaced that with a six-week relationship building component led by peer support within the prison. We had a work line of peer supports.

We really worked on both the informal and the formal leaders, particularly with the correctional officers who were key to get involved and onboard with it. We enhanced ownership. Eventually, the training was taken over by the correctional officers themselves and strengthened. For example, I mentioned the peer work line, where they became part of even the assessment process. And we invited a lot of opportunities for celebration through wards and compensation, as best we could. A lot of it wasn't financial…but just recognition worked a lot. And we tried to create opportunities for people to get rejuvenation, to have opportunities to get exposed to what was going on nationally.

So you have the active ingredients and knowledge transfer poster that you can tap into. You have a crosswalk of how we did it across those nine components; those were all really, really important…and persistence, just an incredible amount of persistence. And what I can tell you is we successfully depopulated a good chunk of the women from the prison system. We moved all the women back from the Mainland. This was in Hawaii. And we decreased the census there in Hawaii as well.

So it had some really amazing results. The warden has moved on, and the approach is still there. Thank you.

Wow, Steve, that was phenomenal. Can you hear me? I'm not sure if my phone is on mute or not.

Yes, I can.

Okay, great…what a big and wonderful piece of work that was from a system's change perspective as well as from building recovery-oriented services and systems. One of the things you mentioned as a key element among others was the important role of peer support in that environment, in that setting.

Melody, as a person in recovery and a very staunch advocate for people still in services, what do *you* feel are some of the key areas where peers and people with lived experience can support system's change and building recovery-oriented systems?

Thanks, Laurie.

I think that we can't even really hope for system's change unless we work to integrate people with the lived experience of recovery into the decision-making and rebuilding of a more recovery-focused system that leads to, but is a piece of, hiring peer workers. Certainly, in the last two decades there's been a big push to different degrees of success across the country. There are some states that have trained literally thousands of people to work as peer specialists, but there's a disconnect in getting those folks hired. So carving out the specific jobs and tasks and skill sets that people can bring to a transformed and invigorated and recovery and wellness-focused system will make it clear where we…people in recovery…can contribute.

One way to think about this is looking at certainly the certification of training that happens, and that the training process is relevant and driven by the actual tasks that people are going to carry out in their positions…and that it focuses on the principles and philosophies that need to be consistent to support recovery.

The development of *specialty* peer workers…so recovery coaches, folks who provide peer work within addiction settings…family peer specialists. For family and child services, those family members who have been through that process, through managing the multiple systems that touch the lives of kids…to have

somebody who can say, "Oh yeah, I know what it's like to have all of those people (inaudible) a piece of what we do; and I can help you with that.

Peer workers in criminal justice areas, in inpatient settings, in emergency rooms, in respite homes or other types of diversion programs…peers working as members of the medication clinic to ensure that truly informed decision-making has happened around the use of medicine and that people have someone who is going to advocate for them in those moments or periods in their lives when they may have difficulty verbalizing their own preferences.

Having people with the lived experience speak in the public…we do an awful lot of talking to ourselves and kind of preaching to the choir and never getting the message of recovery outside of the behavioral health system when it really does need to be there, when we need people with lived experience working as advocates and policymakers in the Legislature, on state authorities and Medicaid authorities for managed care providers. We need to invite and train people with the lived experience of recovery to sit on governance boards of schools, of public utilities, human service and social service boards…all of those places that may be connected to behavioral health but haven't yet heard that we're trying to transform the system…that we want to have a recovery-oriented system.

Our partners in the world need to be a part of who we reach out to, and people with the lived experience can be the *perfect* bridges and navigators to those other systems. In closing though, I want to say the thing that's really critically important is to remember that not every person in recovery needs to be a peer worker. Our employment efforts…first of all, it needs to be an effort; and so employment and education have to be early, early steps in the recovery process and that we spread the reality of recovery by being in the world. So someone might choose to learn how to write computer code or work in retail or be a furniture designer or any of these things…that those people being in the world and connecting with their colleagues and their friends and families help change the system as much as those of us who work inside the system.

So this energy has to be met effort for effort with other professionals in the behavioral health world; but just speaking as a person in recovery, we can do a lot. And a lot of how we do that is to go beyond the behavioral health world. Thank you very much.

Melody, thank you so much for those really thoughtful comments. One of the things that you mentioned is that it's important for peers and people with lived experience to be on the ground floor and getting involved at all levels of the service system. But you also said that it's not just about peers. It's a system that hires a person in lived experience can't, based on that experience alone, call themselves recovery-oriented. It takes an awful lot more than that.

So with that, I want to turn it to you, Pat, in terms of how do we best train emerging professionals? What needs to happen in curriculum in professional schools so that we're getting the staff that we need out here?

Well, I think that's a really good question. One of the things that has struck me as I've listened to everyone talk, and particularly as I've watched the participant list, one of the problems that we have as we

move forward is that we have to avoid simply speaking to the choir and really getting to those, if you will, disbelievers.

I was commenting or thinking about one of the things that Mary said, which is that this is a fundamental shift in thinking. She also mentioned the fact it involves a change in the balance of power, and also the notion that people seem to think that they were doing exactly what needs to be done when we're asking them to do something a little bit differently.

I could tell you the thing that's most interesting to me is I've also been a State director of mental health, where I told practitioners 20 or 25 years ago that group homes and sheltered workshops were not cutting-edge programs. Twenty-five years ago, we had the introduction of strengths-based practice. Bill Anthony talked about recovery being the guiding vision for mental health services in the 1990s, and yet we are still here. So it is a multi-prong effort for us to move forward.

Certainly when I look at what we do in education…and I'll take social work as an example…last year the Council of Social Work Education began talking about this process in earnest with many schools of social work, which means it's taken a long time for that to even begin to get into the genetic code of social work education…let alone get translated down to the individual classes. Let's just think about some things that are going to have to change.

We had the discussion about the different forms of an assessment. I don't know if Indiana University is different than any other university in the school of social work in terms of an MSW program, but we have a particular class on assessment. But that class is going to be predominated by a discussion of the DSM. We have students who come in with a fundamental idea about how mental health practice works, and that's to take charge of people's lives and to fix them…exactly the opposite of the kinds of things that we speak to in recovery.

One of the things that we struggle with is that when we take a look at some medical and even some (inaudible) approaches, they have their own unique language; they have their own unique system; they have categories. This seems scientific; it seems professional; and it seems real. And when we come and talk about the kind of things that really truly do balance power, that puts the individual in the position of being the expert in their own life, when we talk about taking direction from *them*, that's a fundamental different way of thinking than many of our students come into the program with. So we have to get it right down to the things that we teach in the classroom. It gets right down to some simple things.

For example, we know we're moving to an integrated health world; and yet in my school, we have a mental health and a healthcare track…two separate tracks. That's not the way the world is going. If we move toward integrated care after the many decades of work that we have done in mental health, will we see things tilt backward to a medical perspective as opposed to the recovery perspective that we have been working on…many of us…for many, many, many years? How are we going to carve out new roles and new professional roles?

Let's take the peer support specialist role. Shouldn't that be an important role in an integrated health system's world…and will it? Will we be doing things such as real, significant, on-the-streets case

management kind of work; or will we revert back to the case manager being someone that's more of a broker and is more concerned about fiscal issues?

So all these things have to be translated into the curriculums of our school of social work because, quite frankly within social work, recovery speaks right to the values and ethics of our profession; and it ought to be manifesting itself daily in the classroom. I think that's one of the things that could help us begin to move this forward.

Pat, that was wonderful. I'm going to put you on the spot a little bit. You mentioned that you had been – oh, what's basically Commissioner of Mental Health, I believe.

Right, correct…here in Indiana, but yes.

Okay, and we have a question from one of the participants on reimbursements; and I thought maybe you would be interested in talking to that. She asks: "How do you change a system when our reimbursement policies are based on a deficit model?"

Well, I have to tell you, this is a very interesting question because what it tells you is we have to change the reimbursement system; and that's where policy really has force. This is something that often isn't understood. I'll give you a perfect example.

Several years ago, the State of Indiana set aside some money – specific money – for community mental health centers to use if they would establish true ACT teams…true ACT teams. And they set a special pot of money aside for that. And that's great; ACT teams developed, ACT teams were implemented, et cetera. The minute that special pot of money went away, the number of ACT teams in this state diminished because the providers didn't have access to that special pot of money.

In my personal opinion, if we could get perhaps to a prospective payment model in which we put consumer outcomes first – we put that first and at the center of every activity, and we have the right trained people, we have the peer support specialists, everybody on board that knows what recovery practice means and we say, "You do the kind of things that need to be done to help this individual recover, unfettered by fee-for-service models or any restrictive codes," we have an opportunity to advance our system forward. That's one way we can do it. But the current model now is skewed, and it's skewed in many very specific ways.

Oftentimes, I would have advocates come to me and say, "We need to introduce this model in Indiana. We need to do this practice. This is an evidence-based practice." What gets done is what gets paid for. The provider is trying to survive. My answer to that is we have to change the reimbursement system.

Great, we have a follow-up question. I'll throw it back to you, and then Mary may want to add to this. The comment that is it's easier said than done…that these are very large organizations.

It is, right.

I'm wondering…most of us who are working on the lines doing everyday support, whether as peers or as practitioners in other disciplines, we feel powerless to change the funding stream. What can we do?

Right, well listen, I have to tell you…it's not going to be easy. But one of the things that academics sometimes feel…and I am an academic, so I can pick on myself…that if we just present policymakers with data, their hearts will follow. The fact of the matter is their hearts follow the story sometimes more than the number. So the key thing, for example, is we have to convince people that recovery is real. Your average practitioner, for example, often sees people when they're struggling; and they forget about the thousands of other people out there who are recovering and managing their lives and doing well.

We need to bring our legislators and policymakers into our program because their misconceptions about people that we work with are just extremes. We sometimes forget that. So we have to put people up front and personal with them. We need to invite them into our programs. We need to have people to tell their stories. And frankly, sometimes we have to translate that into this is a citizen who is now working and living independently and becoming a full-fledged citizen; this was a good investment of your dollar. That's not how most of us think, but that's the story we have to tell.

Mary, do you want to add to that before we move on?

Yeah, thank you for that. I really want to say I couldn't agree more with Patrick's comments….everything he said, from the need to train our professionals down to changing the system and everything. I would harken back to something that Melody said as well when she talked about the importance of peer providers. And this is one way to emphasize Patrick's comments…if you can bring legislators in or show them, have them meet and learn about the great work that peer providers are doing. I know in my system here, some of the greatest people I know are peer providers. They're smart, they're funny, they're talented, they're highly educated; they're everything, and they are great examples of what a recovery-oriented system can do.

I also want to go back just briefly to the original question about how to change the system when you're operating in a deficit-based model. As Patrick also said, these are incredible times; and most mental health services, unfortunately, are in deficit. The only positive about that is that if people are really serious, this is an opportunity to take a look at what do people really want? What do they really want to invest the limited resources that we have in to try to get the biggest bang for the buck?

I think, to go back to what I was trying to say in the presentation, this is where an honest conversation with all of the stakeholders becomes really important. This is where you bring in the politicians, the finance people, the managers, the clients, the family members, the providers…everybody…where

everybody really needs to get to say what *they* think is truly important. Because there isn't a mental health system that I know anywhere in the world…and as some of you know, I've worked in several countries in the world…there isn't a mental health system anywhere that is adequately funded; *everybody* is struggling with this. So it is one of the toughest questions we have.

I'm really regretting that we only have 30 seconds left of this webinar and can't dig into it a little bit further. But I think some good thoughts have been presented here and some topics that would be worthy of discussing next year in Recovery to Practice webinars.

I want to let you know, if you don't already, that Recovery to Practice does issue a quarterly newsletter. If you do not get it and would like to, please sign up at RTP@ahpnet.com.

Remember, there are a number of webinars upcoming in our series…again, this Wednesday on whole health and recovery, which should be wonderful. We encourage you to join us for as many as you can. On behalf of SAMHSA, I would like to thank all of our participants for taking the time out of your afternoon to join us.

Special thanks to Mary, Pat, Steve, and to Melody for sharing your time, wisdom, and experience. We value your input and find it helpful for developing our future webinars.

So if you would please fill out a participant evaluation, from the box below…you can see it there in "Webinar Links" right there at the top. We're not able, we regret, to offer preapproved CEUs for this webinar; but there is a certificate, which you will find in the "Download Materials" at the lower left of your screen, which you can download and take to any of your Continuing Education providers or to your discipline.

With that…thank you, everyone. This concludes our call for the afternoon. Bye.