Evidence-based Practice and Recovery-oriented Care

Good afternoon and welcome to the fifth session in our Recovery to Practice webinar series. Today's session is titled Evidence Based Practice and Recovery Oriented Care. My name is Elizabeth Whitney. I'm the technical assistant's lead for SAMHSA's recovery to practice project and I'll moderate today's webinar. I'll review some housekeeping tips and provide a brief overview of recovery to practice but first I'd like to acknowledge all of our webinar participants. We have over, almost 160 people in the audience today. On behalf of the Substance Abuse and Mental Health Services Administration, we'd like to welcome you all and thank you for your participation.

I'd also like to thank our presenter, Mary Jansen, for sharing her expertise on evidence based practices and their relevance to recovery oriented services and study.

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This webinar series is hosted by SAMHSA's recovery to practice initiative. Recovery to practice is a work force development initiative that focuses on integrating recovery into behavioral healthcare through multiple disciplines and service settings. The overarching goal is to improve the knowledge and skill of the behavioral health work force and to transform concepts of recovery or anti practice into guidelines and clinical interventions.

So what do we mean by recovery or recovery oriented? Ron Manderscheid described recovery as one of the most powerful words in our behavioral health lexicon and that's because it creates real lives, it promotes hope and it can open doors to enlightened and dramatic care reforms. The concept of recovery is transforming the mental health and substance use landscape in ways almost unimaginable just a decade ago. People with lived experience recovery have fostered decision and SAMHSA has made decision into an every day reality for many.

Recovery is not a journey alone though. Other people, peers, family members, friends, practitioners and supportive communities are fellow travelers on a person's road to recovery.

In 2011, SAMHSA released a working definition of recovery and a set of guiding principles that incorporate aspects of recovery from both substance use and mental health. The four major dimensions of recovery, home, health, purpose and community, and these 10 components of recovery form a structure and foundation for developing recovery oriented lives and building recovery oriented services and systems.

SAMHSA initiated the recovery to practice initiative to incorporate these principles into the behavioral health work force.

The initial phase of the recovery to practice initiative was launched in 2011 and focused on working with six professional disciplines to create discipline based curricula to promote understanding and uptake of recovery principles and practices. These six disciplines were the American Psychiatric Association along with the American Association of Community Psychiatrists, NADDAC which is the Association for Addiction Professionals, the Council on Social Work Education, International Association of Peer Specialists, American Psychological Association and the American Psychiatric Nurse's Association. 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'll find links to each of these association's websites in the box below.

The second phase of the recovery to practice initiative focuses on multi-disciplinary and integrated services and settings. To push out these concepts and resources to more diverse audiences and settings. This webinar series is designed to open the recovery to practice curricula information to a broader audience.

So I'd now like to introduce our speaker for today. Mary Jansen directs Bayview Behavioral Consulting Incorporated in Vancouver, British Columbia, where she advises agencies and health authorities about rehabilitation and recovery services for people with serious mental illnesses. She's authored many organizational publications on rehabilitation and recovery and was instrumental in developing the American Psychological Association's recovery to practice curriculum. Welcome Mary. Please begin.

Mary Jansen:Okay, thanks so much for that Elizabeth and welcome to everybody who is on the webinar. We have a lot of information to share today and so this is really going to be a brief review, just highlighting some of the information that is contained in the curriculum that the American Psychological Association prepared, as well as the curricula of the other organizations. So let's begin.

We're talking today about evidence based and promising practices. Before we talk more specifically about those practices, it is important to say that really there is an underlying set of principles or a platform if you will upon which all of those interventions need to be provided and you can see these principles up there on your screen right now. We need to believe that recovery is possible. We need to work with people in a genuine, emphatic way and form a trusting relationship. We need to be sure that the people that we're working with are involved in decisions about their own healthcare. The services we provide need to be culturally relevant and gender specific and we need to be really clear that we are adhering to principles of trauma informed approaches and we need to identify the skills and resources that the individual wants and needs in order for successful community living.

So there are three kinds of services. One is evidence based practices. Another is promising practices and the third is supporting services. We'll go through many of those today. Not all of them, of course.

What is an evidence based practice? An evidence based practice is one that is supported by a substantial body of research and that has been identified by a panel of experts as an accepted evidence based practice. These particular interventions are in fact now considered the gold standard for helping people with serious mental illnesses and behavioral disorders live successfully.

So the next thing I want to say is that we all want the same thing. There is no difference between you, me or any other person whether or not any of us have lived experience of serious mental illnesses. In order to help people achieve the recovery goals that they have set for themselves, it's important that we recognize that evidence based promising d supporting services all play a role in helping individuals -- excuse me -- to achieve those goals that they've set for themselves. So, what are some of the evidence-based practices that help people build the skills and resources that they need to live the kinds of lives that will be fulfilling for them? A few of these, this is not a comprehensive list by any means, but a few of these include supported housing, supported employment, peer support services, a assertive community

treatment, family-based services, cognitive behavioral therapy, concurrent disorders intervention, and psychosocial interventions for weight control.

We'll talk a little bit about each of these, and then we'll talk about some of the other promising and supporting services as well. But one thing I do want to stress is that when we're talking about an evidence-based practice, in other words, one that has been identified by a body of research that has shown that that practice works when it is provided in the way that it was designed, developed, and researched. It's important that that practice be provided with fidelity, and that means that it be provided according to the way that it was designed and developed and researched.

If we don't provide the service with fidelity, essentially we're not providing that service. We're providing a different service that hasn't been tested and that doesn't really have research to support it. And I just think it's important that we're honest with the people that we're working with about what we're providing. The reason that it's important, if we say we're providing an evidence-based practice, that we do so with fidelity, is because when we don't do that, the service or the practice has a lesser chance of being successful. Then we're doing a disservice to our clients and to the folks that we're serving.

So, what are some evidence-based and promising practices? We've already mentioned some of those, and as you know, SAMHSA has been working for many years to further the understanding and use of recovery-oriented services. The Recovery to Practice initiative is a part of SAMHSA's work. One aspect of this work has been to identify evidence-based practices that promote and support people in recovery from behavioral health disorders.

One of the things that we want to, I think, all support is supportive housing. This is a really important practice. Some of us have heard this slogan, "Housing First." And it really is critical that people have a place to live. Prominent supportive housing which provides people with the supports they need to live in a safe, decent, and affordable housing of their choice in our communities, their communities, is really critical and important.

Supportive housing helps people achieve one of the four basic dimensions of recovery, which is having a home, a stable and safe place to live. I really do want to say that SAMHSA has some excellent materials on its website. If you haven't perused the SAMHSA website, I would really encourage you to do that. There are many resources there, not only about housing, but about many of the other interventions and practices that we're going to be talking about today.

Another service that we want to highlight is peer-run services. Peer-run services often are standalone agencies or programs that are owned and operated by people with lived experience of recovery from behavioral health conditions. I will say the peer support and peer-run services are oftentimes also provided within the mental health service, or by a mental health community agency. So, they can be provided from a variety of venues. They might include drop-in programs, outreach, and support. There are lots of examples of peer-run supported employment, housing, education, and wellness programs, among many others.

So, we'll now talk about supported employment and supported education. Supported employment is one of the most researched evidence-based practices, and SAMHSA has a fidelity scale on its website for supported employment. Again, I would really encourage you to spend considerable time on the SAMHSA website. It is really a terrific website. There are several different approaches to supported employment, but the basic premise of all of them is helping people to participate in the competitive labor market, helping them find meaningful jobs, and, critical, providing ongoing support from a team of professionals.

A service that is often provided along with supported employment, depending, of course, on what the goals of the individual are, is supported education. It's another example that focuses on helping people attain their academic goals often in pursuit of an ultimate employment experience. So, both supported employment and supported education can help people attain the dimension of recovery which focuses on purpose. That is, meaningful daily activities, such as a job, school, volunteering, family caretaking, or

creative endeavors. And the independence, income, and resources to participate in society. Again, many of these materials are on the SAMHSA website.

We'll talk now about the oldest, the original evidence-based practice, and that is assertive community treatment. I'm guessing that most everybody on this webinar has heard about assertive community treatment. As I said, it is not only the oldest, but it is the most extensively researched, having been researched in countries all over the world with essentially the same outcome. It works.

And when I say it works, what do I mean? It is aimed -- it is the most intensive case management program. It is aimed at individuals who need help remaining out of the hospital and staying in the community, living in the community. Reduced recidivism is the desired outcome, and it is the outcome of assertive community treatment, again, as I said, which has been shown in countries all over the world to be successful.

Now we'll go on to family psychoeducation. Some of the essential -- I should also say that family psychoeducation is also one of the most researched evidence-based practices that we have. Some of the essential elements include providing information about clinical treatment to both the individual with lived experience and his or her family members, and/or support network. Teaching coping skills both to the individual and to the family and support network.

It essentially promotes the concept that the individual and family and support system are partners in services. Some of the outcomes can include reduced hospitalization, higher employment rates, improved family member and individual well-being. We know that these programs to be in accord with fidelity to the evidence-based practice should be at least six to nine months in duration. Next, we'll go into skills training and application. Skills training is an application of traditional- excuse me- behavioral therapy. It is not aimed at reducing symptoms. Rather, it is aimed at helping people develop the skills they need, learn how to use those skills and obtain the resources they need to live successfully in the community. Skills training can be used anywhere where better skill performance is desired. With social interaction, learning how to make friends and communicate well in social and leisure settings, in educational settings, in work settings. It is really applicable to any area of life where better skill performance will help an individual live more satisfactually and more effectively.

Included are communication and assertiveness skills. Skills for personal living, learning how to live independently and manage and home and your life independently. Skills for community integration, learning how to take part in community activities. Two of the components of skills training include, didactic information, or instruction, which is teaching, that's a teaching modality and then, modeling of behavior with feedback and helping people actually practice the skills that they're learning.

We'll go on to psycho-social interventions for weight management. I want to say at this point that, while all of the interventions that we're talking about are really important, there are some for physical health reasons, actually for life and death reasons, that are often considered to be absolutely essential in the provision of a good, a service system. One of those is psycho-social interventions for weight management. As we go through this, I think you'll see why.

As you may know, the newer antipsychotic medications actually cause weight gain and an increase in body-mass-index. The prevalence of obesity in the population of people with serious mental illnesses, is much higher than it is in the general population. This is primarily due to the newer antipsychotic medications. The implications of being obese are severe. As we all know. We hear this on the television and we hear it when we go to our family physicians and so on. We know that being overweight and obese are definitely serious conditions.

One that is extremely serious is something called metabolic syndrome. It is much more prevalent in people using antipsychotic medications. Metabolic syndrome can lead to the increased risk of type two diabetes, heart attack and stroke. I think you've all heard, we've all see some of the headlines, that people with serious mental illness die, on average, 25 years earlier than those without. This is due to a variety of

causes and I won't go into all of them. But certainly, the physical implications of being obese can contribute to that lessened lifespan.

Some of the interventions that have been shown to be part of an evidenced based weight management intervention include providing information. I want to say that it is important to start these interventions at the very beginning, before people begin, or just as soon as they begin, taking antipsychotic medication. Of course, if that isn't possible, then it's important to start weight management intervention later, if need be. I think we all know how much more difficult it is to lose weight than it is to keep the weight off from the beginning. It is desirable, certainly, that these interventions be provided right at the beginning of treatment.

What's involved in weight management interventions? Providing information. Helping people set a goal. Providing regular monitoring and ongoing support and feedback. Another thing that can be very helpful is making exercise and leisure classes, such as walking, available so that people have an opportunity to remain active.

We'll talk now about some of the promising practices. These are labeled promising practices as well because they have a body of evidence to support them. But, there may not be enough of that evidence at this point, for them to be designated as an evidence-based practice. According to the PORT study, which is the schizophrenia patient outcomes research team, which have been going on for, close to 20 years now, there are four promising practices that were offered during the most recent publication of the PORT study, in 2010. These are medication management or adherence. Cognitive remediation. Psycho-social treatments for recent onset schizophrenia and peer support and peer delivered services, which we've already talked a bit about.

Let's talk first about cognitive remediation. Cognitive remediation programs are almost always computer assisted training sessions, which are aimed at improving learning, memory, attention, concentration and executive functioning. Why is this important? Most all of us recognize that neuropsychological function is frequently negatively affected, resulting in impaired thinking ability and an inability to function well in social, education and work settings.

A component of cognitive remediation is a skills training program, which we know as social cognition training. This uses behavioral shaping and it is aimed at helping people recognize and respond appropriately to the asset that is displayed by other people. The social cues that other people display. It is aimed at helping individuals- sorry- demonstrate empathy. Attribute what individuals are saying to the most likely cause of why they're saying it. It is aimed at helping people have a [inaudible] mind.

Recently literature, and this is relatively recent, but recent literature reviews have noted that adding cognitive remediation may result in a magnitude of change that exceeds that which can be achieved by targeted treatments alone. Especially when cognitive remediation is combined with social cognition training, illness management, supportive employment and other psycho-social interventions. A range of interventions that is helpful and desired by the individual.

Let's talk now about early psychosis intervention. This is something that is also really important. As we all know, most psychosis, not all, but most, becomes evident at a very critical period in an individuals life, usually in mid to late adolescence, and on into early adulthood. This is a critical period because it is just when we're learning about the communication, educational, and work skills that everybody needs to become successful in life.

Early intervention interventions are important because they can minimize the overall impact of psychosis. Unfortunately, delays in assessment and treatment are common. The chief reason is that when psychosis develops at the age that it most typically does, young people feel so stigmatized. They don't know what's happening to them, they're terrified. They don't want to act differently, but often times they do, and so the last thing they want to hear is that someone is telling them that they have a mental illness, and they have to get treatment for a mental health disorder.

So, another chief reason is that parents often, as much as they want to support their children, they may not know what to do. The family's physician may not know what to do. The delays and assessment and treatment are common. However, reducing treatment lag actually leads to better outcomes and improves overall outcomes. So, I guess a couple other things that are important here is that there is a critical period, which occurs soon after the manifestation of symptoms, where intervention is important to minimize the effects of the illness. Treatment effects from the first intervention may not be sustained beyond the intervention period, and continued intervention may be needed, especially during what is considered the five-year critical period from onset of symptoms. So, it is important to remember that the longer an individual remains without treatment after evidencing psychosis, the poorer the long-term outcomes.

So, what I'd like to do is stop here and ask the audience to type in what evidence based or promising practices are being offered at your organization? So, we're getting a really good range of services that are being offered, lots of services and others. One or two -- many of them, the evidence based and promising practices. This is really super. I'm really pleased to see this. One here says lots of peer support. I mean, these are really great responses, I do want to say. So, yeah. This is really great. Okay. Well, I'm going to go on. Please continue filling in the list, because this is really super. So, I'm quite encouraged. I'm sure Elizabeth and the other folks on the call are really pleased to see this as well. I'm going to continue on so that we can try to get through the presentation today. Please, keep on loading in your responses.

So, the next thing that I'm going to go over are a few of -- excuse me. Few of what are known as supporting services. These are services that support people who are diagnosed with serious mental illness and help them achieve a healthy and satisfying life. They may or may not have any research to support them. Some of these do, and some are on this list that have a considerable amount of research to support them, but for instance, there's an asterisk next to motivational interviewing. Motivational interviewing is an evidence based practice for addictions treatment. The distinction here is that motivational interviewing involves helping people make choices about the behaviors that they either want to continue doing or might want to stop. So, in that addiction, obviously using substances is a behavior. Not to say that it's easy to stop, but it is in a different class of illnesses, shall we say, from serious mental illness, where's there's not really a choice per se about whether or not to have that illness.

So, we're going to talk about a few of -- so, I'm just explaining why that has the asterik there. We're going to talk about a few of these. We're not going to talk about all of them, but as I said, some of these services have achieved consensus among people with experience and service providers. They are really helpful in terms of helping people recover. Sometimes, they are the subject of research to determine their effectiveness. So, many of these services should be provided in an integrated PSR model, as they have been shown to help to improve the functional capability of individuals with serious mental illnesses.

The first one we're going to talk about is smoking cessation. This is another one with physical health implications. You may know that psychotropic medications and nicotine have interactive effects on cognitive functioning. Nicotine is also thought to offer some relief from the side effects of psychotropic medications, and because of the serious health consequences of smoking which we all know about, smoking cessation is considered an essential service. Some things that we might not be so aware of is that smoking rates may be as high as 80 to 90% compared to prevalence rates of 20 to 30% in the general population, and people with serious mental illnesses and concurrent substance use disorders consume 44% of cigarettes sold, and they smoke much more per day. So, you can see the very serious health consequences. The more severe the mental illness, the higher the prevalence of smoking again, because of the therapeutic effects of smoking, which can normalize the deficits in sensory processing and relieve some of the side effects of psychotropic medication and reduce stress and anxiety.

So, what's included in a smoking cessation intervention? First of all, research has indicated that several factors are common to successful smoking cessation programs. The first is advice from the physician, and that this, along with the other components that I'm going to talk about, needs to be ongoing, and there needs to be continued support from the physician to quit smoking. Nicotine pharmacotherapy, both

over the counter and by prescription have been shown to be effective. Again, counseling that is both long-term and intensive and a public health environment and approach that supports stopping smoking and restricts smoking in public buildings and other components of a public health approach.

So, let's now talk about trauma and trauma informed approaches. I think going through this, you'll see why we've chosen to highlight this. First of all, about trauma in women -- up to 97% of women who experience homelessness and mental illness also experience the mere physical and or sexual abuse. 87% experienced this abuse both as children and as adults, and 80% of women experiencing psychiatric hospitalization have a history of physical or sexual abuse. So, let's talk a bit now about trauma informed approaches. Let's talk about men first, because abuse is not only limited to women, although the incidence and the prevalence for women are higher. With respect to trauma and men, trauma was originally viewed as combat stress, or PTSD. Males report four times more abuse by clergy than do women. We've all heard, I think, these reports on television and elsewhere. Unfortunately, however, males are less likely to report abuse due to the socialization of men.

It's important to recognize that trauma is widespread, harmful, and it's costly. However, as more men and women report trauma, the importance of providing trauma-informed approaches is becoming clear. Likewise, with respect to women: as more women serve in combat, and more men talk about their experiences of abuse, trauma is beginning to be better understood and more recognized as a near or relatively universal phenomenon.

I want to put another plug in here for SAMHSA. SAMHSA has some incredible resources on its website about trauma and trauma-informed approaches. I would encourage everyone to go on the SAMHSA website and click on the links for the downloads and publications that SAMHSA has made available.

Let's talk a bit about trauma-informed approaches. These involve a culture shift throughout an organization, an understanding that the prevalence rates for trauma histories is so high that service organizations should adopt a universal expectation that individuals have been abused and experienced trauma and should adopt services and policies that create trauma-informed approaches. Trauma-specific interventions are specialized psychotherapeutic interventions, and they require specialized clinical experience provided in a safe environment. Sometimes these are manualized programs that require fidelity to the model. I want to emphasize that providing trauma interventions requires specialized training. Without that specialized training, we can really re-traumatize and severely hurt again the individuals that were attempting to serve.

Oftentimes, because men or women have endured abuse at the hands of the opposite gender, services offered in gender-specific groups can be helpful. I think it's important to speak honestly with the person that you're working with to find out how they really would feel about having services in a mixed group. Watch for the cues that they give you and be sure that they're not just going along with the suggestion that they accept services in a dual-gender group, because if they are not comfortable, they can be severely re-traumatized, and that goes for both genders.

Now we're going to talk about forensic issues a bit. People who are evidencing symptoms of mental illness have a 67% greater likelihood of arrest than individuals who are not evidencing symptoms of mental illness. We also know that people from minority culture are especially at risk. There are a multitude of co-occurring problems, and these include, as we just mentioned, severe trauma, homelessness, substance abuse, victimization, and poor health. Individuals who are part of the criminal justice and forensic systems and have serious mental illness are extremely stigmatized by the dual stigma of serious mental illness and their criminal record.

I want to talk for just a moment about women and the corrections and forensic systems. First of all, for reason that we don't fully understand, women with serious mental illnesses in forensic populations are twice that of men, 31% compared to 15% for women. Again, we really don't understand why this is the case. Secondly, exposure to violence and trauma is virtually 100% for women in corrections and forensic systems. For this reason it is considered to be the norm rather than the exception. It is virtually 100%.

As we also know -- This is more applicable to the corrections system than to the forensic setting, although it can be true in both -- there are often abuses and dangerous practices in these settings, and this is especially for people with serious mental illness, where they are often bullied, further abused, traumatized by seclusion and restraint, and this contributes further to the trauma that they have received.

The next thing I want to mention about the criminal justice and forensic setting is the importance of transition planning and follow-up. These are critically essential to helping somebody be successful in the community, and yet, unfortunately, oftentimes these are sadly lacking. First of all, there is often inadequate transition planning; but, even when there is some kind of transition planning that is done with individuals, the period immediately after their release is absolutely critical.

Without immediate follow-up, many, in fact most, miss the very first crucial health and social service appointments, meaning that they end up without an adequate supply of medications. They end up without the support of physical and mental health providers. They may likely end up homeless, meaning they're on the street. They quickly return to use and abuse of drugs. What happens: they end up back in the criminal justice and/or forensic system, and this is one reason why it is frequently a revolving door.

I can give you one short anecdote from out here, and that is that, oftentimes, because of lack of transition planning and follow-up, individuals without adequate housing, medication, et cetera, actually commit a petty crime so that they can go back to the forensic setting because that's where they can get housing and a decent couple of meals a day. This is a tragic situation, and I also put a plug in for better funding for mental health and for forensic services everywhere. That's because we all know that the mental health system is tragically underfunded, but the criminal justice system, which has become the greatest what's called treatment provider for people with serious mental illness, and the forensic systems are even more poorly funded. So, we really do need to advocate for increased funding and ultimately, then, for better services.

Hi, Mary. Sorry to interrupt you. This is Elizabeth. I just wanted to, I know that you're getting ready to wrap up. I just wanted to let you know that there's about a minute and then we have lots of questions.

Okay, all right.

The one minute warning.

Okay. So I've already said what's on this slide about needing good treatment housing, employment and transition planning. So just have a couple of takeaway messages. I've already mentioned about the importance of cognitive approaches, so you can see here cognitive remediation, social cognition and CBT combined with other interventions. Interventions to avoid weight gain, interventions to help people stop smoking, trauma interventions, particularly provided by trained providers and oftentimes that are gender specific. Only psychosis intervention and forensic services. The last thing I'll say is that much of what I've presented is from the curriculum developed by the American Psychological Association. The website is there. I would encourage you to go on and get the curriculum and the PowerPoints. Each chapter has PowerPoints that go with it. And if you want to contact me there is my contact information.

Thank you so much to everyone and I'll turn it back to Elizabeth.

Mary, thank you so much. That was such a rich presentation in such a short period of time. Quite admirable and you've generated a lot of interest. I want to start with one question. A number of people were very interested in hearing what you had to say about cognitive remediation. One person is asking, they say that they're using a manual version of a cognitive remediation using worksheets and discussion and wondering, and I don't think that's probably not uncommon where people don't necessarily have access to computer based versions. Wondering about your thoughts on the effectiveness of using that service approach and also very interested in getting resources on computer based versions.

Okay. I'm just making a note here, effectiveness. As far as I know, cognitive remediation approaches that are provided manually have not been studied. Now, having said that, I'll issue a disclaimer. I'm not an expert in cognitive remediation so let me put that out there. But all of the research that I know about has been doing using computer based training programs. There are a few of them out there. What I'd like to do is gather up some of those resources and I can send them to you Elizabeth because I don't have them at hand. Then you can provide them out to people who want them if that's possible. Maybe put them on the website, I'm not sure.

I sort of lost my train of thought there but yeah. I know several agencies are using the computer assisted training programs and the reason that they're helpful is that the individuals have the programs right up there on the screen. They have to, their eyes get trained to follow things on the screen and so on. And there are always support people in the room helping the individuals learn how to use the program. Many agencies have purchased them and so I would encourage people, if you can, to get your agency to purchase one of them. I will get some resources for you.

Super, thank you so much. That's fantastic. One other question here about illness management and recovery as an evidence based practice. I'm wondering if you could speak to that.

Mm-hmm (affirmative). Yeah, sure. Illness management and recovery programs, these are really programs that provide information to individuals and it can be to their families and support networks as well about symptoms, about putting a WRAP in place, about what some of the triggers are that might make them aware that they're starting to feel unwell. About the importance of taking medications, about the side effects of medications, about how to remember, cues for helping people remember medications. Illness management and support, like many of the other evidence based and promising practices combines components of various other programs in a way that helps people learn the information that they need and learn the skills that will be helpful to them to apply that information.

It's more about managing the illness and what they can do to stay well.

Fantastic, thank you. And there are resources online to access [crosstalk].

Mm-hmm (affirmative).

I'll ask you another question about specific models and people were also very, very, there's a lot of conversation about models for health maintenance and particular weight management. Can you tell us any names of specific models or specific approaches? You did a really nice job of talking about the interventions.

Mm-hmm (affirmative). Yeah, no I don't have any names, I haven't actually heard of any names of specific models. I think the research indicates that they include the components that I mentioned. I haven't heard of any manualized models. There may be some out there but what the research has shown is that providing those interventions has been found to be effective.

Fantastic, and I'm seeing in a response from one of our listeners, one of our audience members talking about the in shape program, which is a [crosstalk].

Uh huh, okay, yep, mm-hmm (affirmative). I've heard of that one.

I'm going to shift gears a little bit and talk about working with individuals. When we think about evidence based practice and they're kind of manualized and what not, the question really is about how is individual choice handled in providing an evidence based practice? Let's say somebody's interested in [crosstalk]. Let's say someone's interested in working on just part of a program or wants to start a program or not finish a program, that sort of thing.

Mm-hmm (affirmative). Well, first of all, I think it's important to say the very first slide that we showed, or that I showed anyway, talked about the platform which underlies all of the services that we provide, or that should underlie all of those services. Without having that platform as the principles from which we operate, we're really not providing services in a recovery orientation. Part of that platform is, I think it was called individual choice on that slide. We really do need to be finding out from individuals what their goals are. Not what our goals are. Not what we think they need or we think they should want, but what their goals are. Then we need to be working with them to try to attain those goals in the best way possible.

To go to the question about evidence based practices, if someone says well, yeah, I know I want to work but I just want you to get me a job and I want you to get it for me or whatever. Give me supportive employment but I just want this one little piece of it, I think we need to be respectful of the people that we're working with but I also believe we need to be really honest with people and we need to say we will try to help you in the best way that we can. We know that some services when provided in their full scope have been shown to be most effective and when that full scope hasn't provided people haven't been as successful. So we want you to know that. If you still just want to let's say learn how to write a resume for instance, we can help you do that but we want you to know that it might not be as helpful.

I think being honest with people, for me at least, is really something that's critical.

Thank you, that makes so much sense. It sounds like really starting all of this work, applying some of the best practices of collaborative services and collaborative care, providing information and letting people know what you have to offer and helping them choose.

Absolutely. It's a partnership. It is absolutely a partnership, or it should be, based on the goals and wishes and desires of the individual.

That's fantastic. That might be a beautiful place for us to stop. I'm sorry we're not going to be able to get to all of the question but you've really generated a lot of interest.

Wonderful, wonderful.

That's great.

Well, I certainly want to thank everybody for being on the webinar and I hope it's been useful and helpful.

Great. As I finish up here I do want to let everyone know that recovery to practice does issue a quarterly newsletter and we'd like for you to get on to the newsletter list. Please sign up at our website. It's rtp@ahpnet.com. That's the email address. Please remember there are a number of webinars coming up in this series in the next few weeks so please join us for as many of those as you can. On behalf of SAMHSA I'd like to thank all of you for taking time out of your day to attend today's webinar and for sending in questions and participating. We know you have busy, commanding jobs and appreciate your interest in learning about evidence based services and recovery oriented care.

Special thanks to you Mary for sharing your time and your wisdom and your expertise.

If you haven't filled out the participant evaluation from the box below we will post a link at the end of the session and we really value your input in helping us make these webinars as good as they can be. We are not able to offer pre-approved CEUs for this webinar but you can download the certificate of attendance from the materials download pod. Thank you all very, very much. This concludes our call for this afternoon. Have a great afternoon.

Thanks. Bye.