Incorporating Recovery-oriented Practice Competencies

Good afternoon, everyone, and welcome to today's Recovery to Practice webinar titled, "Recovery to Practice Applications: Incorporating Recovery-Oriented Practice Competencies in Practitioner Training." Today's webinar is a bit different from previous webinars in this series. We'll be looking at the work of psychiatry and social work as models to understand how to use Recovery to Practice resources to build competency.

My name is Elizabeth Whitney. I'm the Technical Assistance Lead for SAMHSA's Recovery to Practice Project; and I'll moderate today's webinar. I will briefly review housekeeping tips and provide a short overview of Recovery to Practice.

But first I'd like to thank all of you for joining us. We have almost 100 people today in the audience. 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 really like to extend a deep thank you to our presenters…Annelle Primm, Erin Bascug, and Patrick Sullivan…for taking the time to share their knowledge and experience with us today.

Let's review the page layout to help you get the most out of the webinar features. You have three options for communicating with us. If you experience any technical difficulties during the webinar, please enter your question in the "Technical Chat" box; and a support technician will quickly help you.

There's a question and answer box for questions for the presenters. We'll try to raise as many as we can at the end of the session.

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We also have a Participant Evaluation link in the "Webinar Links" box. We appreciate your taking a few moments at the end of the webinar to complete the evaluation. Your feedback helps us learn to develop future webinars.

This series is hosted by SAMHSA's Recovery to Practice. It is a Workforce Development initiative with the overarching goal of improving the knowledge and skill of the behavioral health workforce by integrating the concepts of recovery-oriented care into everyday practice.

Why is recovery important?

Ron Manderscheid described recovery as one of the most powerful words in our behavioral health language. Powerful because the concept helps people regain full lives by promoting hope and guidance, and has opened the doors to dramatic care reforms. The concept of recovery has been recognized for hundreds of years, but it is now transforming the mental health and substance use landscape in ways almost unimaginable just a decade ago. People with lived experience of recovery have fostered this vision, and SAMHSA has made the vision an everyday reality for many.

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

It sounds like we've got some background, so maybe everyone can make sure to mute their speaking lines.

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 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 workforce.

The initial phase of the Recovery to Practice Initiative was launched in 2009 and focused on working with the six professional disciplines illustrated on this slide. The goal was to create discipline-based curriculum 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 curriculum into their professional activities and certification procedures. You'll find links to each of these association websites in the "Webinar Links" box below.

The second phase of Recovery to Practice 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 a part of that effort, so thank you for joining us.

I'd now like to introduce our speakers for today.

Annelle Primm is a community psychiatrist currently serving as the Senior Psychiatrist Advisor for Urban Behavioral Associates in Baltimore, Maryland, and as a consultant for several nonprofit organizations. Annelle served as Co-Director of the Recovery-Oriented Care and Psychiatry Curriculum.

Erin Bascug is Associate Director for Educational Initiatives and Research at the Council on Social Work Education. She was a member of the Council's Recovery to Practice Team, where she worked to develop a recovery-oriented curriculum and webinar series for social work field instructors and helped to outline advance practice competencies in mental health recovery.

Patrick Sullivan serves as Professor at the Indiana University School of Social Work. While earning a degree at the University of Kansas, he helped development the Strengths Model of Social Work Practice, and has extended the model to mental health and addictions treatment and policy. Patrick served as a Steering Committee Member for the Council on Social Work Education Recovery to Practice Initiative.

So, I'm really pleased to welcome all of you, and Annelle will start us off today.

Thank you, Elizabeth.

Hello to everyone. It's my pleasure to share with you our agenda. We'll be talking about the Recovery to Practice curricula and discipline practice competencies, especially as they relate to psychiatry and social work. But the good news is that these also are applicable to other disciplines. Some of this information will be a helpful guide for skill development and practice behavior and, of course, the importance of application to multiple practice settings. As well, we will have a vignette that we will discuss a little bit later on.

The Recovery to Practice psychiatry curriculum is really part of a larger SAMHSA Recovery to Practice initiative that aims to foster better understanding of recovery, recovery-oriented practices, and the various roles that professions have in promoting recovery. For psychiatrists, it was really important to us in the field to make sure that we could equip psychiatrists with the knowledge, skills, and attitudes to provide recovery-oriented care and also to foster really solid, meaningful relationships between psychiatrists and people in recovery to really get the best sort of outcomes, including a fulfilling life for the individual receiving services

A little earlier, you saw this slide about the fundamental components of recovery. These are all very important. They should be person-driven; holistic; peer support should be a part of it; culture should be

attended to; a focus on strength and responsibility of the individual; and most of all, hope is a key ingredient.

For the psychiatry curriculum that was developed, there were nine key modules which include the introduction to recovery and recovery-oriented care; the importance of creating a welcoming environment in which the individual feels comfortable; interacting with the psychiatrist and other practitioners; the importance of person-centered care that's tailored to the individual; the importance of employing peer support in recovery as a part of the team; the importance of the role of medication; health and wellness, kind of using a holistic approach; living skills and natural supports, which are so key; and the importance to paying attention to culture and providing culturally-appropriate care; and last but certainly not least, the importance of trauma-informed care.

It just so happens that the psychiatry milestones which have come into being in the last couple of years are a framework for assessing the development and competency of physicians in psychiatry training. They correlate with several key dimensions of the recovery-oriented care in psychiatry curriculum.

I'd like to share this poll with you: Which of the following choicest best reflect the fundamental components of recovery and practice standards of psychiatry and social work and, of course, that apply to other mental health disciplines as well?

[Pause for responses]

I see as people are answering the question, it's kind of split among several of these choices. In actuality, the correct answer is the fourth one: hope, holistic and individualized. The reason why this is the correct answer, if you look at the first answer, it certainly is not linear. In the second answer, recovery-oriented care is certainly not illness-based; it's strength-based. In the third choice, it is not family-centered, even though respect and self-direction are very important. Then in the final choice it is, again, not family-centered. So for those of you who got the hope, holistic and individualized, you've got the picture.

Okay, so I'd like to just share some of the areas of commonality between the psychiatry milestones and the recovery-oriented care in psychiatry curriculums. When we look at the *Introduction To Recovery-Oriented Care,* which is the first module, the psychiatry milestones that are relevant come under the area of systems-based practice, community-based care; and specifically, these address some of the actual foundations of recovery and recovery-oriented care.

In looking at the second module of the curriculum, *Engagement and a Welcoming Environment*, this relates directly to the psychiatry milestone focused on interpersonal and communications skills, information sharing, and recordkeeping in which active listening is critical aspect…communication strategies to ensure that the individual, as well as the family, understands what the clinician is communicating.

The third module, *Person-Centered Planning and Shared Decision-Making*, this has direct relevance to the psychiatry milestone focused on patient care and psychotherapy. In this, we find that it is important to customize the treatment, including psychotherapy or whatever sorts of services are provided, to the needs of that individual. It's important for us to recognize that one size does not fit all and that we need to shape our treatments to meet the needs of the individual and their wishes and goals and so forth.

I think it's important to point out here that there are some very useful resources on person-centered care…one that was provided by Tondora and Miller in 2009. They actually developed a Person-Centered Care Questionnaire, which can be found on the website: www dot "ct" for Connecticut…"C" as in cat, "T" as in Thomas…dot gov, slash "d", "m" as in Mary, h, a, s [www.ct.gov/dmhas]. If you're interested, I think Tondora had a number of materials on the issue of person-centered care, which people might find particularly helpful.

Peer Supports in Recovery constitute the fourth curricula module. This relates directly to the psychiatry milestone focused on interpersonal and communication skills, relationship development, and conflict

management. This is important because it identifies the fact that team-based care, with multiple disciplines involved, including the perspective of peers who have had the lived experience of having mental illness and can impart very important information not only to the person receiving services but to other team members to educate them as well. This is really a key skill and competency for psychiatrists and other practitioners to understand.

The Role of Medication…this is the fifth curricula module, and it relates directly to the psychiatry milestone focused on patient care, treatment and planning, and management. Very important here is to understand what some of the side effects are that may have an effect on the individual and their treatment, as well as having an appreciation of how being on medication might affect the individual in their life…such as having to get bloodwork or transportation or avoiding or reducing certain foods, the use of alcohol or other substances, and perhaps the addictive nature of medication or any sorts of issues that might arise with abrupt discontinuation. So, these are all things that the psychiatrist and other clinicians should take into account.

In terms of *Health and Wellness-Focused Care*, this is a critical element of the psychiatry recovery-oriented care curriculum. It also relates to the area of systems-based practice under the psychiatry milestones, particularly the milestones related to consultation to non-psychiatric medical providers and non-medical systems. It's always important for the clinician to discuss methods that involve the integration of mental health care and primary care in treatment planning.

The seventh curriculum module focuses on *Developing Living Skills and Natural Supports*. This is so important for us to be conscious of utilizing the resources in the individual's environment…whether they be the person's family, neighbors, perhaps those in the faith community, others who can add to the resources that individuals receiving services have at their fingertips. Also, this is important to help the individual fulfill some of their interests in employment, the arts, nature, spirituality, et cetera…a whole wide range of activities that can really enhance the life experience for the individual.

Culturally-Appropriate Care is the eighth recovery-oriented care in the psychiatry module. This maps on almost directly to the psychiatry milestone professionalism/compassion, integrity, and respect for others. It is so important that individuals have a certain sensitivity to diversity in *all* of its forms as one is developing evaluation and treatment. This includes being sensitive to the language that the individual may speak, particularly if their native language is not English, and making sure that medically-certified interpreter services are utilized.

Trauma-Informed Care…this is a critically important module. It relates directly to the psychiatry milestones focused on medical knowledge and development through the life cycle and helps to underscore the importance of understanding, and coming to terms with, the emotional and sexual abuse that the individual may have had and their impact on the development of that individual's personality and their contribution to psychiatric disorders across the age spectrum.

You may have noticed that in discussing the relationship between the curriculum modules and the psychiatry milestones that there is a lot of overlap, particularly in these three areas: person-centered care, culturally-appropriate care, and health and wellness.

I will now turn things over to Erin. Thank you.

Thank you, Annelle.

And thank you all for participating today. I've been especially enjoying looking at the participant Chat. It's like reading postcards to see where everyone is from and just gives us a sense of the national reach of this series. So, glad you could all join us today. Welcome here from Alexandria, Virginia.

Pat and I are going to be co-presenting this section. Before we get started, we'd like to ask you to participate in a poll. I see some of you are already on your way. Just choose what action you think best describes your opinion about who can recover. We'll just give you a chance to respond.

[Pause for responses]

Pat, I don't know if…well, actually, I'm surprised that we have so many people saying that anyone can recover.

Yeah, that's a very satisfying result.

Yes, it is.

We understand that for some there are nuances that they are concerned about, but I think as a general practice principle, that's where you want to begin.

Absolutely. I think everyone has had a chance to participate. I know, Pat, in some of our other presentations, I know you speak to some of the longitudinal research that supports what many people on this webinar are articulating…that anyone can recover. I didn't know if you would be able to say a word or two about that.

Well, I think it's absolutely true. I think we all know that, as Annelle pointed out in one of the earlier polls, we're not talking about a linear process; and we're not talking about a life that's free of symptoms or troubleshooting or challenges, but the ability to live a satisfying and productive and satisfying life for oneself. The data is *very* clear. Even if you take a look at it in terms of not just a process but outcomes, we have many, many longitudinal studies that indicate a significant number of people are able to surmount these challenges, hold jobs, live independently…all those normal milestones that we see. That sometimes is overlooked.

In settings where we work, we often see people when they are struggling at their most; and there is one after another. What we don't see often in offices is outside the walls of the offices, those people who came and used services…or maybe at times did not…and actually are living very satisfying lives.

Great, wonderful.

Again, thank you all for participating in that poll. We'll have another interactive activity a little bit later after our presentation here.

During the first wave of the Recovery to Practice project, the Council on Social Work Education focused on educating field instructors, social work practitioners supervising students in field placement settings that are not familiar with the terms. The field component is known as the signature pedagogy in social work education, and all students at the baccalaureate and master's level must spend a number of hours in field placement during their educational program experience. So field instructors are bridging the knowledge learned in classrooms with the practice realities for social work students, and they provide modeling and mentoring.

It's our hope that by educating field instructors, we would also influence the students who train with them. CSWE…we're in the business of accrediting baccalaureate and master's programs, but also in the business of providing professional development for social work educators. So, we took that to heart when we developed our RTP curriculum package, and we kept our social work programs in mind as well as field instructors…so hopefully found a way to bridge and provide useful resources for both of those audiences.

In our first webinar, as you can see the largest cog on your screen, we used a brown one to define mental health recovery and its connection to social work history and values. Our second webinar in the series, *Recovery in Social Work*, applies the recovery framework to the competencies and practice behaviors for social work practice; and that's the one we'll be talking about…we're focusing on mostly today in our presentation. In the third webinar, we focused on ways recovery could be mobilized in personal practice agencies and in field instruction.

I'll just go ahead and move us along to let you know about that second webinar, *Mental Health Recovery Competencies in Social Work*. Pat, who is on the line today, along with Debbie Plotnick, who is the Senior Director of Sate Policy for Mental Health America, and is also a family member of a child who had experience with substance use disorder and a psychiatric condition, did a fantastic job introducing the recovery competencies for social work practice. They used a case study to model the strengths-assessment approach, and they offered suggestions for taking full advantage of all that peer support has to offer and how our profession can encourage and fully engage people with lived experience of recovery.

So again, our presentation today gives you just a glimpse of CSWE's on-demand offering on mental health recovery competencies. So, we really encourage you to take the next step and participate in our series. At the end of our presentation, we'll give you a link to learn more. All of our webinars on CSWE's website on demand are free for CSWE members and for our guests, so you don't have to be a member to take advantage of it. We also offer one CE credit for each webinar from the Association of Social Work Boards for the completion of the requirements.

So, I will kind of delve into talking a little bit more about the competency development. Using the 2008 CSWE Educational Policy and Accreditation Standards…what we lovingly refer to here as EPAS…these are the guiding principles used to accredit social work programs and specify core competencies needed to practice effectively with individuals, families, groups, organizations, and communities. So CSWE and our RTP Steering Committee formulated advanced practice competencies and mental health recovery bridging our core educational standards with the knowledge, skills, and practice behaviors that would need to be demonstrated for a student to say that they've achieved competency in recovery-oriented practice.

So actually, to develop this document, we drew from the wisdom of our project Steering Committee as well as other organizations such as AHP, the California Social Work Education Center, and also a work group focused on advanced practice in trauma that assembled at CSWE. So, taking all of that wisdom into consideration, we developed our own advanced practice competencies; and that became the backbone to the development of our suite of webinars and resources that supports field instructors and educational programs to be more recovery-minded. Some of the resources we offer include sample syllabi, bibliographies, student exercises, field assessments, instruments, et cetera.

The competencies document was especially designed for social work programs with concentrations in mental health and clinical social work as a tool for curriculum design. So, I'll take a brief look at the 10 competencies that we based our advanced social work practice competencies on to give you a sense of the foundation that we used for our work.

For social workers at the advanced practice level, you can apply these 10 competencies…actually, 5 shown here and 5 on the next slide…to a certain concentration; for example, clinical social work or child welfare. The 2008 EPAS outlines 10 competencies that state what social work graduates must know and be able to do to practice effectively with individual families, groups, organizations, and communities. The ones that Pat and I will be focusing specifically on during this webinar are…you'll see 2.1.4, engaging diversity and difference in practice. Right below that is advance human rights and social and economic justice. We'll also be drawing upon the intervention piece of 2.1.10, so that's engage, assess, intervene, and evaluate with individuals, families, et cetera.

Just to give you a little bit of background too, earlier this summer CSWE released a 2015 version of the Educational Policy and Accreditation Standards. We update our standards every seven years with input from numbers of other stakeholders in social work. There are some major differences between the 2008 and 2015 EPAS. For instance, now we only have 9 core competencies versus 10 when we did our work with SAMHSA to develop the RTP Project. Some of the content for the different competencies has been realigned.

Some new additions to the competencies include environmental justice and cultural humility. These are, again, concepts that are brand new to the 2015 EPAS. However, I just wanted to say that the competency examples that Pat will draw upon in the next few slides are the same core competencies in the 2008

version as the 2015 version. So, we tried to keep it to something that would be transferrable between the versions of our competencies so they're still relevant to you.

So, I am going to hand this over to Pat to delve a little bit deeper into some of the competency areas.

Thank you very much, Erin.

Again, I want to echo everyone's remarks and welcome everyone from across the country. It is really neat to see people sign in. For reference, I'm looking out my window in downtown Indianapolis. I can lean back a little further and see Lucas Oil Stadium. I'm going to apologize. I realized when I was talking earlier, I actually announced the Indy car race in Sonoma, California, this past weekend and came back and my voice was a little rough.

But what Erin is really saying here is that…and this is exciting to me for someone who has been involved in this for a long time…is we're really trying to illustrate and build in the notion that recovery is a part of social work and social work education's genetic code. What is also very interesting about this particular webinar is given what you just heard from Annelle, it is wonderful that you see that all of us who are sort of involved in this system are increasingly on the same page. We may have slightly different roles; but, nonetheless, recovery is an important part.

So, let's take a look at this engage diversity and difference in practices. As noted, we engaged in the process of outlining competencies specifically for social workers; but these examples, we think, from our work apply particularly well across disciplines. As Annelle mentioned, culturally-appropriate care is consistent with the psychiatry milestones and a focus on one of their psychiatry curriculum models in their RTP series.

Taking the 2008 EPAS competency, engage diversity and difference in practice, we outlined an advanced practice knowledge statement that was specific to recovery-oriented social work. So it reads like this: "Recovery-oriented professionals appreciate the complexity of identity and myriad ways in which psychiatric conditions intersect with other factors of diversity; understand historical and global differences in the definition of mental illness or psychiatric disability; and the implication for practice." Now everyone sees these matters the same. We're attuned to the role language plays in reinforcing the oppression and stigmatization of persons with lived experience of psychiatric diagnosis, as well as effects of internalized oppression and shame on their clients.

Let's recall, when I was first involved in this field many years ago, well over 30, we commonly referred to people as "the chronically mentally ill." Chronic may indicate that it's a sometimes long-term condition, but recovery is the indicator that that is not necessarily a downward spiral.

Then we articulated practice behaviors…what the professions can do to demonstrate the recovery-oriented knowledge base around diversity and difference. There are several practice behaviors listed, but here's one to give you an idea.

"Recovery-oriented professionals practice cultural humility through the engagement of individuals with lived experience as teachers and respecting their knowledge and perspectives." And isn't that so much what recovery is really about? When we begin to understand that the people that we are working with are the ones who are the experts on their lives…and that becomes very important.

So, we understand bias it incurs as a result of race and ethnicity, gender, religion, age, and other factors and how that affects diagnosing individuals or providing services to them, including the potential for institutional bias in the diagnosis and issues of access faced by groups that are historically marginalized. That's important to us.

Now, again, as Erin has pointed out, there are several resources available to you to learn more about the value of cultural humility in recovery-oriented practice. AHP's Culturally-Competent Care and Recovery-Oriented Settings webinar on 8/3/15 is available to you on demand. Erin provided an overview of cultural

humility, which was based on a cultural competence and cultural humility presentation and discussion led by Robert Ortega at the University of Michigan's School of Social Work during the CSWE third webinar, *Infusing Recovery in Practice and Field Instruction*. Again, CSWE's webinar series is available to you on demand.

Let's move forward and take a look at another of these competencies, and that's Advance Human Rights and Social and Economic Justice.

Folks, this has been a part of the mission of social work nearly from Day 1. It just happens to fit nicely with the recovery-oriented perspective. Again, this is from the EPAS competency. This proficiency not only resonates with social work. It's also a concern that is addressed by other professions as well. So, recovery-oriented professionals advocate for human rights and social and economic justice for individuals with psychiatric diagnoses.

Let's recall that culture has a great impact, and the environment has an impact. Recovery occurs in social context; and many times, what's required for us is to be advocates as well as someone who simply provides services. We acknowledge that the individuals themselves are agents of social change in their own lives and communities. We recognize that individuals with lived experience of psychiatric conditions have often faced significant and overt oppression, stigma, and shame associated with mental health history. And you know this.

This oppression includes stigma, discrimination, poverty, fear, spirit-breaking professional practice, and structural entrapment by the mental health system. Illustrated by the images you see on this slide, some of the practice behaviors we outline include advocate within the profession and across the behavioral health system for recovery-oriented philosophy, progress, and practices:

Help individuals understand and act on their legal, civil, and human rights; specifically, those rights involving advanced directives, informed consent, and refusal for any particular mental health treatment, involuntary treatment, restraint and seclusion, and equal access to resources.
Help professionals and others involved with individuals with lived experience of psychiatric diagnoses replace demeaning, dehumanizing, and shame-provoking language with recovery-oriented, strength-based, hope-building language and actions.

Again, this is consistent with social work's mission. Recovery is a social process as well, where the absolute standards of strength-based practice is this…that behavior is, in part, a function of the resources available to people. And it is our job to help those resources become available to people that face these challenges.

So not surprisingly, as we move forward, we intervene with individuals, families, groups, organizations, and communities at multiple levels. Recovery-oriented professionals advocate for organizational change and transformation to a recovery-based system. This is the fight that many of you who are keying in right now face. You believe much of what we're talking about, and sometimes you swim upstream. We have to kind of turn that around if we can.

We have to empower the client to assume leadership of his or her own wellbeing through self-directed care, shared decision-making, and self-advocacy and development. We need to assist individuals in his or her quest for meaningful employment, education, or housing, or any other goal that he or she might have. And this is absolutely important in terms of recovery…these opportunities. Now, we have to understand that education and support for family/significant others can be key elements to supporting the individual's own recovery process. You heard Annelle talk about we certainly respect and work with. It's not family-directed, but the family is a key part.

We advocate on behalf of clients so they can access resources and services that support their recovery pathway, and we *absolutely* recognize the importance of peer support and trauma-informed principles. How much have we begun to understand about the impact of trauma on the lives of people?

So, this is really important work that fits very well with the realities we see; and this is a lot about transforming not only our systems, ourselves, but also society as large. This is something that you can perhaps pick up in Webinar #2 that we talked about with CSWE. There's more information, for example, on some simple things like how to conduct a strength assessment; how to look at the person from a completely different light; how to think about the environment outside as a source or resource, not just an obstacle or not just as a challenge. How do we go about the process of advocating for people in a systematic and a smart way, in a way that gives us the greatest chance of being successful…always remembering that the greatest asset is the person themselves, particularly when we truly build upon their strengths and truly join with them and believe that their recovery journey is possible?

So…what are some central themes?

These are themes that you have heard repeated by Annelle. You've heard them probably throughout this webinar series, and they're absolutely critical. The word "hope" comes up often in dialog, in self-reports, in first-person reports, in research on the recovery process. It's about optimism; it's about moving forward; it's the belief that things can, in fact, be better. And this is important. And frankly, folks, some of this often starts with us. We have individuals who life has dealt such a difficult end that they begin to doubt. As a research subject of mine once said years ago, a professional, "Sometimes I have to hold hope for other people until they can find some of their own."

It has to start with us. If we don't believe that recovery is possible…if our language, our attitudes, our body language suggests that nothing is going to happen with this person, this could become self-fulfilling. Every professional out there who cares can tell a story about someone who no one thought would *ever* get a job, live alone, find a significant other; and yet that happened. And one thing we have to do is we have to amplify the voices of those using our services. Help their voices be heard.

And then, using them as our guide, how do we engage in goal-directed treatment…meaning their goals? How do we help them sort of take a look at where they want to go in their life, what strengths that they have, what activities they enjoyed in the past or would enjoy now, where they want to go? How do we translate that into goals; and how do we, obviously, facilitate individual choice and self-determination?

Part of the value of social work practice for as long as I've been in the field, which is a very long time, has been to respect the uniqueness and individualism of people and to respect their right to self-determination. And this really means taking that seriously and making it come alive.

Other important central themes include, as we've talked about, and it has there…you can see, with permission…it includes family and significant others. These people have a lot of knowledge. And I can tell you, if there is one thing that is satisfying in today's world, it's how much we've come from the old family blame models. This has been a significant step forward. We expect that there is life beyond the mental health system. We want true community and social inclusion…meaning the sense of belonging, having meaningful activities, meaningful jobs, living in places that are comfortable for them. That's emphasizing the natural community supports.

Everybody goes for the same segregated, expensive, illness-focused supports. Why don't we look to the natural community supports…people, organizations, clubs, people who want to make a difference? And without question, we know beyond anything that peer support networks and services are *incredibly* powerful. The more that we enhance, help, support, nudge in that direction, the more we are engaging in recovery-oriented practice.

To illustrate this, we have a vignette that Annelle is going to describe here; and then we'll go forward with a little bit of, if you will, detailed conversation about that.

Thank you, Pat.

That was a very inspiring message and, I think, a wonderful introduction to the vignette on Derek, who is a 30-year-old man. He's single. He has a history of depressive illness, one suicide attempt. He's had

some issues with alcohol use and about 10 months ago, was laid off from his job doing data entry, and since then it's been quite frustrating for him to find work. Since his layoff, he's been socializing a lot less; this is something that he used to enjoy. He's been sleeping more, drinking more alcohol. And when he does drink, he tends to get extremely irritable. He was kicked out of his house five weeks ago by his parents, and so now he's living in a community shelter.

In this setting, Derek is meeting with Dr. Smith with his diagnoses of alcohol use disorder, major depressive disorder. And in this vignette, he's essentially having a follow-up meeting to begin to plan next steps in his recovery process. So, my colleagues and I will discuss some questions related to this vignette as we go forward.

The first question is…and would like for the audience to think about this…what would your goal be for this meeting?

I'll give you a little time to think about that, given what we've shared over the last 30 minutes or so.

[Pause for responses]

I see some responses coming in. Patsy said, "My goal would be to do an assessment to assess his mental stability."

Matthew says he'd like to get to know Derek and what his goals, hopes, and dreams are. This is very consistent with how *I* might look at this particular question. I certainly want to create a welcoming environment in which Derek can speak freely. And of course, finding out about his goals…what they are, finding out what his strengths are, and finding out what resources he might call upon are some other goals for the meeting.

I'm seeing from Carol…she's saying, "My goal would be to find out what he cares most about."

Kim says that she would help…or he…would help Derek identify his values and most important roles in his life.

So I think we tend to be on the same page; and I'll ask my colleagues, Pat and Erin, if they have any thoughts about this particular question.

I have at least a couple thoughts. One is it's hard to disagree with any comments that's been offered. It's very interesting. Let's go back to the one that Patsy mentioned first…to do the assessment of mental stability. Even from the most strength-based perspective, if the client is in some sort of immediate danger, some basic needs aren't being met…the person is on the street…you've got to make sure right off the bat that everything is basically okay. From there, I think what's really important is the rapport is absolutely critical. Obviously, we want it to be our goal for the meeting; we want it to be their goal or at least a shared goal for the meeting. And I really like the notion of I see dreams in there, interests in there, relationship in there. I see a lot of discussion about translating this eventually into an action plan. I see some people that are making sort of a temporal sequence of what we go through as a clinician.

Robin put, "Does he have shelter?" That's exactly what I was talking about.

Cher just put in, "Encouragement, support, and hope." I think that's critical because they're not going to move forward with goals and treatment plans or care plans until there's a sense that it's sort of worth it to step forward. So, I really like the comments we're getting.

Yeah, we've had some great participation.

Erin, did you want to weigh in at all?

No, that's okay. I think Pat summarized that pretty well.

Okay, Pat, well, I'm going to turn it over to you for the next question.

So the question becomes with all the great stuff that you all suggested, how do you approach the interview? How do you go about it? How do you build the rapport to begin with? What do you start with?

Let's understand that I've got a great friend here in the Indianapolis area who works a lot with children who have pretty significant problems; and he says the problem that children and families often have is that they've had multiple assessment disorder. And there is that notion that they want to be heard…they want to get to know you. We can't automatically assume that they're going to trust us, so how are we going to approach moving forward to develop these goals? I mean, this is an important part of what we do in social work.

Annelle, what are your thoughts from a psychiatry point of view?

Well, I think one of the things that I like to let the individual know is that I'm really, truly interested in them and what they have to say. Some of that I can convey in what I say as I'm listening…but also even in my body language…I lean forward. So, I'm giving cues from what I'm saying, as well as how I position myself…my eye contact, and so forth…that I'm really interested.

I mention this because when we developed the Recovery to Practice curriculum, the first step was to do a situational analysis. We reached out to many different parts of the country; and we actually had dialog with people who are living with mental illness, as well as other practitioners and other psychiatrists and so forth. But what we heard almost consistently from all of the people who are living with mental illness is that they really wanted to have a relationship with their psychiatrist, and they really wanted to know that the psychiatrist cared about them. And we really took that to heart and made sure we integrated that into the curriculum.

I think as simple as that sounds, that's one of the most important things to do…to establish a kind of relationship in which the individual is going to feel free to talk about their innermost feelings and to want to work with you as a partner in their recovery journey.

I'm struggling a bit because the founder of the longest-standing peer support program in the state of Indiana came to my class one time and said, "When I look back at all the people I've worked with over 30-plus years, I begin to understand that there were times when it didn't even matter if the person really knew what they were doing. What mattered to me most of all is they cared for me."

Now, it has to go beyond just care; but I think care is where it starts. Time and time again in first-person reports, we hear people say that that's the thing that resonates…not the techniques we use, it's about the care. I see a lot of people talking about creating a relaxing environment, a trusting environment…introducing myself, maybe some disclosure on my part. This is a really nice mixture of folks' comments.

Erin, any observations based on the comments that you see in the box?

Well, not on the comments themselves; but I think one thing that I remember Charlie Curie, who used to be the SAMHSA Administrator several years back, mentioned in one of our webinars that it's important to remember that people with substance use disorders and mental health conditions want the same things that we all do. They want to have a sense of connectedness; they want to have a purpose; they want to find a sense of meaning in their life.

So, I think it's important to remember that we have more in common with the people that we serve than differences between us and that sometimes it is difficult, as professional helpers in our respective fields, there is a power differential. I think that's something that I know that social workers try to acknowledge and be mindful of; but it can be difficult to bridge that gap and work on the person-centeredness so that

you're kind of giving and taking and working with one another and respecting their opinion and their person-centered and person-directed needs. So, yeah, those are just some things I'm thinking about.

The comments are really great. I know that this is an interdisciplinary audience, but they really have a lot of things that I – I was like, oh, this person must be a social worker…so a lot of great comments.

I can see we're getting close on time. Erin, why don't you guide us through the next one?

Sure, the last question we have for you is: What actions could you take as a professional helper to make the approach feel more person-centered?

As you all are coming in with your suggestions, some of the things you might want to think about are Derek's situation being laid off…the isolation that he may be experiencing, his living situation. Right now, he had been kicked out from the parents' house two weeks ago and now is living in a shelter. So, what kind of actions do you think you could take to really connect with Derek and let him know that you're approaching him from a person-centered perspective?

Pat or Annelle, anything that comes to mind?

Go ahead, Annelle.

I was just going to say that he really enjoyed socializing. He seemed to like his job, and so helping him get back on track to get reconnected with work…we always need to think about that. People who may be dealing with a serious mental illness, that doesn't mean that they can't work. And if this was important to him in his life, I think that making that a priority.

Very often, as practitioners, we may have certain goals in mind that we have for the individual that we're serving; but their wants and needs and goals really take priority. So, I think putting those up front first tends to really enlist that person's interest and motivation. We really need to use some of the techniques of motivational interviewing to engage them and to make sure that it's tailored to what their wants and needs are. That's one way of showing that we really are listening because we are drawing from their cues/their wants in developing a plan with them.

Thank you, Annelle.

We have some really quick comments. I saw earlier someone said: meeting the person where they are, finding out what his most immediate concerns are, really allowing the individual to lead the process I think are some of the important themes.

I'm going to go ahead and just move on to sharing our contact information because I know we're short on time here.

Pat and Annelle, we just wanted thank you for the opportunity to share a little bit more about our Recovery to Practice work.

You can see at the top of the screen, recovery@CSWE.org, if you're interested in joining CSWE's listserv to connect more with recovery-oriented professionals, we're happy to sign you up. Just e-mail me there.

Pat's information is below.

There's a CSWE Recovery to Practice webpage where you can access those webinars that we were talking about. Also, Annelle's resources are available at www.APAEducation.org.

I'm going to go ahead and hand that back over to Elizabeth.

Thank you…what a wonderful conversation. Boy, we could have kept going with that. You guys really brought this to life and really showed us how to bring the principles into practice and into behavior. What do we actually do when we're talking about recovery-oriented practice…so that's fantastic.

Keeping with the theme of resources, I also want to let you know that Recovery to Practice issues a quarterly newsletter; and here's how you can get on the list to receive that newsletter and other Recovery to Practice mailings.

Coming up, we've got two more webinars in this series. So please join us if you can. One is tomorrow, and one is going to be coming up next week.

Finally, on behalf of SAMHSA, I'd really to thank you all for taking time out of your day to attend today's webinar. We really appreciate your interest and your engagement in the discussions.

And a very special thanks to Annelle, Erin, and Pat for sharing your comments and your responses and your reflections on how to do this work.

Participants, if you haven't filled out the evaluation, please do so. We'll also post the link at the close of the session.

We are not able to offer preapproved CEUs for this webinar, but you can download the Certificate of Attendance and the presenters' bios from the "Materials Download" pod below. So, thank you all very, very much. This concludes today's session. Have a great afternoon.