Partnership, Engagement and Person-centered Care

Good afternoon and welcome to today's Recovery to Practice webinar titled, "Partnership, Engagement and Person-centered Care."

My name is Elizabeth Whitney, and 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 today. We have over 150 people in the audience already. On behalf of the Substance Abuse and Mental Health Services Administration, we'd like to welcome all of you and thank you for your participation.

I'd also really like to extend a thank you to our presenters, Lauren Spiro and Rita Cronise, for taking 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. First, 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.

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This webinar series is hosted by SAMHSA's Recovery to Practice, 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 do we think recovery is so important?

Ron Manderscheid described recovery as one of the most powerful words in our behavioral health language. Recovery is powerful because the concept helps people regain full lives by promoting hope and guidance; and it 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.

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 that are illustrated on this slide. The goal was to create discipline-based curricula to promote understanding and uptake of recovery principles and practices. Each discipline used their own language and frameworks relevant to their membership and developed ways to integrate the curricula into their professional activities and certification procedures. You can find links to each of these association websites in the "Webinar Links" box below.

The second phase of RTP 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 part of that initiative to push recovery-oriented practice to a broader audience.

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

Lauren Spiro is a visionary thinker, educator, artist, and consultant. She has been featured on national media; consults on numerous federal, state, and local projects; and cofounded Emotional CPR and two nonprofit mental health corporations. Lauren also served on the Council for Social Work Education's Recovery to Practice Steering Committee. She recently published her memoir: *Living for Two: A Daughter's Journey from Grief and Madness to Forgiveness and Peace*. She is a survivor of chronic schizophrenia diagnosis and has a master's degree in clinical and community psychology.

Rita Cronise is a technical writer, instructional design consultant, and part-time adjunct faculty at Rutgers Department of Psychiatric Rehabilitation & Counseling Professions. She is a certified facilitator and trainer for several peer support and recovery programs such as WRAP, Pathways to Recovery, Intentional Peer Support, and the National Alliance on Mental Illness Connection support groups. Rita assisted in the development of the Next Steps curriculum for experienced peer support providers that was released in 2014 as part of the Recovery to Practice Project.

I'm really pleased to welcome both of our presenters, and Rita will start us off; and the two will be presenting today together.

Thank you, Elizabeth. And thank you to SAMHSA for all of the great that it has done traditionally to really encourage recovery practices.

For today, our agenda is to introduce an introduction to engagement and partnership; fundamentals of person-center practices; leadership and building effective teams; and we'll have a discussion towards the end of this particular session.

As Lauren and I begin the discussion about engagement and partnership and person-centered care, there's one fundamental question that always needs to be asked whenever we work with a person who is receiving services. And in order for our services to be effective, there's really, truly only one right answer to this question. That question is: Who is in the driver's seat of the person's life?

In a recent scan of research articles, I found this quote that I thought was very, very pertinent to this particular session: "No matter how effective mental health services are now, or become in the future, there of little value should persons with 'mental illnesses' continue to choose not to receive them." In that same research article, the authors found that consumers have attributed their disengagement from care to having core alliances with care providers, including experiences of not being listened to and not being offered the opportunity to make decisions and to collaborate in their own treatment.

In response, the mental health system is moving towards a more person-centered model based on recovery principles to engage consumers in more actively being engaged in their own care.

Rita, I have a thought if you don't mind. This is Lauren.

Yeah.

I really like the question about who is in the driver's seat. Many years ago, actually, I took a class; and the teacher asked all the students to write our autobiography from a place of power, as if every decision we ever made was the best decision we could have made at the time. I really struggled to get my mind around that concept, that possibility that I could actually be in the driver's seat. And it took me a long time, but it was quite revolutionary at the time. And really, what it led to was my entire perception of my life changed. For me, it was like replaying the story of my life, but doing it from a different corner of space. So I appreciate you starting off the webinar with that question; it's very important. Thank you.

Thank you, and I think that's true for so many of us who feel…myself included...that there were points in time where I felt very out of control of my own life and didn't feel like I was anywhere near the driver's seat; and we'll get to that later.

What we're going to do now…Lauren and I are going to do something called a "real play," which I absolutely love because it goes beyond the role play to being something that's very real and immediate in our lives. I'll simply start with this. People with mental health concerns are frequently told by family members, friends, treatment providers, and professionals what they need to do to get better. Well, let's see how this works in a very brief real play.

In this real play, I will play a care provider. I won't specify exactly what kind of care provider, but I will be a care provider. And I'll use some of the very common techniques that most people…you know, it's a very natural thing that people do to try to persuade someone to make a change; and Lauren will play herself:

Lauren, tell me a little bit about what's going on for you.

Well, Rita, I have something I want to talk about that's a little hard for me. It's basically that…I might have mentioned this to you before, but I just really feel like I need to make a change with my meds. I just – I don't – I just don't even feel human anymore. You know, like the lithium, for example…I mean, I feel like a zombie. You know, there's no ups; there's no downs. I'm like a flat line. And I want to feel happy sometimes, and it's okay to feel sad sometimes. But to just have no feelings either way is just – I just can't – I can't do it anymore. I just can't.

Well, you know, Lauren, I understand that it's hard; and I understand that there are a lot of things that are possible…like I've been thinking about some of the newer medications that are out there that can give a little more energy that we might be able to add to what you've got. What do you think about that?

Well, I mean, I've been on a lot of meds; and I just – I just feel like rather than just trying something else, I would like to try to, with your helping me and supporting me, just try to decrease the lithium, for example. We could start with that, I think. I feel the safest changing that one.

You know, Lauren, I remember that it wasn't too terribly long ago that there were some real issues the last time that we tried to do that. And I'm not feeling very comfortable with where you're going or what you're thinking right now. Are you thinking clearly?

Um, you know, I was – I thought you might say that because this is not easy; but I have been talking to quite a few people who have gone off their meds…and lithium in particular…or decreased it. And they all just have positive things to say about it. They all say don't go off it, like, cold turkey…which that's not what I'm talking about. But I really feel like in all the years I've been on it that I've learned some other ways of dealing with my emotions, both when I get excited or anxious and when I'm feeling a little sad. And I just –

I just want to be – I want to feel more human because I just – I feel like I'm, like, kind of dead emotionally, you know. It's like a flat line.

Well, I'm not sure that you heard my first suggestion about some of the new medications that can help to give you a little more energy, give you a lift, give you a boost. A lot of them won't interfere with sleep the way that they used to. So, I'm just wondering if that might be an alternative.

Well, I know there are lots of medications out there; and I do hear what you're saying; but I'm not sure if you hear what I'm saying. I mean, I just really want to try and be more of Lauren without so much lithium. So, I want to just decrease a little bit…slowly…and see what that's like. I mean, I don't want any disaster to happen, you know.

Yeah, okay.

So, I think we're going to stop for here because there will be another part of this role play. But for a moment, I would like to just ask the audience in the Chat, just based on that role play that we just did – or real play that we just did – if you were Lauren, how would you feel about making a change?

Lauren, I'm going to ask you that very same question as the audience chimes in. How do you feel about making a change right now?

Well, I mean, you know, I brought it up because it's important to me; and it was hard for me to bring up. So I don't really feel like we were on the same page. I don't really feel like you were listening to me, and I don't feel like you were supporting me. I don't feel like you were trusting my thinking. It's like you have your agenda…and, yeah, so that didn't feel very good. And it's a little unnerving. I feel like you don't really believe that I can do it, and it's important for me to feel like people believe in me, you know.

And, fortunately, I do have allies and other people in my life who *do* believe in me and do believe that I can – and they all encourage me to work with my treatment provider, which is why we're having this conversation. But to go off it slowly…I'm not in any hurry. But I just want to feel like you really hear me and support me.

Okay, Lauren, thank you. We'll get back to that in just a moment.

This particular real play is based on one of the exercises that we do in the Recovery to Practice training for peer supporters, and it's very much about different approaches. Part of what we do is we stop this demonstration and we do an actual very physical demonstration. So, if you could just imagine with me, if you were in a classroom and you saw this demonstration live, here is what it would look like.

Two people stand facing each other, palms touching. One person gives a forceful push; the other person instinctively pushes back in order to just maintain balance. And it's a very common human reaction to push back when you're pushed; resistance is natural. But let's think about how we might do this differently.

There's something called a "righting" reflex…and that is r-i-g-h-t-i-n-g…righting reflex. It's something we all have when we think we have the right answer or want someone to do what we believe is the right thing. But when we stop and ask open-ended, thought-provoking questions, people are able to start to consider options, make choices, and live with consequences that are their own…not the consequences of choices that are imposed upon them.

So at least in the peer support world, whenever we think *we* have the right answer or approach to someone else's problem, we rob that person of the ability to explore options in light of their own values and beliefs or to discover a range of choices and own the decisions…to take ownership of the decisions or solutions or approaches that come up.

As you can see in that first Chat and what Lauren was very clearly saying to me, trying to fix what's wrong can feel dehumanizing and disrespectful; and it steals a person's dignity.

So we're going to go on now to Part 2 of this real play. I love that real play because it really is a real kind of thing. And this time, it's a Take 2 of the earlier real play; but in this case, I will play the same caregiver using a very different approach. This time, Lauren describes the change she would like to make as before; but this time I will ask these questions that support change…that will allow Lauren to consider for herself whether or not she's ready to make the change and, if so, how she'll go about doing it.

Are you ready, Lauren?

Yep.

Okay, so, Lauren, what's going on?

Thank you for asking, Rita. I just -- I wanted to talk to you about changing my meds or really decreasing lithium, to be specific. You know, I've been on it for several years; and it's just gotten to the point where I feel like I'm a zombie…you know, like I'm emotionally flat lined, like dead. You know, there's no highs; there's no lows. I feel like a robot, and I just can't – I can't bear it anymore. I just really can't.

I hear how difficult that must be for you. What else is going on that wants you to make this change? Is there anything else that's happening?

Well, I mean, my life's been going pretty good…nothing special. You know, I'm working. There's stress, but I'm able to handle it. I've learned other ways of, you know, managing my emotions. And I have a pretty good support system now, which I didn't have years ago. So, I don't think it's anything out of the ordinary. You know, it's like life. Life is always throwing you these curve balls, but I think I'm getting pretty good at handling them. I just really can't stand feeling like a zombie. You know, I want to feel more human…more, you know, happy or sad. And I just don't have those feelings, and I think it's the lithium really. So, I'd really like to—

What have you tried already related to the lithium or anything else that's related to that? Are there things that you've tried to make you feel better at this point?

Well, yeah, I mean, I do -- I've tried a lot of things over the years that really help. I mean, exercise…I'm eating well…meditation. I do a lot of self-care *things*.

Wow, it sounds like you're doing things very differently than you were doing a couple of years ago.

Yeah, well, I feel really motivated. I've been very motivated. I've never liked being on the drugs; but, you know, I felt like I had to – you know, the people – my family, my friends, people wanted me to. And I thought, okay, I'll trust their thinking. I don't want to be hospitalized anymore and lose jobs and lose friends.

It sounds like you've really thought this one through and that you're really doing everything you can to support yourself towards making this change. So if you decide to make this change, are there any other ways you might go about doing it? Is there anything else you've thought about?

Well, I mean, I've thought about doing it on my own – you know, without telling you. And, you know, and I can do that; but I'd rather have your support.

I feel very honored. I feel honored that you're trusting me…thank you.

Well, it's important. You know, this relationship is important to me. You know, you've been supportive of me and open to exploring different things. So, will you support me in this? I'm not in any hurry. I'm not

saying – I don't have any preconceived notions other than just decreasing it slowly over time…maybe being off it completely in a year or so. I haven't thought it through in that detail.

So, that sounds like a pretty reasonable plan to me. I think I can support steps along those – and we'll just keep checking in with each other as we go through the process. So, what are the three best reasons that you can think of right now towards making this change?

Well, I do pretty good self-care; and I'll continue to improve that probably my whole life. I do have concerns about putting any chemicals in my body, even if it's naturally occurring in nature. I just – I don't want to use a chemical or anything if I don't think I need it. And I don't think I need this much lithium right now. And I really want to have feelings. I don't want to live life like an emotional zombie. Did I get all three? I don't know. I stopped counting.

It sounds really, really healthy to me. So, what do you think you'll do right now?

Well, if you're okay – I mean, I'm on 1,000 milligrams a day. Just maybe just take it down 10%...just go down to 900 milligrams. Do that for – I don't know – two weeks and we can reassess.

Okay, well, let's stay in touch. We'll work towards that and let's stay in touch. And thank you; I appreciate you letting me in.

Well, thanks for listening, you know.

So, if you were Lauren, how would you feel about the change this time? This is for everybody's chat purposes.

Lauren, how did it feel when I asked you what you wanted to do this time?

Well, I felt like, you know, you trusted my thinking…that you wanted to hear what *I* wanted, that you cared about *me*. You know, I wasn't just another patient or client sitting in the chair…even though we've been working together for years. It just felt like you were respecting me and that we were on the same page. I mean, you had a few questions there; but that's your job, and they were good questions. But mostly, it's about valuing my thinking and being there for me, supporting me.

Great, thanks, Lauren.

I'm just sort of scanning through the Chat right now. I'm going to go ahead and move ahead to our next slide, which will sort of summarize. These are the kinds of things that we hear in the Recovery to Practice training, and I'm seeing a lot of it echoed in what's happening in the Chat and what you just said too, Lauren.

"When someone *tells* me what to do, I tend to feel defensive, not heard, not understood, overwhelmed, discounted, agitated, angry, oppositional, trapped, disengaged, resistant, disregarded, disconnected…I'm looking at the Chat right now…not in control, alone, defeated, talked at, discouraged, unheard, dismissed. So, those are some of the things that happen when someone *tells* me what to do, which is all too common. It's a very common thing that happens in all relationships. But it's something that if we can take the step back that I talked about with that righting reflex, you know, when *we* think we have someone's right answer, we're not allowing the person to come to their own conclusions.

So, on the other side of the fence is when someone asks me what I'd like to do. I feel comfortable; I feel heard; I feel understood; I feel valued; I feel excited, open-minded, new options, partnership, freedom to choose, very supported, positive, encouraged, listened to…I'm just reading through the Chat right now…confident in whatever decision I make, I can trust you to trust me…these are beautiful…what I want matters, responded to the respect in individual question for self-assessment.

So you see that there's a very different feeling that goes with the approach that somebody has to engagement. The one thing that we point out in the training that has been true in every single session that we've ever done using this exercise…it is exactly the same person that you are engaging with. The only thing that has changed is your approach. I think that's a really powerful thing to say about engagement with people.

So, let's see…

Rita, can I add something here?

You absolutely can.

Oh, thanks, yeah. So, what I'm still learning to embody…and this is the *real* Lauren, not the real play…is that the more deeply I live in accordance to *my* values and *my* vision for a collaborative and peaceful society, the more I am able to communicate and integrate this way of being…everywhere, including all behavioral health care settings. So why would we be one way in the world and another way at work? Our work is about integrating what we know about ourselves and about humanity into our lives. So the more deeply I respect you and you respect me, the more our work together will be authentic and healing for both of us and for all stakeholders.

Thank you. I agree 1,000%. The more real we can be with each other, the more healing that we share with each other. The more real we are about our own healing processes, the more we can help others to heal too.

I'm going to move into a couple of just concept-level slides for the moment here…principles of person-centered practice and strategies of person-centered practice…because we wanted to talk a little bit about person centeredness. These are just points that we have in some of the trainings that we've done…some of the very *key* principles of person-center practice or self-determination. It's rooted in the principle that nothing occurs without the person's input or consent…the old nothing about us without us. It's a shift from compliance and dependency to choice and responsibility.

So in the end, it's the person's life and the person's choice whether or not to follow a recovery plan…no one else's. If the plan is created *by* the person, it's easier for the person to take personal responsibility for following the plan. It also does not provide a justification for clinical disengagement and abandonment. The foundation of engagement is principled and respectful, with persistence.

The next key point is empowerment. It's a complex concept. It's multi-dimensional, but it best describes a process rather than an event. It's supporting a person in taking back his or her own power to choose and to take back the ability to take personal responsibility. It is closely tied to self-determination and decision-making, and it's frequently used in decisions about recovery-based care. It's important to remember that nobody can empower somebody else. It's the person themselves taking back their own power.

Finally, community inclusion is the opportunity to live in the community and be valued for one's uniqueness and abilities, just like anybody else. That's a quote by Mark Salzer. So, the only key point I wanted to make here is that specialized service settings can play a pivotal role in somebody's recovery; but over a prolonged period of time, they tend to perpetuate a sense of alienation or patienthood. Those specialized settings that isolate a person from this community also perpetuate a stigmatized view of mental illness and can contribute to discrimination and unethical practices on the part of community members.

Those are just a few key points that I wanted to make about these three principles, which are huge; and each one of these can be a webinar in and of itself. But I just wanted to highlight a few areas there.

Lauren, did you want to add anything about any of these three principles?

Well, yeah, actually, Rita, I think that most people in general…like in society out there…have really absolutely no idea how people are treated in mental institutions – or at least they were when *I* was in a mental institution. But we're taught that we have broken brains. It destroys our self-esteem. We're taught not to trust our thinking, not to trust our feelings. So now if I take *that* dynamic and intersect it with the idea that we live in an age of passive receptivity, where critical thinking is missing from our institutions, we can perhaps more deeply appreciate how absolutely *key* our choice is. And when I say "choice," I mean self-determination, freedom. It's all part of what goes into person-centered planning.

Thanks, absolutely true.

Now I'm just going to very quickly again go through five strategies for person-centered practice. The strengths approach looks holistically at each person, focusing on what's strong rather than what's wrong. It moves from an illness to a wellness sort of perspective. Strength-based language is empowering because it recognizes that a diagnosis is just one small part of the whole person. It emphasizes what a person *can* do rather than what a person can't do.

When we talk about culturally aware, there are *so* many things that have to do with culture; but it really comes down to stereotypes. Everybody creates stereotypes about other people. The cultural humility is one way to get beyond those stereotypes. When you admit you don't know things about another person's culture but you'd really like to learn, you're being humble. And being genuinely curious about others is a universal way to get people to open up and to share about themselves.

Moving into being sensitive to trauma…experiences of trauma can play a significant role in the ability people have to recover from mental health or substance use conditions. Most people who experience these conditions have experienced tremendous amounts of trauma in their lives. Using person-centered approaches with people who have experienced trauma, in conjunction with the very trauma-informed question of what *happened* to you as opposed to what's *wrong* with you. When you say, "What happened to you," it's a way to help people regain a sense of trust, control, and hope. One should expect people will reveal traumatic events gradually, after a trusting relationship is strongly established.

The holistic approach looks at a whole life as a whole life of a person, not just the symptoms of an illness. It can be helpful to speak with individuals about their lives before they were diagnosed…if they were diagnosed. What were their dreams about? What were their passions, likes, dislikes, and hopes for the future?

Unfortunately, as you mentioned, Lauren, many people in the mental health system have come to view themselves in very limited ways. They see themselves *only* as what they're told they are…and that is ill people and people with a lot of symptoms that have to be fixed. Helping people to explore and rediscover other important dimensions to wellness is an important part in your role as a person-centered care provider.

And then there's shared decision-making, which is an interactive and collaborative process between people and their care providers to make decisions pertinent to the person's recovery. Shared decision-making uses the principles we've discussed so far of choice, self-determination, and empowerment. (Audio break) a person's involvement in his or her own care, and it has the evidence of positive recovery outcomes.

A good quote by Pat Deegan is that "Shared decision-making is founded on the premise that two experts are in the consultation room. Neither should be silenced, and both must share information in order to arrive at the best treatment decisions possible." Pat Deegan spoke that back in 2007.

And then hope…hope is the last, but certainly not the least by any means, of the strategies. And I love this quote, which was by Jerome Groopman, who wrote a book called *The Anatomy of Hope*. "Hope can arrive only when you recognize that there are real options and that you have genuine choices. Hope can flourish only when you believe that what you can do can make the difference, that your actions *can* bring

in a future that's different than the present. So never underestimate the power of hope; without it there can be no recovery. With it, the possibilities are endless."

Okay, before I move on, Lauren…anything?

Well, just yesterday actually I was reading in a book and it said…I'm looking for it…oh, hope is a desire in love with wisdom. That's from a book by Jan Phillips…"Hope is desire in love with wisdom."

Wow, excellent.

Okay, I'm just going to very briefly touch upon this tool, which is available on the Internet. And one of my most respected mentors in the area of person-centered planning is Janis Tondora. Janis Tondora and Neal Adams and Diane Grieder and I did a project a few years back on person-centered planning. Janis has been doing a lot of work in the area of developing assessments for person-centered care planning. There's one tool in particular that can illuminate areas where providers in particular can improve their practices to better meet the needs and expectations of the service user…to have conversations about the scope and limits of services.

Basically, what it is, is there's a questionnaire that a provider can fill out; and a person receiving services fills out a companion question with the same questions, just worded from the service user's perspective. After those questionnaires are filled out, the service user and the provider compare answers; and they look for areas of difference…where there are differences in opinion on agreement or disagreement around the provision of person-centered care. And I'll just highlight a couple of the kinds of questions.

For instance, treatment plans are written so that each person and his or her family members can understand them. No professional language is necessary; I explain it.

So that would be 1 out of the 30 some questions that are on the questionnaire. Providers fill it out; service users fill it out. They look at areas where there are differences, and then they have opportunities to be able to make changes in the way that they deliver person-centered planning and care. I just really wanted to point that out very briefly.

I'm going to end this section on partnership. In the very beginning, I said there is one fundamental question that must always be asked. That question is: "Who is in the driver's seat of the person's life?"

Janis Tondora had a great answer…or actually, a great quote from somebody who she was working with at one time on one of her projects. It's: "You keep talking about getting me in the driver's seat of my treatment and my life, when half the time I'm not even in the damn car." I think that's a really good summary of that piece.

Lauren, did you have anything to say before we transition to your piece?

No, I'm ready to transition. I think you've said it very well, Rita.

Great.

Okay, thank you so much.

The five tips for building effective teams was actually a resource I found from HRSA, the Health Resources and Services Administration. Effective primary care and behavioral health teams share the following five components; and bringing these components to your organization will hopefully make teams more effective, collaborative, and integrated.

The first component is leadership in organizational commitment. This is mostly about taking risks and creating a clear vision and focusing on providing the right care at the right time. So, when I think about what is leadership, I think of someone or an organization that is visionary; leads with dignity;

transparency; certainly includes everyone; it sees the big picture; has a focus on justice and equality; is able to make the right decisions at the right time; and whether it's the individual or the organization, that people have a support system.

Rita, any thoughts about leadership?

Well, I think always with leadership the more than an organization or a group looks at including people in recovery in all levels of the organization, that's a real leadership strategy.

Absolutely, I agree completely. Yeah, at really all levels…planning, evaluation, training, everything…so absolutely I agree with you. And I find that recovery, like life, is holistic and encompasses mind, body, spirit, and community. The array of services and supports available should be accessible. They should be trauma-informed, culturally responsive, individualized, integrated, and coordinated…so never too high of a bar to hold.

The second component is team development. This is about fostering strong team relationships, hiring the right providers, creating clear roles and responsibilities, and cross-training providers. Shared decision-making, as Rita mentioned earlier, can have a profound impact on treatment and services and help embed recovery principles into multiple service settings. Shared decision-making is a process that, if used correctly, changes conversation between individuals and service providers.

In the first webinar of this series, we discussed how many of us think that we already *do* share decision-making. But we're finding that when people begin to use the tools emerging in behavioral health, most of us stop short of full shared decision-making.

The third component is a common framework. This is really about creating and carrying out a shared social contract that ensures multiple health disciplines working in concert and worthy of the trust of service users and the public.

Rita, did you have anything to add on that one?

I think it's interesting when we talk about a common framework because if you look at a person-centered plan…an individual's person-centered plan…that can actually also be created for an organization-center plan where the same kinds of recovery principles for an organization are as applicable as they are to the individual. And that can become a common framework for an organization to work towards recovery-oriented services.

Absolutely, big point.

The fourth component is about team process, and there are three types of communication mentioned in this article…clinical case review being the first, the second is the day-to-day operational communication, and the third one is process communication.

I'd like to focus a little bit on process communication. In the first webinar of this series, I discussed Western Lapland and Finland as having the best outcomes in the Western world for [first-rate] psychosis. In Western Lapland, they use a person-directed approach. We do know that there are different perspectives and many pathways to recovery. In Finland, however, they conceptualize emotional problems as problems in communication; and the focus is on understanding the service user.

They also understand that psychosis doesn't exist within the individual…that it resides in the in-between spaces. So, that foundation is consistent with person-centered planning. So, communication is often challenging with someone in an altered state of consciousness or altered state of mood. Service users have insights no matter what their state of mind is; we never lose our insights. But we're challenged sometimes to communicate them. So, what's most helpful is when the provider or supporter takes time to create safety and a trusting relationship…like you did in the second real play. It's important to understand that people go into isolation and other emotional states as a defense mechanism…for self-protection.

So, if we take that a step deeper, we can begin to understand that the possibility that it isn't so much isolation as it is perhaps actually going into a deeper state of collective unconscious. When I myself have been in an altered state, I'm experiencing catastrophic vulnerability. I *need* the provider or the supporter to show respect and acceptance for the invisible gap between people and to be interested in my inner experience; that is, the service user's inner experience…*dare* we risk being vulnerable.

I also want to share a thought about clinical case review; that is, if we are really going to behave as if we are all experts, then the service user needs to be *in* the clinical case review meetings whenever possible and feasible. Does that change entirely what gets said conventionally behind closed door? Absolutely…everything changes…our language, our attitude, what we say, how we say it…absolutely everything. That's the kind of system's change we need going forward…one based on equality and respect and transparency and dignity…everybody being at the table and sharing our best thinking.

Rita, anything to add on that?

Sure, nothing about us without us.

Absolutely.

So the last component is team outcomes, and this is really about identifying clear outcomes as *key* to guiding a shared treatment approach, as Rita talked earlier about the quality of life measure. I just want to say that recovery is very personal for all of us…for all stakeholders. Our work changes lives. Our work impacts all systems at all levels. Although there are tools, such as shared decision-making, that can assist the process, forming partnerships is more art than science. Each one of us has an extraordinary opportunity today to bring forth our inner wisdom and our *deepest* values to transforming behavioral health care.

Genuine person-centered care is a micro process which invites us to infuse our humanity into the macro process of social and organizational dealings. Our words have power. Our essence has energy. The more in tune we are with our authentic self, the more effectively we engage and support others on their journey to mind, body, and spirit health.

So with that, I'm going to turn it back to Elizabeth for our Q&A.

Wow…thank you, guys. You really have given us so much to think about and have done it in such a creative fashion, so I really appreciate that. I have been listening closely, and thinking…kind of going off of what you were saying, Lauren, about the really sort of fundamental, personal transformation that's needed to engage with this approach…not just people (inaudible) but practitioners who are doing this work and how authentic everyone needs to be, and also the notion of how absolutely key providing choice is and allowing for choice. So, I appreciate all of that.

Let me start with a question. I'll start with you, Rita. This is fabulous *and* some practitioners feel uneasy with person-centered planning approaches. It's not necessarily what they're learning in graduate school, and they may feel like it kind of diminishes their role. So, I just wonder if you could talk more about that.

I think that's a great question, Elizabeth. It's one of those things where I'll share a very brief story. When I was doing a training not so terribly long ago where I was in an intentional peer support training; I was a participant. And somebody said to me, "Gosh, it must be really, really hard for you to be so intellectual in trying to do heart work with people and trying to work with people in their hearts."

And I felt like I had been stunned because I thought I was really helping people. I thought I was really in being able to think through and help to fix people and to do the things that (audio break) their issues. I never once considered what the person themselves wanted so much. And it really was a life changer for me because I am a person who has a college degree, but I don't know that I was working from my heart as much as I was working from my head. And in order to do this kind of recovery work, it really does

require being authentic. As Lauren has said, it requires being right with that person at that person's level. I may have an area of expertise that I bring that's different, but it's not better than or superior to what the person themself is experiencing.

And I know when I was in the flip role of receiving services, I fired at least two providers who were not hearing me and treating me as if I didn't have a voice in my own treatment or care. So I guess I probably went on a bit, but that's what I would say. It really does require a realignment of relationship in order to do really good recovery-oriented work.

Thank you, Rita. And two quick points I wanted to make was, one, yeah, I think relationship is what changes the world. That's nothing new. The quality of our relationships is what's going to change our lives…change the lives of the service user.

The other thing is that I think helping and supporting…those words…which I was trained to be a conventional provider. I think helping and supporting is kind of going to be replaced with co-learning…that we're in this together and we're both experts.

That's wonderful, thank you. What you're both speaking to is that it's not that there's not expertise in the room, but it's sharing expertise and also bringing your own expertise to the conversation and be able to have conversations.

And let me just jump back in with that quote by Pat Deegan, which I think really is very important: "Shared decision-making is founded on the premise that two experts are in the consultation room. Neither should be silenced, and both must share information in order to arrive at the best treatment and decision possible." I think that's one of the best descriptions of recovery-oriented care that I can remember.

And it's a perfect lead in…thank you, Rita…to our next question, which is if we're working in systems or programs and services, how do we make sure that we stay focused on the outcomes that the person wants? Many of us work in systems where the focus is more on symptoms or on problems. How do we make sure we keep the person at the center?

Lauren, maybe you can take that one for us?

Yeah, it's absolutely critical that the person…that their vision is what we're working towards. And whenever it's not that, they know it; and it's disempowering. So there are any number of ways of doing it if you're looking at a treatment plan or a recovery plan…that the goal is very clearly stated, and the objectives and the steps are very clearly stated as much as possible in the person's words. Understandably, they have to meet all the regulatory bodies; but we can still have it be a person-driven language, person first language. The most important piece is that the person feels heard, empowered, and in control…in the driver's seat, which is how we started this whole webinar.

So we need to align our thinking with that…no matter what other outside pressures are pulling at us. We need to rethink how we're doing it to keep the person first.

And I think it's going back to that righting reflex. Anytime we think *we* have the right answer and we're not asking them, it's are we telling them what to do or are we asking them what *they* want to do? If we keep coming back to that real play…am I telling someone what they ought to be doing, or am I really asking them? The more we ask them, and the more we empower them to be able to make those decisions as much as they can for themselves, I think that's one way to do it.

That's a good point, Rita. Also, I think the question is for a provider or a supporter to ask, how am I feeing right now? What is the motivation behind my saying this at this point in time? And if we take that question seriously, sometimes I think we see how we…meaning the provider…is running the show rather than it being a co-learning experience. If we're asking out of fear or covering our butts or something that's *not* an integral part of the relationship, then I think it's time to sit back and breathe and reflect on what we're

doing. Are we going to have a heart-to-heart, values-driven relationship of equals, or is this – we really need to be aware of the power dynamics and level the playing field. That's not easy.

No, and actually, some of the questions and comments that are coming in have to do with, as a practitioner, if I'm worried about someone experiencing very serious symptoms, whether it be stopping or slowing down a medicine or in other ways, how do I balance that…my own fear or worry…with really sticking with the person's?

Well, hopefully, it's understandable that clinicians, providers, supporters get nervous when somebody wants to *do* something…whether it's change the meds or whatever. I think it's important that we have a space to talk about how we feel and to think well. So, I think often that's going to be with someone other than the person we're serving. Sometimes it might be with the person we're serving. You know, is it okay for a provider to say, "I feel a little scared, a little nervous, when I hear you talk about going off meds"? It changes the conversation, but it may change it to one that's more honest and authentic and helpful.

It's not what we're taught to do in school, but it's what I've been taught to do in the real world…particularly the past 10 or 15 years.

Rita, do you have any thoughts you want to add to that?

No, I think that was right on.

Yeah, well, thank you, Rita. I know it goes against conventional wisdom. But I think that there's a very high percentage of people who are not accessing services, and those people have good reasons for not accessing services. So, we *need* to do things differently. We need to expand our thinking, open our hearts, open our minds, to really learning *from* the people we serve, as we've talked about…that we're *both* experts in the room. We have different expertise.

We're coming close to the end, but I've got one other burning question, which is, Lauren, you spoke near the end about team process and involving people in team meetings, some people work in settings where that isn't happening regularly or even happening at all. I'm curious if you have some thoughts on what gets in the way of that and what practitioners who want to do that more can do…what advice you have?

Well, I think it really gets back to basics. If we are transparent and we want to empower people, then we need to invite them to the table. And I know it's not easy; I've done it myself as a clinician. The conversation…everything we say and do is different when we have the person we're serving in the room; but it's a great way to level the playing field and to model co-learning…that this person who we're serving is smart and has survived all the curve balls she's been thrown in life. There's a tenacity there; there's a will to live; and there's an intelligence.

And the person we're serving has a lot to teach us, and can we be open to that learning? So a little different than what we're taught in graduate school. And we stumble together. We stumble, and we figure it out together; and that's all part of the process, part of organizational change, individual change within organizational change. I'm very hopeful.

That's fantastic. I really can't thank both of you enough. I'm sure that we could continue to have this conversation for quite some time. Unfortunately, I'm going to need to wrap things up for now.

I do want to remind everyone that Recovery to Practice does have a quarterly newsletter; and if you'd like to sign up, the address is here: RTP@ahpnet.com.

We have three more webinars in this series coming up the rest of this week and next week. So please join us for as many of those as you can.

And finally, thank you. On behalf of SAMHSA, I'd really like to thank you all for taking the time out of your day to attend today's webinar. We *really* appreciate your interest and your taking time out of your jobs and your demands.

And special thanks to you, Lauren and Rita, for sharing your comments and your responses and your expertise today with us. I just think we've all been enriched by that.

If you haven't filled out the Participant Evaluation from the box below, we will post the link at the close of the session. We really do value your input and your help in helping us develop future webinars.

We're not able to offer preapproved CEUs for this webinar, but you can download the certificate from the "Materials Download" pod below.

Thank you all very, very much for joining us. This concludes our session.