Good afternoon, everyone. We are *so* glad that you could join us today. We are beginning a new series under the Recovery to Practice Initiative, and this is the first of three webinars.

My name is Melody Riefer. I'm going to be your moderator today, and I will help to facilitate the movement through the parts of the webinar that are designed all for your learning and edification.

Just a quick reminder about the room that you're in. I know that some of you have been on our webinars before; but for those of you who are new, all of the information that you're going to be hearing reflects the opinions and view of the presenters and not necessarily the views and opinions and policies of the Center for Mental Health Services, the Substance Abuse Mental Health Services Administration for the U.S. Department of Health and Human Services. As we go through the room, you might want to pay attention to the different boxes or pods that I'm going to speak about briefly.

We have a pod that is labeled "Tech and Topic Questions," that's right below the PowerPoint slides that you're seeing right now. In this area you can, and should, enter any questions you have that are of a technical nature. So if you're having difficult with volume or with the way images are looking or things like that, you can request technical assistance there. Also, if you have any questions for the presenters, please enter those questions in the "Tech and Topic" box. That way we're able to get those to make sure they don't get lost in the conversation and refer to them at the end of the webinar during our Q&A.

Closed captioning is available. If you look right under the pictures of the presenters, you'll see a box that will give you information about accessing the closed captioning.

There is a "Participant Chat" box just on the left side of the screen, and I can see that you all are already chatting it up. We're glad that you're doing so. I think that the community that we create during these webinars and from one to the other is excellent. We're so glad that you all are getting to know each other and that you're here.

As a reminder, you can get credit for attending these webinars. They're good for one hour of continuing education. The way you access that is at the very end of the webinar, there will be a link to click on; and you'll need to fill out a brief quiz and be able to print and download your certificate for that continuing education hour.

So with no further ado, let me introduce you to our presenters. Rusty Foster and Gina Shoen both happen to live in New York, and we are really glad that they can join us. Rusty is a Senior Implementation Specialist at the Center for Practice Innovation, and Gina is an Advocacy Specialist with the Office of Consumer Affairs for the New York Office of Mental Health. Both of these folks come to us with a lot of experience and have thoughtfully considered this topic and are going to share with us their best wisdom. I'm going to turn this over to Rusty now as he kicks us off for this webinar.

Thanks, Rusty, for being here.

Well, thank you, Melody.

I am very excited about being here and doing this webinar. I'm looking at the "Participant Chat" box, and there are people from all over the country; it's pretty impressive. I'm glad everybody is with us.

These are the learning objectives for today. I'm not going to read them; hopefully, you will kind of look at them yourself. We want to go right into the meat of the presentation. The goal of the presentation is to think about what helps engage people in services and keeps them engaged in services.

What we want to do is a start with a little definition of engagement. It's from...and I'm sure that everyone on the call recognizes these two names, Miller & Rollnick; this is from their "Motivational Interviewing" text, Third Edition, and it's pretty meaty:

"Engagement is the process of establishing a mutually collaborative, trusting, and respectful helping relationship."

Now, you can see that there are three words in bold. Those are the kind of terms that we want to see if we could elaborate and also figure out what things we could do to develop a collaborative, trusting and respectful, helping relationship. So that's the definition. You might have other parts that you want to say would define engagement. You're welcome to write them in the box; we could share those in the "Chat" box, but this is the working one that we're going to start with today.

Now, why is engagement important?

Well, this is just an incredible kind of series of bullets. One, half of all people with a serious mental health problem had not received mental health treatment in the prior year...that means in the past year. That means half of all the people that have a serious mental health issue in the United States were not receiving treatment. This is information that came originally from the Epidemiological Catchment Area study.

Now, why is that an issue?

Well, low engagement or non-engagement can lead to exasperation of symptoms, increased rehospitalizations, and not fully realizing the potential benefits of treatment because they're not in treatment.

The last bullet is if people do engage in treatment and they stay in treatment, they have improved outcomes. That means they stay out of the hospital; they have less involvement with the legal system. So there's less of the negative consequences, but there are also some positive consequences. They tend to go back to school; they go back to work; they have improved outcomes; they're functioning a little better; they're managing their symptoms better. So engagement is *crucial* to the treatment process, and it's the first step in the treatment process.

So what works in engaging people?

Well, this is a survey of consumers. Individuals that were in services said that what works for them is, one, the relationship they had with the practitioner, the provider, the therapist, the case manager; that relationship was *key* to the engagement process.

And what does that relationship look like?

Well, from our perspective...from the provider's perspective:

Warm respect, friendliness, interest in the person...you're really clearly interested in what they have to say and what they're thinking and what their life's been like for them and what their values and goals are.

Patience...that you're going to not try to rush things, we're not going to have these kind of external pressures apply inside the relationship.

Sincerity...that what you say is genuinely who you are.

Now, when you look at those, I don't know if they seem obvious to people; but it's what *we* would ask to be a part of all the relationships we're in. So this is the first thing that's important that individuals receiving services say.

The second thing is that providers showed acceptance and support. We're going to talk a lot about acceptance and support, but acceptance being you accept the person for who they are. They don't have to be different for you to appreciate them. And you're going to support them around the things that they're interested in. You're going to give individualized care. It's not fitting the person into the program; it's designing a program of care for the individual based on what they consider their needs, their goals, their values.

You're going to focus on meaningful life goals. That is, going to group is not a meaningful life goal. It might be a means to get to a meaningful life goal; but the focus is on developing relationships, identifying a nice place to live, managing symptoms, going back to work. These goals *must* be identified by the individual, not by us. It's their goals that drive the treatment and keep people engaged. So that's what individuals say.

So what could we do to put those into place?

Well, the overarching or the big framework that we're going to work within first is recovery-oriented care. What recovery-oriented care does is, first, it identifies...and these are like goals of recovery-oriented care. These are like foundational elements. So you identify and you build upon the individual's assets, their strengths, their areas of health and competence. So it's looking at what it is that's going well for this person, what you appreciate about this person, what their strengths are...and not just looking at the areas of symptoms, the areas of weaknesses, et cetera.

So recovery-oriented care is strength-based; and the idea is to support the person in achieving their sense of mastery, where they develop a sense of mastery over their mental health and drug and alcohol issues so that they have a way of – it doesn't mean these symptoms will all go away. But they have a way of focusing their goals within their ability to manage these symptoms.

Then, helping them regain their life and a meaningful constructive sense of membership in the broader community...which means helping them go back to work, go back to school, reconnect with family, et cetera.

The last kind of recovery-oriented care is looking at this process. The more definitive definition within recovery-oriented care around engagement is engagement involves making contact with the person rather than the diagnosis of disability...strength-based...looking at the human being that's in front of us. That's very important in any helping relationship. When you do that, you can build trust over time; you can look at and attend to the individual's stated needs; and directly or indirectly, you provide a whole range of services that are in addition to clinical care...things like supported employment, supported education, helping people with housing, helping people get health benefits, helping people deal with Medicare, Medicaid, et cetera.

Finally, recovery-oriented care enhances the relationship between the individual and the provider. That's doing what we were saying in the first two slides helps build and enhance the relationship. And we know that a good relationship is the foundation of any kind of successful treatment. Recovery-oriented care aids in the development of mutual understanding, hope, empathy, trust, safety. We're going to look at these in a more expansive way when we talk about the next two methodologies for engaging consumers. Recovery-oriented care promotes advance in personal as well as treatment goals, and it supports the individual staying involved in the treatment. So when we do all these things and when we adopt these positions and values of recovery-oriented care, we're going to enhance engagement.

So that's the framework we're going to work with. Now, there are a number of treatment approaches and methodologies that help us move toward the recovery-oriented care when we work with consumers. The first one we're going to talk about is the stages of readiness of change.

Now, I know you guys probably all know the stages of change. This is Prochaska and DiClemente. I just want to review it very quickly just to make a simple statement. What they came up with...and it's odd that no one thought about this before because they did it in the '80s because it's hard to not think this way anymore...but change is a process not an event. People change in stages from free contemplation all the way to maintenance. So what does that mean?

Well, here's an illustration of what happens when we *don't* work in terms of understanding and connecting with a person's readiness for change. We often want a person to change. We are in the helping profession. The person comes in; we see they've got all kinds of issues; and we want to jump in and help them change. We come up with lots of ideas. We come up with treatment plans. We've got goals...you should do this, you need to do that. The individual though might not be ready to make a change *even* if they voluntarily enroll in your service, and what happens is there's a mismatch between what *you* think should be done and what the consumer is ready to do. If we don't do something about that mismatch, the individual is going to end up feeling very misunderstood; you're going to feel frustrated.

I've talked to lots and lots of practitioners; and lots of times they'll say how almost frustrated they are, how almost angry they are, that the person is not following their treatment plan. They say they want to do it, but they're not doing it; and you really almost want to say, "I can't take it anymore." What happens is when you put all that together, the individual disengages from treatment; they drop out. What we need to do is when we feel frustrated...this does not mean you never feel frustrated. But when you feel frustrated, you recognize you might be in the wrong stage. You might be in a different stage than the consumer is in, and what you need to do is recognize that they might be not ready to change; and slow down and move back and reconnect with that consumer in the stage they're in. That's how we need to look at engagement from a stage of readiness for change perspective.

Here are some other things that we should consider when we talk about stages of change. Ambivalence is normal; it's part of the change process...so not pathologize it. We have to figure out how we're going to identify a person's readiness for change; and then are several tools out there...one of them being the readiness ruler...that help you understand where that person is at around changing a particular behavior. We always have to match our treatment to the individual's readiness.

So if they're in pre-contemplation or contemplation, we have to not, for instance, say, "You need to go to a group to do this." What they need to do is explore their ambivalence and think about maybe the idea that changing would be in their best interest...for them. We need to guide but not direct. We can provide information and give advice to people, but we have to do it with permission. We *could* say, "I have an idea what might help you. Would you be interested in hearing it?" or "Other people I know that I work with did this; I don't know if you want to try it."

Then the final thing is we have to honor their autonomy. No matter what we do, in the long run *they* get to choose. We can give them a menu of stuff, but they always get to choose. When people choose something they're interested in doing, they're more likely to follow through and stay engaged.

Okay, connected with stages of change is motivational interviewing. I don't know how many people have been trained. Probably everybody has had some training in motivational interviewing. But in terms of engagement, how we view an individual is one of the keys to the engagement process. We need to have an openness to a way of thinking and working that is collaborative rather than prescriptive. "Let's work together," versus "Here's what I think you should do."

As we said before, we have to honor the individual's autonomy and self-direction; and we need to do more evoking than exploring; in other words, we need to have a discussion in a way that we ask *them* what their ideas are. We ask *them* what they would like to do. We ask *them* what their values are. We don't try to put stuff in them on how to change.

Finally, motivational interviewing includes at least a willingness to suspend an authoritarian role. We are not in charge. We are not the experts that could solve the problem. We are not an authority figure. We are part of a collaboration.

And these all go together. You see how all these can go together. When we do this work, when we're working in a recovery-oriented care kind of format, we want to use the spirt of motivational interviewing. That includes acceptance, collaboration, compassion, and evocation. If we do these...if we are accepting of that person as they are, absolute worth, we develop a partnership; we show a person we care about what happens and we're going to do whatever it takes that is going to get them to where they want to be; and we use evocation...we are developing a trusting, caring, therapeutic relationship that's going to go a long way in getting that person engaged and staying in treatment.

So we want to do active listening. People will more likely develop a trusting working relationship if you *listen* to them. You don't criticize. You let go of your agenda, which is not hard, trying to direct them to do what you think they should be doing. You have to stop that and be open in a mindful way to what they're saying. Let them tell their story, but be very interested and curious...and you automatically will when people tell their story...about what they're saying.

Here are the things that you might *not* want to do. These are roadblocks: confronting; ordering; directing; warning...if you do this, you're going to end up in the hospital; lecturing or preaching; judging. These are things we want to stop doing if we're going to engage people. These things actually set the path towards disengagement.

Then there are the "or's", and each of these are ways of opening the conversation so that that person feels heard, feels listened to, and feels that we're interested in what they have to say: open questions, reflective listening, affirmations and summary.

Finally, you've got recovery-oriented care, you've got stages of change, you've got motivational interviewing all working together. Then you have shared decision-making. In shared decision-making, there are a number of steps. This is a methodology of working collaboratively around treatment decisions. So both the individual and the practitioner take steps in sharing the treatment decisions. The practitioner brings certain things around information, around what helps for mental health problems, drug and alcohol problems, what the different treatment benefits are, risks and benefits, the evidence for what works and doesn't work. The individual brings information on their personal experience. They work together; the practitioner actively solicits the individual's perspectives on their problems, their preferences, their values, what *they* think of the potential solutions.

The individual is involved in all treatment decisions; they're part of the treatment team if there's a team working...if not, then they're part of the decision with the individual practitioner. They're the expert on their own values, treatment preferences, and goals. And then the team, or the practitioner and the individual, come to consensus regarding the preferred treatment option.

The way these two...motivational interviewing and shared decision-making...are a little different is motivational interviewing helps engage people and works well with people who are ambivalent. Shared decision-making helps people keep engaged but it assumes that there's already a relationship; the individual is ready to decide, and they're focusing on the best options. So it's collaborative; and when we work this way, people stay engaged who have already developed a treatment relationship.

That is my piece. I am now going to turn it over to Gina.

Thanks, Rusty. Let me transition here.

As everyone can see, I'm going to focus on peers and what peers can bring to the service delivery. We bring more than just another way to build; we bring another viewpoint, and a way to connect and reach folks who otherwise might not be able to be caught before they fall out of the system. We're translators between clinicians and individuals, and we often have an immediate connection with people through our shared living experience.

Peers have played an integral role in many different service delivery areas...from vet to vet group facilitation to crisis respite, and as members of the (inaudible) team. We're uniquely suited to offer a variety of services and support people in mental health and substance use recovery services. We're role models for family members who may think that our mental illness may last forever. We're proof that recovery is possible. We demonstrate to individuals that healthy connections within our communities are not only possible but they're enjoyable, and they're within reach of everyone.

We role model for clinicians that recovery is possible. Every day, it is reinforced that the people that they serve can someday return to the workforce and lead fulfilling lives as well; so we don't just represent that for the people that they serve but for them also.

The presence of peers is so important. It's not just how we view the individuals that we serve. As Rusty pointed out in some of his earlier slides, it's also important to be open to working collaboratively rather than just prescriptively. I believe that employing peers is part of these two concepts.

Peers can bring a new perspective to the treatment team, and they can reinforce the desires of the people that we all serve. As peers, we keep the focus on recovery and empowering the people that we serve. If clinicians are able to work with a peer and view them as an equal and truly see the value in their position, they may be able to effectively help with the problems in the engagement process in a more meaningful way.

Peer support has an established history as an evidence-based practice. Outcomes are dramatically improved when we include peers in programs. We have a unique perspective and are able to bridge the divide that often occurs when people are disengaging from treatment.

The stages of change are a great example...when Rusty discussed how individuals sometimes feel misunderstood and providers feel frustration and how this leads to people disengaging.

Peers are unique because we're able to be translators and bring those two back together. We don't replace clinicians, however. We work with them to help facilitate and further the discussion with folks who are often distrustful or burned out or fearful. We encourage and empower people to be part of their treatment and realize their potential. We share information with the clinician that the individual may not be able to articulate on their own. We facilitate the discussion with both parties, and we use active listening and motivational interviewing ourselves; but we're not messengers. We help people find their voices and their own path to recovery.

The certification of peer specialists to work in the mental health system is another important link in providing recovery-oriented services. It doesn't just ensure that people reach certain competencies in their training; it helps keep certified peer specialists engaged in ongoing education and professional support for themselves and gives them a strong background in the pillars of peer support. The difference between a certified peer specialist and a non-certified peer is not just the ability to bill for services, but the standards that they have to meet to become and remain a certified peer specialist. The classes, the testing, and certification process are challenging as well as time-consuming; and it takes dedication to participate in this process.

The Academy of Peer Services here in New York is a great example. So many people have contributed their expertise and their time to it, and they're constantly developing new content for it. They engage peers in order to build a better process for that. These positions have become integral in places like crisis respite, emergency departments, and psychiatric facilities, both inpatient and outpatient at their clinics. The role is ever-expanding and it's finding new footholds daily.

The great thing about peers is that they can build an instant rapport. We help discover someone's reasons for disengagement, and we also discuss their life goals. Everything that we discuss with people is based on individualized care, and it's all recovery-oriented. We use recovery-focused language, and we demonstrate recovery to the people that we work with and for.

When you work with a peer on the treatment team and you see them as an equal partner, it's a good way to reinforce and reaffirm your belief in recovery for your staff *and* for the people that you serve. You get to see that the power of your belief in the peer system works for you and as the peers work with the people who are hard to engage, have already disengaged, or perhaps have had long-term inpatient stays and need to reintegrate in the community.

So if you truly believe in the peer support system, it's going to pay off. When you show the individuals that you work with that you believe in recovery enough to work side by side with a peer supporter, you're also telling the people that you serve that you believe that they also can do it; and it's a powerful statement to someone who is in recovery.

The power of peers in engagement is their relatability to the clients that you'll be working with. Peers work from the context of recovery and, when included in a variety of settings, the statistics show that length of stay are shortened; treatment costs are reduced; and recidivism is reduced as well. Peer support can help reduce the need for, and the overall use of, traditional mental health services over time as well.

The reality of all of these studies is that peer services work. Whether it's a peer-run respite, a peer support group, peers on a treatment team, or peers in an emergency department, when peers provide services to someone who is in a similar circumstance that they once found themselves in, it not only saves money; it shortens the duration of treatment, and it provides better outcomes. Now, this isn't just reported by the people that we provide the services to; it's reported by the people who track these services...not just the people at the programs, but the people at Medicaid Services as well.

Whether it's part of a formal process or in an informal group, peers easily engage one another. We're more comfortable when we feel a kinship, regardless of who you identify with as a peer. Whether it's someone who has received mental health or substance use services, as a veteran, a police officer, or a teacher, people naturally feel comfortable with someone they have something in common with. We are more likely to share something we feel stigmatizing with someone who has also felt the sting of that stigma. It's not about locking out clinicians; it's about trusting someone to lead us to them and be a translator until we can find our own voice. Peers are a natural choice to include in the engagement process.

I ended really quickly.

Rusty, would you like to summarize?

Thank you, Gina. That was terrific, thank you.

I'm going to do a couple of summary slides, and I think then we're going to open it up to questions and answers. I see the "Chat" box seems to be filled with them, so we want to make sure have enough time to try to answer as many as possible.

In summary...and it will be interesting, Gina, to see because this is a summary a little bit about what I was saying and some of what you were saying, but how well this fits in with the kind of focus on recovery-oriented care that peers provide.

The first bullet is: Keep the focus on the individual and their identified goals. Try not to take the A to Z perspective, the program's perspective, your agenda; but try to find out what it is the individual wants in their life and work towards that with them. Keep the focus on that.

Engagement hinges on receiving what can be considered – let me rephrase that. Engagement *often* hinges on what could be considered non-clinical services. It's unfortunate that it's considered non-clinical because these add to everybody's mental health. So we have to make sure people have good housing. If they're homeless, we have to help them find housing. We have to provide supported education if they

want to return to school or employment...these kinds of practical needs are crucial to make sure that we're providing services around if we want to engage people.

And this is what people who are coming in and we're trying to engage often come in with. They come in with practical needs; they don't come in with clinical needs. If we kind of try to force them into clinical services when they really need practical services, they get disengaged. So look at the potential of providing not clinical services but practical needs services.

Reach out to individuals and provide services in their natural living environments. Sometimes we can't just expect people to come into our office. Sometimes we have to, like, when people are beginning to get disengaged or they're struggling coming for services, we have to reach out and provide services in their natural environment.

The other thing is we have to be consistent and persistent in our efforts to actively engage reluctant individuals. We can't say, well, they're not interested and we're going to go on to the next client. We've got to keep trying and be hopeful because in some ways...and whether we're a peer or a practitioner...being hopeful gives them hope. A lot of times people come to us and they're feeling very hopeless, and they don't see that the treatment is actually going to help them.

A couple of other things to keep in mind...many people fear or initially do not want to change, and we have to accept that. People might not want to change, right? We can't force change on people, so we have to accept that; and sometimes in accepting that, it opens up space to the idea in that person's mind of actually changing. We have to respect their autonomy. The individual's perspective and wishes matter more than our sense of what might be best.

We're thinking "this is going to be best," and they have a different perspective and they have different things they want. That's what matters. That's what we're going to connect with. We have to set aside our own fears, values, and choices, in order to join with an individual in making his or her own choice. Sometimes it feels we're letting go and there's going to be this terrible thing happen, and we have to, like, overcome that if we want to stay engaged and connected to a person.

The last thing...and I got this from a consumer. It was a case presentation. He was actually a peer specialist on staff; and he said, "Change takes time". Remember, change takes time; and this is what he said "...over time, not overnight." We have to hang in there and keep working at this so that we can engage people that have real needs.

That's the end of our presentation. I just wanted to show this. This is our references. You're going to get these slides, so I don't have to go through them; and you'll be able to look at these.

I guess we're going to open it up for questions, discussions, and comments. I know we've got a lot of them, so we'll start.

Thank you, Rusty and Gina. We do have a ton of questions, and folks are very engaged on this topic of engagement. I think that it's because we all know how important it is to people being successful and getting what they need while they're receiving services. I'm going to pose questions that have directed specifically by the audience member that submitted the question. Some are perfectly appropriate for you both to share your opinions on in terms of the answer; and so I would invite you both, Rusty and Gina, to be prepared to respond to *any* question.

Gina, if you don't mind, I'm going to start with you; and I have a couple of questions about peer specialists. One participant wrote: "As I understand it, as a certified peer specialist, one has to have a mental health diagnosis. Why is this a criteria?"

Well, (pause), it's hard to explain. Ethically and morally, we believe that in order to provide mental health services as a peer specialist, you should be able to relate to someone on the same even playing field. Now, some people have become certified peer specialists; and they feel like they can provide those

services because they're family members. Other people who are receiving the services from those peer specialists, they're not upset by that.

I guess that for me, I *am* a peer; and I'm also a certified peer specialist. I feel it's very important to be able to meet people where they're at and to be able to relate to them and share with them that I *am* a peer. I think it's very important that they know that I've *been* where they are and that my recovery is a journey and that they can be where *I* am...that it's not a lifelong sentence. I think it's very hard for someone who doesn't have a mental health diagnosis to relate to someone else and be able to say those words..."I've been where you are, and you're going to get better; and this is where you too can be." You just haven't been down that road, and you haven't walked in their shoes.

So for me, in my opinion, that's why that criteria is there. There have been a few disputes. I've had some conversations with people who feel that as family members or loved ones, spouses and such, that that shouldn't be the criteria. But there are positions for family support specialists, so there isn't really a need to become a certified peer specialist to hold those positions.

Thank you for that. I think that it's important to know that there's not a universal or national answer to that question because each state actually makes the rules around who can be certified and what the criteria is.

Yes.

So that was a great answer, Gina, thank you. To move on--

Melody, can I – you know, there's a lot of conversation in the "Chat" box. Would you mind if I read Rex McQueen's response to that...to this question?

Absolutely.

Rex, I hope you don't mind if I read yours.

"As far as being a peer specialist with the VA, as a veteran it automatically gives us credibility. Furthermore, being diagnosed with a mental illness and being in recovery adds strength to the hope of recovery."

I couldn't agree more.

So that's an interesting response from the group of people on.

Thank you, Rex.

Absolutely, it's always great because one of the suppositions is around the universality of expertise. So certainly your specialists have expertise, and our audience has incredible experience and expertise to share with us.

Another question...and, Rusty, this one was directed to you. It's a little specific. The question is: "Suggestions for how to help providers stay focused on the person's strengths when funding for services through a third-party payer system is focused on pathology for illness."

Right, this is where there are external pressures on practitioners that impact on how services are provided. I don't know how your documentation is written and whether you have to put in, like, the problem kind of thing.

In person-centered planning and person-centered treatment plans, you often start with what the *person* wants. So if the person says, "I want to go back to school," then you would then talk about the steps they're going to take to do that and the barriers. The barriers might include what would be considered a pathology. You would do what are the strengths that they have, what are the resources that they have to go back to school, and what might be the barriers...so that you're documenting some of the issues. You

can't be Pollyannaish and say this person has no issues, right? But you don't want to pathologize what's happening in the person's life and make it that the goal is to get rid of the pathology. You want to work from strengths and then list issues that might get in the way of goal achievement.

I don't know if you're all right with that. We could talk more if you want.

All right, I think one of the things that I share with people when I'm doing training is this need to perhaps be bilingual. And for those that are payers, they want to see what – if you consider that we sit inside a healthcare system, they want to see people move from illness to getting better and better and better and what those steps are. They don't want to pay for people who are well because then they wouldn't be receiving the services.

But if we know that focusing about illness does not help people recognize their wellness, then we kind of become bilingual and use language that might be more diagnostic or clinical or medical-focused and with a person, really talking about their experience and their lives and their wellness.

So *I* resonated with what you said, Rusty.

We have a questions...and I think this would be for either or both of you: "How do you work with clinicians who believe that people just aren't motivated and that's why they're not engaged?"

Well, I think you have to think about what – you might – I don't know. Here's my answer to this...to drop the idea of motivation and think about what is this person – you might even need to – if you're trying to engage this person, you might need to talk about things that have nothing to do with motivation, with mental health treatment. You might need to talk to people about some practical needs and things that they're interested. It could be sports; it could be TV shows. Because if you don't have that connection with the *person*, then you're not going to get anywhere in terms of change.

I'm assuming when we say "motivation" that the person is interested in changing something in their life. Sometimes you've got to – it's an odd kind of phenomenon, but you've got to drop that push to get the change. Because if the person's not ready for that, the more you push the less likely they're going to stay engaged, right?

So you might need to think about saying – you could say, "Look, I've been trying to get you interested..." and when we say motivation, we mean motived to do *something*. You're just not motivated; you're motivated to do something. And you might have to say, "Look, I've been trying to get you to drink less; I've been trying to get you to come to group. This is not something you seem to be interested in. I'm just going to drop that and just talk to you about what *you're* interested in. What would *you* like," and having a gentle kind of conversation that you would have with a friend on some level.

Now, I don't know if that's the answer you're looking for; but that's how I think about it.

For me, honestly, I've worked with several clinicians who have had issues seeing true motivation in people; and I've always had the discussion about the difference in values with people. Not everyone values personal cleanliness, for instance. Not everyone values a lot of money. Not everyone values a lot of personal property. That's hard for people from every different point in life to believe.

So when a clinician will say to me, "Well, I just don't think that Tim is very motivated."

I tell them, "Well, why do you believe this?"

If I believe that Tim really is motivated, I try and encourage the clinician to examine why Tim's values might differ from the clinician's values, and how can we engage Tim and find out what he really values and what might motivate him as opposed to what might motivate the clinician. When our values differ from one another, sometimes we don't recognize other people's motivation.

As Rusty said, it isn't always about, geez, you're not coming to group and you're not coming to treatment. When you have two completely different value systems and they're at odds with one another, sometimes you just can't *get* somebody; and that really makes for a difficult relationship. So I always encourage people to examine their own value system and are you trying to impose it on someone. Sometimes we do that; we impose our own values on people without realizing it; and that happens more often than we like to believe. It's not like we're literally shoving our values on someone; but we're superimposing, I guess, our values onto other people; and that's why we don't recognize their motivation.

You know, that really is a very, I think, helpful way to think about this because one's culture and personal values really does influence what motivates them and what moves someone towards engagement. Clearly, if we're not being culturally responsive to what people are showing us...even if they aren't telling us that, but if they're showing us that...we need to kind of change where we're sitting and the lens from which we're looking to be able to connect with people. So both of your answers were really helpful. Thank you for that.

I'm wondering...there was a question about shared decision-making. It appeared as though some people in the audience were less familiar with shared decision-making than others. I'm wondering if either of you could answer what the difference is between shared decision-making and supported decision-making.

Rusty, do you want to take this one; or do you want me to?

Gina, why don't you start; and Rusty can come in.

Okay, so for me, shared decision-making is where the clinician – I've never – I've always had a clinician come to me and say, "Listen, I'm having trouble engaging someone and these are the things that we have to go over." So they've always given me certain things. I've never actually done shared decision-making with someone unless they've come to me and needed help with it.

So I would present the decision that we have to make...like, maybe, okay, housing. Do you want to move into a community residence? Do you want to live on your own? Blah, blah, blah. So we give them a series of choices and discuss the pros and cons of each one; and hopefully we can come to an actual decision about where they'd like to be and it's going to match up to a healthy place, rather than, hey, I want to go live on the side of the road in a shack and it's going to be an unhealthy decision.

But oftentimes, it isn't as easy as that. Sometimes people want what they want. So shared decision-making, basically, is offering good healthy options and hoping that people are going to pick from those options.

Well, yeah, I think that starts to touch on it. Frequently, shared decision-making kind of references the process and the two people using each other's expertise to determine a next step. Supported decision-making, to my mind, is kind of the specifics...like, here are the options, and let's learn about them and look at them so that there's information on which to base a decision.

I just noticed that we are almost out of time. So we're going to have to move forward. What I want to do is let folks know that the PowerPoint and the recording is available. So if people want to be able to read through the materials and see the resources that are available, those are all going to be on the slides when you print them.

Gina and Rusty, I really appreciate your willingness to bring us expertise.

Melody?

Yes.

I don't know if I can make one last thing on shared decision-making.

We are close to out of time, so 30 seconds...go.

Okay, so in shared decision-making, it's a collaborative process where the practitioner brings the expertise around what might be available in terms of resources around a problem that the person wants to focus on; and then they try to come to consensus. But in the bottom line in shared decision-making, if the person doesn't want to do what the practitioner wants to do, it's still – you've got to honor autonomy. It's their choice. That's it.

Yep, it's not shared decision-making unless they're both sharing it and in agreement.

They agree, yeah.

And so the foundation for all of this really is based on how we define an approach to recovery. SAMHSA has given us a definition of recovery that's based on ten principles and four dimensions. So right there, you know it's complex. But ultimately, recovery is based on what the person wants out of *their* life. And Recovery to Practice is committed to helping people who work in the field be able to take these principles and dimensions and apply it to the work that they do, both under the auspices of their discipline but in those day-to-day services that they deliver.

We have additional resources that address this topic and look at engagement. For those of you who want more information, there's plenty to be had. These articles, we believe, are a great jumping off point.

We also have a newsletter that is focused on family engagement. There were a couple of topics and themes that we weren't able to touch on: family engagement, inpatient services, things like that. They're all worthy of exploration and discussion.

As I mentioned at the beginning, this is the first webinar in a series of three. Our next two webinars are going to be in May. We're going to look at engagement and the use of WRAP, the Wellness Recovery Action Plan. Then later in May, we're going to look at engagement and technology; so that's really about reaching out to people and being able to make concrete connections with folks.

We're going to be also releasing, in the very near future, some online courses that look at integrated behavioral health themes as well as peer support for people experiencing homelessness. So our goal here at the Recovery to Practice Initiative is to provide you all with reliable information to be able to continue your learning as you work in the field.

Remember, you can receive a Certificate of Attendance or earn a continuing education credit by clicking on the link that you see in front of you.