Good afternoon everyone and welcome to today's Recovery to Practice webinar titled "The Role of Medication and Shared Decision Making in Recovery-Oriented Care." My name is Elizabeth Whitney and I am the Technical Assistance Lead for SAMHSA's Recovery to Practice Project, and I'll moderate today's webinar. I'll 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 120 people in the audience, and we really thank you for coming. On behalf of the Substance Abuse and Mental Health Services Administration, we'd like to welcome you all and thank you for your participation. And I'd also really like to extend a thank you to our presenters, Ken Thompson and Melody Riefer for taking time from their busy days to share their knowledge and expertise with us.

So, let's review the page layout to help you get the most out of the webinar features. You have three options for communicating with us. If you experience any technical difficulties during the webinar, please enter your question in the "Technical Chat" box which is over to the left, and a support technician will quickly help you. There's a question-and-answer box for questions for the presenter. We'll raise as many questions from this box as we can during the discussion. And finally, you can use the chat box for general comments and discussion with other participants. We ask you to please keep chat relevant to the presentation.

If you'd like to zoom in on the slides we're sharing today, you can make them larger with the full screen button in the upper right corner of the display pod. To exit full screen, just press the "Escape" key on your keyboard. This allows you to view the presentation without the pod so it's not as confusing, or to switch back to the pod use so that you can pose a question or make a comment.

You can download a PDF version of today's presentation, additional resource materials, and a certificate of attendance from the "Download Materials" box. The webinar is being broadcast via your computer, so please make sure your computer speakers are unmuted and adjust your volume as you need. If you do not have computer speakers or your sound is not working, please let us know using the technical chat box. We'll have an option for you.

Finally, we've put a participant evaluation link in the webinar links box. We'd appreciate your taking a few moments at the end of the webinar to complete the evaluation. Your feedback helps us to learn from today's presentation and develop future webinars.

This webinar series is hosted by SAMHSA's Recovery to Practice, which is a workforce development initiative with the overarching goal of improving the knowledge and skill of the behavioral health workforce by integrating the concepts of recovery-oriented care into everyday practice. What do we mean by recovery and why is it important? Ron Manderscheid described recovery as one of the most powerful words in our behavioral health language. It creates real lives, it promotes hope, and it can open doors to dramatic care reform.

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 ten components of recovery form a structure and foundation for developing recovery-oriented lives and building recovery-oriented services and systems. SAMHSA initiated the Recovery to Practice initiative to incorporate these principles into the behavioral health workforce.

The initial phase of 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 uptick of recovery principles and practices. Each discipline used language and frameworks relevant to their membership and developed ways to integrate the curricula into their professional development and certification procedures. You will find links to each of these associations' websites in the webinar link box below.

The second phase of Recovery to Practice focuses on multidisciplinary and integrated services and settings to push these concepts and resources out to more diverse audiences and settings. This webinar series is designed to open the recovery practice curricula information to a broader audience. I'd now like to introduce our speakers for today.

Kenneth Thompson is Clinical Associate Professor of Psychiatry at the University of Pittsburgh, and Medical Director for the Pennsylvania Psychiatric Leadership Council. He has focused his career on community health and improving psychiatric services. Ken has also worked in a clinical and leadership capacity across the spectrum of community behavioral health and primary care settings, and has an extensive background in behavioral health services research. Ken previously served as the medical director of SAMHSA's Center for Mental Health Services, where he provided expert psychiatric consultation, public policy formation, and implementation.

Melody Riefer is a senior program associate at Advocates for Human Potential. She has over 30 years of experience in mental health services. She previously worked as Director of Training for Pat Deegan and Associates. Melody has also served as a member of the Office of Mental Health Research and Training at the University of Kansas School of Social Welfare, and as the director for the Office of Consumer Affairs for the State of Oklahoma. All of Melody's work is informed by and benefits from her personal journey of recovery from serious mental illness. I'm really pleased to welcome both of you. And Ken, you can begin.

Thank you very much, Elizabeth. I hope you can hear me okay.

Yes.

I'm really pleased to be able to talk to all of you and to see the process of Recovery to Practice rolling out. One of the things that I was most proud of of my time at SAMHSA was being involved in the initiation of this effort. So, I'm glad to do it and I'm glad to see so many people from all over the country signing in to be a participant, and I know there have been others, in the series that's going on and will continue.

My agenda today is to talk about the role of medication in recovery, to talk about shared decision-making, and strategies and challenges in addressing those issues. We're going to do a quick poll on what shared decision-making is. And what I'd like you to do is to take a look at the five definitions for what shared decision-making is and pick the one that you think is the best or accurate -- most accurate definition, and I'm going to give you just a couple of seconds to do that.

Okay. I think we've got a reasonable sample. I'm going to move on, but if you can still vote and it's in your position to vote, please go ahead and do that if you haven't already. The main issue that I want to talk about relative to medication in psychiatry is the fact is that, in psychiatry at the present time, we don't have a medication that is a silver bullet, that you take it once or you even just take it for a week and you never, ever have to take it again. We don't have a simple cure for most of the psychiatric challenges that people face.

What that means is that medication becomes something that is -- that you're going to have to continue to use in some form or fashion over time. It requires effort and it requires work, and it requires dealing with a whole range of potential side effects or other concerns that come up with medication. So, the act of engagement of a person in their care, in the use of medication is absolutely essential. And that, I think, is one of the fundamental findings of a recovery-oriented approach is that you've got somebody who is in the process of recovery trying to use tools that are helpful to them in that process, and medication is one of them.

So, necessary considerations for that, medication and our other treatments must be seen as being helpful. If it's going to take work and effort to do it, then people are going to have to feel like they're getting something out of it. We do know that, at the present time, many, many times medication scripts are unfilled and bodies are never -- bottles are never emptied because people don't take them. And clearly if the medicine is going to be useful, two things have to happen. One is that the right medicine has to be prescribed for the right circumstance and the person who's taking it has to agree that it's the right medication for the right circumstance because otherwise they're unlikely to take it, unless they see some benefit from it.

So, recovery-oriented use of medication means that it's about a personal choice. I do want to say that there are obviously some circumstances, hopefully very limited in number, in which medications are not a personal choice, and that has a lot to do with issues about -- concern about safety and concerns about violence and other kinds of things that are very unusual, fortunately, and probably require a separate discussion. But I think that in general it's fair to say that the choice to use a medication is something that people who are in a process of recovery are going to face on a day-to-day basis.

The successful use of medication requires, if it's going to be done in a collaborative way, that there is a sharing of information and decision-making, and that there's got to be some capacity to be flexible and to assume, in some ways, that we're not going to know everything there is to know about the effects of a medication, and how to best combine medications all the time. And there's some assumption of risk in doing this. As I said, it's a tool and it's not a solution in itself, and it's one of many tools that we use in the process of helping people recover, supporting their recovery.

So, this is a paradigm shift. We're moving away and the whole process of recovery is to move away from thinking about what's wrong with a person, and merely focusing on what those symptoms are, or the problems, and moving more towards incorporating wellness and the wellbeing of the whole person in the process of their recovery. I think probably, if I can just speak, you know, momentarily, one of the things that was really turned my thinking about all this around was to realize that, in a lot of ways, our assumptions about people -- this is speaking from the medical/professional side -- our assumptions about people were that they did not have as much role in their own process of getting better as it turns out they actually, one, have to have if they're going to recover, and two, actually have.

So, the process of recovery is really about incorporating the capacities and the capabilities of a person into their own work of recovery. The successful use of medication is predicated on the support of other helping services and resources that help move the therapeutic alliance forward, because obviously you're more likely to be willing to take risks with medications, to try options, if you have some sense of basic trust that the person who you're working with, the professional, is somebody who's actually attending to the other concerns and other issues that are coming up in your life.

There's lots of perspectives on medications. You know, I've kind of been alluding to this. People hopefully find them useful, they find them helpful in their healing and that they actually make their lives easier to live. And there's a flipside to that that sometimes medications are perceived as not being useful or causing discomfort, and both these things can actually exist at the same time. Clearly, there's the concept of the right medication at the right dose at the right time, and that implies that there's the wrong medication at the wrong dose at the wrong time. So, we're -- it's nothing new to think that medications may, at times, be problematic, nor is it something new to think that they might actually be beneficial.

So, why would somebody take a medication? As I said, while they're not a cure, they can help, they can help reduce symptoms, they can help people feel like their lives are having some meaning and quality in them, and they increase, hopefully, the capacity for people to deal with the things that come up in life on a day-to-day basis and allow them to pursue opportunities that they would like to pursue to have lives that they want to live. As I said, it's a tool. When it works, it can be a lever that a person can use to help accomplish things in their life that they want to get to.

This is something that I frequently -- and I think it's a culture that we have to kind of work against -- there is a culture out there that the medicine or anything that we do on the medical side is going to be a silver

bullet and that the work of the individual is going to be minimal. The truth of the matter is medications work, but they require a lot of work. They require the work of taking them. They require the work of understanding what their effects are and dealing with them. They require the work of taking care of yourself, making sure that you're eating, sleeping, taking care of the stuff that you can take. And sometimes it's stuff that, for example, people who are depressed don't want to get up and exercise. The dilemma that we've got is that unless you start to find a way to do that, the antidepressant that you're taking is not going to work as well. So, unfortunately, none of these medicines work without work on the part of the person who's taking them.

So, this takes us to shared/collaborative decision-making. And fortunately I've got Melody joining me a little bit later on to talk about this from the perspective of somebody who's on the receiving end of medication. The notion of shared/collaborative decision-making comes from the concepts that I've been talking about before, that a person who is in a process of recovery, who is trying to put their lives into a different place and deal with the challenges that the psychiatric [indiscernible] condition that they're facing creates for them, in order for them to do that work, they need to be engaged and involved. They've got to have a sense that they are participating in their own recovery, and that the medicine is something that they are using in a way that they understand and that they are okay with.

So, collaborative decision-making fosters trust, demonstrates respect. It's built on the idea that people are sharing learning and exchanging ideas and understandings. It's built, as I said earlier, on the idea that both the professional and the person who's on the receiving end of the medication have capabilities and capacities to understand and to manage and deal with the kind of challenges that taking medications requires. Clearly, the goal of taking medication and having a life that you want to live is that you have -- you know, that you're able to be self-reliant and exercise responsibility. So, if you're not involved in decisions about what medicines you're taking, it's arguable what level of self-reliance or responsibility you would be operating on.

And, as I said at the beginning, you know, unless people are engaged and part of the process of their own recovery, what kind of recovery would that be without that. So, it's necessary and essential that there be shared and collaborative decision-making about something as important as medication, as well as a number of other decisions that people have to make in the process of pursuing recovery.

This process of shared decision-making starts off by really working together, the professional and the person -- the prescriber and the person who's considering taking medication by looking at the individual's experience, thinking about what prior medications have been helpful, what their particular circumstances are, then thinking about what are the things that are important to them in their lives, and where does the medication potentially fit into that. It involves obviously considering a range of interventions, not just medication but other things that can help take care of or help people address issues, thinking about the pros and cons and then making a selection, implementing it, and following up to see if what the hope -- goal -- the hope or goal of whether or not it's been attained or not.

The evaluating experience part is really trying to understand and share with each other, between the professional and the consumer of services, what the problem is, what the nature of the problem is, as well as what the capabilities and capacities are of the person, what they feel they are up to dealing with at that moment, as well as understanding what prior experience has taught in terms of dealing with various kinds of medications or various kinds of interventions, and what's happened in the past.

Clarifying the goals for change is really all about having a conversation with somebody about what they want to do with their life and where they want to go at that particular moment. This is an essential point on this slide. We often get this idea that what measure -- a way to measure whether somebody is getting better is whether or not they're being "compliant" or "adherent" with their medication. And I think that that has been a sort of subtle approach, maybe not so subtle sometimes. Part of this culture of the idea that what makes people better is medication or a particular intervention. The truth of the matter is that what makes people better is people using tools to help them put their lives in a place that they want their lives to go. And medication can be that, but it is not the goal itself in treatment. The goal of treatment is to support people in their process of recovery.

So, discussing options, once you've got some idea about what the circumstances are, what the goals are, then you have a range of different kinds of things that you can consider. What are the things that -- what kind of therapies, what kind of complementary approaches, what can family and peer and community do to support folks, what are the ongoing stresses and strains of so-called social determinants of health that may be impinging on things that need to be addressed, and then the various range of therapies, psychological, rehabilitative, recovery support therapies, things that don't necessarily involve medications, and then obviously medications are part of the toolbox of options. All these things have to be considered by the person who's in recovery and hopefully by the professional who's working with them to think about.

When you get down to through that list and you get to the medications, then what you'd like to be able to do is to think about the options are around medication, which different kinds of medications, what's their likely effectiveness, what's prior experience been, what are the things that hopefully will be improved with a particular medication, how does it affect day-to-day living, that can be about what the schedule is for taking the medication, what it does in terms of sedating people or not, kind of a whole range of effects on day-to-day living in the process of addressing targeted symptoms and being potentially less or more effective.

You also have to think about what people's beliefs and attitudes are about medication, and address those. You know, we have a society which, while it often values or overvalues what medications can do, it can also be a society that says, "Well, medications are all bad, nobody should ever take them, I can do this all by myself, I don't need this tool." That may be something that can, you know, interrupt somebody's capacity to recover significantly if there is a medication that actually might be useful to them.

In addition, you'd need to consider other disorders, medical problems, et cetera. Clearly, a big one that's going on recently in the last number of years has been the whole issue of dealing with people and their weight, and the fact that some of the medications that we use can, unfortunately, put a great deal of weight on people. So, these kinds of issues need to be considered, talked about. Sexual side effects, for example, all these things can have a major impact. Interaction with other medications are all part of the process of education, and that's a conversation that needs to go on between the provider, the prescriber, and the person who's receiving the medication. In fact, it's probably a useful list just to think about having this in front of you, if you go in to see a doctor, if you're a doctor or prescriber, to be able to say, "This is how we might think about the medications that are potentially of use to you."

There are lots of choices, so there's lots of room for negotiation. Which medication, how do we decide and think about the effects, the risks, and the costs; how much medicine do we take, how fast do we take it, what time of day to take it; at what point would we think about tapering it or stopping it; and how to take it, do I take it with food, do I take it at a particular time of day; and how do I do that tapering or stopping, do I do it in a very, very slow fashion, can I just cut it off; at what point should I think about tapering or stopping. So, all those questions are things that can be discussed and I think are kind of the bread and butter of shared decision-making, of collaborative decision-making, because any one of these things can be ratcheted back and forth a little bit and worked out to people's personal preferences.

So, what are the challenges in doing this? The primary one is developing trust, you know, how do you make sure that when you sit down with somebody there's an alliance that what you're hoping to do as a patient or as a consumer of services, that what you're hoping out of your life is going to be something that the person who's giving you medication is going to help you attain, that they're going to be willing to listen to you, to feel that they're going to attend to the things that concern you. That trust really has to evolve over a bit of time. And one of the best ways that it evolves is when people are transparent and they have an open discussion about risks and benefits.

Other problems that we have, and I've sort of talked about a few of these in passing, one of them is, you know, just the nature of the very short appointment that we often have, the limited time for discussion and sort of reconsideration. I've talked about the cultural focus on medication, both positive and negative, that sometimes interceded and make it difficult to have a reasonable conversation about how medications can or cannot be useful. That ties very much into the personal/emotional meaning of medication that people

have, and the sense that -- you know, there are people I've clearly run into, I'm sure you may know some yourselves, people who feel that if they take a medication, it's like they're admitting defeat, that they are somehow putting themselves even further down by having to take a medication, which may or may not be helpful, or not.

Cognitive challenges, part of the dilemma about these meds and their utilization is that the information we have about them is complex. Unfortunately, none of these things are going to be simple, straight-forward, always working. They're going to have, you know, risk in them. How do you evaluate how much risk? They're going to have benefit. How do you evaluate how much benefit? So, it's a hard thing to wrap your head around all the issues that could come up. Even before that is the whole problem of how much we don't often know about medications and their effects, and their effects in particular people. Probably the largest problem we have in terms of prescribing medications is that, while we have a general idea about how they work and what they do and what they may do for a number of people taken together, oftentimes we cannot predict for an individual what the effect will be, and clearly there are people who will take a medication and have a side effect that we would have no idea that they would necessarily have.

And then there is the issue -- the personal issue that comes up for providers is, you know, what do I do if somebody wants me to do something that I'm not comfortable with. What if they want me to prescribe a medication in a way that I don't feel is safe or useful? And I think the bottom line that I've come to on that is that there are some things that are not negotiable, and I think we probably, both on the consumer side, on the patient side, on the person side who's going to be taking medication, and on the side of the prescriber, there are some things that we have to decide that we won't do. And I, for example, if I feel that a medication is going to put somebody's life at risk, I'm not going to be willing to do that. I'm not interested also in feeding addictions and a variety of other kinds of situations. I just will do my best to avoid bad medicine, the practice of bad medicine. But these are challenges that come up from time to time.

Now, what are new resources that help us with this whole process of shared decision-making in the face of these challenges? One of them is that we've got increasing focus on having healthcare teams so that it isn't just one person trying to do all this sharing of knowledge and exchanging knowledge, and developing trust and making connections. There can be a number of people who all work together to help support a person in their recovery. We're doing a lot more to engage families in ways that hopefully are seen as productive by people who are seeking services. Clearly, the whole movement around peers and the involvement of peers has been an essential part of making sure that information is disseminated and that there's knowledge and capacity-sharing going on between peers and providers, and people seeking recovery-oriented services.

And then, lastly, we are, you know, with the electronic health record and the capacity that we have through data, as long as we are clear about issues related to confidentiality, et cetera, we can collect data and have much better idea about what the impact of medications are and keeping track of what medicines have and haven't worked over time for an individual, there's no small benefit of having an electronic health record if we make sure that it attempts to that issue.

So, in summary, medication is one kind of tool. People make decisions about their lives, and their medications are part of that. Our job is to educate and guide and support people in their recovery, and the respectful collaborative approach is essential to helping people in that process. In the end, the goal of having a shared collaborative approach to medication and the whole process of recovery and treatment, and treatment that supports recovery, is that we're all trying to find a way forward to find the hope, to find the place that we might be able to move into that allows us to have lives that we all want to live and that fulfill the role of being a healer, if you are a healer, and being a person in recovery if you are a person seeking recovery.

And I think with that, I'm going to turn this over to Melody. Shared decision-making takes two. We need the expertise of both the prescriber, the provider, the professional, and the person that's receiving services, and hopefully the more we do this, both within individual or team relationships, and over time we will get increasingly good and have the resources that support this. We're trying to maximize the expertise of both the provider and [inaudible].

Ken, this is Melody, I'll step in at this point.

I'm going to stop there, because it looks like Melody is talking.

There you go.

Good. Hi, Melody.

It's always great to hear your voice. It's even better to see you in person. But I'll do with your voice today. Thank you for that information. You know, it's really so important to be able to hear from physicians who are working in behavioral health who have the broad and deep understanding of recovery-oriented services that you do, and I always enjoy seeing how you can eliminate these issues. And my take is not a contrarian viewpoint to yours, but is really -- I think that we affirm each other in the importance of shared decision-making and behavioral health care. It really does take two.

The idea or the basic premise that there are two experts in the room when shared decision-making is happening is very important for us to understand, and that I seek out a healthcare provider because of their expertise, because there are things that they know that I will never know as a layperson. However, I know that they can't make or even suggest good options to me without my active role in that decision-making dyad; that I am the expert in my values, in my culture, in helping feel in my body what motivates me, what the level of activation is that I have in terms of do I feel beaten down by my symptoms, do I feel beaten down by the system, or am I, you know, coming from a place of strength and empowerment? Do I have others aligning themselves alongside me; that all of those things really are valuable pieces of information that need to be considered when discussing any type of medical support for recovery.

One of the things that's really important about shared decision-making and that distinguishes it within behavioral health care is that it's not a single-point decision. In general health care, where shared decision-making has been being used to great success for a number of years, and is identified as evidence-based practice and where there are clear studies showing how shared decision-making is beneficial, I think that the emphasis of decision-making was slow in coming to behavioral health care because it's really a series of decisions rather than a crossroads decision.

So, if I'm trying to make a decision about having surgery to, let's say, have a mastectomy, that's because I've been diagnosed with breast cancer, that's a cross roads decision, and it's not a decision that can be undone or even revisited to try to alter the next steps; whereas in behavioral healthcare, so many of our decisions are continuous decisions, and there is room for some back and forth, some latitude, side to side, some experimentation, if you will, to see what's going to work best, all the while looking for what's working best for the person, the person in their community, and their goals and meaning and purpose in life.

Shared decision-making leverages the points of consensus. I am a firm believer that if I want to enter into a long-term therapeutic relationship with someone, I achieve that by looking for where we have strengths and how we can move forward together. And I want the providers that I see to build on my strengths. I don't need help learning how to be sick. I don't need my illness even necessarily defined for me. I need my strengths and my wellness to be underscored and to become foundational.

Also, shared decision-making helps identify the actual next steps that can be taken. We operate in a deficit reimbursable system; meaning that, you know, people can stay in services as long as they're sick, and there's this huge jump between being sick and being well, when, in real life, we want those steps to be certain and to guide us in a path towards an overarching recovery. And so, my treatment goals may be something that someone feels will take a year of two to work on, but my shared decisions that I make with my providers really should be incremental, and it should matter what I do between one appointment to the next, because it's in those small steps that real momentum is developed.

Shared decision-making understands that I am an expert; that my life experience matters, and the more my expertise is acknowledged the greater my capacity to interact with somebody with a different expertise, because mutual respect helps us move together further, faster, the practice of strengthening the relationships that built on specific and concrete interventions, activations. So, what is it that helps me go from a dormant couch potato, if you will, position to doing something, doing anything? And the truth is, if somebody is making it to services, or somebody is asking for help, if someone is staying connected to other people in their lives, then they have strength and they're achieving short-term activated steps of recovery, and the more we build on those the better, and then the ongoing development of a strength-based community built on shared decision-making.

It's unrealistic to think that a physician in a public mental health center is going to have the time to sit with someone to do a complex series of decision aids to work towards some collaborative decision-making in a 10- to 15-minute appointment, and so shared decision-making also needs to be acknowledged as and a principle or activity that permeates the entire fabric of the agency and all services. And so, the care manager knows, the therapist knows, if the person is in psychosocial rehabilitation, that those staff people know, anybody that's on the treatment team is engaged in shared decision-making, as well as the team communicating around what each other are working on, and to assess how's it going, how did it go. So, the shared decision made in one appointment is followed in the next appointment. Were you able to do that? Have you been able to take those steps? How can we help you to take those steps? And to use that to help, again, propel the person forward in this services that they receive.

These points of consensus, the collaboration and activation, are even critical when we disagree. So, Ken talked about how, you know, every responsible prescriber is going to have a line that they will not cross, and they cannot, are not to do bad medicine. And so, you know, if I come to my prescriber and ask for something that is contrary to best medicine practices, then the place to begin is for us to agree to disagree. And maybe on a different day, or maybe with more information, I can see where that's a beneficial position to work from.

Another position to work from is maybe I'm not ready to take the step that someone on my treatment team is asking me to take, and so watchful waiting and seeing how things go, or data collection is really important. So, if I'm having a difficult time sleeping, maybe the answer isn't a Benzodiazepine. Maybe the answer is a sleeping diary so that we can learn everything that's not working in order to identify what might work to help improve my sleep that's not dependent on a drug in my system. It takes more time. It's more thoughtful. It requires more of everyone, the treatment team and the person engaged in service. But our lives are dependent upon it. We are dependent upon those important and good decisions, so we want those to be made.

Identifying the actual next steps, I think it's important that the steps are achievable; meaning that the goal isn't, by next week, I'm going to have completed a college semester, because that can't happen in a week. And so, but what is achievable before my next appointment? And it's through a series of small successes that confidence and resilience and wellness and energy are built, and so we want to push that forward.

Partner with each other to provide support and education. Shared decision-making is a perfect place for peer work and peer workers to help shore up the organizations and the services that are provided to people, because so often what people need is someone to walk with them through early steps of recovery, not to do for, not to incapacitate, but to -- you know, if you're forging your way through a heavy forest, it really is nice to go with somebody who's gone through that trail before, and who has some insight into what it means to do that work. And so shared decision-making taps into the resources and the capacity that peer providers bring to the table.

The other thing that's important about shared decision-making, from my perspective as a person in recovery, is that the decisions be framed in a way that the language is understandable and that the terminology is accessible. So, when I get a new prescription and I try to read it, I don't know -- I've not been to medical school. I'm not a nurse. You know, I'm not a CMA or any of those things. I don't know what the shorthand for the prescribing instructions are. And so, when I get the prescription, so when I'm

looking at that the written prescription, I don't really understand it. When I pick up the medication at the pharmacy in, generally, plain language it will read, you know, take two tablets at night 30 minute before going to bed. And it's like, oh, I understand that. And so, shared decision-making needs to be the same way. The language needs to be responsive to the individuals involved with the shared decision-making. So, my care provider needs to have an understanding of who I am and what my frame of reference is.

And I need to work with people who can help me -- perhaps care providers -- be able to communicate more effective with my care provider. So, I might need to come up with a more descriptive language. If I just walk in and I say, "I'm depressed," and I don't have the capacity to talk about what that looks like, then the provider is saying I need more help. I need some more language to understand. And that's where things like decision aids that help us clarify what's going on, where we can do a checklist of, like, what's going on and say, oh, this is it and this is it and this is it, and it's not that really can help the providers make good decisions together.

So, shared decision-making begins before the consultation begins; that preparation for going into the medication consultation or before I see my therapist, and the more prepared I am, the more thought I've given it, the more likely I am to be able to have a say in the agenda. And I can be clear on what I'm asking for. And I can take somebody in with me if I feel like I need an advocate or if I need someone just to hold me up while I'm asking that thing that I'm afraid to give voice to. And it can help if I am clear on what my meta-goal is. The meta-goal is that thing that really drives me in my recovery.

And, as Ken said, the goal is not to take medicine. The goal is to be as well as with possibly can, to be healthy, to be engaged in meaningful activity, be it work or art or relationships, but that that thing that drives us is what we're working towards. It's not easy. It's never going to be easy. It's part of the reality of living with the pain and symptoms that are grouped together in what we call behavioral health. But we can have meaningful exchanges and have a voice in our services.

So, with that information, I'd like to ask you all to consider the poll that we took at the beginning. And based on what you've heard today, do you change your vote? Do you wish to see a different outcome? Do you feel like you have a clearer understanding of what shared decision-making is? So, take a second to review the options that we've outlined for you. Click on the radio button for the option that feels most correct to you and we will make those polls available to you as we wrap up the webinar.

Thank you for caring enough to set aside some time today to learn about this really important topic. Elizabeth.

Thank you so much, Melody, and thank you, Ken. You know, both of you, it's just such a compelling discussion about why and how trust and collaboration matters in doing this work. And you also both have underlined the idea of the effort that this takes, so the work that goes into having good relationships and sorting out what's going to work toward recovery. I loved Ken's comment about incorporating capacity and the ability of the person in their own recovery and that's what we're trying to achieve.

So, there are a bunch of questions, a lot of interest of what you're talking about, not surprisingly. And one of the things that was starting to fire up in the chat was about the concept of, you know, a lot of people are worried about talking with their doctor about what's really important to them, or their prescriber, worried about speaking up for fear of perhaps being seen as difficult or not a good client, if you will. So, what advice do you have, particularly if you're working with someone who doesn't typically use a shared decision-making approach? And, Ken, maybe I'll put that to you, and, Melody, then you can also tell us what you think about that.

Well, it's clearly a tough situation, because if you have a professional prescriber or somebody who is perhaps not a person who is interested in having either their authority challenged or is worried that -- maybe insecure about their authority, that challenging that is a significantly difficult thing to do.

Having said that, though, I think what I hope people will do is be able to say to the people that they're working with, that, you know, they have some goals in life that they would like to pursue, and they are

hopeful that the treatment and the help that they're getting will help them be in a position to pursue those things. They may not even know what those things are, what they want to pursue yet, but they want to have something in life that is better than just feeling like they're receiving a treatment that isn't making them feel better or that isn't helping them because of their variety of side effects, and that what they say to the provider is, you know, I respect you, I appreciate your, you know, knowledge and your awareness of these things, but I need to let you know, for various reasons -- whatever the reasoning might be -- where we are with this particular medication isn't working, or I'm very anxious about taking that medication, because the last time I did I had this effect, those kinds of things. To start from a position of saying, you know, I've got some experience myself and I have some understanding of how and what I need in my life, and I need you, as the professional, to work with me on it. And maybe that will start to introduce this concept.

I have to imagine that before we had this concept of shared decision-making, that there were probably people, patients, consumers, you know, people in recovery, who were having these conversations with their psychiatrists and other physicians, providers, probably on the seeds of this entire movement.

When I think about this, one of the things that I think is really important is that we expose people to the concept of shared decision-making, and, in places outside of the medication clinic appointment, help people practice with speaking up, and to make it okay. Create a culture at the agency where it's okay for someone to be empowered, and that any time we're addressing a healthcare concern, ours is the most important voice, because we're the only people who can speak to our experience, what it feels like. I do know that he it can sometimes feel like a risk, and that's when you want to make sure you have some backups.

The other thing that I think is important -- and we don't usually frame it this way -- is data collection. And so, if I go in and can show my doctor where I've been tracking a particular side effect and what its impact on my life is, the more clarity, the more facts I can give to that. You know, remember, most subscribers come to this through a scientific lens, and so if I meet them at that lens and say, you know, this is the amount of weight I've gained or this is the impact that, you know, this particular medication is having, and it happens with this frequency, with this degree of difficulty, and then I think you're talking in a language that the prescriber can respond to, rather than just, you know, I don't like this medicine, I don't like you, because there's not much one can do with that.

Yeah. No, both of you are speaking to very nicely to that point of, again, in collaboration that we find a place to meet in the middle, and some of that is finding language and approaches that we both can understand, so that makes a lot of sense.

Kind of a follow-up question to that, there have been some questions about, you know, well are there some people who either their symptoms interfere too much or they don't have insights enough to make the conversation about some of the shared conversation possible, and related to that -- and I know we have just a couple of minutes here -- but what about people who decide to use medicine intermittently, to stop the medicine?

So, you know, I think that the process of recovery, this comes back to the notion of risk that we were talking about a little bit before. The process of recovery involves a whole bunch of different kinds of things. Among them is figuring out, in your own life, how you are going to understand and think about and address the challenges that your life is presenting you, including whatever the psychiatric challenge is. And that process of doing that is a learning process, and I think that the issue of -- I guess how I think about intermittent medication use or how I think about the process of people, you know, folks not having insight, that what happens with people is that you have to work with them over a period of time.

You have to figure out how to develop an alliance and the capacity to solve problems that are meaningful to them at that particular moment. And hopefully what happens is, over time, people begin to develop an appreciation and a trust and a willingness to consider things that may be helpful to them that they wouldn't have tried before, and then take that risk, and, hopefully, at least often enough, it works.

That's fantastic. Thanks so much, Ken and Melody. I would love to hear your thoughts on this, and I want to be respectful of the time, so perhaps another time.

Absolutely.

Great. So, I am going to just wrap things up here. I would like to let everyone know that we have a newsletter, a quarterly newsletter, and if you would like to receive the newsletter, we'll post, I guess, here. It's rtp@ahpnet.com. And remember that we still do have four more webinars in this series coming up in the next few weeks, so please join us for as many of those as you possibly can.

On behalf of SAMHSA, I'd really like to thank all of you for taking time out of your day to join us and to participate with questions and chat, and special thank you to you, Ken and Melody, for all of your thoughtful comments and your expertise, and for being here and sharing what you know.

Thank you.

To the participants, we have the evaluation, so please do download the evaluation and complete it. And we are not able to offer pre-approved CEUs from the webinar, but you can download the certificate of attendance from the materials download pod. So, thank you all very, very much, and this concludes our call from today. Have a great afternoon.

Thank you.