Whole Health Care Part 2: Evolution of Recovery-oriented Practices

Good afternoon and welcome to today's Recovery to Practice webinar titled, "Whole Health Care Part 2: *Evolution of Recovery-oriented Practices*." My name is Melody Riefer, and I'll be your moderator for today. Let me briefly review housekeeping tips and provide a short overview of Recovery to Practice, and then we'll begin the presentation.

I'd first like to thank all of you for joining us today. We have almost 100 people already logged into the webinar. On behalf of the Substance Abuse and Mental Health Services Administration, we'd like to welcome you all and thank you for your participation. I'd also like to extend a thank you to our presenters, Wesley Sowers and Renee Kopache, for taking time to share their knowledge and experience with us today.

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

So why is recovery important?

Ron Manderscheid described recovery as one of the most powerful words in our behavioral health language…powerful because it describes a process of positive change to help people reach their full potential. It also promotes hope and guidance, and has opened doors to dramatic care reforms. The concept of recovery has been recognized for hundreds of years, but is now transforming the mental health and substance abuse landscape in ways almost unimaginable a decade ago. People who lived with people with the lived experience of recovery have fostered this vision, and SAMHSA has made the vision an everyday reality for many.

Recovery is not a journey alone. Many people…peer workers, family members, friends, practitioners, and supportive communities…are fellow travelers on a person's road to recovery. In 2011, SAMHSA released their working definition of recovery and a set of guiding principles that incorporate aspects of recovery from both substance abuse and mental health. The four major dimensions of recovery…home, health, purpose, and community…along with 10 components form a structure and a foundation for developing

recovery-oriented lives and building recovery-oriented services and systems. SAMHSA initiated the Recovery to Practice initiative to incorporate these principles into the behavioral health workforce.

The initial phase of the RTP initiative was launched in 2009 and focused on working with the six professional disciplines illustrated on this slide. The goal is to create discipline-based curricula to promote understanding and uptake of recovery principles and practices. Each discipline used language and frameworks relevant to their membership and developed ways to integrate the curricula into their professional development activities and certification procedures. You can find links to each of those association's websites in the "Webinar Links" box.

The second phase of RTP focuses on multidisciplinary and integrated services and settings to push these concepts and resources out to a more diverse audience and setting. This webinar series uses a part of that effort.

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

Wesley Sowers is a Clinical Professor of Psychiatry at the University of Pittsburgh Medical Center and the Director of the Center for Public Service Psychiatry of Western Psychiatric Institute and Clinic. He also has extensive clinical experience in the provision of treatment and services to multiple populations.

Supporting Wes is Renee Kopache. She is the Coordinator of Wellness Management for the Hamilton County Mental Health and Recovery Services Board in Cincinnati, Ohio. She has assisted with numerous mental health recovery projects and conducted workshops, trainings, and keynote presentations throughout the United States. As an avid photography enthusiast, Renee is actively involved in the consumer arts community and promotes art as a tool for personal wellness and combating stigma.

I'm very pleased to welcome both of our presenters.

Wes and Renee, you may begin now.

Okay, thank you, Melody.

I hope you can hear me well; and if not, please let me know.

Today we're going to be talking a little bit about how medical care kind of fits into the scheme of recovery-oriented services. Over the past several weeks, these webinars have been looking at recovery-oriented services and its various aspects. So, we're going to just think a little bit about how health care, and medical care in particular, fits into this.

I think everybody is aware that there have been significant shifts in the way medical care is delivered in the past few decades. There are a variety of social and economic forces that dictate these changes which I'm not going to go into in any great detail, but it really has changed the way that we are able to interact with one another. The end result has been some general dissatisfaction among the people using services, feeling that it's sometimes impersonal and mechanical. And physicians feel quite dissatisfied often as well. They don't have enough time to do the work that they do as well as they would like and to establish the kind of relationship that they would like to have with patients.

So, it probably would be useful to look a little bit at the evolution of health care. Prior to the explosion of technology in the mid-20th Century, most health care was provided by community healers in a variety of forms. Depending on the culture, various means were used to address illness and injury; and they were not really scientifically informed in the sense that we think about it today. They were derived from experience, from trial and error; and often the evidence was rather coincidental.

But in any case, there was a perception that these interventions made a difference. So, this kind of begs the question, how was it that these healers were effective and why were they respected?

When we think about our own situation really in the 20th Century, the local general practitioner was the provider of most health care; and they used a limited number of medications, many of which were of dubious value. Bone setting and deliveries of babies, palliative care, were the practical things that they could offer. But they were, in many ways, very similar to healers from less developed cultures. But doctors were esteemed, and certainly not because of their wealth. They didn't really make much money.

Some of you may remember the series *Marcus Welby, M.D.,* which sort of exemplified this idealized community GP in a little bit more of a contemporary context. But the idea was really that why were these folks effective and respected? It's a little bit of a rhetorical question; but they were people that were making sacrifices, that were dedicated to the services, that had significant relationships with the community and the people in the community. And that led to trust; and from that trust, people could develop hope and a belief that what they were offered would be beneficial. And in many ways, belief may be the most powerful aspect of healing.

I'm sorry, I didn't give you a "next." I realize I am forgetting this, Melody. We should be on "Sources of Change" now.

As we refined the scientific method, the concept of medical practices changed quite a bit. Much more is known about the biologic basis of disease. Pharmaceutical treatment of disease has expanded pretty dramatically, as has the industry promoting them. I think we can hardly turn on TV these days without seeing a commercial about medication. Also, our research capacities have greatly expanded; and we've come to rely on carefully constructed evidence to guide our practices. Much of this research is government funded, and some of it is privately funded.

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The business of health care has become another element that has really had a significant impact on the kind of care that we deliver. In the U.S., the provision of health care has been largely left to private enterprise although a significant amount of care is government financed…such as Medicare, Medicaid, the VA, and so on.

The cost of care has risen dramatically, and that's been mainly due to technological advances and partly due to the way that we've organized our systems of care and prioritized our use of resources. There's been a focus on illness in our system rather than on health, and clinicians have really been asked to do more to generate income to cover some of those costs.

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So how has this had an impact on physicians?

There's really been a trend towards specialization and often towards more lucrative specialties rather than general practice. That has been for a variety of reasons. Many doctors graduate with huge debt. The knowledge base has become so large it's difficult to stay abreast of it all, and there has really been more prestige associated with medical specialties. With that, and the time constraints and pharmaceutical advances, the idealism that drew many physicians to service has been really harder to commit to. So we're kind of operating under adverse circumstances in many cases.

And we really have developed a medication culture, so that there's a sense that every illness or every malady has a medication that is going to cure it. Pharmaceutical companies have really fostered that perspective, even among physicians. So, that has had an influence on practice as well.

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So how has that impacted psychiatry in particular?

Conformity to other medical specialties has been something that has been embraced to some extent since those have a more scientific biologically-based concept behind them. Psychiatry has always been a little bit on the fringe of the medical profession and has yearned to join it in many ways. It's a little bit of a quest for respect.

Part of what has resulted from that is that there has been a narrowing of the scope of training and skills. We don't train our psychiatrists to do psychotherapy, group therapy, family work, as much as we did in the past and even to understand the systems that they work within. There's been a heavy reliance on medication and biological treatments, and that's what training has focused on. So that has made a difference, I think, in the kinds of relationships that they've been able to form with their clients and has led to a focus on diagnosis…and, again, illness…rather than paying attention to health and those things that help people maintain it.

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So, there's something that we can think about that we might call technology-oriented care. These developments have led to a style of practice that is sometimes referred to as the "medical model"…I think more appropriately, the technological model…which is perceived to be somewhat mechanical, perhaps insensitive at times, as an approach to addressing illness. And when we talk about technology here, a variety of interventions have become part of how we think about meds. Medication is a result of technology but also X-rays, imaging, prosthetics, surgical equipment, life support…all those things have added to our technological stash or stockpile.

And then psychiatry refers to biologically-targeted interventions…so medication again and often with complex delivery systems that make them quite expensive: electroconvulsive therapy, vagal nerve stimulation, and a variety of other biologic treatments.

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But how do we really practice medicine? When we talk about this technological model, it's really sort of an extreme vision and not one that most physicians would embrace. And really, the desire of physicians to do more and have more opportunities to work on relational aspects of care is much greater than is commonly perceived. So humanism is alive and well in medicine.

But what we have failed to do, I think, is articulate an alternative vision of what holistic medical care ought to look like. To do that, we really need to get back to our roots and pay attention to the whole person and a recognition that their beliefs and their trust in healing relationships probably has more to do with recovery than most of the medications that we have to offer.

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So, recovery came on the scene, and this is the little of a counterpoint to this idea of technology or technological models that we just talked about. Recovery-oriented approaches to care gained a bit of traction in the past 10 to 15 years. They've been spurred by the Institute of Medicine's Crossing the Quality Chasm Report in 2001 and the President's new Freedom Commission Report on Mental Health in 2003.

Person-centered or recovery-oriented care has blossomed over the last decade and is now one of the major drivers of behavioral health policy on the federal and state levels. But the history really goes back much further.

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So how did recovery evolve?

There's been a long-standing tension between segregation and assimilation of persons with behavioral health challenges, and part of that tension has been the faceoff of fear and empathy; and fear usually wins, and risk management is prioritized. So there's been a separation of prejudice against those who have these struggles and a general alienation.

Asylums were originally envisioned as sort of idyllic places of rest and rejuvenation, and one of the modes of treatment in those facilities was what is sometimes called "moral treatment." It was really based on the principles of respect and kindness, activity, and community therapy…and actually really did return many to the community. So, in those days before services were curtailed for a variety of reasons and many of these asylums were overwhelmed with numbers of people being sent to them, prior to that they were actually places that were often able to get people back on track and back into society.

So where did the term "recovery" come from in its broader context than we think of kind of getting over an illness?

These organizations…the founding of Alcoholics Anonymous in the 1930s…and at the same time, in the area of mental health, Abraham Low was talking about principles of recovery in that realm. They grew over the next 20 years to become significant forces for persons with behavioral health struggles, and that's particularly true of Alcoholics Anonymous and its many 12-Step offshoots.

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So, 12-Step Recovery emphasizes mutual support and community, personal responsibility, and accountability, tolerance and acceptance. People are welcomed through its doors no matter what their situation is. It's an opportunity for catharsis and hope. It provides mentoring. It helps people to think differently about their situation and their life, and it's really a blueprint for living. It has undergone really a dramatic growth and has been incorporated into many professional approaches.

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So, in mental health, the story was a little bit different. Recovery Incorporated, which was a paradigm that really was more inclusive of professional involvement than the 12-Step paradigm, didn't grow to the same extent. Recovery Incorporated was derived from the teaching of Abraham Low, and it grew somewhat but certainly didn't reach the levels that the 12-Step movement had. But the idea of recovery in mental health reemerged pretty robustly toward the end of the 20th Century.

But even further back, the consumer survival civil rights advocacy movement started to grow around the middle of the 20th Century; and the bio-psycho-social model of Engel came on the scene in the 1970s, which again expanded the scope of how we thought about mental health issues. Psycho-social rehabilitation models, which really anticipated the recovery model of today, were developed on the East and West Coasts by Anthony and Lieberman in the late '80s; and community psychiatry became a growing subspecialty in psychiatry. And the formation of the AACP, promoting many recovery principles, became more prominent in the 1990s.

When we reached the new millennia, we began to see that peer-delivered services and collaborations began to be a more prominent part of how we think about recovery-oriented services. So today, recovery concepts have had a significant impact on transformative processes in behavioral health ever since the President's New Freedom Commission Report; and, obviously, SAMHSA has had a big role in that. We've begun to really integrate the 12-Step and mental health recovery concepts so that they're more compatible; and there's really been a recognition of the universal aspects of recovery and that everybody, in fact, has things that they must recover from. And the change process is remarkably similar for all of us. Hope, autonomy, and community are really the pillars of personal growth and fulfillment.

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So how do we promote recovery?

Recovery-oriented care is about potentiation, capacitation, and empowerment. It emphasizes a personal role and responsibility for health, recognizes the power of hope and purpose, focuses on strength and health, and community connectedness. So community supports, both professional and natural supports, become a significant piece of the equation and the idea of collaborative empathic relationships, so that healing is really based on relationship, faith, effort, and community support.

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So, we've talked about these two different or apparently markedly different approaches to care: technology-oriented and recovery-oriented care. When we think about some of the things that we've considered prior to technologic advances, they are really strikingly similar to what we think of as recovery-oriented care. So, this relationship-based care and community service remain a major reason that people are attracted to medicine today. I think rather than seeing technology- and recovery-oriented practices in opposition to one another, we really need to recognize that technology can serve these ideals when it's used properly.

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So, we need a new vision. We need to go back to the future to articulate a new vision for medicine in general and psychiatry in particular and, to whatever extent possible, kind of discard this persona of technician and stress the relational aspects of care. Use the strength of hope and belief in the healing process and embrace the role of advisor, coach, partner, and friend as a way to help people towards recovery. Informed choice is another way that we work in a collaborative manner with folks, using the evidence base that technology provides and has put at our disposal to help people in their decision-making process.

One of the big principles, obvious principles, of this new vision of recovery-oriented care is integrative care, with a recognition that physical aspects of our being interact with the mental functioning. There are a number of aspects of health that need to be considered and are critical to our health. We have, obviously, run into the situation where we have become aware that people with mental health issues have a much higher mortality rate; and so it's really something that we need to turn our attention to in the years ahead.

I think at this point I'd like to ask Renee…you've had to listen to me blab away all this time, and it would be nice to hear some of your thoughts.

Yeah, thanks, Wes.

On this particular concept of integrative care, I don't know how many people were able to see Part 1 of this webinar series, but the thing that I want to emphasize is that when we talk about recovery planning and health being included in it that we realize that health is dependent upon all of the different aspects or dimensions of wellness, and that it's very important that that not be reduced to solely physical and emotional health but also that it incorporate the other dimensions of wellness because they are interrelated.

For example, social health has an impact on our physical health; and social health has an impact on our mental or emotional wellbeing. Similarly, the environmental wellness or occupational or financial…all of those things collectively determine our overall sense of health or wellbeing. So, when we talk about integrative care and we move forward into a new environment of providing services that are holistic that we do so in a way that we keep in mind all of the aspects of a person's being because all of those things combined impact our health and wellbeing. So that's just something that is kind of a carryover from the last presentation, but I also wanted to plug it in here again.

With that, Wes, I'll turn it back to you.

Okay, thanks.

And all those things are really critical when we think about recovery planning and kind of putting all those things into the equation to come up with a plan that is really going to be effective.

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So, what is the place for technology?

Obviously, it has a very important role to play; and we need to understand its strength *and* its limitations. But, obviously, it's played a very important part in improving the lives of many people and helping them on their road to recovery, as have other more biologically-based interventions.

We need to know when and how to use it appropriately, understand that it can be overused, and a reliance on it as sort of the only answer to the problems that people come seeking help for may do more harm than good. So, we just need to use it appropriately and judiciously, and it has a very significant part in the healing process.

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We need to think a little bit maybe about what's the appropriate use of medicine, what kinds of things need to go into those decisions. Probably first and foremost, the idea that medication use is a personal choice and there are few exceptions to that. When we share decision-making, we really need to provide information and help people and support people in making wise decisions about what they would like to do with medication.

I think the other aspect is we need to be honest about what some of the limitations are and the fact that we really can't predict outcomes all the time for any particular individual. We can certainly give information about how it has affected most people; but there's a little bit of risk involved, and there's a little bit of trial and error involved. Sometimes people talk about feeling like they are a guinea pig, and I think that can be the case if they don't really have information and they don't really understand the full scope of what needs to be considered in making these decisions. So it's really important that we share that information.

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It also requires a shift of focus. So, we shift from symptoms and illness and solely medication to one of wellness and the whole person. We talked a little bit about this in considering the idea of integrative care.

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So, collaborative decision-making is kind of a critical aspect of building relationships. Working with our clients to finding solutions to disturbing circumstances is what enhances trust, empowers the individual, and builds investment in the solutions that we choose or that they choose.

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I'm not sure, Renee, if you wanted to make a comment here about this whole idea of collaborative decision-making?

Yes, just a real quick comment about that…when we talk about these things of getting to the point of promoting self-reliance and responsibility and having opportunities to learn, those things at the bottom there require the beginning, which is the establishment of a trusting relationship. It's really, really important that that relationship incorporate trust as a two-way, that it goes both ways. By that I mean that the doctor says and does the things that are necessary to earn *my* trust; and, likewise, I say and do the things that are necessary to earn my psychiatrist's trust. In doing so, what happens is that there's this

sense of the provider asks for my thoughts, and they value my opinions, and they start to trust my judgment. When that happens, then you have a truly collaborative relationship that exists that allows for some building on. It's kind of like that's the fundamental part, and then you have building blocks that continue to grow and grow upward from there to allow for growth on down the road.

But what happens oftentimes…and there were numerous times in my own treatment…where that trust wasn't established. There was more of an expectation that I, the client or the patient, was expected to trust just because the provider was an expert. And there was that expectation that there would be trust, even though I'd never seen that person maybe before. That even though they were asking questions that were personal…sometimes questions that were painful or embarrassing…and then there was confusion around why I wasn't engaged in my treatment. I wasn't engaged because I didn't trust, and I also likewise knew that they didn't yet trust me.

So, one of the things as we move forward in talking about decision-making and recovery-oriented integrative care is there needs to be an emphasis on establishing that two-way trusting relationship.

Thanks, I'll turn it back to you.

Okay, that's a really good point, Renee, thanks for coming in with that.

So, what is the process for shared decision-making?

I think it's mostly pretty simple. We really want to take some time to look at and understand the client's experience, help them in establishing goals for change, identifying those things that they would like to change; looking at the various options, potential interventions; examining the advantages and disadvantages of each. This is where the technology helps us, and the evidence base can help inform the people that we're working with. And then just selecting and implementing the most attractive options with an opportunity to evaluate the outcomes and to make changes and adjustments as necessary.

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So how do you look at all those medication options and the priority of individuals?

We have a slide here that was put together by Ron Diamond, who is a very well-known community psychiatrist in Wisconsin and really a very wise and articulate guy. It kind of condenses a longer presentation, but what are all the things that need to be considered when making these kinds of decisions? What's most important in a person's life?

If sedation is a side effect, how will that affect the client's need to drive or nighttime childcare for example? Is it most important to kind of get rid of the symptoms, even if they interfere with other things that are part of our lives; or is a person more interested in just getting symptoms to a level that they can tolerate so that they can continue to do some of the other things that are important in their lives?

So, we consider all of this when we think about side effects and informing people about, again, this whole process of giving information and identifying those kinds of priorities that any particular individual has and needs to consider if they're going to feel comfortable with the treatment that they choose.

Any thoughts on that, Renee?

Yeah, I think I'd offer also that we put out on a table or consider a third option…and that would be the option to consider the elimination or reduction making symptoms tolerable is that there is the option of non-medicinal tools or strategies.

For example, for myself in my own personal recovery…photography, ice cubes around self-mutilation, mood bulbs, exercise…these were all tools that I used once I decided, with the support of my psychiatrist, to discontinue medications. So even though for the vast majority of individuals who are experiencing a

significant mental health condition or disorder, medications are going to be a critical part of that. It's important that we not exclude the possibility that for some individuals, the best option is the option that allows us to use some tool or some resource other than medication.

I say that, and I want to state this and be very clear about this. I'm not advocating that individuals stop their medications or that psychiatrists stop prescribing medications, but more so that we keep in mind that medications are an asset. They're a tool that allows us to reduce distress to the point that we can move forward in our roles and in our recovery. And my point is simply that it's important to be open to the possibility that for some individuals, like myself, we may respond more favorably to some intervention other than medications. And recognize, again, as I said, that's what's worked for me. That may not be a good option, or even a favorable option, for other individuals; but it's something to keep on the table and it's something to keep in mind.

As you mentioned previously, we live in a society that expects a lot out of medication. If someone has a headache, they take a pill. If someone – you know, their tooth aches, they take a pill. Well, if I have a headache, I go for a walk first. If I feel stressed, I grab my camera; and I go out and engage in that activity. Then, if those things don't work, I focus on taking a medication that will help alleviate my symptoms. So, the overall point is that we keep the options on the table broad enough that they're fully inclusive.

With that, I'll turn it back to you.

Yeah, and that's really right on point. A lot of what you're talking about is what we might term self-management. In many ways, if we find ways to manage symptoms, there are many benefits to that…not least of which is it gives us more control. So, that's something that really helps in the recovery process…when we have things that we can do *ourselves* that really alter the way we experience the symptoms of our illness.

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There are obviously some real challenges to working in this way. We have made some comments about time constraints and the productivity pressures that many of us have to work under. And that really presents some challenges to establishing trust and to really creating the kinds of relationships that are nurturing and healing that we've mentioned.

There are many cases in which people may have cognitive or emotional impairments that really interfere with making a connection or make that connecting process a very difficult one. But there has also been this real emphasis on medication management, and I think that's the role that many physicians have been cast in. On some level, our patients expect that we're going to be mainly interested in medication. In many cases, our other health professionals have that same expectation…that there is a fix through medical management. We know that is not always the case.

On the next slide then, how can we make the most of short visits?

As Renee said, the time that we have to spend with people is much less than it was in the past. Obviously, we don't necessarily need to do psychotherapy with everybody that we meet with, but we can make the most of the time that we have and really focus on the relationship building piece if we are able to figure out some ways to get at some of the other issues more quickly.

One of the things that has been tried is the pre-visit questionnaire so that some of the explicit things that need to be addressed can be identified in advance so that the process doesn't have to take a whole lot of time. CommonGround, a program by Pat Deegan, is one example of that. We can also do just a paper and pencil version of that, particularly if we collaborate with other clinicians. One of the great things that has been added to our teams has been peer professionals.

So, the whole interaction that we have with service coordinators, peer professionals, other mental health professionals, nurses, and so on, can be really helpful in helping us gather information, identify issues that need to be addressed. Through that process, we can really carve out more time devote to relationship building, to getting to know one another, and to really focus on the healing process.

So, those are the main comments that I have on the next slide just to kind of summarize:
Medications and technological interventions are one of many important tools in developing a recovery toolkit.
People in recovery are the ones who ultimately decide how they're going to use their medications. So we want to really create an atmosphere in which we can be honest with one another, that we trust one another, and that we can help people to make the best decisions possible.
Our challenge is to see ourselves a little bit differently in terms of our role in educating and supporting and guiding folks to that decision-making process.
Collaboration is key.

On the next slide, just to emphasize that doctors can't work effectively in isolation. A multidimensional approach to health is really something that's critical, and partnership with other professionals and natural supports is really the key to success.

This last slide says when "I" is replaced by "we," even "illness" becomes "wellness." That might be a good place to end, and maybe we have a little bit of time left to consider some of your questions.

Melody, is that…?

Thanks, Wes, for your presentation and, Renee, for your comments and helping to illuminate an additional point of view as we ponder this topic.

Renee, I'm wondering, do you have any thoughts about how, given that appointments have become shorter in time and less frequent, you're speaking about non-technology-based or non-medicine-based interventions are not what you go to first, I'm wondering what you do in between visits for self-care and to extend the benefit of the appointment?

I think that, as you clarified, early on in the recovery process, it's difficult to do that. It's part of the learning; it's part of the growing; it's part of overcoming all of the chaos that's in our lives. But as we achieve some stability, then it really becomes not only our responsibility but to our benefit to do a better job of not only preparing for our appointments but, more importantly, understanding that our recovery and our growth really is what happens between our appointments and that we utilize our appointments with our psychiatrists or our other providers, recognizing the shortness of time for what they're targeted to do. In terms of psychiatry, they're targeted, in this day and age, to address any concerns or any challenges or any questions that we have about our medications or maybe some physical health issues about it being somehow connected to medications and health.

But in between those sessions…and in a lot of cases, that's a month, sometimes three months…that's where our growth happens. So, it's really critical that we focus on our overall wellness and what are the different things in our lives that allow us to continue to maintain and grow and develop and move forward into a great amount of independence through self-responsibility and through personal care.

For me personally, a lot of that really was learning to use things like mood logs…understanding that it was not a good idea to self-mutilate and that there were other tools that would have the same impact but not damage me. So, it was really a matter of self-exploration that allowed me to move into utilizing resources that extended outside of the mental health treatment community. That's what recovery and wellness ultimately is all about.

Thank you, thank you for those comments.

Wes, when you're talking about this evolution of the relationship between the care provider and the person receiving services, what do you feel can be done to establish better communication between doctors and other professionals, including peer professionals…because as the relationship changes with one person on the treatment team, it would feel logical that the relationship could change with other people on the treatment scene?

Well, yes, I think that's true. I think that we have not done a very good job of using our time creatively. We kind of got caught on this wheel, like a hamster, just kind of running around in circles trying to spit out contacts and billable services. I think obviously, that's not something that we can just do away with. We have to think more creatively about financing. But I think we also need to think more creatively about how we use the different resources on the team and really kind of creating opportunities for people to talk to one another.

It's great, for example, when other clinicians can sit in on sessions so that we're all on the same page and we're all kind of hearing the same story and kind of working together to find solutions to the concerns that a person has. So, I think that's something that isn't often done; and, really, we have some greater opportunities now to do that with more commonly being connected with peer professionals who are working with our clients. So, that's one way.

I think particularly in outpatient mental health, we have not found creative ways to have team meetings; or we have not made the time to do that that would really provide an opportunity for people to get together and work more effectively to meet the needs of clients in the community.

Thank you. Another question from our participants…there's been much concern over the reduced life expectancy for persons with serious mental illness, and people are concerned about the role that medication plays in this. What do you feel is the role of the psychiatrist in helping to either mitigate the challenges or in providing supplemental primary care?

Well, it's something that I think has been neglected quite a bit in the past. We really need to think in a more preventive mode and to address physical health issues within the context of our visits with clients…with the recognition, again, that physical health has a significant impact on mental health as well as vice versa.

I think the information sharing process is critical. Some of these medications do have significant side effects and can contribute to poor health in the long run. So we need to be able to weigh that with the person in service and come to some kinds of decisions about what is most important at the moment, and that's ultimately the individual's decision. We may have our own opinions about that; and I think that we need to find ways to communicate our concerns, but we really need to be cognizant of, and very honest about, some of those possible complications and side effects.

Thank you.

Renee, I'm wondering if you have some thoughts related to that question.

Yeah, sure, I think the first thing that I frequently say when this type of question comes up is that it's important to keep in mind that that research has now been dated and that that research followed individuals *prior to* the movement to recovery-oriented care or the movement towards integrative health care. So, one of the things I think we face as a challenge is are those trends still there, or have we made any progress in kind of narrowing that gap?

I think the other thing that's important to keep in mind is that, at least for me, I still question…is it the mental health or the mental health disorder? Is it the medications? Or is it something like substance abuse and environmental wellness?

There's also research; as a matter of fact, it was just on the news the other day. It says African Americans die on average, I believe it was 10 years earlier. Is that because of mental illness, or is that because of poverty? So, I think there needs to be a better understanding there.

Then also, the last piece I think that's really important is that when we talk about helping someone experience a longer life longevity, again, it means that we address that whole person because they don't live in the silo of just their mental illness. They have other pieces of the puzzle that have to all come together that all collectively help enhance their physical health, their social health, their emotional health, their financial health…because all of those things probably collectively are what's contributing to that discrepancy in terms of life longevity.

Thank you. Those are all *really* important questions to ponder, and I think that what I find on these webinars anyway is that along with a lot of good information I have many more things to think about and research. Thank you for that.

I want to let you know that the Recovery to Practice Project issues a quarterly newsletter. If you'd like to receive the newsletter, you can sign up at RTP@ahpnet.com.

We do have one more webinar in this series coming up next week. Please join us if you can.

On behalf of SAMHSA, I would like to thank you all for taking the time out of your day, and especially during this busy week, to attend today's webinar. We know you have demanding jobs and appreciate your interest.

A special thanks to Wes and Renee for sharing their thoughtful comments, responses, and expertise with us today.

If you haven't filled out the Participant Evaluation form in the box below, we will post the link at the close of this session. We value your input and find it helpful in developing future webinars.

We are not able to provide preapproved CEUs for this webinar; however, you can download the certificate and the presenters' bios from the material below so that you can apply at your local CEU Office.

Thank you all very much. This concludes our call.