



# Practicing Recovery: Expanding Person-Centered Care

Issue 2: April 2015



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## A NOTE FROM THE PROJECT DIRECTOR



Laurie Curtis, M.A., C.P.R.P.  
Project Director, Recovery to Practice

### In your last appointment with a behavioral health provider, did the provider:

- » Make a clear effort to help you understand your [behavioral] health issues?
- » Make an effort to listen to the things that matter most to you about these issues?
- » Include what matters most to you in choosing what to do next about these issues?

**Informed.  
Engaged.  
Empowered.**

**Shared decision making is about changing the conversation.**

### Good collaboration skills, such as shared decision making, are a hallmark of person-centered treatment and service approaches.

The three simple questions above comprise the CollaboRATE scale<sup>1</sup>, a validated tool for measuring the level of shared decision making (SDM) in a clinical encounter from the person served's perspective. The scale provides valuable feedback for assessing service quality and provider performance. Research finds that in both medical and behavioral health contexts, there is an imbalance between service-provider and person-served's perspective of the quality of service and provider performance.

Shared decision making sounds simple, but providers and persons served often find it challenging. This issue of the Recovery to Practice newsletter explores concepts and issues related to implementing shared decision making. These stories, tools, and examples offer ways persons served, providers, and organizations can incorporate shared decision making into practice. As we learn to navigate increasingly integrated, multidisciplinary recovery-oriented service models, shared decision making can help keep individual persons served at the center—where we belong.

1 Find it at: <http://www.collaboratescore.org>



## Shared Decision Making in Behavioral Health

By: Elizabeth Whitney, M.S.W., L.I.C.S.W, Senior Program Manager, Advocates for Human Potential and Laurie Curtis, M.A., C.P.R.P., Senior Program Manager, Advocates for Human Potential

**SARAH:** Doctor, I am not happy with my medication. I feel sleepy all the time, and I need to be alert when my children are home.

**DOCTOR 1:** Have you tried going to bed earlier at night so you get more sleep?

**DOCTOR 2:** Fatigue is a common side effect of your medication, but it's working well for you. We could try lowering the dose a little, but I don't think that's a good idea given your history.

**DOCTOR 3:** Being a good mom to your children is very important to you. Any medication you use should help you be a good mom, not get in the way. Let's see what our options are.

Which doctor's response is most likely to start a meaningful conversation with Sarah about her medication concern? If you answered Doctor 3, you are right. Yet, many persons served regularly encounter Doctors 1 and 2.

Shared decision making (SDM) occurs when persons served and their providers make healthcare decisions together, taking into account the best scientific evidence available and the person served's values and preferences. Any decisions about Sarah's medication must be made in light of what is most important to

her—being a good mom—not just the medication's effectiveness in managing symptoms. Sarah and her doctor must be equal partners in making these decisions. The doctor knows the pharmacology and common medication responses, and Sarah knows what is important to her and how the medication affects her life. Providers are not always good at predicting what treatment or service options their clients want. Mulley, Trimble, and Elwyn (2012) argue that misdiagnosis of preferences is an epidemic that has a significant impact on healthcare quality, effectiveness, and cost.<sup>1</sup>

High-quality, shared decision making relies on three factors: engagement, information, and dialogue.

### Engagement

Historically, engagement has meant connecting people diagnosed with behavioral health disorders with services; that is, "getting people into treatment." But, engagement also involves supporting people in actively managing their own care. Many persons served find it difficult to assert themselves with their providers. They are not sure what questions to ask, how to ask them, or how to weigh information and

<sup>1</sup> Mulley, A. G., Trimble, C., & Elwyn, G. (2012). Stop the silent misdiagnosis: Patients' preferences matter. *BMJ*, 345. *Continued on page 4*

evidence against their values or goals.

Further, people often worry about being perceived as “difficult” or “non-compliant” if they voice concerns about recommended medical or behavioral health treatment. Evidence shows, however, that people who are engaged in learning and making decisions about their services and treatment are more likely to choose options that they feel good about, are less costly, and lead to positive outcomes.<sup>2</sup>

Engagement means helping persons served plan and prepare for meetings with providers, develop skills in asking questions and making decisions, and understand their right to be full partners in decisions about their treatment and services.

## Information

Good decisions are based on good information. Both persons served and providers need transparent and objective information about available options, including the potential benefits and risks of those options. Objective information includes evidence from research about how options compare in terms of cost, side effects, effectiveness, and other variables. Persons served need this information to figure out which options might best fit their values and preferences. For example, a medication that significantly impacts sexual functioning may not be a good fit for individuals who highly value intimate relationships.

Decisions can be easy to make when overwhelming evidence demonstrates one option is better than another. But most behavioral health treatment decisions are not so clear-cut. Sometimes, more than one good option exist or the choice is among poor options. These scenarios can result in decisional uncertainty for both persons served and providers. Ethically, when no single “right” answer exists, person served’s preferences must guide decision making.

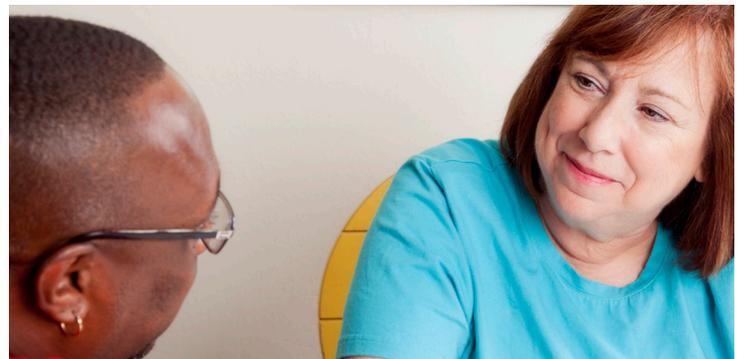
Decision support tools such as decision aids (DAs) are designed to provide structured information about a specific decision. For example, medical DAs are carefully constructed to provide research-based information about a specific condition, its treatment options, the risks of each option, and offer

opportunities for individuals to weigh the information against what is most important to them. Other decision support tools are provider-focused and help clinicians engage people during consultations. The majority of DAs presently available are for medical conditions, but decision support resources for behavioral health are beginning to emerge.<sup>3</sup>

## Dialogue

The heart of shared decision making is the conversation between an individual and his or her service provider. Open information sharing and collaborative dialogue are essential. Tools, decision aids, and other resources can help promote and facilitate meaningful dialogue. Instead of holding vested interest in a person’s ultimate care decision, clinicians need to focus on the process of helping individuals make fully informed and reasoned decisions. As we saw in Sarah’s situation earlier, how a provider responds can dramatically influence both the process and outcome of the discussion.

At times, we all rely on experts for answers or guidance. However, when it comes to our medical and behavioral health, most of us want to be full partners in making decisions about treatment and services. We value objective information about our options, including potential benefits and harms. We want to consider our options in light of our personal goals, concerns, and preferences. We expect to be heard, valued, and respected as part of the decision-making process.



As clinicians and service providers, we know we cannot be truly effective if we make decisions for others. We want people to have reliable information and engage with us collaboratively to make the best decisions possible. We also need up-to-date information and tools and support to engage in more meaningful decision-making conversations. We all want to be informed, engaged, and empowered. ●

2 O’Mally, A.S., Carrier, E., Docteur, E., Shmerling, A.C., Rich, E.C. (2011). Policy Options to Encourage Patient-Physician Shared Decision Making. NIHCR Policy Analysis No. 5. <http://www.nihcr.org/Shared-Decision-Making.html>

3 See: Resources on page 16

## 5 TIPS

# The SHARE Approach by the Agency for Healthcare Research and Quality (AHRQ)

What is the SHARE Approach? It's the shared decision-making process summarized in five easy steps to engage meaningful dialogue about what matters most to each person served.

1



Seek person served's participation.

2

Help person served explore.



3

Assess person served's values and preferences.



4

Reach a decision with person served.



5



Evaluate decision with person served.

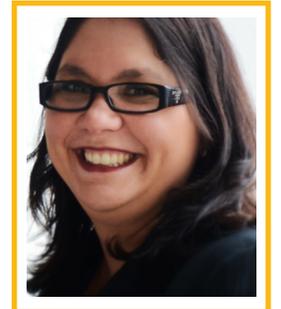


## Sharing Decisions about Depression Medication

By: Rebecca Stouff, MPH, Senior Analyst, Center for Social Innovation



Annie LeBlanc, Ph.D., Assistant Professor of Health Services Research, Mayo Clinic, Rochester, MN. Read Dr. LeBlanc's bio [here](#).



At the Mayo Clinic, Dr. Annie LeBlanc is part of the Knowledge and Evaluation Research (KER) Unit, a group of investigators that strives to understand the way person-centered healthcare is delivered and maintained at the point of care. KER Unit examines and reviews evidence-based, healthcare components and translates them into practice through the design, evaluation, implementation, and sustainability of person-centered interventions, and studies the overall impact on person-identified outcomes.

### How Did It Start?

Dr. LeBlanc understands that clinical practice is complicated and many physicians and service providers strive to provide evidence-based care to each individual they serve. Evidence-based care requires that clinicians have accurate, current, and easily accessible information that is employed within the context of each person's needs and preferences. When providers and persons served engage in shared decision making (SDM), they are able to engage in meaningful conversations about available

evidence and the person served's unique needs.

Dr. LeBlanc and her colleagues are developing decision aids (DAs) with the help of individuals and physicians. DAs help clinicians share evidence-based knowledge and expertise and elicit individuals' values, preferences, and experience to identify and implement the kind of treatment that best fits each person's goals.

### How Does It Work?

Physicians and other providers are inundated with information. To synthesize evidence-based information for direct integration into decision-making consultations, Dr. LeBlanc and her team have created simple, lightweight, easy-to-use tools that help foster conversation.

Let's consider medication treatment for depression. Standard, decision-making practice requires prescribers explain all the medication options and their side effects. The initial focus is on the treatment;

discussion about preferences becomes secondary. What if this focus was reversed, so that preferences drove the discussion of options? Wouldn't this be a more person-centered approach?

Dr. LeBlanc and her team developed a DA for depression medication that begins with the individual's concerns rather than explanations of medications. Through focus groups with persons served, the team identified some of their most common concerns about medications for depression such as weight gain and impact on sexual functioning. The team also explored the most frequently asked questions such as "What happens if I miss a dose?" or "What if I want to stop

**Dr. LeBlanc and her team developed a DA for depression medication that begins with the concerns of the individual rather than explanations of medications.**

this medication?" With this information, Dr. LeBlanc and her team created a set of cards that compare depression medications with the information persons served most want to know. They also produced resources for clinicians on how to use the cards

in decision-making consultations. The cards are "light" in that they summarize and synthesize information rather than provide an exhaustive presentation of the evidence on these medications.

In field testing, clinicians embraced the DA on depression medication. It allowed them to focus directly on individuals' concerns, reduce worry, and address misconceptions about the medications.

Step-By-Step Guide provided courtesy of Mayo Clinic

## a clinician guide to:

Using the Depression Medication Choice Decision Aid (DA) with Patients



**1** Clinician and patient discuss the "What You Should Know" card.



**2** Clinician asks, "What issues concerning a medication to treat depression symptoms would you like to discuss first?" Patient selects first card.



**3** Patient and clinician review this card.



**4** Patient selects a second card and compares the two.



**5** Medication options are discussed.



**6** Medication choice is made— brochure given to patient to take home.

## tips:

- Clinician decides how & when to use - and may elect not to use
- "Considerations" and "What You Should Know" cards are not given to patient as part of the comparison process
- Typically 3-4 cards are used

The DA provides evidence-based information about depression medication options and their characteristics to help patients take part in the clinical decision making process during the clinical visit. This video provides an example of how the DA may be used: <http://tinyurl.com/32bpmv>



The clinicians appreciated the structured way of providing transparent information and effectively engaging individuals in meaningful conversation.

## What Did They Learn?

Clinicians quickly learned how to use the DA and found that implementing the DA in clinical consultations did not significantly change the length of the encounter. At the clinicians' request, Dr. LeBlanc and her colleagues are developing an accompanying resource that will focus on contraindications (i.e., drug-drug interactions).

In developing the DA on depression medications, Dr. LeBlanc's team observed that persons served were engaged in their care and clinicians found the tool helpful. In contrast, when developing a similar DA on hypertension treatment, focus group participants did not see the benefit of the tool and were uninterested in engaging in conversations with their prescribers about these drugs. "To get it right, you have to ask people, 'What is your goal?' and 'What do you want?' And then follow their guidance," says Dr. Leblanc. As a result of engaging end users from the start, acceptance and uptake of the depression medication DA has exceeded expectations.

## What's Next?

The KER Unit continues to research and develop shared decision-making resources that have a broad and wide impact in healthcare. In the future, they hope that the shared decision-making philosophy and practice infuse all aspects of both medical and behavioral healthcare.●

## Making Wiser Choices About Medicines

A take-home guide to help patients compare depression medicines.

### What You Should Know

#### Will this medicine work for me?

- The antidepressants presented in this decision aid all work the same for treating depression.
- Most people with depression can find one that can make them feel better.
- 6 out of 10 people will feel better with the first antidepressant they try and the rest will have to try other antidepressants before they find the one that is right for them.

#### How long before I feel better?

- Most people need to take an antidepressant regularly for at least 6 weeks to begin to get the full effect.

#### Understanding side effects

- Most people taking antidepressants have at least one side effect.
- Many side effects go away after a few weeks, but some only go away after you stop the medicine.

This information reflects the best available research studies. It was prepared by Mayo Clinic researchers without funding from makers of depression medicines.



## Decisions in Recovery: Restoring the Dignity of Choice

By Niki Miller M.S., Senior Research Associate, Advocates for Human Potential



The muted colors of the San Francisco sunrise flew by the windows of my taxi as it wound its way out of the Tenderloin, passing alleyways, bar rooms, and clubs I had stumbled in and out of for years in varying states of hilarity and desperation. I once dreamt

about this counter-culture mecca where I would be the girl with flowers in her hair. Shortly after I arrived in 1977, at age 19, I had become the androgynous street waif with a safety pin in her ear. The only experience remotely related to my flower child dreams was an unsuccessful attempt at the Haight-Ashbury Free Clinic's heroin detox program. Fast forward to 1983, I was heading home to Cleveland, Ohio to enter a hospital-based unit for addiction treatment.

My journey in what I recognize today as dual recovery has offered me a choice every day since. The choice to remain in recovery and take the steps required to safeguard it became increasingly more complex over time. My recovery also involved addressing health issues that demanded alliances with providers I could trust and underscored the importance of shared decision making.

Elevated liver enzymes were a constant during my first decade of recovery, despite testing negative for hepatitis B. When I lost a dear friend to what, at that time, was referred to as non-A/non-B hepatitis, it occurred to me I might have something that had not yet been identified. In 1992, the antibody test for Hepatitis C became available and confirmed my suspicions. Early treatments included a year of interferon injections, debilitating side effects, and

recovery rates between 9 and 30 percent. For the next two decades, providers helped me weigh the benefits of all prescribed and over-the-counter medications against the burden they placed on my liver. We conferred on the efficacy of each new treatment and the degree of scarring and inflammation my liver had sustained. Today, I am completely free of the virus. I owe a lot to the providers who helped inform the difficult tradeoffs I faced—starting a treatment versus postponing it with the hope that better treatment options were in the pipeline.

After a car accident that left me with damaged discs in my upper back, many years of insomnia, and two liver biopsies with no anesthesia, I concluded that my blanket moratorium on all potentially mood-altering drugs was not sustainable. Prescribers who fully inform recovering individuals about the properties of each medication, all available options, and alternative treatments for managing pain and anxiety are a lifeline for people in long-term recovery. I am forever indebted to the pain management specialist who informed me that cyclobenzaprine (Flexeril) was also a tricyclic anti-depressant with low abuse potential and introduced me to the option of topical pain relief.

Working side by side with others in recovery remains a distinct privilege and a testament to the power of choice. Today we know that no single recovery pathway is right for every person. My experience has shown me that people in recovery are more motivated and more capable of carving out their individual pathways to healing when they have objective information and respectful decisional support. Today, I am grateful for the professionals and peers that have afforded me the dignity of choice. ●

## Recovery Center of Hamilton County, Ohio



## Peers Helping Peers to Engage in Shared Decision Making

By: Angela Ostholthoff, C.P.R.P., C.P.S. Training Coordinator, Recovery Center of Hamilton County and Mary Hornback, C.P.S., Recovery Specialist, and SDM Class Facilitator

### How Did It Start?

Since 2006, the Recovery Center of Hamilton County in Cincinnati, Ohio, has empowered individuals with mental health conditions to live more meaningful lives. The Center is peer-driven and peer-run, and offers up to 50 classes a week on topics such as personal growth and recovery and education and vocation. Shared decision making (SDM) became part of the Center's practice after staff participated in an intensive online class offered by the SAMHSA BRSS TACS initiative.

### How Does It Work?

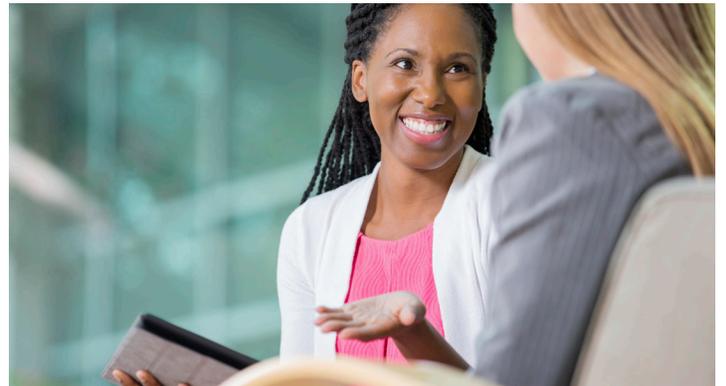
Students at the Recovery Center participate in a 10-week class where they learn about general decision-making skills, SDM, and decision-support tools such as decision aids (DA). The class also covers the importance of self-advocacy. The curriculum is drawn largely from SAMHSA SDM tools and resources. The goal is for participants to use what they learn in their meetings with case managers, therapists, and prescribers. Class participants universally express a desire for more meaningful dialogue with providers. The hope is that with information, tools, and peer support, participants will feel more prepared for engaging in these conversations.

The first week of the 10-week course focuses on learning how to develop personal recovery or life goals. This can be a challenging process for trainers and participants, especially if individuals have not considered personal recovery or life goals as different from "treatment goals." Substantial time is dedicated to helping people develop these goals. Other group meetings focus on basic steps for making quality personal decisions. Throughout the class, the focus is on life goals and decisions, not just decisions about medications or services.

The Recovery Center is independent and not directly affiliated with local service providers. Center staff have met with local providers to explain the Recovery Center's SDM program and how it may affect participants' approach to their meetings with providers. The Center also shared the tools that class participants are introduced to and discussed ways providers may incorporate the tools into treatment and service.

### What Is The Impact?

Recovery Center staff are confident that this initiative is valuable to both the peer and provider communities. "It reminds us of why we are here," says Angela Ostholthoff, the Center's Training Director.



“Peer voice must be the foundation and ultimate reason for providing services and supports. The SDM course helps put the mission and values of the organization into practice.”

The Center also collects data about the impact of the course on participants’ lives and relationships with providers. Pre- and post-class surveys assess factors such as whether participants feel listened to or are able to provide feedback during their visits with providers. Informally, participants report that taking decision tools or worksheets to provider appointments has been helpful.

### What is Next?

The Center relies on local service provider feedback and support for their program participants. Despite informational meetings about the

program, provider buy-in has yet to be fully established. These are not necessarily philosophical disagreements; often logistics and internal changes in provider agencies affect buy-in.

**“I enjoy asking participants how they have used their voice or other tools with practitioners or their family/support system. It brings awareness of how often we actually speak out about our concerns and needs. None of this is rocket science, but by giving yourself permission to use common sense and allowing yourself to be the expert on you, you have the best possible chance for a positive result—and with your total involvement.”**

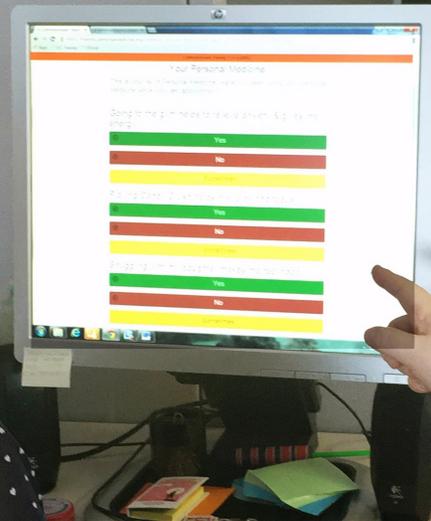
—Mary Hornback, SDM Class Facilitator

The Center plans to conduct more extensive training for providers and identify key champions within provider agencies, building on a shared commitment to recovery-oriented services. Over time, the Center will assess changes in service provider attitudes, receptivity, and use of SDM approaches and tools.

Decision-making and self-agency skills are concepts that can be incorporated into other classes offered by the Center. Staff aim to explore how SDM could be more actively integrated into other classes, particularly around employment and community involvement. ●

### Community Care Behavioral Health Organization

Images provided courtesy of Community Care



## No Longer a Waiting Room: Introducing Decision Support Centers in Mental Health Centers in Pennsylvania



By: Kim MacDonald-Wilson, ScD, CPRP, CRC, Senior Director, Recovery & Wellness



Learn more: <https://www.patdeegan.com/commonground>

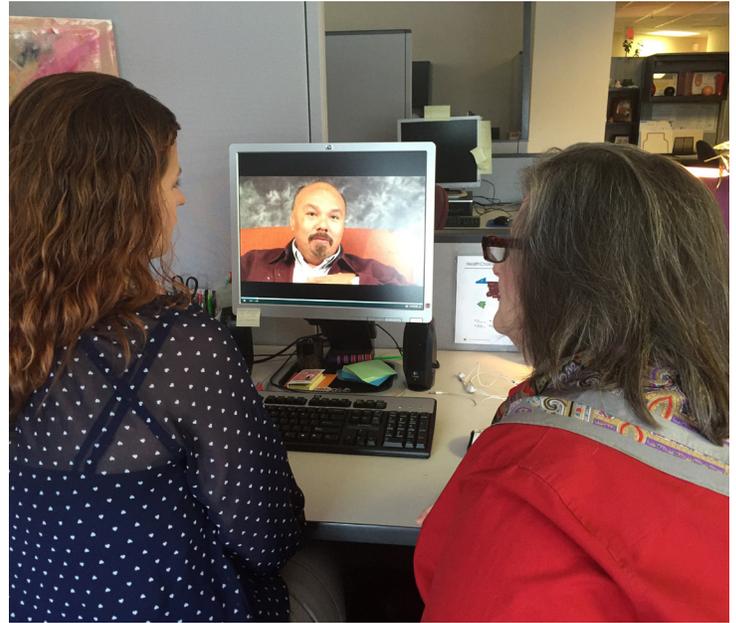
### How Did It Start?

In 2008, the Community Care Behavioral Health Organization (Community Care), one of the behavioral health, managed care organizations for Pennsylvania's Medicaid program, began working with Pat Deegan & Associates (PDA) to implement a comprehensive recovery transformation initiative and develop a "culture of recovery" within its service network. A cornerstone of this initiative was the launch of CommonGround, a web-based application developed by Dr. Deegan, that helps people prepare to meet with psychiatrists or treatment teams and arrive at the best decisions for treatment and recovery. This comprehensive shared decision-making system helps amplify the voice of people in recovery about their treatment and services.

Community Care introduced CommonGround in several mental health centers within their network, with extensive consultation from Dr. Deegan and support from many stakeholders including persons served, community providers, county officials, and the state Office of Mental Health and Substance Abuse Services. This initiative was an important way to generate a "culture of recovery" and underscore the work of peer recovery specialists who staff the CommonGround Decision Support Centers (DSC).

### How Does It Work?

CommonGround transforms the "waiting room" experience. Rather than sitting and waiting for appointments, individuals use this time to prepare for how to best participate in decision making with their care team. The DSC peer staff help individuals use the tools and resources available through the CommonGround web application. For example, individuals can generate a personal health report



and track their progress over time. They can obtain information about medications, side effects, or other concerns. Individuals can develop personal goals for the appointment, draft a Power Statement about how they would like treatment to work for them, and identify Personal Medicine—self-care strategies they can use to support their treatment and recovery. Each person enters their appointment with a personal report and is prepared to participate in decisions with the care provider.

### What Is The Impact?

Since the CommonGround initiative began, Community Care and its partners have increased the number of DSC from 12 to 23 sites across Pennsylvania. A combination of dedicated leadership, supportive partner agencies, and the excellent coaching and support by DSC peer staff were pivotal to the success and growth of this program.

Recent evaluation of the Community Care CommonGround initiative shows that the majority of participants who utilize DSC resources for at least 18 months report having increased ability to discuss medication concerns with their doctor. Participants use Personal Medicine frequently, and state that peer staff are integral in assisting them with meeting their recovery goals. The findings suggest that individuals using Personal Medicine are empowered to work with their prescribers to find a balance between what they do to be well (self-care) and what they take to be well (medication). Pat Deegan describes this balance as “a pathway into recovery.”

### What Was Learned?

Significant organizational and cultural change is required to truly achieve clinical interactions that reflect collaboration and shared decision making. The shift starts with incorporating peer staff as valued team members.

Any change takes time to implement. Full buy-in is not easily acquired, especially when staff view the change as an interruption to the traditional workflow. To increase buy-in at Community Care, each agency established a leadership team that included persons served, clinicians, and administrators. The leadership team developed and implemented a work plan, identified and monitored achievement of key milestones, and brainstormed solutions to implementation barriers. Community Care worked with each leadership team, providing training and technical assistance, collaboratively reviewing feedback, and identifying ways to improve the quality of care. The most successful programs and those with positive outcomes reported active involvement from senior leadership, clinical staff, physicians, peer staff, and persons served.

Implementation and start up require substantive resources. The Pennsylvania Managed Medicaid program (HealthChoices) and Community Care supported the CommonGround initiative. Costs include personnel and staff development, acquiring equipment, and renovating space to create a DSC. Intensive training is crucial. Persons served and providers must be comfortable with the program, and peer staff must have the skills to interact effectively with individuals and the

*Continued on page 17*

## The Brien Center



# A “Shared” Work in Progress: Integrated Care Teams Champion Shared Decision Making to Achieve Recovery Goals

By: Melinda Randall, M.D., Medical Director, Community Services Division and Denise Galvagni, L.C.S.W., Division Director, Community Services Division

*The Brien Center for Mental Health and Substance Abuse Services is a community-based, non-profit agency with a long-standing history and mission dedicated to promoting physical, mental, and emotional health along a continuum of care for children, adolescents, adults, and families with serious and persistent behavioral health disorders in Berkshire County, Massachusetts.*

### How Did It Start?

The Brien Center’s shared decision-making (SDM) initiative began with a research study that measured the impact of implementing SDM approaches. Results found that persons served who learned about SDM in an educational group reported increased confidence and control during meetings with prescribers and felt that they had the right information and support when making medication decisions.

Nurses in The Brien Center’s Community Services Division were trained in SDM and encouraged to use it with persons served. These nurses then helped train all staff in SDM. “Just introducing staff to decision aids wasn’t effective,” said Denise Galvani, The Brien Center’s Community Services Division Director. “They need to learn how SDM fits with their work and add their own voice to the process. The recovery principles embedded in SDM—empowerment and voice—resonated immediately with peer staff at the Center. They instantly understood the need for



Learn more: <http://www.briencenter.org>

SDM and became leaders in promoting SDM with both persons served and agency staff.”

Persons served interested in SDM attend a multi-session group facilitated by nurses. They also meet individually with nurses to talk about their use of medications and prepare for their prescriber visit. Dr. Melinda Randall, The Brien Center’s Medical Director, and other prescribers are enthusiastic about the changes they are seeing. When persons served come to their meetings knowledgeable about their medications, more time is available to talk about their life and goals. It is a mutually beneficial situation.

### What Is The Impact?

At the heart of the culture shift is the promotion of a recovery-oriented philosophy. Team members have changed how they provide services. For example, staff no longer simply refer questions or complaints about medications to the psychiatrist. Instead, nurses talk directly with persons served about their concerns, identify options, and provide education and support so that persons served are informed and ready for meetings with their doctors. The change in perspective and attitude by both persons served and staff testifies that the best decisions are made through conversations between the provider and the person served.

The SDM initiative makes the philosophy of person-centered planning more tangible for both staff and

persons served. Decision support tools and resources help to concretize and enrich person-centered service and treatment planning overall. As staff witness persons served taking more control over decisions about their medications, they recognize how medication,

psychosocial services, and wellness approaches can fit together. “It is not just the psychiatrist’s decision,” said Denise. “Staff and persons served both see how decisions about medications are integral to personal recovery goals.”

Cultivating this culture shift has taken substantial time and dedication. The Brien Center has spent more than a year training and expanding the practice, which now influences how all services are provided. Training is not just “one-time and done.” Classroom training is an important component, but equally important are efforts the Center leaders have made to help staff take ownership of their own learning and embed discussion of SDM in all meetings.

### What Is Next?

The SDM initiative underway at the Brien Center is a work in progress. Those leading the initiative continually receive and assess feedback to make improvements in the program. Rather than focusing on distributing medications to persons served, staff now focus on providing other recovery support services. As Denise stated, the most important impact of the initiative to date is that “staff see person served’s abilities differently.” ●

**“SDM is the ultimate challenge to custodial care. Traditional approaches to prescribing medication reflect the hierarchy of the medical model with the physician at the top, knowing best. SDM challenges this approach, empowering people around their medication decisions. This helps challenge the perception that medication is the solution and primary tool for recovery. SDM encourages staff and persons served to work toward self-efficacy and utilize the entire array of service and wellness options.”**

—Dr. Melinda Randall



From *Note from the Project Director* (page 2)

**collaboRATE Scale:** Learn more about this patient-reported measure of shared decision making. <http://www.collaboratescore.org>

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From *Shared Decision Making In Behavioral Health* (page 3)

**Policy Option to Encourage Patient-Physician Shared Decision Making:** National Institute for Health Care Reform [http://www.informedmedicaldecisions.org/sdmmonth/wp-content/uploads/2014/02/NIHCR\\_Policy\\_Analysis\\_No.\\_5-1.pdf](http://www.informedmedicaldecisions.org/sdmmonth/wp-content/uploads/2014/02/NIHCR_Policy_Analysis_No._5-1.pdf)

Shared Decision Making in Mental Health Decision Aid

**Considering the Role of Antipsychotic Medications in your Recovery Plan:** <http://archive.samhsa.gov/BRSS-TACS-Decision-Tool>

Ottawa Hospital Research Institute (OHRI): A-Z Inventory of Decision Aids: **Browse the listing decision aids based on topic.** <http://decisionaid.ohri.ca/azinvent.php>

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From *Thought Leader* (page 6)

**Mayo Clinic Shared Decision Making National Resource Center:** Access and view Decision Aids (DAs) and explore the other resources offered by the Resource Center. <http://shareddecisions.mayoclinic.org>

Specific link to the Depression DA mentioned in the article: <http://shareddecisions.mayoclinic.org/decision-aid-information/decision-aids-for-chronic-disease/depression-medication-choice>

From *No Longer A Waiting Room* (page 12)

**Pat Deegan and Associates' CommonGround:** Learn more about the web-based application and access the RECOVERY library <https://www.patdeegan.com/commonground>

Other Resources

**A Coding System to Measure Elements of Shared Decision Making in Psychiatric Visits:** Journal of Psychiatric Services <http://journals.psychiatryonline.org/article.aspx?articleid=1262267>

**BRSS TACS Shared Decision Making: Decisions in Recovery:** Medications for Opioid Addiction YouTube Video Playlist: <https://www.youtube.com/user/brsstacs/featured>

**Decision Making in Recovery-Oriented Mental Health Care:** Psychiatric Rehabilitation Journal <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3980461>

**Minnesota Shared Decision Making Collaborative: Shared Decision-Making Implementation Roadmap:** [msdmc.org/pdf/MSDMCRoadmap.pdf](http://msdmc.org/pdf/MSDMCRoadmap.pdf)

**SAMHSA | Shared Decision-Making in Mental Health Care:** Practice, Research, and Future Directions <http://store.samhsa.gov/product/Shared-Decision-Making-in-Mental-Health-Care/SMA09-4371>

## SHARE YOUR STORY!

The Recovery to Practice team wants to hear how you, your team, or your organization have integrated the principles of recovery into your life or your services. Send your story to [RTP@ahpnet.com](mailto:RTP@ahpnet.com).

## Conferences

### National Council for Behavioral Health

2015 National Conference

Orlando, Florida

Click [here](#) to learn more about the conference.

APR  
20-22

### American Psychiatric Association

168th Annual Meeting

Toronto, Ontario, Canada

Check out the [site](#) to register for the conference.

MAY  
16-20

### Psychiatric Rehabilitation Association

The Recovery Workforce Summit:  
2015 Annual Conference

Philadelphia, Pennsylvania

Check out the [site](#) to register for the conference.

JUN  
1-4

### American Psychological Association

2015 Annual Convention

Toronto, Ontario, Canada

Check out the [site](#) to register for the conference.

AUG  
6-9

### American Psychiatric Nurses Association

28th Annual Conference

Orlando, Florida

Check out the [site](#) to register to register for the conference.

OCT  
28-31

## What's Next?

### Training and Technical Assistance Opportunities

The RTP Virtual Learning Series will begin in May 2015, featuring interactive events on topics related to the implementation of recovery-oriented principles. Event and registration details will be shared via the Information Updates on this ListServ. Stay tuned!



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care team. Once a DSC is operational, ongoing costs include regular training and technical assistance. Medical service reimbursements provide ongoing financial support for the program.

## What Is Next?

Community Care has demonstrated that SDM benefits individuals and is central to person-centered, recovery-oriented, behavioral health care. The organization continues to pursue opportunities for ongoing research and program evaluation. In April 2014, the University of Pittsburgh Medical Center, Center for High Value Health Care and Community Care, in partnership with Dartmouth College and Pat Deegan and Associates, won a Patient-Centered Outcomes Research Institute award to compare the effectiveness of CommonGround with standard care. The study will involve 2,400 participants from 15 community behavioral health centers in Pennsylvania and evaluate the outcomes that matter most to individuals in treatment, their relationships with care providers, and their involvement in decisions about care. ●



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May  
is Mental  
Health  
Month!