The Role of Shared Decision-Making in Advancing Recovery

Advancing Recovery Webinar #4
Wednesday, April 6, 2016

Funded by California Department of Health Care Services
Presented by California Institute for Behavioral Health Solutions
Presenters

Expert Faculty

- Rick Goscha, Executive Director, University of Kansas Center for Mental Health Research and Innovation
- Kellie Spencer, Consultant & Trainer, University of Kansas Center for Mental Health Research and Innovation

Moderator

- Karin Kalk, Associate Director, CIBHS
To Sign Up for Continuing Education Credits

- In the question box, enter the name and email of each individual who will be requesting educational credits (within first 15 minutes of session)
- Attend the entire session
- Complete the CE packet (to be provided by CIBHS after the session) and submit it to CIBHS per instructions in the packet

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Session IV Agenda

1. Introductions & Brief Review of PRP
2. What is Shared Decision Making
3. What Shared Decision Making Is NOT
4. Using Shared-Decision Making Processes
5. Summary
6. Next Steps and Wrap Up
Strengths Model Practice
Orientation Scale

• As you learn more about these practices, reconsider your scores and revise them if you need to
• We will be asking for your scores during Session 6 and discussing how the scale can be used to support an organizational conversation, including what you and your agency what to do next

Build awareness of where you are versus where you want to be
<table>
<thead>
<tr>
<th>ITEM</th>
<th>LEVEL D</th>
<th>LEVEL C</th>
<th>LEVEL B</th>
<th>LEVEL A</th>
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</thead>
<tbody>
<tr>
<td>#1 Client Centered Goal Identification and Achievement</td>
<td>Considering all the clients you serve: Focus of the work is on diagnosis and treatment of illness and/or problem behavior. Goals are written in clinical terms and focus on diagnosis and symptoms (medical necessity and functional impairment) rather than goals that are meaningful and important to the person.</td>
<td>Considering all the clients you serve: Focus of the work is on diagnosis and treatment of illness and/or problem behavior. Client centered goals are acknowledged, but subservient to deficit-based/symptom focused goals.</td>
<td>Considering all the clients you serve: Focus of the work takes into account both client-centered and deficit-based/symptom focused goals, but it is not always clear how the two are integrated/related.</td>
<td>Considering all the clients you serve: Focus of the work is on client-centered goal identification and achievement. Problems, barriers, and challenges are discussed in the context of meaningful and important goals and in relation to their relevancy to these goals.</td>
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<td>#2 Identification and Use of Client Strengths</td>
<td>Identification of client strengths occurs primarily at intake or initial assessment. Strengths are fairly vague and loosely tied to goal achievement.</td>
<td>Identification of client strengths occurs at least annually or during treatment plan updates. Strengths vary in specificity and are loosely tied to goal achievement.</td>
<td>Identification of client strengths occurs in routine practice with clients but not in any systematic way. Strengths vary in specificity and are often tied to goal achievement.</td>
<td>The work revolves around continuous identification, organization, and mobilization of highly specific strengths to achieve a meaningful and important goal or remove a barrier to a specific step toward goal achievement.</td>
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<td>#3 Goal Planning</td>
<td>Goal planning occurs annually as a part of treatment planning. Goals and objectives rarely change until this formal process occurs.</td>
<td>Goal planning occurs quarterly or bi-annually as a part of treatment planning. Goals and objectives rarely change until this formal process occurs.</td>
<td>Goal planning occurs monthly (in addition to formal treatment planning). Goals may or may not remain the same from one month to the next, but objectives are continuously evolving.</td>
<td>Goal planning occurs during every contact with a person (it is an iterative process; each week’s work determines next week’s steps toward achieving a goal).</td>
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<td>#4 Contacts with Individuals</td>
<td>Most contacts tend to be crisis/reactive driven. Little evidence of proactive, planned, purposeful contact in relation to goal achievement. Most contacts are in the office.</td>
<td>Most contacts tend to be crisis/reactive driven. Some evidence of proactive, planned, purposeful contact in relation to goal achievement. Some interactions are out in the community.</td>
<td>Most contacts are proactive, planned, and purposeful in relation to goal achievement (outside of crises). Crisis/reactive interactions are no longer the main focus. At least half of interactions with clients in out in the community.</td>
<td>Most contacts are proactive, planned, and purposeful in relation to goal achievement (outside of crises). Crisis/reactive interactions are infrequent and associated mainly with new clients. More than 75% of contacts with client are out in the community.</td>
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<td>#5 Individual Movement through the System</td>
<td>Stabilization and maintenance is considered a positive outcome of services. Few individuals exit from services or graduate to a lower level of care.</td>
<td>Stabilization and maintenance is considered a positive outcome of services, with focus on individual achieving a life of meaning and purpose outside of the formal system of care considered for some with less than 1% of individuals exiting from services or graduating to a lower level of care each month.</td>
<td>Individual achieving a life of meaning and purpose outside of the formal system of care is considered an important outcome of services with 1-3% of individuals exiting from services or graduating to a lower level of care each month.</td>
<td>Individual achieving a life of meaning and purpose outside of the formal system of care is considered a key outcome of services. High rates (more than 3%) of individuals exiting from services or graduating to a lower level of care.</td>
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Introducing Rick Goscha

• Director, University of Kansas Center for Mental Health Research and Innovation

• Co-author with Charles Rapp on the book The Strengths Model: A Recovery-Oriented Approach to Mental Health Services (now in its 3rd edition)

• Has been practicum student, case manager, team leader, program manager, and director of an agency. Now involved in systemic implementation of evidence-based practices, policy, research, and program design.
Introducing Kellie Spencer

- Consultant and trainer, University of Kansas Center for Mental Health Research and Innovation
- Supports community mental health centers in implementing evidence-based and emerging best practices including CommonGround shared decision-making, Illness Management & Recovery (IMR), and Peer Support
- Previously supervised a CommonGround Decision Support Center at a community mental health center in Kansas
The Personal Recovery Plan (PRP) is a shared agenda/roadmap between the worker and client with the purpose of helping people achieve meaningful and important goals related to their recovery.

The PRP can help the worker and client celebrate smaller steps of success while making forward movement on larger recovery goals.

When used regularly, the PRP can help drive the nature of the work, activities, and interventions between the worker and client.

The PRP can help clinicians be more purposeful and prepared for their work with clients.
Questions & Feedback from Testing of the
Personal Recovery Plan
Shared Decision-Making

What is it and when do you use it?
Shared Decision Making

• A collaborative process that allows people and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the person’s values and preferences.

• Common elements include:
  – A two-way exchange of information
  – Options
  – Choice
  – Decision Talk
Shared Decision Making

**What it Requires**

- Belief that during each meeting important decisions are being made that impact the life of the person
- Belief that there are two experts in the room
- Belief that people are capable and have a desire to be involved in decisions
- Ability to let go of some of our power, our ownership of people’s recovery journey, and not take people’s decisions personally
The Context of Strengths Model Practice

Engagement
- Understanding
- Hope
- Alliance

Methods/Tools
- Strengths Assessment
- Personal Recovery Plan
- Group Supervision

Recovery
- Meaning
- Purpose
- Identity
Getting to Level A Practice
(Strengths Model Practice)

CLIENT GOAL

Recognizing that people bring an expertise about what is meaningful and important in their lives

MEDICAL NECESSITY

DOCUMENTATION

PROVIDER INTERVENTIONS
Recognizing that people bring an expertise about their experience of illness as well as their perception of problems, barriers, or challenges that may impact the achievement of meaningful and important goals.
Recognizing that people bring an expertise about what helps and doesn’t help and hold the power to decide how strengths are applied to the achievement of a goal or removing barriers to goal achievement.
Getting to Level A Practice
(Strengths Model Practice)

CLIENT GOAL

MEDICAL NECESSITY

DOCUMENTATION

PROVIDER INTERVENTIONS

Documentation: Brings together a written description of how decisions were made in the evolving storyline of helping a person achieve meaningful and important goals.
What is NOT shared decision-making?
How Does *Coerced* Decision-Making Occur?

Why do we need to talk about it?

**Disclaimer:** We are not advocating for the use of ‘coerced’ decision-making. We are exploring it here to help participants understand the principles behind coercion, how it occurs, and dynamics to watch out for when it might be occurring.
What is does it mean to coerce?

Merriam Webster definition of “coerce”:

Full Definition of coerce
co-erced  co-er-c-ing
transitive verb
1 : to restrain or dominate by force <religion in the past has tried to coerce the irreligious — W. R. Inge>
2 : to compel to an act or choice <was coerced into agreeing>
3 : to achieve by force or threat <coerce compliance>

We typically think of coercion as force or associated with violence.

Coercion can also occur when people are benevolent, have good intentions and believe what they are doing is in the person’s best interests.
What is Needed to Coerce

We must possess something or have access to something the person wants or have the power to take away something the person wants to keep

AND

The person must perceive that there are no other viable options to access it or prevent it
What is the Difference Between **Coercion** and **Persuasion**?

**Persuasion** requires understanding and implies that we have an ability to choose.

**Coercion** requires only power and the inability to choose, whether real or perceived.
Can we learn anything from sales?

How much does the person know about what they want?

Why does the person want what they want (the active ingredient)?

How much do we like the person who is describing the product?

To what degree do we view the person as an expert or is knowledge about the product?

How much does the person know about other options?
Examples of Subtle Coercion

- Elizabeth initially only took medications because her mom wouldn’t let her live at home if she wasn’t taking meds and receiving services at the CMHC.

- Person accepts specific services (e.g. psychosocial groups) because of the need for housing.

- Getting a person to work on a specific goal because of their desire for relationship with the worker.
Importance of Understanding What People Really Want

- Housing
- Immediate Safety or Stability
- Relationship or Connection

- To avoid something
- To avoid losing something
- To get something specific
Transparency When Power Dynamics Can Be Exercised

- Imminent risk of danger to self or others
- Reporting of abuse or neglect
- Other obligations to report based on professional ethics
Be Aware of Power Dynamics

There are power dynamics in ANY relationship.

The more you are aware of it, the more effective you can be at shared decision-making.

You can be more aware by taking time before and after each meeting with a person to reflect on possible power dynamics that might be at play.
Questions?
About Shared Decision Making

Creating Dialogue
Promoting Choice
Supporting Recovery
Decisions

We make multi-faceted multi-cultural decisions every single day (outside the context of our work within the mental health system)

- What do we make decisions about?
- What helps shape our decisions?
- What gets in the way of decision making?

What about decisions for individuals seeking support in the mental health system?

- What do they make decisions about?
- What helps shape their decisions?
- What gets in the way of their decision making?
Decisions and the Danger That Exists Within the Behavioral Health System

Think for a moment...where would you be if others had made decisions for you up until this point?
Introducing Sawyer
Overview of Sawyer at the beginning of his road to recovery (2008)

19 year old, white, heterosexual male
Diagnosed with Schizophrenia & Autism
Living with parents & 1 sibling
Limited supports, mostly isolated
Experiencing numerous side effects from medications
Frequent fights with family, treatment staff, and numerous hospitalizations
Overview of Sawyer at the beginning of his road to recovery (2008)

- History of significant trauma
- Wants friends, but doesn’t know where to start
- Wants to live on his own and work, but parents don’t think he can
- Attends psychosocial groups 5x week for 8 hours
- Wants to get off medications, but treatment team doesn’t think he’s ready
Where Sawyer is now (2016)

- Lives in own apartment
- Active volunteer in spiritual community
- Special Olympics athlete
- Works part time at a movie theater
- Has circle of friends from apartment complex, church, and Special Olympics
- Improved relationship with parents & sibling; meet weekly to go out to dinner together
- Disengaged from most mental health services and discontinued medications
What *shifts* created the environment to help Sawyer recover?

<table>
<thead>
<tr>
<th>Sawyer:</th>
<th>“Other people in my life are making all the decisions for me. I don’t have a voice in anything and no one will listen to me.”</th>
<th>“I’m an expert in my own life. I want to be involved in the decisions that affect me.”</th>
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<tbody>
<tr>
<td>Case Manager:</td>
<td>“I know he is frustrated, but we are doing the best we can.”</td>
<td>“I’m nervous, but if he is going to recover I need to help him explore possibilities.”</td>
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<td>Parents:</td>
<td>“We need to make all the decisions for Sawyer. He can’t make his own or live independently.”</td>
<td>“He wants to move out and get his own apartment. We are nervous about it, but this is his life.”</td>
</tr>
<tr>
<td>Prescriber:</td>
<td>“He has returned to baseline and needs to be medication compliant to maintain his level of functioning.”</td>
<td>“He wants to get off his medications to have a better quality life. I think a plan is in place to try this.”</td>
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*View of self related to decisions; expanding the power and who has it*
What *shifts* created the environment to help Sawyer recover?

<table>
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<tr>
<th>Sawyer:</th>
<th>Case Manager:</th>
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<tbody>
<tr>
<td>“I want to get off my medications. They make me feel worst. I have gained 50lbs and I can’t stay awake.”</td>
<td>“He has schizophrenia so taking his medications will be a high priority.”</td>
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<td>“The voices don’t bother me. There are many other ways I can manage my stress. I want to be out doing things.”</td>
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<tr>
<th>Parents:</th>
<th>Prescriber:</th>
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<td>“We see him talking to people that aren’t there. He also has a hard time controlling his temper.”</td>
<td>“He needs to be medication compliant to manage his symptoms and control the auditory hallucinations.”</td>
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<tr>
<td>“We’ve seen a big change since he started volunteering at church and joined a Special Olympics basketball team.”</td>
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<tr>
<td>“The voices don’t seem to bother Sawyer. He wants to focus on getting off medications so he can stay awake so he can work.”</td>
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View of medications and symptoms
What *shifts* created the environment to help Sawyer recover?

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<tr>
<th>Sawyer:</th>
<th>“I’m not sure...my parents want me to take medications and not get in trouble.”</th>
<th>“I want my own place. I want to work at a movie theater. I want friends to do things with.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Manager:</td>
<td>“Referral to Psychosocial Program to increase socialization and decrease symptoms.”</td>
<td>“I am helping Sawyer get connected to Special Olympics and he is starting with Voc. Rehab this week to find a part time job.”</td>
</tr>
<tr>
<td>Parents:</td>
<td>“We need to make all the decisions for Sawyer. He can’t make his own or live independently.”</td>
<td>“He wants to move out and get his own apartment. We are nervous about it, but this is his life.”</td>
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<td>Prescriber:</td>
<td>“Take medication as prescribed.”</td>
<td>“Work in collaboration with Sawyer and his CM to develop a safe plan to taper off his medications.”</td>
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**Goals: Creating Alignment**
Making a Shared Decision Around Medications

Goal and Value Statements

**Sawyer:** The most important things in my life are to have a place of my own, a job, a few close friends, and my family’s support. I want to find a way to help me better organize my thoughts and reduce stress without medications.

**Parents:** The most important thing to us is that our son is happy and safe. We want him to have the life he wants, but not at the expense of him being unwell and unsafe.
Making a Shared Decision Around Medications

Goal and Value Statements

**Psychiatrist:** I have an ethical responsibility to provide evidence-based care to ensure the well-being and safety of my patients as well as others in the community. I am willing to consider a plan that is responsible and protects the wellbeing of my patient and the community.
Making a Shared Decision Around Medications

Perspective (expertise):

Sawyer: The voices do not bother me as much as it seems to bother others. I do have difficulty sorting my thoughts and anxiety, but the meds seem to make this worse rather than better.

Parents: Sawyer hearing voices makes us feel uncomfortable and we are sad he has to deal with this. He seems more calm on the meds, but he also doesn’t to engage in anything else in his life which also makes us sad.
Making a Shared Decision Around Medications

Perspective (expertise)

**Psychiatrist:** Sawyer’s diagnosis and symptom profile typically warrants an antipsychotic, though not all patients will respond to these medications. Sawyer doesn’t seem to respond to the voices as much when he is on medications, which demonstrates that the medications are to some extent effective. The side effects he experiences are typical for this particular class of medication.
Making a Shared Decision Around Medications

Options

**Sawyer:** Wanted to know what other options there were related to helping with thoughts and anxiety

**Parents:** Were willing to consider options, but wanted to ensure that Sawyer was safe and there was evidence he was improving
Making a Shared Decision Around Medications

**Options**

**Psychiatrist:** Was willing to consider options, but wanted a plan in place that included specific interventions and supports. Wanted a detailed plan of how progress would be monitored and steps taken if things did not work well.
Sawyer and his case manager will work on developing personal medicine and keeping a mood and symptom calendar.

Parents will encourage and prompt Sawyer to use personal medicine and give feedback on how he is doing.

Psychiatrist will meet with Sawyer monthly and slower taper off medications if personal medicine is having an impact on symptoms.

Sawyer, case manager, and family will develop a crisis plan (Wellness Recovery Action Plan).
Personal Medicine is:

- What we do to create wellness in our lives that brings meaning and purpose
- Can be the big things like work, family, faith, and community. It can also be the smaller things that add quality and pleasure to our lives like hobbies or areas of special interest.
- About what we DO, not what we take
- The active ingredient (how it helps) reflects something unique about each of us – we are also more likely to incorporate things into our lives when we know exactly how they benefit us

(Personal Medicine Tool-Kit by Pat Deegan, PhD)
Sawyer’s Personal Medicine Supports Strengths Practice

- Basketball
- Movies
- Spending time with friends
- Going out to dinner with his family
- Walking
- Working
Decision Support Tools can be...

- A workbook
- A computer program; like CommonGround
- Weighing the pros & cons
- Evidence or research information
- A questionnaire
- A mood tracking calendar
- Medication fact sheet
- Input from a peer, friend, or trusted family member

*Shared Decision Making in Mental Health Decision Aid.* US Department of Health and Human Services: Substance Abuse and Mental Health Services Administration (SAMHSA); 2012.

Key Ingredients: **GIRP+**

- **Goal**
- **Intervention**
- **Response**
- **Plan**
- + Important observations that have relevance to the person’s goal or well-being.
<table>
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<tr>
<th><strong>GOAL</strong></th>
<th>Met with client in community to continue work on goal of finding ways to self-manage stress without psychiatric medications.</th>
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<tr>
<td><strong>INTERVENTION</strong></td>
<td>Used the Strengths Assessment (SA) to identify ways client is currently able to manage stress and has managed stress in past. Helped client clarify what is most important and meaningful in his life and how medications have helped or hindered. Supported client in expressing his experience of hearing voices and its impact on him and others important in his life. Discussed pros and cons of taking psychiatric medications. Discussed possible strategies to self-manage stress that client can try this week.</td>
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<tr>
<td><strong>RESPONSE</strong></td>
<td>Client shared importance of making friends and eventually working. He identified side effects of medications have made it difficult to communicate with others and maintain relationships. Client stated that being able to manage stress was still important to him. Client felt hopeful after identifying several ways he already manages stress that he was not aware of. Even though client stated his goal is to get off medications, he wants his mother and psychiatrist to be supportive of trying this.</td>
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<tr>
<td><strong>PLAN</strong></td>
<td>Will meet with client next week to help him plan for his med appointment. He plans to continue adding items to his Wellness Toolbox chapter in his WRAP book between now and then and wants to share this with his prescriber.</td>
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What Else Made the Shifts for Sawyer Possible (A Little Context)

- The agency started implementing Strengths Model case management:
  - The Strengths Assessment brought into focus what Sawyer wanted
  - Revealed strengths that contributed to his wellness
What Else Made the Shifts for Sawyer Possible (A Little Context)

- The agency started implementing CommonGround shared decision-making:
  - Developed power statements
  - How I am Doing Scale
  - Concerns with Medication
  - Personal Medicine
What if others do not share my views of shared decision making?
Things to keep in mind.....

• There are already decisions being made that are within your control

• People have goals, values and preferences whether we help them make these explicit or not

• Validating these does not commit us to anything
Things to keep in mind.....

• Understanding people’s experience is not a search for an “ultimate objective Truth”

• Helping people explore options does not commit us to any particular choice

• Our role is to help people navigate decisions based on a full range of desired goals, values, preferences, resources, and supports.
Next Steps:
Getting Answers to Your Questions
Try it!!

Contact Karin Kalk (kkalk@cibhs.org) about your experience and willingness to share about it and what you learned during the next webinar.
## Next Webinar

<table>
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<tr>
<th>SESSION</th>
<th>DATE AND TIME</th>
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<tr>
<td>Session I: Overview &amp; Orientation</td>
<td>Wednesday, January 6, 2016 Complete/Recorded</td>
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<tr>
<td>Session II: Amplifying the Well-Aspects of the Person - Identifying and Mobilizing a Person’s Strengths</td>
<td>Wednesday, February 3, 2016 Complete/Recorded</td>
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<tr>
<td>Session III: Identifying Meaningful Goals and Developing a Plan to Achieve Them</td>
<td>Wednesday, March 2, 2016 Complete/Recorded</td>
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<tr>
<td>Session IV: Using Shared Decision-Making</td>
<td>Wednesday, April 6, 2016 Recording to be available shortly</td>
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<tr>
<td><strong>Session V: Achieving Goals and Advancing Recovery</strong></td>
<td>Wednesday, May 4, 2016 12:00 – 1:30 pm</td>
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<tr>
<td>Session VI: Supporting Individuals to Prepare to and then Exit the System</td>
<td>Wednesday, June 1, 2016 12:00 – 1:30 pm</td>
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<td>Key elements of the personal recovery plan and how it helps with goal achievement</td>
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<td>Breaking goals into smaller, measurable steps that are individualized to the person</td>
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<td>Evaluating progress and updating the plan at each visit</td>
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<td>Key system supports for goal achievement</td>
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<td>Involving individuals and resources from their natural environment</td>
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Thank You!

Please complete the evaluation to follow!