National VA Mental Health Wellness & Recovery Webinar Series:
A Win-Win: Trainees as Promoters of Recovery on Inpatient Mental Health Units

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Dr. Samantha Hack: I'm going to turn the Webinar over to our presenters.

Dr. Dimitri Perivoliotis: Thank you so much. Thank you everybody for joining us today, we're really pleased to be here with you all. Happy New Year – wishing you all a better year than last year. [laughter] I'm Dimitri Perivoliotis. Thank you for having us, we really look forward to our hour with you. So we're talking today about getting recovery into the inpatient unit, inpatient mental health units of the VA. Just to give you a brief overview of the agenda, we're going to start with, I'll start us off with a overview of this transformation, what the research tells us. Talk a little bit about what a PRRC is and the roles of the PRRC's in this transformation, and then we'll move into the main crux of the talk which is the connection between training and trainees in inpatient units and recovering from inpatient on the unit. I'll talk to you a little bit about the PSR fellowship and then my colleagues will take it over and describe the nuts and bolts of how we have integrated trainees onto out inpatient unit here in San Diego, how trainees are supervised for that purpose, and I'm very happy that we have, well actually, really, all three of my co-presenters are past PSR fellows, Dr. Tamara Rumburg is our most recent one, so I'm really happy that she's here to talk about it from her perspective. And then reflecting on challenges that we've experienced in this process and lessons learned, and we hope to leave a good chunk of time at the end to answer your questions. So please, keep them coming and in the chat box and we'll be keeping an eye on them and try to address all of them hopefully. So, um, let's talk a little bit about the overview first about the VA's inpatient recovery transformation. So, when you really look at that, I'm sure a lot of you are very familiar with this already, when you really look at the materials that have been released by the VA, I don't think transformation is an exaggerated word. It really, it does, it really is a large effort that the VA has its sight's set on. Its outlined in multiple policy documents – I've pointed out a few of them here for you. If you aren't familiar and you'd like to do a little

bit more reading. And I have some quotes selected on the bottom there just to give you a little bit of a taste, if this is new for you, about just what the VA has in mind and to give you a sense of the magnitude of this transformation to inpatient mental health units. I just wanted to point out a few of these, uh, handbooks. At 1160.06, inpatient mental health services is a really good one if you're looking to do this, or you're involved with this kind of work because, you've probably seen it already, [laugh] but in case you haven't, it really operationalizes really nicely what it means exactly to have a recovery-oriented inpatient unit, because a lot of times, you know, we look at it as a lofty aspirational goal, but this document really goes into some specific details about the components, like recovery plans and evidenced-based psychosocial rehab practices, and evidence-based psychotherapies and involvement with PRRC's and so forth. So that's a really good one. VHA directive 1163 is also great, particularly if you're involved with a PRRC like we are because it talks about how PRRC's and other psychosocial rehabilitation and recovery services should be run, and also, in relevance of our talk today, what they should be doing on the inpatient unit. That's another good reason to review that document, 1163, is that it really nicely outlines how the VA sees and defines recovery and outlines the fourteen recovery domains that the VA has in mind, when they use the word recovery. And as you can see here, this is really treating the Veteran as a complete person. It's very holistic care as you can see here, it's not just optimizing psychiatric symptom management that third red box on the top, but it's really everything else too from spirituality to overcoming stigma, optimism and hope and so forth. These are the things we have in mind when we talk about doing recovery. The mental health inpatient recovery services toolkit is also really useful, very practical tool that the VA developed to help sites implement recovery principals and practices on inpatient units, and it has things like a checklist where you can conduct a self-assessment of your site to see where your strengths and weaknesses are, and specific steps involved

in implementing a recovery model of care on the inpatient unit. So that takes us to our first polling question. We have a series of four polling questions we will present to you today, just to get a sense of how things are going at your site. The first one here is “Do you feel, in your opinion, that the recovery model is sufficiently implemented on your inpatient unit?” And what do I mean by that? Um, you know, what I mean is, do you have psychosocial rehabilitation services, like vocational rehab, social skills training, um, illness management and recovery, these kinds of things. Are there evidenced based psychotherapies like cognitive behavior therapy? Are the Veterans asked about what they want their life to be [pause in dictation] be about beyond just their symptom relief? Is there talk of what their recovery goals are? Are their peers involved on the inpatient unit and so forth? So we’ll just give that a few seconds more. This is a really cool feature, I’ve never used before, I love this. Wow, I feel like I’m on TV [laughter] on a game show or something. So, all right, this is a very nice, thank you all for replying. This gives us a sense of where we are at. Um, I wonder how this compares to what your expectation was going in. This is actually a little bit, [inaudible; laughter] I’ll be honest, I’m very happy to see that more than half of the respondents feel like “yeah it is sufficiently implemented”, a little less than half say no, so obviously we have a ways to go so, but good to see though that it’s moving in that direction. So let’s get back on track here, all right, so what does the research tell us about this whole concept, you know, recovery is great, I think a lot of us believe in recovery, it sounds nice, getting on inpatient units, great, but what about the research? Well, the research, as you might not be surprised, first of all, it’s not a ton of it, there’s really a lot of room for growth in this area. I think this is relatively new, kind of focus of research, but what research we do have suggests that it is hard. It is easier said than done. There was a very nice 2016 review of studies where they found only eight studies looking at recovery implementation in inpatient psych units, and what they found was that the staff had varying definition

and often times vague, sometimes even contradictory definitions of recovery. They described it in different ways. Many of them knew the general concept, but had a hard time articulating what it is and how to applies to their practice on the unit. A lot of them felt positive about it, but expressed difficulty applying their knowledge of recovery to everyday practice which, you know, to me was very validating because that's exactly what we see in the real world. Um, now why should we have recovery? Other than it sounds great as far as the whole recovery movement in the United States, well, there's actually some good research, not a ton, because there's still a lot of work to be done in this area, but there are some very promising glimpses of the benefit that bringing recovery to inpatient units can have. For example, when recovery has been brought into the inpatient units in a number of studies, through a variety of ways that I won't get into probably today, um, we have found things like reduced use of seclusion and restraint. Patients reported improved benefits to their recovery process and decreased re-hospitalization rate even in one study, and one study also found an increase in staff satisfaction and there was another study where they found that attitudes of the staff improved in terms of working with people in inpatient units. So some promising signs in the research that this is a good thing to do and actually leads to positive changes. So definitely, if any researchers are on the line this is a ripe area for more research. So, what about PRRC. So many of you on the call are probably well aware and familiar with PRRC's, either psychosocial rehabilitation or recovery centers, with the program manager of our PRRC here in San Diego. Just to take a direct quote from VHA directive 1163, "PRRC's are intensive outpatient specialty mental health transitional learning centers designed to support recovering integration into meaningful self-determined community roles for Veterans challenged with SMI and severe functional impairment." There are a lot of key words in there, it's a specialty mental health program really geared to specialize in Veterans with SMI. Ours in San Diego is a little unique in that we focus

exclusively on psychotic disorders, but most PRRC's are broader than that to include MDD, depression, bipolar disorder, PTSD and so forth, and we really target our care, our services to Veterans who are experiencing difficulties with their day-to-day lives, and it's a very recovery-oriented holistic model of care. Why do we talk about PRRC's on this call, well, they're very specific directives from the VA about the role the PRRC's should have on the inpatient units, specifically, we are mandated to offer, according to VHA directive 1163, PRRC Bridge Groups on inpatient units, and these are defined as psychoeducational outreach groups, and the purpose is to have a PRRC staff go to the unit and provide education about, not just the program, but about recovery in general and really kind of, you know jazz up the Veteran, help them, if they're not already, to start thinking about what their recovery process and journey and goals might look like and how they can work toward that. And, another reason for their Bridge Group, is to facilitate referrals to the PRRCs. Hopefully get the Veterans excited about the program and also get the staff to be more aware of it so that they can refer once the Veteran is discharged from the inpatient unit. And also, another purpose of our groups is to teach about the principals and definition of recovery for the Vet. Go back to that slide here. All right, so here in San Diego ourPRRC is called the Center of Recovery Education or CORE, and we have a lot of, um, we go a little bit beyond the Bridge Group, and I want to give you a bit of a snapshot of that today. We're going to spend most of the time talking about what are trainees do on the unit, but from a bigger picture, we do a few other things too. We provide clinical services, both to our trainees and staff. This mostly takes the shape of running therapy groups and psychosocial rehab groups, but also some assessment in psychotherapy. We try to facilitate referrals by, of course having the Bridge Group, but also bringing program brochures to the staff. We have a staff brochure and a Veteran brochure that are kind of written differently to describe the program. We have the fortune of having a vocational rehabilitation specialist embedded part-

time in our PRRC, and she goes to the…, a lot of this by the way is pre-COVID. Right now we're still struggling with getting services on the inpatient uses – I should make that disclaimer. [laugh]

But when we were going to the unit, our voc rehab specialist would go there weekly and run a group to educate the Veterans about the benefits of work in terms of recovery, and also the voc rehab services including supportive employment that are available at the VA. And again, try to jazz them up to sign up for those services with the VA. And we have a lot of collaboration with multiple disciplines. We periodically will train the inpatient staff on a variety of things, like a Nurse's Education Day that we're going to get into a little bit more in a minute. We also, um, in the past, have shared our peer support specialist would also run groups on the unit, and Dr. Gallegos Rodriguez who is on the call today, is our, is in the PRRC, but also serves as our local recovery coordinator and our director of peer support services, it's really nice to have staff who are involved in multiple recovery focus programs like that. So that brings us to our next polling question, number two. I'm curious, we're all curious to hear if all of you have a PRRC or some other recovery-oriented mental health service. For example, MHICM at your VA that specifically has trainees, just so that we can get a sense of how likely is it, you know, to get this kind of effort of having trainees from a recovery-oriented service onto the inpatient unit possible. Okay, this is, wow, this is amazing, so a vast majority do have such a service with trainees. That's wonderful, that's really, really great…let's see 82, hovering around 82% it looks like. Awesome. Thank you all. All right, going back to the slide… So I'm going to, uh, shift gears a little bit and start talking about training. So, why are trainees important? Many, many reasons. [laugh]

First of all, the VA conducts the largest education and training efforts for health professionals in the United States, and it's the largest trainer of psychologists in the county. However, obviously we don't just train psychologists, we train social workers and psychiatry residents and so on and so forth, occupational therapy training, chaplain training, many, there's a huge training presence in the VA. And, I've been involved in supervising and training trainees for a long time, and can tell you that a lot of them really come to us wanting inpatient experience. Some of them had a taste of it before they got to us and want more, others realize there's a gap in the training. They really want this and the VA is a really great place to be able to deliver that, fill that training need for our trainees. And, the other thing to keep in mind in terms of psychology, is that as many of your have probably heard, last year our Serious Mental Illness was finally, uh, determined to be, or, accepted as an official, or designated I should say, as an official specialty of psychology. Believe it or not, it had never been. So what that means is, is I think it's a watershed moment for the field, um, what that means is that um, the APA now recognizes that hey, this is a special kind of branch of psychology, requiring specialized skills, and specialized training that people don't particularly get in a clinical psychology graduate program. And we're gonna be seeing a lot of benefits coming out of this. First of all, bringing attention to Serious Mental Illness. It's going to really, I think, improve the rigor and standardization of training for people in Serious Mental Illness, and I think alternately, we hope, it will lead to better treatment and better outcome for people with Serious Mental Illness. So, having inpatient training available is very attractive to trainees, and is also going to be of a direct relevance, particularly to psychologists who eventually want to be board certification in Serious Mental Illness. So, one example of training in Serious Mental Illness in the VA is the PSR Fellowship. So that's the name of the fellowship on the top, it's very long. We just call it the PSR Fellowship for short. The purpose of the fellowship is right there – really it's to develop

future mental health leaders, um, who will transform mental health care systems by emphasizing functional capability and rehabilitation and recovery, where I really like that mission, really our training future leaders, and Dr. Ehret, Dr. Gallegos Rodriguez and Dr. Rumburg, who are co-presenting with me today, I think are wonderful examples of that, and are former PSR fellows themselves. So really quickly, before I turn it over to them, the PSR Fellowship is run through the VISN 5 MIRECC, Uh, Dr. Richard Goldberg is the director, Ralf Schneider is our amazing coordinator who was probably on the call today, has six sites across the country, and we recently submitted some applications to get I think one or two more – I forget if it's one or two. [laugh]

So we're going to be expanding by at least one more and it's an interdisciplinary fellowship. So, we accept trainees from a lot of those disciplines that I mentioned previously. Here in San Diego we accept psychology, typically social work and voc rehab, but also some sites accept OOT, Chaplaincy, nursing, psychiatry residents and the idea here is that the, and we're also, by the way, in our thirteenth year of training here in San Diego, we've trained fellow, sorry, fifteen fellows from six different disciplines, and the idea here is that the trainees train at sites, VA sites, that are involved in proving PSR, psych social rehab for Veterans with Serious Mental Illness. Um, so here in San Diego the PSR Fellowship is one of five mental health training programs that have trainees that our PRRC. We also have interns, practicum students, psychiatry residents, chaplain fellows – it's a very rich training environment. The way we do it here in San Diego is that our fellows train primarily at the PRRC and each do a mini rotation at the inpatient unit about a day per week, although they often say that they would like more. [laugh] And their training is organized with the training plan, and a training plan is basically a living document that we create at the beginning of the training year, that outlines what they want to

accomplish, what are our requirements for them to accomplish and um, and that includes what exactly they would like to do on the inpatient unit. And it helps to keep everyone on the same page so that expectations on both sides are clear. And I have to tell you, um, I'm not exaggerating when I say that universally, when I ask the fellows at the middle and at the end of the year when I check in with them formally, what do you think about the inpatient experience? I am literally always, they say, it was amazing. I've never seen such universal praise for any aspect of a training program before. [laugh] They say they really enjoyed it, it was a nice change of pace from the outpatient unit, and it was really important skills, they felt like a leader, and so forth. I won't say more. I'll allow Dr. Rumburg to tell you her experience directly So I'm going to hand it off now to Drs. Ehret and Gallegos Rodriguez, and Dr. Rumburg for the next piece, which is getting into more details about how exactly our trainees have been integrated into the inpatient unit.

Dr. Blaire Ehret: Thank so much Dr. Perivoliotis for that incredible overview. Um, this is Dr. Ehret, um, I would love the opportunity to meet each and everyone of you, but we'll have to do it virtually for now. I wanted to take us into focusing on, you know, really looking at what we have done at the San Diego VA. Uh, to give you all an example of just how we've integrated our trainees onto our inpatient unit. And, this is a little bit of an overview here that kind of outlines the different aspects that our trainees are involved with, and I'll speak as well to the importance of having a consistent staff liaison to kind of facilitate the transition from trainees as they move through their rotations. But I wanted to just touch briefly, um, you know, the inpatient trainee integration took place far before I joined the program as a trainee and as a staff member, but in terms of kind of understanding how things got started, we took a look at the connection between the PRRC and the inpatient leadership. So there was a lot of collaboration in terms of understanding how our trainees could fill a need for recovery-oriented services on the inpatient unit, as well as how the inpatient unit could provide a rich

and comprehensive experience for our trainees. So, there was really, um, a nice synergy I think between leadership and other PRRC stakeholders, and we were able to successfully develop a program in which integrates our PRRC trainees onto the inpatient unit as Dr. Perivoliotis mentioned. One thing that I think has been a really important aspect to not just the development, but also the maintenance and strengthening of having trainees on the unit, is having a consistent staff member of the PRRC serve as a liaison to the inpatient unit. Um, I currently serve in that position, but prior to myself one of our PRRC's social workers, Eric Eichler was the liaison and what's really nice about that is that that's a consistent individual for the inpatient unit to create a relationship with, and they help to really just kind of bridge the transition between the fellows as they move through their different rotations, and so some of those responsibilities really include um, continuing to attend monthly inter-disciplinary team meetings, um, and just being available to develop different types of SOPs related to the process, meeting with the different inpatient staff as needed, and just overall being a facilitator. So, on this slide you'll see that our fellows, not just our PSR fellows, but other trainees that we have in our PRRC are pretty active on our inpatient unit. So, as Dr. Perivoliotis mentioned, we typically will have four psychosocial rehabilitation fellows, which they will each do three months on the inpatient unit, um, and there will be a little bit of an overlap to help with the transition between the fellows, but not more than just a week or so. We have other trainees in our program outside of the PSR fellowship. We have often several psychology trainees – these can include interns and practicum students, as well as social work interns. And we also include peer support specialists. So, we have a wonderful peer on our unit, as well as we currently have a vacancy in our program for a peer support specialist, but when that position has been filled in the past, that individual has been a really important part of providing PRRC services in collaboration with our trainees and our staff on the unit. In terms of supervision, and we'll talk a

little bit more about this in a couple slides, but really, there's a strong coordination between the PRRC supervisors as well as the unit supervisors. We are very fortunate to have a phenomenal clinical psychologist who is full-time on our inpatient unit, and that was a recent transition. Previously we had a wonderful part-time psychologist. But really connecting and collaborating with the supervisors that are on the unit that can provide those in the moment supervision opportunities is a really huge asset and I think one of the things that has made our integration of trainees on our unit really successful. As I mentioned when I talked about staff member liaison, um, we also really include our trainees onto the team the unit team, which I think is another really important element. Um, so our trainees are to, they attend morning psychiatry rounds and nursing rounds, as well as the inter-disciplinary treatment team meetings that take place throughout the year. They take, you know, they attend the rounds that they are able to attend on their respective days of their rotation. They're not expected to attend every single day, but really just kind of when they're expected to be on the unit. And then in terms of clinical duties, um, many of our fellows have a wide range of clinical activities that they participate in. Of course they facilitate groups. Often they will conduct intakes for the PRRCs, so if we get a referral from the unit for a Veteran to be seen by the PRRC, the intern or the fellow will complete an intake assessment on the unit. From time to time, there are psychological assessments cases that can really help with the trainee's training plan that might fit a few assessment goals that they have, but also really help out the inpatient staff by completing a few psychological assessments. Individual therapy as well takes place. And another piece that I'll mention is that, you know, often times we will have folks who are in the PRRC who go on to the inpatient unit and it is a really, I think, a wonderful way to bridge care when that Veteran's recovery coach can go and visit them on the unit, and maybe even, you know, work on the recovery plan together and giving them a sense that, um, they have a plan for when they leave the unit and

that, you know, they're still very much a part of the PRRC. And then lastly, for folks who are familiar with vertical supervision, this is a really great opportunity for trainees, but also for staff as well. Um, and this gives mainly our PSR fellows an opportunity to provide some junior supervision of some of their junior training colleagues. And so, for example, we may have a fellow, um, who provides some vertical supervision of a practicum student, maybe as they facilitate one of the inpatient groups together, and it's just another great opportunity for training. So in terms of um, you know, just kind of to bring what our trainees have contributed to life a little bit, these are a few just absolutely beautiful examples of the ways in which our trainees have integrated onto our unit, but also really been able to make meaningful contributions above and beyond kind of what we lay out in terms of the expectations for their rotations. So many of these projects are things that were, that trainees collaborated with one another, or they may have collaborated with inpatient staff, or even PRRC staff or all of the above. Um, so, for example, development of a recovery plan, a recovery workbook, which I will talk about a little bit more in detail for the inpatient, bridge to recovery group, as well as an Act group that we've developed. Um, again, I'll speak to that a little bit more specifically in a couple of slides. Social skills training is a phenomenal opportunity to integrate onto the unit, and many of our trainees will facilitate those groups, and in addition to that, I'll just highlight a couple of other areas here. Firstly, in services, are really remarkable contributions our trainees make. So, to give you some examples, um, when I was a fellow, I had a really cool opportunity to present to the psychiatry residents and the medical students on recovery-oriented care for persons with Serious Mental Illness, and it was a great opportunity not just to get to meet some of my medical colleagues, but also to have the opportunity to learn some skills of presenting to a discipline other than folks in psychology, as well as to start to spread some recovery knowledge to, um, individuals who are interacting on a daily basis with patients with

Serious Mental Illness. In addition to that, our Nurse's Skills Group Day is something that started in the last couple of years, and, um, basically how this was developed was our nurse coordinator on the unit approached myself and a few of the trainees and said “We would really love to help our nurses become better at delivering some of our recovery-oriented groups”. And so now, several times a year, we put on a Nurse's Group Skills Day, where the trainees will assist in basically going through and training folks, nurses, specifically on how to be involved and help us deliver our recovery-oriented services. And it’s just, again, another opportunity to really get to know the unit staff, to integrate and, again, to really connect over recovery-oriented services. I’ll go briefly through this really, let’s see if I can get my pointer out, this like really pretty um, card here that says SHINE. This is actually developed by, um, I want to point it here, this one over here, not this one, sorry, whoa… never mind, I’m not going to use that. [laugh] Um, this really pretty card over here, was actually designed and created by a Veteran and um, I created a PRRC group called Caring Cards when I was a fellow as part of my dissemination project. And, long story short, in conversations with our occupational therapists, we decided that this could be a really great art-based activity for Veterans on the unit to actually get involved in and so, um, in coordination with them and we effectively launched a group that we had in our PRRC’s over with the OT’s facilitating, and it’s been really successful, particularly as part of weekend art-based care, and the Veterans really enjoy the opportunity to create these cards and then these cards are actually then sent to other Veterans who may be in need of some additional support in the system. Okay, so I’m gonna turn things over my colleague Dr. Gallegos Rodriguez, to go through this next slide.

Dr. Yuliana Gallegos Rodriguez: Thanks you so much Dr. Ehret and Dr. Perivoliotis for your warm introduction. So I just wanted to speak about the treatment and recovery plan we have – this is kind of like a sample we have going on, and this example, um, is

actually from a dissemination project from a social work fellow who eventually became staff at our PRRC, Mr. Eric Eichler. Um, in this treatment, or recovery plan, has now evolved to be used with individual in our inpatient unit, but it also has been incorporated into the unit's treatment plan. So pieces of it have also been incorporated into the recovery workbook that we use in groups, which also another psychology fellow, Dr. Francesca Bond created while she was working with our current unit psychologist, Dr. Andrew Bismark. So, I particularly like this recovery plan because it has examples on the bottom of the prompt to guide Veterans with the type of goals they can focus on, and then eventually, obviously it breaks it down from the big picture to a smaller shorter-term goal and then further, you know, you see 1, 2, 3, so we can break it down further into steps and barriers that can um, that can come up during, um, pursuing the recovery goals.

Dr. Blaire Ehret: Great. Thank you. Um, so, I had mentioned earlier when I was discussing some of the different uh, contributions that our trainees have made, that there is a recovery resource book that was developed in collaboration with one of our recent PSR fellows, Dr. Francesca Bond, and our inpatient psychologist, Dr. Andrew Bismark, and this recovery workbook is absolutely stunning. I believe that we do have this available in the files for download. If you would like to take a look, it's titled Recovery Workbook, Final. And basically the development of this workbook was created out of a need that was being noticed by our PSR fellow, Dr. Bond, that a lot of the folks on the inpatient unit had a lot of downtime, kind of in-between their groups or on the weekends or if a group happened to be canceled for whatever reason, in addition, there might be a few Veterans who may struggle to be appropriate in groups – whether they're, you know, getting settled on the unit, or they've gone through a recent medication change and it's just made it difficult for them to sit in a room and, um, participate in a group. Dr. Bond wanted to develop something that was really an opportunity

for Veterans to be able to start to do some of the recovery-oriented and skill safe learning work on their own during these downtime periods, as well as for folks who may not be able to access groups as effectively as some of the other unit members. And so this workbook is really phenomenal, and just walks through a lot of different types of skills-based learning and recovery-oriented, um, components, and has been

[inaudible-recording skips] recording may have skipped as speaker 3 stops abruptly and speaker 4 begins speaking]

Dr. Yuliana Gallegos Rodriguez: …. And as mentioned, according to VHA directive 1163, the PRRCs are required to provide Bridge Groups in inpatient mental health units. So here we begin helping our inpatient Veterans focus on personal life and their recovery goals, and we point out alternative definitions of what recovery means, but also beginning feeling hope and empowerment empowering them to think about their goals and their sense of purpose. So it's a reminder that VHA directive focuses on psycho ed outreach, providing a new patient about PRRC and recovery, assist with transition to PRRC or other recovery-oriented services, and the definition and principles of recovery such as goal setting, strengths and barriers, hope, intro to community integration or inclusion and introduction to peer support.

Dr. Blaire Ehret: Thank you. And another beautiful example of our trainees outstanding contributions to our inpatient services is and an Act group that was developed by, now Dr. Montague – at the time she was our psychology intern, and in collaboration with other PRRC trainees and staff, um, Dr. Montague developed what covers eight main topics of acceptance and commitment therapy, and it's covered across sixteen unique sessions. She was really clever in the way that she developed this, such that each topic had two unique sessions that focused on the values, um, and committed action and diffusion and different variables of Act. She did this

purposely because she noticed that several Veterans, although several may move through the unit quickly, there are several others who stay on the unit for a while and/or, um, come back to the unit, and so she wanted to make sure that we had enough material to keep things fresh for folks who might have already been in the Act group and might have already received that particular session. Um, again, this is something that I would be more than happy to share with folks, um, if people are interested in that, but it's a really fantastic group, and really, uh, geared towards really the inpatient audience as well. So I mentioned a little bit earlier, um that I talked a little bit about supervision approach, because this can be often a little bit of a difficult thing to coordinate and over the years we have developed some pretty great procedures, I would say. Um, and I'm also happy that it's not in files, I just feel like I wanna give you guys everything but, um, [laugh] I'm also happy to share our SOP, which is also kind of a living document the trainees developed and they refined kind of as the year goes on. But in the SOP, there are really clear outlines in terms of how this supervision is going to work for folks so there isn't really kind of a second guessing of whose supervising beyond this case. So, of course I mentioned we're incredibly fortunate that we have a full-time inpatient psychologist who absolutely loves training and has been phenomenal to work with. So a lot of the unit specific care is supervised by Dr. Bismark, which is, you know, he's outside of the PRRC; however, when it comes to interactions with Veterans who are already a part of the PRRC and they happen to be returning to the inpatient unit or being admitted for the first time, that supervision would then be provided by the trainee's PRRC primary or secondary supervisor, depending on whoever caseload that individual falls under when they are not on the inpatient unit. Um, we do break up the supervision of CBT for psychosis, Dr. Perivoliotis runs a fantastic peer consultation group that takes place every two weeks are part of our PSR seminars following out inter-disciplinary team meeting. So CBT for psychosis cases that take place on the inpatient unit

will be provided with some peer consultation by Dr. P. In addition the vertical supervision piece to the junior trainees that I mentioned and to peers, that, in terms of who kind of supervises the supervision of that, um, will be in collaboration and determined based off of what makes the most sense. So, for example, Dr. Bismark currently supervises our Peer on the unit, and if a trainee is looking to get some supervision experience of the peer, it would make more sense for Dr. Bismark to supervise the supervision of the peer. Whereas, for example, if there was another trainee, let's say, a psychology practicum student that say Dr. Gallegos was supervising, it would make most sense for the fellow to supervise the peer, excuse me, to supervise the practicum student and have Dr. Gallegos supervise the supervision of that. So we kind of were flexible in terms of what makes the most sense for supervision as well. Um, and then supervision of groups, we've pretty much just kind of split it down the middle – so actually I supervise the Act group and Dr. Gallegos Rodriguez supervises our bridging and social skills groups as well. Um, we have recently in years added a third group, a CBT group that is supervised by our unit psychologist, Dr. Bismark. So, we kind of break things up accordingly to give everybody a diverse experience of supervision, but also to, you know, in real life, give the supervisors a little bit of a break as well, because supervision is hard, it's um, part of your, you know, daily caseload, so, important to balance that out. So, I would love to turn things over to Dr. Rumburg, who, as Dr. P. mentioned um, was a, our most recent former PSR fellow, to share a little bit about her perspective.

Dr. Tamara Rumburg: Thank you Dr. Ehret. Can everyone hear me okay?

Dr. Blaire Ehret: Yes.

Dr. Tamara Rumburg: Okay perfect. Thank you. All right, well thank you for my team for providing such great introductions to the PSR Fellowship so far and just a great overview of what trainees do on the unit. So I'm gonna share a little bit about my experience. I think the opportunity to train on the inpatient unit is such a rich learning experience. Um, so, particularly first with clinical training of course. Um, you heard a little bit about the groups that we facilitate, the Bridge to Recovery Group and the Act group are like the main ones that I facilitated when I was on the unit. We do sometimes do social skills training, um, on the unit as well, which of course was, um, ceased due to the pandemic, but hopefully that will be back on, too, soon. Um, so I think those were great opportunities. Also, delivering individual therapy. So I actually set up kind of an agreement that like every Tuesday, which was our inpatient day, I would see one person on the inpatient unit prior to running group. Um, and often times that was CBT for psychosis, sometimes it was focused on different referral questions, but it was such a great opportunity to integrate, kind of, individual therapy focused on brief intervention. Of course leadership and program development. You all saw some of the groups that some of our PSR fellows have developed in the past, as well as other clinical material. So, often times we were given the opportunity to like chose what group we were going to run, um, and really focus the interventions on the type of people we have in the unit at the time, um, you know, being able to attend rounds in the morning was a great opportunity to get the know the patients that were on the unit and what kinds of things they were coming in with so we could really tailor the group content to meet their needs, which was a really awesome opportunity. Attending those morning rounds with psychiatry and nursing staff was a great opportunity to get to know the team as well and the unit and everything that was going on because we were only on one day a week. So, going for those morning rounds were really important as a trainee. We also had the opportunity to choose Veterans for groups, so some of groups, like the Act protocol,

um, isn't really a good fit for everybody on the unit all the time. Um, sometimes people come in that, you know, are a little bit less suitable for groups – I think going to those morning rounds we got an idea of who would be a good fit for the group knowing what the group focused on, um, and then the Bridge to Recovery Group I think was like more open and really could work for anybody on the unit. Um.

And then working with Peers. So, one of our Peer Support Specialists I worked with actually when I was on the unit, is on the call today, and it was such a pleasure to work with our Peer Support Specialist and have them facilitate groups with us. Um, it's, you know, we can say all we want when we're in groups with Veterans, but when they hear it from a Peer Support Specialist it just like really drives the message home even more, and then of course supervising junior trainees. So, I actually ran a couple of groups with some of the junior trainees that I was supervising and providing vertical supervision for, which was such a great opportunity for live supervision and um, learning to co-facilitate groups together, so, um, that was definitely one of my favorite parts. All right, let me see if I can advance this slide here – okay, hopefully that worked. Um, so I was going to talk about some challenges and lessons learned, um, while working as a trainee on the inpatient unit. I think one of the things is that it can be challenging to integrate into the team when you're only on the unit one day a week. Um, so I have had the privilege of working on an inpatient unit five days a week when I was on internship and it does make a difference to be there every day. Um, but I do think that that means that it's a great professional development opportunity to learn to develop your clinical voice on a team and speak up in rounds, collaborate with providers as much as possible, and really get to know the patients when you are there. So, on my inpatient days sometimes I would just like walk around the unit and poke my head into people's rooms and chat with them and really try to get to know them as best as

I could. Some of them I would only see one time, but others ended up being on there for a few weeks, or even a month or more, so…um, having that time to just kind of connect with them on the day I was there as really important. I think as a trainee we're super tuned into issues of ethics. I often noticed Veterans mentioning things that were potentially reportable to CPS or APS, and there are a couple of times where I noticed that in a prior note from another provider, and it was hard to tell who reported it or who was responsible for reporting it. Um, so I think that really gave way to a learning opportunity for how to discuss reporting requirements with other providers, providing psychoeducation when it was necessary about what is reportable, etc. Um, and then for owning your expert role, I think particularly as a post-doc, you know, we have our doctorates, we have extensive training up until this point, but it can be easy to feel kind of like lower on the totem pole so to speak when you're a trainee and only on the unit one day a week. Um, so I think, you know in that situation I really learned to trust myself and my clinical judgment, my supervisors, um, both of my supervisors had been former trainees as well in PSR fellowships, and so they also were on the inpatient unit and so their guidance was really helpful in this [inaudible]. Um, and just how to be an assertive member of the team so that other people knew my role and my expertise. Um, I think there are plentiful learning opportunities to be creative, develop new group sessions, I kind of touched on that already. I particularly noticed being able to be really creative as a clinician in my individual sessions – I mentioned each week I'd see someone right after rounds, I'd get a referral question like, you know, this Veteran wants to work on emotion regulation, I then have 45 minutes, if I'm lucky, with that person, to quickly establish rapport, teach them a brief skill. They learn to really review what I knew about something, chose a few brief interventions to have in the forefront of my mind when I'm going into the session, and really be flexible to pivot if something unexpected came up. I think that was such as great opportunity to think like, "Okay, if I only have one

session with this person, what do I want them to walk away with? What do I want them to remember, to get the most bang for our buck." Of course prioritizing safety is always at the forefront, and it sometimes can be challenging. As I mentioned, one of our roles as a trainee on the inpatient unit was to decide who seemed fit to come to group. Um, and that as sometimes challenging since the milieu is always changing from one week to the next. Um so I really trusted the other staff members to help me decide, you know, who was a good fit for group. Um, and sometimes people would be let into group that really weren't a good fit, so, you kind of have to get comfortable with being uncomfortable and making sure we're able to like have someone excused from group, or redirect some staff to please assist them into their room in order to keep everyone safe. Ethical issues – I sort of touched on that a little bit. Um, on the previous slides, and think this is something, I always think about particularly on the inpatient unit, because it does look different. So, for example, someone's verbalizing SI or HI, it's not like we're calling the police or, they're already at the highest level of care. So, it does look different. I always made sure to like loop back with my supervisor and the team, who often knew a lot more about the patient than I did. And that was really essential in deciding kind of if we were to proceed with a report or not.

Dr. Blaire Ehret: [inaudible 48:33]

Dr. Tamara Rumburg: Go for it, Dr. Ehret. [laughter]

Dr. Blaire Ehret: Thanks, and I'm realizing that on time we're a little crunched, so I just want to make a really quick mention about SAIL considerations, when providing PRRC-based services on the inpatient unit. Um, obviously I know that there's a lot of, thought behind and a lot of, you know, maybe emotions behind SAIL, I know certainly on my part there are, um but with that said, I just want to keep in mind for folks that um, there are some challenges, meeting certain SAIL measures and receiving certain credits for PRRC-

based measures by including inpatient encounters. Just very briefly, for example, particular measure highest 72 and 73, although they include inpatients, and outpatients who meed PRRC diagnoses in the denominator, they actually explicitly exclude inpatient encounters by PRRC from the numerator. So, you know, when you're looking at and you're talking to your leadership about developing having more of a PRRC presence in the inpatient unit, you may just want to really consider and think about SAIL and how that may be affected. Um, so, I just wanted to put that out there for you guys.

Dr. Yuliana Gallegos Rodriguez: Now I have another polling question for you guys. Do you currently have mental health trainees providing recovery-oriented psychosocial rehab services on your inpatient unit?

Dr. Dimitri Perivoliotis: [clears throat]

Actually, I think this is the wrong question. There should be number 4, what are the barriers?

Dr. Blaire Ehret: Yes, that's what I have also.

Dr. Dimitri Perivoliotis: There you go – there it is. [laugh]

Dr. Yuliana Gallegos Rodriguez : Thank you. So what are the barriers to integrating trainees on your inpatient unit or challenges you have experienced in doing so? We'll give a few seconds because I know we're running short on time. We're almost wrapping up though. All right, so we have lack of leadership support, lack of staff buy in, lack of experience providing training and supervision for inpatient Serious Mental Illness for PSR services, no trainees available, lack of trainee interest and inpatient work, and other. All right, we have it looks like, we can go ahead and close the poll and from what we have, the highest recorded answers are lack of staff buy in and lack of experience providing training and supervision for inpatient Serious Mental Illness. We also have some others.

I wonder if we can see the answers briefly. So quickly, I just wanted to point out the settings needed for success and after consulting with our colleague, Dr. Andrew Bismark, our inpatient psychologist, um, we thought that it was helpful to have recovery-oriented leadership who support programming and trainee integration, also to actively attend treatment rounds and presenting clinical work, or assessment results, taking an active role in unit level treatment planning meetings, to make time for direct greater hands-on experience, ownership or PSR groups and material such as the Bridge Group, SST, uh, certification, whole health, and to integrate specific training – again, like SST, social skills training certification, targeted assessment in an interpretation, as well as screening patients for transfer to our PRRC once they're being discharged from inpatient, and facilitating that transition to care or continue to get trainee- Veteran relationship. And last, but not least, shadowing inpatient staff whenever possible.

Dr. Dimitri Perivoliotis: Terrific, thank you Yuliana. We're almost out of time. I'll make the summary very fast. [laugh]

Basically I hope that what you've all gotten out of today is um, you know, understanding, which I'm sure you already did, that how important and how really big this effort is to transform our inpatient mental health unit to recovery-oriented modeled care, and that there are challenges to that which I'm sure many of you are well aware. Um, but then mental health trainees really need and want that experience and can be successfully integrated onto the unit in a number of ways. Um, and I really truly believe that the arrangement is mutually beneficial. Um, you know, I've heard a lot of feedback, not just from the trainees about how great of a training experience it was, but from the inpatient staff telling us that they like having our trainees on the unit, it really helped them. They also learn a little bit too, and also from the Veterans as well. I'll never forget I had nurse one time tell me that "Our Vets are just kind of calmer when you guys are here doing your groups." [laugh] And it also gives them something else to do. You know, so, I

don’t, we don’t have data on it yet from our site, but anecdotally I think it seems to be beneficial for the Veterans too, which is obviously the most important thing. So, um, some keys to success, I think Dr. Bismark’s slide really encapsulates that really well about what needs to be done to make this work, and we really appreciate you all being here and listening. I know we’ve gone almost to the very top of the hour. [laugh] I’ve been monitoring the chat and responding, I think I responded to most of the questions. There were a lot of requests for materials and I think it's best if you all E-mail me with that – I tried to paste your names, but just in case I missed anybody. [inadubile] Um, there was a very good question about “How do you advocate for having a full-time psychologist on the unit?” I mean, that’s a really good question. I’m not entirely sure, uh, but I think our chief of psychology and inpatient psychologist would know more about that so… Um, to that attendant, I will try to connect you to them and hopefully they will have some words of wisdom. “Any interest in providing brief EBP’s for PTSD on inpatient?” That’s a great question. Um, our PRRC focus is mostly on psychosis, so when we have done brief therapy it has been for, um, psychosis; however, um, I am now, I’m glad you mentioned that Mary because I am reminded now that we had a fellow once who was, uh, in our PRRC as a PSR fellow, but came to us with a lot of trauma experience, and he actually did exactly that. Yes, he delivered a brief intervention that he had developed actually as part of his dissemination project for the fellowship for trauma, and got some very compelling, good findings, too. Um, so for what it’s worth, you know, we do have some precedent there that, yeah, you can also do some good, valuable, brief PTSD work on the unit. It wasn’t really designed as a be all end all, it was more designed as a primer to continue psychotherapy once outside the unit, but he was finding some good results and presented on those actually. I think it’s a good sign. Um, so Mary I will try to connect you to him, yep, absolutely.

Ralf Schneider: Thank you everyone, we are about out of time. Ralf Schneider, I would just like to remind everyone that the next presentation will be on February 9th, 12:00 Eastern Time, Dr. Donna Ames will be presenting on Prompting Recovery, Resilience and Suicide Prevention with Holistic and Spiritually Integrated Treatments: Taking Care of Our Veterans and Ourselves. So look out for that invite, and thanks again to our presenters.

Dr. Dimitri Perivoliotis: Thank you everyone, thank you Ralf, take care.

Multiple speakers: Thank you everyone. Bye.