For a number of years delegations from Japan came to the Village regularly to take part in our immersion trainings. Speaking through translators was difficult. Speaking across cultures was even harder. These Japanese professionals, consumers, and family members were all living in a culture with many more walls than American culture. I wrote this article, and it was translated into Japanese, to help them break down walls. Over time, however, I've found it more than relevant to our lives in America. It's just harder to see your own walls than someone else's walls.

Now I like it enough that I hand it out at almost every workshop I do. I feel it brings together the major elements of personal transformation in a brief article, emphasizing both the walls to be broken down and the growth to be pursued after the walls are broken through.

The Four Walls
(1998)

In 1989, the California State Legislature authorized the funding for three model mental health programs, including the Village Integrated Service Agency in Long Beach, in part to answer the question, "Does anything work?" We created a radical departure from traditional mental health services basing our entire system on psychosocial rehabilitation principles, quality of life outcomes and community integration. Arguably, we have created the most comprehensive, integrated and effective recovery based mental health program anywhere. In recent years, encouraged by our success, both our attention and the legislature's have turned to the further question of "How can our whole system be more like the Village?" Undoubtedly, there are numerous serious bureaucratic, funding, and system design issues relevant to that question, but I would like to focus on the personal issues staff must face.

I believe that basing mental health services on recovery is the paradigm shift that can finally make the dream of deinstitutionalization a reality. We are a society that promotes mainstreaming people with disabilities instead of isolating and protecting them, that promotes integrating all kinds of people rather than segregating undesirable ones, that promotes freedom of choice in the face of both amazingly positive and destructive choices, and that promotes individual independence despite a severely fragmented community. In this type of society, recovery based mental health services are what are needed. I also believe that to truly implement a recovery based paradigm, we must change more than the signs on our doors or the forms we use. We must change ourselves.

Looking back, I can see "four walls" that we had to break through to change ourselves: (1) The wall of the medical model, (2) The wall of professionalism, (3) The physical wall of our building, and (4) The often hidden wall of stigma and prejudice inside us. The vibrancy of the Village, our emotional intensity and warmth, and ultimately our members' recoveries has resulted from us breaking through these four walls.

(1) <u>The Wall of the Medical Model</u>

I could personally write a great deal about this breakthrough, because for me, as a heavily trained psychiatrist, it was the most freeing. I realized that my job is not to treat illnesses. It is to help people with serious mental illnesses lead better lives in our community. Symptom relief itself is not the goal. Improved quality of life is.

A woman once told me, "My psychiatrist asks me about my voices, my paranoia, my sleep, my side effects. He never asks me about me." The people we help are not just interesting cases of psychiatric illnesses. They are people living the profound human experiences of the destruction and recovery from mental illness. It is crucially important to consider both how the person impacts their illness and how their illness impacts them. For instance, all feelings of depression or anger are not symptoms; all noncompliance is not a product of delusional lack of insight; all recovery is not a product of medication stabilization and symptom reduction.

The route to holism is not by adding more areas of specialized analysis, as advocated by a bio-psycho-social model for example. It is by interacting as whole people. When we meet someone in crisis in an emergency room, we are not well served by putting on our medical model blinders and analyzing their neurochemical imbalances instead of helping them find hope, meaning to their suffering, and a responsible path to recovery. When we meet a hungry homeless person, we are not well served by trying to establish a medically necessary reimbursable treatment plan instead of feeding them.

If we ask people what was most helpful to them they rarely describe our clever diagnosis and elaborate combinations of medications. They describe moments of human kindness and caring, of believing in them and inspiring hope, of listening to them and making them feel precious.

Recovery is not a process in which illness is treated. It is a process that people achieve. If we are to succeed in promoting recovery we must interact with people, not just their illnesses. We must break through the medical model wall to form trusting relationships with them. A woman with schizophrenia who had taken medication only intermittently and suffered a great deal as a result once told me, "If I had a doctor who talked to me like you do, I'd take my medications."

The pervasive helplessness that has descended upon our work, relieved only by the excitement surrounding the introduction of a new medication, is not the product of the limits of human potential. It is the product of surrounding ourselves with the walls of our medical model.

(2) <u>The Wall of Professionalism</u>

When I was in medical school I was taught that a doctor needs to block out his emotions to efficiently do whatever is needed medically. I was also taught that my patients needed to be comforted by me knowing all the answers and taking care of their illnesses for them.

In psychiatric residency I was taught that maintaining boundaries is very important and that role blurring needed to be carefully avoided. The hospital staff taught me that strict rules were necessary to maintain control of dangerous psychotic people. Yellow lines for them to stay behind, glass walls to

separate us from them, and regular threats of seclusion, restraints and involuntary medication injections created the needed "structure". I never really figured out why we needed segregated bathrooms as well.

All of this "professional distance" creates separateness between staff and patients, which feels very comforting and protective to us as staff. Unfortunately, it usually feels degrading, disempowering, and isolating to the people we are trying to help. We must devise other ways for us to feel comfortable and safe that would be less destructive than the wall of professionalism.

For people to stop being passive, helpless, irresponsible, unable to care for themselves, chronic mentally ill patients, we have to stop being active, knowing all the answers, taking responsibility, caretaking, chronic mental health professionals. If they are to have roles other than patient, I must have roles other than "pill pushing" doctor. Even within the role of doctor there are many aspects that have been discarded over time, including family friend, caring fellow human, trusted advisor, confessor, healer, advocate, empathetic sharer of pain and suffering, motivator, and guide. Tapping into these additional roles has immeasurably increased my ability to promote recovery, even though most are no longer considered professional, taught, or overtly valued.

Even more helpful has been to expand to other roles beyond doctor-patient. I work beside people with serious mental illnesses as colleagues whom I rely upon. I share experiences as a husband, parent, Laker fan, moviegoer, poor musician, etc. I've shared hotel rooms with patients, taken them sightseeing with my family, had them come to my children's school as anti-drug abuse speakers, gone to their graduations, weddings, births and funerals. Breaking through the wall of professionalism has dramatically deepened our relationships, our mutual respect, and our personal growth. One woman once told me, "It's not that you come down to my level, or that I come up to yours. It's as though there were never two levels in the first place."

(3) <u>The Wall of Our Building</u>

Years ago while working at a community mental health center we were very worried about a depressed woman who had missed her appointments and had recently gotten a gun. She had no phone so we sent her several letters urging her to contact us. Several months later she shot and killed herself. We had never ever considered driving over to her house to see her, simply because it was never done. It was beyond the paradigm of our roles. We only thought that patients went to clinics or hospitals for appointments in order to receive treatment and be helped.

Now that we've left our building and become actively involved in people's lives in the community, it's hard to imagine not doing it. Our staff spends most of their time out of the building. There's a clear difference between helping someone be a good patient participating in treatment activities at the Village and helping someone improve the quality of their lives and become better integrated into our community.

When someone is in a severe crisis, they deserve to have someone they know and trust come to try to help them, rather than a stranger - an emergency team, or the police - come out to assess them for involuntary hospitalization. Home visits are an invaluable crisis intervention tool. They are also a great way to get to know someone, to really understand what their life is like, to show a willingness to meet them where they're at, and to really get involved. After all, if someone is going to recover, their life will be in the community, not in the treatment center.

We tend not to sit in the office and talk with people about how they would feel about doing things in their lives. Instead we go out and do things alongside them, even if the tasks are as mundane as standing in line at the social security office or going grocery shopping with someone or learning to ride the bus. Motivation is often a challenge for people with mental illnesses. It is often very helpful to have someone there, doing something with them, instead of having to face it alone. This also creates the opportunity for skill training in the actual situation to help the person grow and increase independence. The gap between having someone do things for them and doing them entirely independently, is bridged by a staff joining them in the community.

Continuity of care, or more to the point, continuity of relationships, is crucial to success. Outreach visits into the community are essential tools to avoid dropouts and people "falling between the cracks."

Advocacy is also often pursued most effectively in the community, negotiating difficulties or facing prejudice directly. Sometimes it is our job to help people with mental illnesses be able to live better in our communities, and sometimes it is our job to help our community become a better place for people with mental illnesses to live in. Either way we need to break out of the walls of our buildings to be effective.

(4) <u>The Often Hidden Wall of Stigma and Prejudice Inside Us</u>

A psychiatric resident who trained at the Village, who has a sister with manic depression, said it was only at the Village, with the separateness gone and nowhere to hide, that he had to confront how he really felt about people with mental illnesses.

Most prejudice is not the product of ill will, but it can be damaging nonetheless. The nurse at the USC follow-up clinic who called the patients "my little sickies" as she lovingly took care of them wasn't aware of the damage she was doing. Neither was the psychiatrist who wanted to know if it was safe to eat the cookies in our café that were made by someone with schizophrenia. Nor was the psychiatrist who said she wouldn't be comfortable eating lunch with "those people".

Deep inside us all are some feelings towards people with mental illnesses of fear, blaming, revulsion, pity, disgust, etc. The more we work through these feelings the less protection we'll need to be comfortable and the less segregation we'll need to impose. In addition, the depths of our acceptance and empathy will increase, which are both powerful recovery tools.

Recently, I noticed that I was personally making real progress. A person with severe mental illness was walking down the street, rather disheveled, yelling at his voices. Two angry young women yelled at him "Get off the street, you psycho." I yelled back from across the street, "I think he has just as much right to be here as you or I do." And I really meant it.

The medical director of the psychiatric hospital we use told me one evening, "I think the reason the Village is able to succeed with such difficult people when no one else was, is because of the special kind of respect your staff shows for all of your patients". Even if we have to struggle personally to achieve it, they deserve nothing less as they strive to recover.

As the voices promoting a recovery-based paradigm grow, especially the compelling voices of people with mental illnesses themselves, we will be forced to answer them. We can withdraw into the security of our professional expertise, press for increased coercive powers, and discount their desires as unrealistic or naïve. Or we can reach out to them, often releasing the same, almost forgotten voices within ourselves.

A role the Village can play as more people strive to break through their own walls, is to give you hope and credibility. It can be done, and it works.