Building a Recovery Based Psychiatric Practice: Setting Priorities for Limited Resources

(2011)

Over the decades CMHCs have evolved under almost constant pressure of inadequate funding and personnel to meet people's needs. Along the way many staff have left as the losses mounted feeling they were no longer able to work in a helpful and ethical way. Those who remained have gradually adapted and taught new staff the limitations. The true mission of CMHCs today are closer to "we do the best we can with what we have" than the lofty goals of the 1960's.

Some of the adaptations have been implemented primarily on the system level (for example defining target populations, billable services, pharmacy coverage, and legal mandates). Some have been implemented primarily on the program level (for example staffing patterns, team responsibilities, intake and triage practices, time allocated for various services, waiting lists, and types of services provided). Some have been implemented by individual psychiatrists (for example deciding what to focus on during med appointments, individual risk management and self-protection, accessibility, interactions with other staff and outside providers, collecting past histories, including families, and responding to disability report requests.) Unfortunately, almost no one feels good about the choices they've been forced to make and all three levels feel powerless to a large extent.

Almost all of these adaptations have been made within the perspective of the medical model. Reimbursement systems use medical insurance techniques like determining medical necessity, authorized diagnosis based treatment plans, and approved LPHA professional providers. Multidisciplinary teams are structured along professional lines. Service eligibility is made along diagnostic lines. Medications are by far the most relied upon treatment. The surviving service system is an emaciated edition of the "medical model", but it's still unmistakably a "medical model".

As the recovery model has emerged as an angry outsider revolutionary movement it has preyed upon the weaknesses of the system as though they're failures of the medical model itself rather than the results of malnutrition. Now that the recovery movement has a substantial insider presence, it too has to face the realities of impoverished budgets and worn out staff. System designers, program leaders, and line staff, including psychiatrists are increasingly likely to include recovery values as they make decisions about service delivery and practice.

It is relatively easy to describe a comprehensive, idealized practice for a recovery based psychiatrist. Unfortunately, it is also relatively easy to discard it as impractical. That doesn't mean that substantial transformations aren't possible without additional resources if recovery is prioritized.

Here's an example of a description of that comprehensive, idealized practice:

1) **Welcoming / engagement** – connecting people with staff, program, peers, relationship building, build "usefulness", collaborative goal setting, shared decision making, self disclosure

2) **Crisis interventions / Responding to basic safety and community expulsion threats** - hospital usage and linkage, jail diversion and legal advocacy, emergency shelter and avoiding homelessness, , safety interventions – medical, harm reduction, dangerousness, suicidality, "protection"

3) **Assessments –** assessing goals and needs, understanding their view of themselves, mental health assessment, Quality of Life assessment, co-occurring conditions – medical, substance abuse, developmental disorders, "eligibility" determinations

4) **Building and maintaining safety net / "protective factors"** - benefits assistance, poverty services, charity, safe and secure housing, family connections, get ID, connect to basic social services, connect to cultural contexts, connect to spiritual strength and security

5) **Motivating / Involving in growth oriented activities –** motivational interviewing, outreach, exposure to opportunities, exploration of possibilities for future, connecting with positive peers

6) **Treating mental illnesses to reduce barriers –** gaining control over illness, symptom reduction, medication services, building coping skills, building wellness skills, treatment of acute symptoms and relapses

7) **Providing and building support –** connecting to resources internal and external, connecting to treatment, social services, community activities and agencies, and family, advocacy, adding structure to their lives, making decisions for them, providing support directly - "caretaking"

8) **Rehabilitation / Skill building –** teaching, supported models, in-vivo learning, self help skills, building and practicing meaningful roles

9) **Building personal growth and responsibility –** personal developmental stages, building self responsibility, building self efficacy, empowerment

10) **Community development –** developing connections beyond mental health and social services, develop community opportunities, niches, roles, being a good neighbor and citizen, investing in and giving to community in positive ways

11) **Promoting self reliance, separation from services, and graduation –** building financial independence, obtaining insurance, preparing for graduation, facilitating relationship changes with staff, giving back to others, developing self advocacy skills, developing friendship skills

Which of these service areas should be prioritized and which ones discarded? The answer may be different for different patients but unless the overall practice description includes the possibility of a given area it can't be included even on an as needed basis. Our usual practice is built upon illness centered considerations like diagnosis, severity and acuity of symptoms, insight into illness, suicidality and dangerousness, compliance with medications, co-occurring conditions, and stability of symptoms. In contrast, a recovery based practice is built on person centered considerations like these:

1. How will we build trusting relationships?
2. What are their goals and how can we support them?
3. What is their view of their situation?
4. What strengths and resilience do they bring?
5. What barriers do we expect and what services might help?
6. What is their level of engagement and self-responsibility?
7. How can we include the community?

Which of these service areas should be done by the psychiatrist and which one by other staff (or community members)? The ability to have other people join in the effort depends on our ability to work as a team. Our present practices focus almost entirely on diagnosing and medicating mental illness which has led us to devalue working as a team since the psychiatrist often feels they can perform that function most efficiently on their own. Sharing evaluations and plans, seeing patients together, working in shared office areas, attending team meetings, and building relationships with other staff have often been thought not to be worth the time investment and cut.

Typically about a third of all patients are "meds only". The most common form of collaboration is with a therapist doing therapy while a psychiatrist is medicating them during separate appointments, often with limited communication and coordination. Outside of ACT teams widespread coordination with benefits assistance staff, consumer staff, supportive housing and employment staff, etc. is unusual. A relatively common approach is to have the other staff work as a team leaving the psychiatrist to work on their own. Some consequences of saving time that way is that it's difficult to alter medications to support life goals, it's difficult to share assessments to benefit less trained team mates, it's difficult to share welcoming and engagement to decrease dropouts, it's common for the psychiatrist to be pursuing protection while other staff are pursuing growth driven risk taking, it's difficult to coordinate support to try to get off medications, etc.

Effective recovery services will likely prioritize teamwork, *including the psychiatrist,* higher than we do at present. Recovery services benefit from team work:

- To integrate a range of quality of life services beyond any one person's competence
- Because people at different stages of recovery require different staff skills – engagement, building skills and support, moving on
- To increase accessibility to "someone I know"
- Because none of us is Mother Theresa, but between us we can create "one Mother Theresa" a broad "counterculture of acceptance" welcoming, engaging, and emotionally connect to people who "normal society" would reject

- To safely and ethically lower boundaries and adopt multiple roles we need to support and watch out for each other
- To maintain staff morale and avoid our traumatization and burnout we need to stick together and take care of each other

One of the main differences between traditional medical model services and recovery based services is shifting responsibilities. Instead of the responsibility being on the staff to do treatment to the person and on the person to be compliant with that treatment, the responsibility is on the person to work hard to rebuild their lives and recover and on the staff to guide, coach, inspire, and stick with people on their journey. Making services client driven doesn't mean just to enhance shared decision making. It means that they have to actually work to recover. Just taking their medications and waiting, isn't likely to work, although it is likely to build our cases loads. Examples of things they can do to rebuild their lives and recover include:

1. Talk to other people instead of isolating
2. Actually feel feelings and emotions instead of deadening them, medicating them, avoiding them, or getting high.
3. Learn some emotional coping skills
4. Learn to "use" medications instead of just "taking" medications
5. Engage (or re-engage) in activities that make them more fun and interesting
6. Take responsibility for their own life and make some changes in themselves
7. Go to work even when they're not feeling well
8. Do things outside of being a mental patient and outside the mental health system
9. Improve their physical health and wellness
10. Love other people – family, partners, and kids
11. Work on acceptance and forgiveness instead of blaming and vengeance
12. Give back by helping others
13. Find meaning and blessings in suffering and reconnect with God and spirituality.

Prioritizing time on activities that gets people working on these things potentially multiplies our impact.

Many psychiatrists will respond that even this level of discussion about prioritizing our time is unrealistic because we must spend all of our time prescribing medications as fast as possible to as many people as possible, a service that no one else can provide that is in very high demand. We are, in effect, required to be prescribing machines. Yet we rarely reflect on why we're prioritizing responding to that rising demand as paramount. We rarely reflect upon how much of the cuts have been caused by prescribing more and more pills to more and more people. In Los Angeles County DMH the expenditures on one medication alone, Seroquel, has gone from $3 million in 2000 – 2001 to $9 million in 2009 – 2010. Redirecting that $6 million increase could have more than paid for an additional psychiatrist in every CMHC in Los Angeles. Nationally, we're fast approaching the point where nationwide we're spending more on pills than on all the staff put together.

We don't often ask ourselves if we should spend extra time engaging with someone to increase the chance they'll return and pay for the time by prescribing only one medication instead of two. We never go through our caseloads to find people who appear to be getting the least benefit from their medications and take them off them to pay for other services. We never ask people if they would rather have a $300 per month rent subsidy instead of adding Abilify to their medications for depression like they saw on the commercial. How much medication is being used to relieve suffering caused by precarious, impoverished, unemployed lives? How much of the cutbacks have we caused ourselves by prescribing so bountifully?

When I ask someone what I've done that helped them recover the most, they rarely respond that it was that clever combination of Paxil, Depakote, and Resperidone. They usually point to some moment of human kindness and connection: The time I hugged them when they were crying because their children were taken away and I knew how much that hurt, when I spent extra time to do a long SSI report to make sure they'd get it because I knew they couldn't survive on the street any longer, when I believed in them even when they didn't believe in themselves because I knew they had strengths inside them, or when I told them straight out that their liver was going to kill them soon if they didn't stop drinking and they knew I'd miss them. When we design our practices in times of severe shortages we have to make sure we don't cut our most effective moments.