This year one of our longstanding psychiatrists left the Village. He had gotten very involved in almost everything about people's lives and often acted as psychiatrist, assistant team leader, case manager, primary care physician, and money manger all in one. Saying "no" wasn't in his character even when he was overwhelmed. This made it very hard for his replacement to define a more realistic, effective role.

I wrote up this set of guidelines to help the team recreate a balanced effort. Some of it is idiosyncratic to the Village (which remember is staffed like ACT teams) but I thought it was worth posting anyway because rarely are these "nuts and bolts" discussed overtly.

Dr. Mark's Guidelines for Psychiatric Teamwork

(2009)

In most places the psychiatrists aren't really part of the team. They work behind closed doors mostly prescribing meds apart from everyone else. At the Village we believe that the psychiatrist is a full team member and that working together leads to better results. The psychiatrist does have a unique role and responsibilities within the team. It takes work by the entire team to keep the psychiatrist both included and unique. Everyone has their own style, strengths and weaknesses. Here are some of my thoughts about how to do that. (By the way, nurse practitioners have a very similar role to psychiatrists, but they must work in collaboration with a psychiatrist to prescribe medications, getting supervision and consultation, and there are quite a few papers that require an MD signature.) This is not what "everyone has to do" but hopefully it can guide you into a practice that works well for you and the members.

Common tasks:

1. **Evaluations –** Some evaluations are done when a person first joins the Village, but every time a psychiatrist begins to work with someone new, whether they are new to the Village or not, it is a new evaluation and requires about an hour. The rest of the staff can help by sharing what they know about the person, by filling out the AIA (Adult Initial Assessment) form, by collecting old records and labs, by decoding the MIS episode screen, by encouraging the person to bring in pill bottles or med sheets, and by contacting collaterals. The first step in evaluations is to gain some trust so the person will tell you their story. Other staff can share their relationships and trust they've built up. If the other staff sticks around for the evaluation it could be a learning experience, they could help the psychiatrist, and it would help them make a plan together. This can include Homeless Assistance Program staff coming up to the neighborhood to introduce the new psychiatrist. For brand new members, try to get the referring agency to provide 30 days worth of pills so there is some flexibility in scheduling the first psychiatrist visit instead of it being a same day out of meds emergency. MD's are also asked to fill out annual physician assessments to determine ongoing medical necessity for treatment. This is a time to really look at, with the team, whether the member should be a member for another year or their slot given to someone else and to make a plan for the year. These are timed to coincide with the PSC (Personal Service Coordinator – our "case manager") doing their annual service coordination

plans so they can work together. These are also an opportunity to reassess the diagnosis and have it changed in the MIS system.

2. **Medication refills and adjustments –** Requests for medication refills come from many places – from pharmacies, Board and Care homes, members, PSCs, family, our own med room. Almost all med refills should be done by seeing the person face to face and generally require half an hour. Seeing each member on medication once a month is not an unreasonable burden in an intensive program like the Village. For members who have difficulty keeping track of their medications the PSC should try to help keep track of when medications should be due for refill. For more complex situations or serious medical problems the team nursing staff should assist as well. PSC's can check and see if they actually picked up their medications. Theresa can help check with the pharmacy if there are issues. Sometimes bringing in bottles or med sheets from Board and Cares can be helpful. Requests for medication re-evaluation and adjustments may also come from a variety of people. It is important for the staff to tell the psychiatrist if someone, including the member, thinks the medications should be adjusted. It may not be obvious to the psychiatrist that someone else has complaints about the member and they might not mention it. It is also important for the PSC to check with the member and others after a medication adjustment to give the psychiatrist feedback on how the change is working. A change that is going very badly may need attention before the scheduled follow up. Even if the meds are unchanged, there are other things to do in a med visit – education, teaching self-help, reassessment of both illness and life situation, building self responsibility and preparing for graduation, encouraging pursuing other life goals, building trust and relationship, assessing how the person is actually using their medications, assessing side effects and physical health status. Vacations are a good time to give refills without seeing someone. The member's insurance status – MediCal, MediCare, HMO, other, none – effects what medications we can provide, what prescriptions they go on, whether Theresa needs to enter them in the computer, what pharmacy they can go to, how they get physical care, labs, and how pills are paid for. The psychiatrist needs updated insurance rosters and if you know of insurance changes (for example, they just got SSI and MediCal) pass it on.

3. **Paperwork, forms, and letters –** Doctors are asked to sign lots of forms. Don't just leave them on their desk to "take care of." They might need information from you or the member to fill them out. There may be choices involved. But, most importantly, doing that changes the process from "I'll help you get this taken care of" to "I'll take care of it for you." Teaching responsibility, not taking care of things applies to forms too. Don't let them interrupt for "this will only take a minute" even if they've procrastinated and waited to the last minute and it's urgent now. That's not teaching how to take responsibility either. Forms come in many types: Disabled bus IDs don't need a doctor to fill out if they have SSI. Just attach proof of SSI. SSI applications are by far the most important forms we fill out. It's worth helping the member fill out their part. It's worth spending 1 to 2 hours to write a disability evaluation (We can bill SSI

for them.). Each successful one is worth an average of $250,000. You can help gather information or even write it together. The team should have a tracking system for everyone in the process of applying for SSI, because deadlines are easy to miss and the mail SSI sends is confusing. Other forms include jury duty, NSA, HUD, DR, disabled students, loan forgiveness, payee, conservatorship, etc. Many of these are connected to goals or have long term implications. The team should be involved in many of these decisions. There are also letters to write to courts, children's services, probation, schools, etc. You can help with these too.

4. **"Crisis" evaluations and intervention –** Many members will say it's an emergency or at least urgent and they need to see the doctor NOW. It can't wait. How do you figure out when to get the doctor involved and when not to? Try to assess the crisis: First, whose crisis is it? What do they need? Second, why is this a crisis? Some choices are: 1) Their self care is overwhelmed by internal distress or external situations and they feel a loss of safety and control, 2) To gain accessibility, 3) To gain assistance, 4) To gain attention, support, 5) Someone else is fed up with them or wants to force them to do something. Third, what are our goals in this crisis? If they are "Unengaged," it's engagement. If they are "engaged, but poorly self-coordinating," it's to help them recognize pattern and learn changes needed to make suffering not recur and skill building. If they are "self responsible" it's to help them mobilize personal coping skills and natural supports and build confidence in self directed care. Will including the psychiatrist help or hinder those goals? If we get to the point of deciding there is no way to combine their internal resources and natural supports and whatever supports we can add to keep the member in the community safely, we may think hospitalization is an option. That decision can only be made by someone with "5150 power," the power to involuntarily hospitalize someone. The doctor has that power and so should at least one other person on your team.

5. **Emotional support, skill building, healing –** Our program does not rely upon licensed therapists doing formal therapy, group or individual, to provide emotional support, skill building, and healing. Therefore, it falls on everyone to include emotional support, skill building, and healing in our everyday actions and in our overall environment. The doctor contributes, by collaborating with other staff to prepare their approach, by contributing to the overall environment (for example, by attending celebrations and funerals), and directly during their medication visits. Each member should have some coherent emotional approach the team has created together. In intense situations (for example, rapes, deaths, children's services involvement, suicidal behaviors, banning from the Village, evictions, childbirth, etc.) the psychiatrist should be actively involved in the discussion and decision making.

6. **Staff consultation and education –** Our teams include staff with all different educations and expertise. An advantage to having an accessible psychiatrist on the team is the ability for other staff to pick their brains and get consultation and advice (or even just general education). This

should happen in team meetings, but also in more in depth individual conversations. As much as possible schedule these into slots in the psychiatrist's schedule or ask about "no shows" so there is time available without disrupting everything else. It's just as disruptive for a staff to say, "Can I talk to you for a minute?" (and it's really almost never a minute) as when a member does it. We want psychiatrists to talk a lot to other staff (and bill consultation for it) but we don't want to do so at the expense of scheduled members.

7. **Community development –** We like our psychiatrists to be part of the outside community. We may already have connections we can use to promote mental health and the Village. Sometimes other opportunities come up (for example, talking to landlords or police or the media or a church or local doctors). Psychiatrists (besides just me) are more than welcome to be part of our immersions, buddies, training and workforce development, advocacy, etc. to help make the world a better place for our members to live in. Other staff can invite us along.

8. **Have fun with the staff and the members!**

Prioritizing time:

The psychiatrist has a direct service billing expectation of at least 4 ½ hours per day. (I tend to schedule my last appointment for 3:30 so there is an hour at the end of the day for charting, other paperwork, phone calls, "running late", or even a last minute same day visit.) If the average visit is 25 to 30 minutes with 10 minutes for paper work, that's about 7 visits a day or 140 per month. To achieve that level of efficiency, other staff may have to help remind people when their appointment is or even help them get here. If about 100 people get monthly medication visits that would leave about 40 "slots" for extras. Who should get them? The answer is not "whoever asks for them, whenever they ask for them." This is an example of how we are not entirely "member driven." We are "value driven and member centered." We have to ask ourselves if we value enough the reason the member wants to see the doctor to support them in getting extra time. What is their goal? How should we support that goal? Here are a few tools:

1. Pressing / important: We can divide issues into these four categories:

Pressing and Important	Pressing, but not Important
Not Pressing, but Important	Not Pressing or Important

Try not to spend too much of yours or the doctor's time on things that are pressing, but not important. Each team always has a handful of members who have lots of issues that are pressing, but not important. The member believes their concern is important, but if you look at past experience, it really doesn't matter that much what is done, so responding the they way they want isn't important even if they are in distress. Instead of repeatedly reacting in the moment, the team needs to make a proactive

strategy for each of these members to try to help them out of this crisis cycle into something more productive and goal promoting. The strategy should include the psychiatrist.

2. Who gets seen first? - When there is more than one person who wants to see me, I generally prioritize as follows: 1) Member who has an appointment. It is rarely necessary to not see someone with an appointment to see someone else "in crisis." One of the main behaviors we want to reward and develop is coming to appointments. Graduation is usually possible only with appointments. 2) Members who rarely come in, "wild blue yonder" are next. Most of these members are not well engaged and welcoming them when they do show up may help engage them. 3) Members who are around a lot are last. These members are usually "engaged, but poorly self coordinating" and this is an opportunity to get them to think more proactively and considerately and self responsibly.

3. The "3 R's" - I usually want to spend extra time and effort with members with the "3 R's," relationship, risk, and ready. 1) Relationship - I want to spend more time to build a relationship with people who I don't have a relationship with. I don't want to be medicating strangers. I'll be more effective in a crisis if I'm trusted and know them well. The doctor should rarely be the most important relationship, but we should be one of several. Other staff can help me connect with people I don't know. 2) Risk – I want to spend more time if there is a real risk of losing something important or deteriorating significantly. Maybe their symptoms are deteriorating and they need a med change. Maybe they're at risk of hospitalization or losing their job or getting evicted or losing their kids or going to jail, etc. Most of these things require us to work together to minimize or at least prepare for the risk. Rarely should you just bring them in to me to "take care of it" and then go do something else if risk is why I'm seeing them. 3) Readiness – Some members are actively working on some goal and some extra help from the psychiatrist, even reassurance or encouragement, might increase the chance of achieving something. Talking on the eve of a new job or school class or moving into a new apartment or drug rehab is worthwhile to me. I'll help you and them look at the preparation and plans and may be able to help. Note that in all three of the "3R" situations I'm usually spending the extra time with the member and other staff together, not alone. These are also the most frequent reasons for me leaving the building to see someone (along with celebrations and fun).