After three or four years the residency director at UC Irvine left and I never had as strong of a relationship with the next director or as much commitment to the Village approach. When there were problems while I was away on a four month trip around the world in 2000 with my family, the program fell apart and it was discontinued shortly afterwards.

In 2003, Dr. Michael Schwartz, co-director of the Irwin Foundation, invited me to come to Akron, Ohio to join one of their nationwide Recovery Celebrations and to meet with a rather distinguished group of psychiatrists from all around the country who were active in the recovery movement to talk about training and retraining psychiatrists in recovery. Coincidently, the day we were meeting together was the same day the President's Commission Report on Mental Health was released and we were given copies hot off the presses that to our astonishment urged a transformation of the entire mental health system into a recovery based system.

It was surprising how similar our ideas were even though we'd developed them separately from each other. Ron Diamond from the evolving PACT program in Madison, Wisconsin and I could literally have given each others presentations. I've repeatedly experienced that kind of convergent thinking in the recovery movement which reassures me we're on to something real.

This paper was my contribution to the group. You can see that it contains many ideas I developed in the previous papers packaged into coherent guide for psychiatrists. To me, the overarching goal is for psychiatrists to be an integral part of recovery, not to define what's special about us to distinguish us from everyone else.

Psychiatrists' Recovery Curriculum: Engagement, Assessment, Treatment and Outcomes

(2003)

With the growth of recovery programs, psychiatrists face a choice of whether to remain apart while assisting our patients to use these programs, or joining in becoming embedded within these programs. Joining in would likely lead to improved integration and cohesiveness of treatment for our patients and to a reduction in the antagonism between some recovery oriented consumers and the psychiatric establishment. Joining in would not require an abandonment of our present skills, but it would require an adaptation to a new treatment culture (somewhat analogous to doctors working in a hospice, a sports medicine rehabilitation clinic, a research ward, a pain clinic, or the CDC, for example). In my opinion, the fundamental difference between the medical model culture and the recovery model culture is that the focus of treatment shifts from the treatment of mental illnesses to helping people with mental illnesses have better lives. This paper outlines a basis for a curriculum for teaching psychiatrists the adaptations necessary to join the recovery model culture in four areas: Engagement, assessment, treatment, and outcomes.

Engagement

In the medical model it is more crucial to engage with the patient's illness than with the person themselves. This is generally achieved through a diagnostic assessment. Once this has been achieved and a treatment course determined, staff and programs can be substituted, so long as the diagnosis and treatment plan is passed on. A psychiatrist can medicate a patient they don't know so long as they have access to this information.

In the recovery model the person's active participation in the treatment is crucial, as well as a collaborative, personal relationship between the person and the psychiatrist. The focus is on transforming their lives rather than on treating their illnesses. (This is why initiating treatment coercively, for example, by locked hospitalization and forced medication, while useful in treating illnesses is particularly destructive within a recovery model.)

Many psychiatrists will find this recovery-promoting relationship familiar because it is similar to the psychotherapeutic relationship. Techniques for building a treatment relationship from psychotherapy can be revived including creating empathy, and managing defenses and transference.

Other engagement techniques (that can precede or be included in a diagnostic assessment) include:

1) Giving people material things they want, or helping them access them. (In homeless treatment lingo, it's "meeting people where they're at")
2) Giving people medications they want (Hopefully they will decrease symptoms, but the goal here is engagement)
3) Nonjudgmental, knowledgeable discussion of substance abuse (Hopefully useful in motivational interviewing, harm reduction or promoting abstinence, but the goal here is engagement)
4) Uncovering, discussing, and empathizing with emotional pain and suffering (Hopefully emotionally healing, but the goal here is engagement)
5) Uncovering, discussing, and revering moral and spiritual conflicts.

Within a recovery culture, creating a welcoming atmosphere is highly valued. An engaging psychiatrist can become an important element of that culture. Many programs would consider themselves successful if after 6 months a difficult person had been engaged, even if their illness hadn't been treated at all.

Assessment

In a recovery culture assessing a person's life is more important than assessing their illness. The classic first question, "What seems to be the problem?" is replaced with "What do you want in your life?" Issues around housing, legal problems, child custody, finances, etc. are not the background for the symptoms, to be relegated to a social worker. They are the areas we are trying to impact. Symptoms

and side effects are evaluated in terms of their effect on these areas (e.g. "What difference would it make in your life not to hear voices?") Goal setting is a valuable assessment tool as strengths and barriers are discovered within a practical, motivating context.

The recovery model shifts the focus from an objective assessment of the patient's signs and symptoms of illnesses, to a subjective assessment of their experiences (whether experienced as an illness or not). Being able to experience the world from their point of view becomes a crucial skill (like an actor getting into a character to discover their motivations). Focusing on listening and empathetic skills is needed.

Our DSM-IV diagnostic system emphasizes concise communication between professionals, funders, researchers and pharmaceutical developers. They are often incomprehensible to or not shared with our patients. Again reviving a psychotherapeutic approach, within the recovery model it is important to share with people what is going on with them, what has led to where they are now, and what could be done to improve their future. This has to be done in a way they can relate to, and ultimately own. They must be able to understand the words and the world view being described. It is our obligation to be fluent in a number of world views including psychobiological, interpersonal, psychodynamic, traumatic, spiritual, etc. in order to connect with people (e.g. "This medication helps strengthen your mind so the Devil won't be able to harm you as easily"), rather than relying upon a psycho-educational approach alone, demanding they learn our world view . Cultural competency and spirituality, frequent concerns in the recovery model, are often incorporated here.

To begin a recovery process, the assessment must lead to a narrative, cause-and-effect formulation. These features must be added to our syndromic DSM-IV assessments. Hope comes, not as much from our ability to relieve symptoms through medications, but from our forming a shared vision as to what causes can be changed (often some by the person themselves and some with our help) to transform their lives.

Assessment in a recovery culture is not so much something we do to people, but a shared exploration.

<u>Treatment</u>

Illnesses don't recover, people do. Mental illnesses create a great deal of suffering and disorientation. People's lives are profoundly affected. Treatment assists with the personal journey towards recovery. Our patients need us to be not detached experts, but rather compassionate, experienced guides and companions (perhaps like Virgil was for Dante). This requires us to decrease the emotional distance between us compared to what we've been taught. Intentional touching, to welcome and comfort, story telling, and even sharing our own person experiences are valuable new behaviors.

Instead of caring for someone and reducing their suffering, the focus is on creating learning so they can make difficult changes to avoid future suffering. Risk taking, learning from mistakes, understanding natural consequences, and personal growth are all highly valued processes we can facilitate.

Progress can be marked by progressive goal setting, learning and accomplishments. Psychiatrists can encourage people in setting and pursuing their goals, rather than ours, without overprotecting or overly limiting, for example, by waiting for people to be "ready". Managing failures so they are opportunities for change rather than demoralizing or traumatizing, requires skill.

Medication can be used as a tool to help achieve goals, rather than passively taken. It can be given in a collaborative way, even with very impaired people, including giving meaningful education and meaningful choices. A shared knowledge about their personal responses to various medications should be developed and written down together.

Recovery can be conceptualized as a developmental process with fluid stages analogous to Kubler-Ross' stages of death and dying. My formulation has four stages:

1) Hope -- believing a better future is possible

2) Empowerment -- believing we have the strength to achieve that future

3) Self-Responsibility -- taking our own steps to achieve that future

4) Attaining Meaningful Roles -- moving beyond illness to meaningful roles within our community.

We can use these stages as an auditing tool to see what practices are helpful and which are hindering progress in these stages. We can also model these traits in our own behavior and the way we interact with other staff.

For people to move on to roles beyond dependent, helpless patient, we have to move on to roles beyond care taking, helpful psychiatrist. In recovery settings we are expected to bring in more of our "real" selves and play multiple roles (e.g. wedding guest, fellow mourner, customer, fellow husband, father, or sports fan) and even openly learn from our patients.

Both this role blurring and decreasing emotional distance create potentially problematic "boundary breaking". We cannot become romantically or sexually involved with our patients, exploit or assault them, or let ourselves become emotionally or physically harmed by them. Without the numerous medical model culture rules and conventions to restrict us, we must be sure we have a high level of awareness and understanding of ethics.

Outcomes

The fundamental outcome in a recovery model is not symptom reduction, improved mental health, or even improved function, though all are valuable. It is having a better life. Our individual interactions should incorporate an ongoing discussion of what a better life would be for them and how much progress they've made in attaining it. Ideally, their vision of what's possible will expand as they grow and lead to initially inconceivable achievements

There are socially desirable qualities of "better lives" that can be defined, measured, and counted for the benefit of our funders and society at large (that hopefully resemble our patients' goals). These generally fall into the categories of housing, money, employment, education, legal problems, and social and family network.

The recovery model conceptualizations also lead to several "process" outcome clusters:

1) Engagement -- Are they connected to the program and individual staff? Are they participating actively, even "driving" their treatment process and goals? Or are they participating only reactively, in times of crisis or severe need? Is all their treatment involuntary? Have they been "lost to follow-up?

2) Goal setting -- Are they achieving goals? Do their plans reflect learning and change? Are their goals increasingly ambitious? Are they increasingly responsible for setting and achieving their own goals?

3) Community integration -- Are they excluded from our community, or at risk of exclusion. Are they avoiding the "failures of community integration": homelessness, jailing, psychiatric hospitalization and institutionalization, suicide, and violence? (These are generally measurable and socially important outcomes.)

4) Recovery development -- What stage are they primarily in? What progress are they making in that stage?

Many of these outcomes are subjective and hard to measure, but they are useful for team discussion, supervision, internal evaluation and personnel allocation.

As I come to the end of this section on psychiatrists I have mixed feelings. On the one hand, I like the content. Between these four papers I've described a comprehensive view of recovery based psychiatry. On the other hand, very few psychiatrists are actually practicing it or even really moving towards it.

I don't think the fundamental problem is really lack of motivation on the part of either administrators or psychiatrists. I think the fundamental problem is that there aren't nearly enough psychiatrists – good, bad, or indifferent – to be included in anything, including recovery based transformation.

When I'm asked to talk to psychiatrists I usually recommend that they be included in the trainings I'm doing for the rest of the team to begin to transform along with everyone else, but they rarely are. Instead, I can have lunch with them in between their seeing patients or maybe they can stay for the first hour of a day long workshop. The worst dynamic was when one medical director forced all his doctors and nurses to spend a half day with me separate from the rest of the staff to stop them from being so defensive. Even in the clinics I'm working intensively with month after month, the psychiatrists only came for the introduction and haven't been in any of the work groups designed to have staff take ownership of the transformation process. Psychiatrist time isn't really too expensive. It's simply too scarce.

I'd estimate that we would need about twice as many psychiatrists as we presently have to run our present system reasonably and even more to run a recovery based system because of its emphasis on relationships. Our present system has coped with the ongoing shortage not just by limiting psychiatrist's roles, but by limiting their time with each patient. The present norm is about fifteen minutes every two or three months. An efficient psychiatrist can prescribe $2 to $3 million worth of pills in a year that way. Unfortunately there's a good chance they're not very helpful pills. A study a few years ago by the RAND corporation in a county clinic and a VA clinic in Los Angeles found that only a minority of patients were getting medication management of their pills that seemed connected to their actual symptoms and side effects. My similar observation is that I can substantially improve the symptoms and side effects of about three quarters of patients from a clinic, not because I'm a better doctor than they are, but because I'm able to spend more time to work on it.

The suggestions I've come up with for dealing with this profound shortage range from a "barefoot doctor" system like China had to use when they didn't have nearly enough trained doctors, to severely restricting who can get medications teaching people self help skills instead of giving them pills that would work better, to pairing psychiatrists with clinical coordinators in hopes that together they could give a good integrated service to twice as many people as the doctor alone. Unfortunately, that idea is almost as bad as our present system, if not downright unethical or illegal.

Even at the Village where we make a commitment to psychiatrist availability, we have a serious problem finding enough psychiatrists. It takes us an average of six months to a year to fill any vacancy, and that's usually with the help of a recruiter we pay $20,000 to help us. Only once in the history of the Village have we ever had two applicants to choose from. The rest of the time we've hired the first psychiatrist willing to take the job. Because we try to maintain high standards, we've had to ask several psychiatrists to leave, but I don't think most programs would do that. I know my residency program didn't. Two of out thirteen residents in my class clearly shouldn't have graduated, but everyone did.

The shortage isn't the fault of our residency programs. A large portion of residency training slots go unfilled each year. Our local Psychiatric Rehabilitation fellowship program was too difficult to recruit for. Our medical schools simply aren't graduating enough people interested in psychiatry. If we weren't taking large numbers of foreign medical graduates we'd have only half as many residents as we have now. I think so long as surgeons and internists are controlling the front door to medical school we'll never have enough psychiatrists, and I don't think that's going to change.

As long as this severe shortage goes on my first goal of including psychiatrists will remain very difficult to achieve. That makes it difficult to leave this section of the book on a hopeful note.