This paper goes inside the teams and examines what people will actually be doing. I've put it together from my experiences at the Village and from the issues staff has repeatedly brought up around the state as I've promoted recovery based transformation of their services. Many staff has jobs they like and haven't asked for major changes. Some look like "deer caught in the headlights." Before we attack them as resistant, create management structures to promote their compliance, or invite them to leave if they don't like it, I believe we owe it to them to explain as clearly and concretely as we can what's likely to be expected of them. I've tried to do that in this paper.

I recently read an article written by staff at Yale who had been promoting recovery throughout Connecticut that discussed how to respond to the ten most common objections of clinicians. The line that struck me the most was that the question isn't how to fit recovery into treatment, but how to fit treatment into recovery. This paper takes recovery values, principles, and practices as a given and explores the adaptations we'll all have to make to fit into them.

I presented this material at the annual System of Care conference for the state of California. Many of the organizers and participants knew me and had heard me speak before, so I was asked to focus on the most pressing practical issue facing everyone – how to implement Full Service Partnerships. Having reread the paper, however, I think that the issues it addresses are much broader than FSP teams. Almost all of it, except the specific staffing patterns towards the end, can be applied to any of our new team based community recovery programs.

Staffing Full Service Partnership Teams

(2006)

A substantial portion of the new adult Community Support Services money from the Mental Health Services Act will be going to create new Full Service Partnership Teams. Full Service Partnership (FSP) is a new name designed to build on the concepts of ACT teams and Integrated Service Agencies without constraining ourselves within those models' definitions. FSPs are considered a powerful part of system transformation because they target resources to those people in highest need, they facilitate outreach if needed to help engage people, they accommodate people who do poorly with appointment based services, and they are able to incorporate quality of life support services and funding. Those are all features that are weak in our present system that the transformation is trying to improve.

To actually run a FSP will require programs to create teams that include both present staff in altered roles and new staff. Many of our present clinics run more or less as a group of individual practices with each professional staff responsible for their own caseloads and the services they provide, with only limited sharing of clients and teamwork. Therefore, creating teams will be a change for many current staff.

Creating teams offers a number of potential advantages:

1) No one staff is capable of assisting people with the entire range of quality of life services - from employment to housing to money management to health care to legal assistance to family support to education to benefits assistance to substance abuse assistance to community integration - they may need. Without a team people are likely to be offered only whatever services the staff they are assigned to feels comfortable with providing leaving their other needs largely unmet. It is possible for a team of staff to assist people with the entire range of services if the team is carefully assembled.

2) If more than one staff member is familiar with each client, it is possible for their primary staff to be serving someone else in the community and still have another staff available to assist them. This makes it possible for staff to combine community, appointment based, and walk-in services.

3) If staff is assembled that are not just a multidisciplinary team, but also a multi-experiential team they will be able to engage and work with a wider variety of people than any one staff member could. For example the team can include someone that works well with paranoid people, psychotic people refusing medications, actively substance abusing people, drug dealers, depressed, hopeless, unmotivated people, dirty, smelly people, women who won't leave battering men, men who batter women, prostitutes, pimps, thieves, and people with severe personality disorders. It would take a saintly staff member to engage and work with all those people successfully, as we are now expected to do. It is more realistic to expect a team consisting of a variety of caring staff to work together to create a counterculture of acceptance able to engage and work with all those people successfully.

4) Recovery work often depends on staff taking on a variety of roles besides clinician so that the people being served can take on a variety of roles besides chronic mental patient. Recovery work also often depends on staff creating more adult-to-adult relationships with the people being served while including emotional connectedness, guiding, and healing into these "friend-like" relationships. Both of these tasks require altering the traditional roles and boundaries rules that were constructed to protect both staff and clients in private practice, office-based, professional and psychodynamic treatment settings. In order to alter these rules while maintaining strong ethics, and personal, emotional and physical safety staff must work in teams. Teammates are needed to dilute transference relationships, give each other emotional strength in times of need, watch each other's backs to avoid ethical lapses, and protect each other emotionally and physically. If a team creates a strong emotional and ethical matrix, boundaries and roles can be safely lowered and healing relationships dramatically increased.

However, creating teams also has its challenges:

1) Many staff and clients prefer individual work. They like the additional privacy and sense of intimate safety that comes with a good individual therapy relationship. It feels easier to open up emotionally. Trust is built that isn't easily transferred to other staff. It can be difficult for staff to convince new clients of the advantages of a team milieu especially if they don't believe it's better themselves.

2) Many staff are working in programs where they don't really like or trust many of their teammates. Hiring doesn't generally have much input from the people who have to be teammates with the new staff. Firing or reassignment are often more dependent on civil service rules, unions, or administrative

needs than on compatibility of teammates. While on paper teams have a variety of important strengths, in practice they can easily deteriorate with personal conflicts, antagonism, and form factions.

3) With high workloads, that sometimes feel like being stuck on a conveyer belt, staff may prefer to try to get their own work done as best as possible rather than create a system of shared responsibility that they have less comfort with and control over. Many staff feels that some of their coworkers are slackers likely to give them extra work without reciprocation in a shared system. Staff is also afraid of being cast in the slacker role so they're unlikely to ask for help from their busy coworkers even if they need it, and more to the point, even if their clients would benefit from it.

4) Our programs are generally set up with professional differentiation. Each profession values their particular skills and identity. They tend to have their own treatment schemas, languages, processes, and goals. For someone to be qualified to supervise their work properly the supervisor needs to be of the same profession as the supervisee. Therefore, teammates usually are not accountable to their team leader as much as to their professional supervisor which can badly weaken the team itself. There is a large resistance to altering this structure because it feels like a direct attack on the professions themselves and the inherent value professional roles bring to staff.

5) It may be difficult for staff with substantially different educations, salaries, and experience to act as "classless" teammates. Often internal hierarchies will be formed with some staff expecting other, "lower" staff to work for them. There's a classic definition of teamwork as "a group of people doing what I tell them to" that captures this issue.

A FSP is likely to incorporate four groups of people into its teams who have not often been teamed together before: Psychiatrists, paraprofessionals, consumer and family member staff, and licensed clinicians. Each of these groups brings their own gifts that would be missed without them and each brings their own challenges.

<u>Psychiatrists:</u>

The time when psychiatrists were fully included on teams in CMHCs, including many in leadership positions, is long past. While decreasing the number of and roles for psychiatrists may have been initially driven by cost cutting concerns, we are now at the point where there often aren't enough psychiatrists available even if funding were to be allocated. Psychiatrists have been so consistently relegated to isolated, highly reductionistic, exclusively medication oriented roles that there is very little desire to increase their roles or belief they would contribute substantially if they were more included.

The most obvious advantage of including psychiatrists would be to increase the probability of engaging people with medications. People are more likely to take medications if they have a good relationship with the psychiatrist or if another staff they have a strong relationship with accompanies them to their medication appointments. Since FSPs are designed to target poorly engaged people and they're designed to continue to work with people when they miss appointments and stop medications, instead of just discharging them, this is an important concern.

The most obvious challenge to including psychiatrists is professional differentiation. It is difficult for psychiatrists to be comfortably supervised by non-psychiatrists and there is a tendency for psychiatrists to expect to automatically be at the top of the hierarchy like other physicians rather than be true colleagues. The relationship between the team leader and the psychiatrist is crucial.

Beyond those issues, however, are other challenges unique to psychiatrists. First is the high caseload expectation. It is difficult for any person to keep track of more than 150 people's stories and relationships in their head. Every other staff routinely has a caseload less than 150 whereas almost every community psychiatrist has a caseload larger than 150. The two most common ways of dealing with this are for psychiatrists to focus their attention very narrowly on the illness part of the person and to use the chart as a memory crutch. Both of these widespread practices are likely to be harmful to the people being served. In addition, trust is usually based not on an actual relationship between the two people, but based on the doctor role itself: "Trust me. I'm a doctor." A well functioning team can serve as a memory and relationship extender for the psychiatrist and promote real trust.

Second, is the difficulty differentiating between symptoms and feelings. If a psychiatrist only gets to know, and only writes down to remember, features of the illness, they are more likely to diagnose feelings as symptoms and treat them with medications instead of addressing emotional or life circumstance issues. Many people find it easier to take a pill than to make emotional or life changes and willingly collude in a "medication only" treatment plan. Unfortunately, it's only rarely really successful. For people not willing to collude in labeling feelings as symptoms, we often accuse them of lacking insight and being noncompliant and the psychiatrist simply doesn't know the person well enough to offer what they want. A well functioning team can assist with the information needed to make differentiations between symptoms and feelings and assist in helping people work on their lives.

Third, psychiatrists routinely have ultimate legal and medical responsibility for people even if they don't know them very well. This is likely to lead to caution, self protection and risk avoidance. Decisions ranging from involuntary hospitalization to employment to child custody to becoming your own payee are likely to be affected. Usually this protective bias hinders recovery. The team can make more group decisions and share responsibility. In crisis situations every team has an "emotional core" person they can turn to. If this person is not the psychiatrist, there may be a conflict between emotional cohesion and following the psychiatrist's medical orders. Who the team really trusts and whose decisions get implemented may be different people.

<u>Paraprofessionals</u>:

There is a substantial resistance to hiring more paraprofessionals instead of more licensed clinicians. Hiring people with "just" Bachelor's degrees or "life experience" feels to many professionals like we're "dumbing down" our staff. They argue that since we're focusing on people with very serious, persistent mental illnesses we need the most clinical training and expertise we can get in our staff.

Within the medical model paraprofessionals have serious liabilities. They don't know how to do diagnostic assessments. They have limited understandings of psychopathology and psychodynamics.

They can only bill for certain services and often need the licensed staff to cosign their notes. At best, they are likely to be viewed as helpful underlings or "go-fers."

Within a recovery model paraprofessionals serve two crucial roles: Generalist "case workers" and specialist support service providers.

Whether they're called case workers or community workers or personal service coordinators, their two main functions are engagement and coordination/skill building. Being able to engage someone is sometimes a clinical skill, but more often it's a personal skill. Staff must be able to accept people who would normally be rejected, open their heart to people, and have a willingness to connect with people instead of distance themselves from them. It's easier to create a true counterculture of acceptance when paraprofessionals are included to increase hiring choices and staff diversity. Less experienced staff may need help from more experienced staff to preserve their emotional strength and maintain strong ethics without distancing and dehumanizing. Coordination/skill building often requires going into the community doing things alongside people while teaching them how to do it themselves. People may need help coordinating an enormous range of things from grocery shopping to Social Security benefits to employment interviews to their love life. Many licensed staff are reluctant to perform these services because it's not what they were trained to do or because it's unprofessional or even because they're just not very good at it. Engagement and coordination/skill building are not "lesser" services. They are core recovery services.

A FSP should include a variety of specialist support service staff like housing, employment, education, substance abuse, community integration, money management, and family support. These jobs require a high level of specialized skills which are not often taught in the usual professional training programs. Staff will usually have learned these skills through life experience or on the job training. It is usually not very effective to have staff without these specialized skills try to do these jobs even if they have other professional training.

There is a choice of whether to have these staff included as full team members or as attached specialists. There is also a choice of whether to have these staff relate primarily to clients or to the community.

<u>Consumers and Family Members:</u>

When consumers and family members are included in the team there is a choice whether to have them work in designated consumer and family positions or as paraprofessionals. A program may have consumers and family members hired as peer advocates or as consumer and family representatives to insure inclusion of consumer and family perspectives or to provide peer support services, but those are unlikely to be full FSP team members. FSP team members will likely have the same generalist and specialist roles as other paraprofessional team members.

There are substantial risks involved in creating designated consumer and family positions. They may be treated as second class employees rather than as equal teammates. There is a risk of low expectations and other staff caretaking them. If instead, they are treated the same as any paraprofessional staff (or

even professional staff if they have professional training) they will break down the "us vs. them" boundaries and we will all become less stigmatizing. They should be hired, not out of pity for their disabilities or struggles, but out of respect for the added strengths and skill sets their "life experiences" have given them. The relevant qualification is not a documented diagnosis or open case in treatment, but rather the ability to use past experiences and self disclosure to help people. As with any person with a disability, they may need accommodations to perform their job, but they shouldn't have lower job expectations or demands. Consider how differently we treat a blind colleague than a mentally ill colleague. Consumer or family status is not an excuse for substandard work.

It may be helpful to have a consumer or family member mental health worker training program to increase the qualifications of new consumer or family staff. Some of this can be combined with other paraprofessional training programs or on the job orientation and training, and some can be separated out, especially for unique "consumer" or "family" issues (e.g. self disclosure, changing self identity and roles, Social Security benefit changes, and not expecting everyone to need the same things that helped you.) Special attention should be paid to helping consumer and family staff not reenact their own harmful treatment experiences as either victim or perpetrator. Programs may want to have volunteer, transitional employment, or training positions for consumers or families to prepare them to be staff (permanent staff who are identified consumers or family members can contribute unique supervision and support), but overlap between people's treatment providers and their mental health employment may create substantial problems. Therefore, the more separation between the two sites the better. Treatment providers are encouraged to advocate for, coach, and support the people they are serving who are working in mental health, just as they would any employment, but hiring of consumers or their families by the same team that is serving them should be limited to temporary engagement, exposure, or training positions. Permanent employment should be separated. Once they are hired as permanent staff, it's preferable to treat them as responsible equals.

Staff who have mental illnesses themselves or who have family members with mental illnesses may freely chose whether to disclose that information universally, selectively, or not at all. Although there are clear benefits for the people being served from staff disclosure including increasing hope and decreasing stigma and the walls between us, disclosure is entirely a personal decision. Staff should not be pressured to disclose. In addition, supervisors and co-staff should not discriminate against or hinder someone because they have disclosed and acknowledged their role as mentally ill consumer or family member. They must be treated with respect as a colleague. Demeaning them or creating a hostile work place for them should not be tolerated.

<u>Licensed Clinicians:</u>

Although many licensed clinicians admire and are touched by the goals and values of the recovery movement, most will also perceive it as a clear threat to their way of life. The role of therapy seems to be being transformed from one of our most essential, mission defining services (perhaps second only to medications) to a vague activity to be incorporated into other services. Many therapists may resent being asked to be therapeutic outside of the usual parameters of office based individual and group therapy and being asked to work in ways that are often contrary to what they were taught. A range of

fears, including physical and emotional danger, ethical concerns, malpractice claims, inability to bill productivity, and loss of effectiveness are likely to emerge. Although standard therapy formats may have limited effectiveness and be unusable by many of the people we serve, they are comfortable to therapists and feel safe. They are also what they have been trained to do, have mastered, enjoy doing, and value. Therapy has been internalized into their identities: "We are therapists. What will happen to us if therapy isn't what we do?" A true personal transformation is being forced upon them.

Transformation requires three steps: breaking down, adding new features, and reforming.

Step 1: Breaking down involves looking within the practice to find the values and functions. Staff came to the various licensed professions for a variety of reasons, trying to accomplish a variety of things, and hopefully found ways to be fulfilled and of service within therapy structures. Therapy structures may not be essential for fulfillment and service, but they are how they're commonly achieved in our present system.

What services actually require regular, individual or group, appointment based structures? Many "targeted," "manualized" therapies claim they do (for example, EMDR, CBT, DBT, behavioral desensitization, trauma groups, skill building, and psychoeducation). To be fair though, most experienced therapists don't practice "manualized" therapies. They've made adaptations to the techniques, pick and chose what fits their personal styles, and incorporate them into a more "eclectic" long term, supportive therapy structure. Transference based psychodynamic therapy, for example, has evolved to depend more on training people to be conscious of their psychodynamic patterns and making interpretations than on creating and resolving true transference regressions. Recovery isn't asking for the abandonment of these techniques, but it is asking for new adaptations, picking and choosing, and incorporation into an "adult-to-adult," "friend-like," case management relationship.

Most therapists are able to safely and comfortably have a variety of fulfilling, helpful friendships outside the therapy structure. Therefore, at least theoretically, what recovery is asking for is possible. Friendships, like recovery relationships, aren't relationships without boundaries. They have different boundaries than therapy structured relationships that are often individually developed depending on the person.

Step 2: We're adding two new features: 1) Instead of using long term, supportive therapy as the underlying, relationship maintaining matrix to incorporate our therapeutic techniques, we're using the same engagement and coordination/training the paraprofessionals are doing. This helps us achieve a variety of quality of life goals and help people build community based skills and supports while achieving therapeutic goals and healing. 2) We're being flexible enough to maintain relationships with people who would normally drop out of appointment based individual or group therapy and be lost to us or require coercion to re-engage.

Step 3: We're reforming a new "therapy – case management" role. We can address all those fears (including physical and emotional danger, ethical concerns, malpractice claims, inability to bill

productivity, and loss of effectiveness) within our transformed roles and create new protections and comforts while preserving the old fulfillments and services.

Licensed clinicians also have to perform a variety of tasks to keep the entire team functioning. They are usually responsible for doing intake assessments and triage. They have to oversee treatment planning authorization and documentation. Often, though not necessarily, they are the administrative and emotional leaders of the team. They may have supervision, treatment modeling, and teaching responsibilities as well.

They also have a responsibility to create a "therapeutic milieu." In the not terribly distant past, there used to be something called "milieu therapy" that was included in almost everyone's treatment plan. The idea was that the staff, in addition to performing individual services, together created a healing environment for the people being served. Under pressure from budget accountability, medical reductionism, high case loads, risk avoidance, poor building maintenance, and even professionalization "therapeutic milieus" have almost disappeared from our community clinics. Most simply do not have a very welcoming or healing feel to them.

FSPs, because of their flexibility to accommodate drop-ins and because of the intensity of services and relationships can create internal healing cultures – like a group therapy without any set hours – that aren't generally possible in standard outpatient settings. Licensed clinicians can bring special skills to help create a healing environment. Some of this work is done directly by being part of the environment (for example, by helping to maintain relationships with difficult people, providing "corrective emotional experiences," and training people to be conscious of their psychodynamic patterns and making interpretations) and some of this work is done indirectly by supporting teammates (for example, by consulting and educating, sharing counter transference reactions, building team cohesiveness and emotional strength).

Like the paraprofessionals, many of the licensed staff will bring specialist skills and services (for example, medication management, health care, crisis management, specialized assessments, community advocacy and development, and rehabilitation) that can be accessed by all the people on the team.

FSP Staffing Patterns:

When we've put together all these ideas, we've found that the overall "staff items" making up the teams have changed. Compare these two sample 100 member FSP staffing patterns.

"Traditional-Clinical" FSP team	"Recovery-Based" FSP team

1 Psychiatrist	1 Psychiatrist
1 Supervising Social Worker	1 Team Leader (Supervising SW, psychologist or MH RN)
3 Psychiatric Social Workers	1 Psychiatric Social Worker or 1 RN (depending on leader)
1 Mental Health Counselor RN	1 Psych Tech or nurse aid
1 Psychologist	5 Case Managers (may be consumers, case workers, or community workers)
2 Medical Case Workers (one housing, one employment)	1 Housing specialist
2 Peer Advocates	1 Employment Specialist
	1 Benefits Worker/ Financial Planner
	2 Outreach workers (one licensed, one consumer, case worker, or Community worker)

(Both teams cost about the same $900,000.)

Notice the following differences:

1) We've define our recovery-based staffing pattern by roles rather than by allocated quotas for each profession. This is especially relevant for jobs that aren't really taught in any professional school (e.g. team leader, housing specialist, employment specialist, and outreach worker). Hiring by profession could easily get you stuck without the needed skills. Incidentally, the State MHSA Workforce Development Committee has already taken the approach of looking at function instead of profession too.

2) Consumers are integrated into the team, hired because of their skills, rather than as segregated, potentially second class employees.

3) Because of cost savings by decreasing licensed personnel three addition staff could be hired. That dramatically decreases the case loads. For example, if you decide that the team leader, psychiatrist, housing specialist, and employment specialist don't have case loads, but the nursing staff, financial planners, and outreach workers do, and that this team has 100 members, the "traditional-clinical" caseloads would be 14 and "recovery-based" caseloads would be 10. Another way to look at that is that

the "recovery-based" team could have a specialized financial planner and half sized case loads for the nurses and the two outreach workers and still have the same caseload as the "traditional-clinical" team.

Implementing FSP teams with staffing patterns like those on the "recovery-based" side of the table will present substantial challenges to Human Resource Departments creating job descriptions and to Unions advocating for their professional guilds.

As I reread this paper, part of me feels somewhat overwhelmed by all the changes we are asking people to make, but part of me also feels excited by the prospect of being able to help a lot of people who have fallen between the cracks. For me, that's what this transformation is all about.