Designing Transformed Clinics

(2006)

I have been working with several clinics in Los Angeles over the past year as they have begun to transform themselves while incorporating new Mental Health Services Act programs – Full Service Partnerships and Wellness Centers. Although there is significant individual variation between the clinics, some common design issues have emerged. This paper describes a four-part design and includes some of my thoughts. Hopefully it will be useful to those of you are also working on transforming your clinics.

The emerging design contains four program rams, elements (we're still working on the names):

Welcome Center	Engagement Triage Charity Supported Referrals "One Session Psychotherapy" Crisis Care – walk-in Medications Substance Abuse Outreach
Full Service Partnership	ACT services Intensive support services (housing, financial, employment, legal, etc.) 24/7 Crisis Care Substance Abuse Medications
Core Support Services	Supportive therapy Problem solving / Case Management Growth Modules (benefits assistance, housing,

	employment, focused therapy, focused medication, skills training, health care, active substance abuse treatment, parenting, etc.) Crisis Care – ongoing clients Medications Family support / education Graduation preparation (WRAP, etc.)
Wellness Center	Self help / mutual peer support Wellness focus activities and groups Community integration Health care Substance abuse – relapse prevention Crisis care - self directed Medications

We intend to promote active flow through the programs to less intensive / more self-responsible levels of care and even out of the clinic entirely.

Here are some thoughts about each program:

Welcoming Center:

At present after a brief screening everyone who is eligible is given a full clinical and financial assessment and creates a six month treatment plan. This takes about 3 hours and is often an inadvertent barrier to people coming in. After this lengthy assessment and planning many people never return. The redesign attempts to broaden the menu of options. Each person will get a single visit assessment and be offered some help that day. Triage will take place over the course of two months while we continue to help people in the welcoming center, assessing whether the person has a serious mental illness, whether they live in the clinic's area, whether the clinic is the best treatment setting for them, whether they are engaged enough to return to the clinic regularly, and what program in the clinic and even what staff would be best for them. The triage process has an inherent tension between the need to ration clinic resources and refer out and the need to openly welcome people and not set up obstacles to them getting the help they need. The full assessment and treatment plan will be done after the extended triage within two months by the accepting staff.

The Village's Homeless Assistance Program developed a triage schema that may be useful:

Green – The person should be admitted to the clinic. They're eligible and engaged. Choose best program (FSP, Core, Wellness) and assign to "matched" staff.

Red – The person should not be admitted to the clinic either because they don't have a serious mental illness, they're out of area, or can be served by other providers (e.g. Parole MH, VA, private providers), etc. Give short term help and supported referrals.

Yellow – It's unclear whether the person should be admitted or not or it's unclear if they are engaged enough to return to the clinic regularly. Continue to help them in the Welcome Center while increasing engagement and further assessing options.

Blue – The person has been seen in the Welcome Center but has dropped out or been lost. Help again if they return and try to re-engage. Consider outreach.

Staffing would likely include a supervisor/ licensed clinician, a community worker /case worker, a substance abuse specialist, and a psychiatrist, working with all the core program clinicians on a rotating basis.

Full Service Partnership:

This program has been largely defined already including ACT services and supported housing, employment and money management, building on the existing AB2034 model.

A key issue that has been emerging is that since the criteria for admission are social rather than clinical (homelessness, jailing, repeated hospitalization, institutionalization, or only avoiding the above because of overwhelmed family support) there will be people the clinic feels are in "need" of this level of service who are not eligible and will have to be treated less adequately elsewhere in the clinic.

There are several important choices available to the program:

1) Will case loads be assigned individually or be shared team case loads?

2) How will the professional and paraprofessional staff interact and work together?

3) Will the support service staff (housing, employment, financial, etc.) be dedicated to their specialty or have case loads too?

4) Will the specialty staff primarily focus on developing relationships with the clients or with the community (e.g. their "case load" could be 20 landlords or employers)?

Although FSP case loads are low by traditional clinic standards, it's amazing how difficult and time consuming this work actually is. There will often be the risk of getting so involved in reactive daily crisis work that proactive growth work is short-changed. Rationing staff time is a constant challenge.

The Village developed a priority guide that may be useful:

1) Engagement – First priority is to develop a relationship with the client (actually multiple relationships). Poorly engaged clients are difficult to help in crisis or to help pursue any goals.

2) Risk – All crises are not high risk. The less that staff get in the habit of responding to all crises as high risk the less the clients will present in crisis to get staff attention. "Pressing" is not the same as "urgent."

3) Ready – When clients are motivated to pursue goals staff should allocate more time to supporting them to obtain their goals. Be wary of staff deciding someone "isn't really ready" and discouraging clients.

After a year, and flexibly thereafter on an ongoing basis, FSP clients should be reassessed for moving on to core services (or, more rarely, to the Wellness Center). Both staff and clients should view FSP as a transitional program to create a culture that promotes flow. There can be a substantial transitional period of co-enrollment in both programs.

Core Support Services:

The majority of the clients in the clinic are likely to be in this program working with staff with quite high caseloads. It is hoped that by treating "unengaged" clients in the Welcome Center, high intensity homeless, jail diversion, frequently hospitalized, and institutionalized clients in the FSP, and more advanced recovery clients in the Wellness Center that the core support services will become more focused and effective. Nonetheless, it is likely that many clients will be only vaguely known by the staff and receive only modest services.

Within this unsatisfying reality several transformative steps are recommended:

1) Clients can be initially "matched" with staff by the Welcome Center rather than being assigned randomly based on what day the intake happened to be.

2) The staff can work more as a team so that individuals can receive services from a variety of somewhat specializing staff rather than staff working in de facto private practices as a "Jack of all trades."

3) Specialized services can be organized into time limited, growth oriented modules (for example, benefits assistance, supported housing, supported employment, focused therapy, focused medication, skills training, health care promotion, active substance abuse treatment, parenting, etc.) that motivated clients can access, regardless of who their primary supportive staff is.

4) A culture of flow can be promoted by regularly assessing the clients' stage of recovery and using it, by creating "moving onwards" graduation preparation programs including WRAP and community integration, and by having regular rituals and celebrations of clients' progress and recovery.

Wellness Center:

Creating an effective and desirable Wellness Center that clients will feel they can rely on and will want to move on to and that staff feel confident graduating people to is essential if flow is to occur. Once again, there can be a substantial transitional period of co-enrollment in both programs.

The fundamental elements of a Wellness Center are being defined by DMH with widespread input. At this point they include:

1) Wellness and recovery-focused mental health and supportive services, including emphasis on physical health assessment and linkage to appropriate services.

2) Focus on coaching and advocacy and health education.

3) Linkage to services that will enhance recovery and contribute to reintegration into the client's community including academic skills enhancement resources, medication management, psychotherapy/counseling, vocational and employment services, housing services, and primary care services.

4) Voluntary participation with potential graduation from participation and/or exit from the mental health system.

Hopefully, we will refine our practice as we learn from our experiences.

My work at MHA's Wellness Center generated several related concepts that may be useful:

1) Consumer Run: Although the Wellness Center includes professionals, including a psychiatrist, it is fundamentally consumer run. The consumer led administration of the program collaborates with the professionals to support consumer goals paralleling the desired collaborative individual clinical interactions between the professions and the clients. There are some situations both administratively and clinically in which professionals have increased responsibility but the "default" setting for both levels is self-help and self-responsibility.

2) Network Support: The fundamental support relationship is not a case-manager-client relationship. Instead support is mutual, with both give and take, with members supporting each other. The primarily consumer staff has expertise in running self-help groups and activities, providing peer support, developing WRAP plans, and identifying community based network and supports, not in taking care of people.

3) Safety Net: The program is intended to be its own safety net. While the Urgent Care Center, Emergency Rooms, Hospitals and even returning to the Village exist; the vast majority of crises are handled within the Wellness Center itself. Some staff may temporarily take some responsibility for members in crisis rather than leaving them entirely to self-responsibility if they are occasionally too impaired to be self-directed. However, the emphasis in all crisis care is on teaching skills to enable the next crisis to be averted entirely or self-directed (e.g. with advanced directives).

4) Team Medication Services: In place of the rapid psychiatrist med refills without crisis accessibility most self-responsible clients receive, the Wellness Center uses a nurse practitioner-psychiatrist team to expand medication services. Both do assessments, sometimes together, and "know" the members. The nurse practitioner focuses on routine refills, "Wellness Checks" and documentation. The psychiatrist focuses more on supervision, crisis and transitions.

5) Getting Even Better: Patricia Deegan wrote "Some people with mental illnesses get well, and then they just keep getting even better." The primary actions of the Wellness Center are not managing crisis, providing ongoing medication and documentation, or achieving stability, although these are the most urgent reasons for its creation, it's most costly and heavily reimbursed functions, and its clearest social mandate. The primary action is ongoing growth and recovery for the members "getting even better." This includes education, employment, wellness strategies, advocacy, self-help, community integration, family, romance, and deeper psychological healing and spiritual growth.

Overall, this four-part design structure seems possible to implement even with our far from ideal staffing patterns and, I believe, creates a firm foundation upon which truly recovery based programs can emerge.