As I've traveled widely promoting recovery, the number one obstacle staff bring up is that their case loads are too high. They simply do not have enough time to build relationships with people, to communicate with their coworkers to build effective teams, to follow up with people who drop out, to learn about and connect with community resources, to leave the office, to support people with quality of life goals, or to do any of the recovery based work I'm urging them to do. They insist that they need lower caseloads to succeed. (They're directors see it slightly differently: They think they need more money to hire more staff.)

Since even with the MHSA I don't foresee massive hiring of new clinicians in our clinics, I've come up with three other approaches to the "case load problem" all of which require substantial system restructuring and therefore all of which will encounter substantial resistance: 1) We can hire large numbers of paraprofessional and consumer staff to capably provide a variety of non-clinical case management and quality of life support services as well as growth oriented recovery promoting services. (The Village has only about 25% licensed mental health professional staff.), 2) We can substantially alter our "welcoming menu" of services so the lone offering isn't "extensive intake assessment" that leads to a 50% non-return rate. This practice uses up an enormous amount of staff time, largely on paperwork, and frustrates both staff and clients, and 3) We can create flow in our system. So long as almost no one moves through our system or graduates from services and we get new people coming to our door every day, case loads must go up and up no matter how many staff we have.

Creating flow for even some of our consumers turns out to be an incredibly difficult and complicated thing to do. This paper attempts to tackle some important aspects of flow. I have to warn you in advance that it's one of the most complex and dense pieces in this collection and you have to have a solid grasp of recovery practices and design to really follow it. Nonetheless, since without flow I don't think we'll ever solve the "case load" problem, read on.

The Power of Flow

(2006)

As we begin to build new programs with Mental Health Services Act (MHSA) funds many of us are facing the sobering realization that even in a transformed recovery based system with a good funding source it seems we'll never have enough services to help everyone in need. It seems inevitable that whatever new program we build to meet an unmet need will be filled up sooner or later and turning away new people. Is there any way out of this besides continually asking for more money? I think one way we can get unstuck would be by changing from a capacity point of view to a flow point of view. For example, the MHSA planning process asked us to look at unmet need and what services would have to be added to "meet the needs." Instead, we should look at what services could move people from "in need" to "no longer in need." Working on making this change has been the hardest thing we've ever attempted at the Village. The more we work on it the more complex it's become.

This paper will discuss six important aspects of flow that we've struggled with:

1) The difference between illness-centered flow and person-centered flow,

2) The need for services at various levels of engageability, appointment keeping, and self-responsibility,

3) The need for services to be growth oriented instead of care taking,

4) The difference between growth oriented cultures and structures,

5) The difficulties maintaining relationships as people grow and flow, and

6) The need for community integration to graduate people from professional services.

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1) The difference between illness-centered flow and person-centered flow

From an illness-centered point of view as long as the illness exists the need for services exists. The obvious implication is that if we focus our services, as we should, on those people with serious, persistent mental illness of indefinite duration we need to provide services of indefinite duration. This was one of the foundational principles of the Village and, similarly, MHSA's Full Service Partnerships (FSPs) have been designed to be "no fail" programs of indefinite, usually lifelong, duration. Inevitably, like the Village, the FSPs will fill up and be unable to take new people.

It is easy to see that flow and graduation is what's needed to open up new slots, but hard to see how to achieve that. At the Village we had to figure out how to alter our teams to be "transitional" programs of indefinite duration. If we could graduate some people to lower levels of service or even no service at all we'd be able take on new people.

Certainly, moving people on to lower levels of care is not a new concept, but in our normal service delivery system it hasn't worked very well. Many people keep revolving through the same services over and over instead of really progressing. Ultimately, that's usually just too demoralizing so the system stops pushing people forwards and is happy when they're stable. Can a person-centered, recovery based approach really do better?

From a person-centered point of view the need for professional supports and services exists until the person develops enough skills to be self-responsible and enough community based supports to live successfully regardless of their symptom level. The obvious implication is that the more services help people develop self responsibility and community supports the less professional services they'll need and we'll be able to move them on to lower levels of service or no service, even if they're still symptomatic, while we move on to new people in need. There's some hope.

From an illness-centered point of view the system developed a spectrum of services based on the acuity of the illness. People move on to lower levels of service when their symptoms are controlled. Since the illnesses tend to wane and wax, people tend to revolve instead of progress.

From a person-centered point of view we can develop a spectrum of services based on the person's recovery. Since people tend to grow and develop, despite setbacks, they tend to progress instead of revolve. There's some more hope.

Let's take it even further: Illness-centered point of view services respond to the level of symptoms with limited regard for the person's level of recovery. (For example, MediCal rules for paying for ongoing hospitalization are entirely dependent on clinical acuity without even considering whether the person is voluntarily engaged in their own treatment or not.) Why? Because when the focus is on the course of the illness, symptom relief, functional improvement, and even personal recovery are all presumed to run in parallel. Therefore, the level of service can be chosen based on symptom acuity alone. (For example, traditionally if someone is seriously suicidal with a plan, it doesn't matter what their functional level or stage of recovery is. Based on their symptoms they should be hospitalized.) In reality, however, symptom relief, functional improvement, and personal recovery don't always run in parallel. (For example, someone can learn a great deal of self-responsibility from an experience of high symptoms, and some people can work and live independently even while experiencing severe hallucinations and delusions.) The illness-centered point of view sees these instances as rare, puzzling exceptions (We frequently incorrectly attribute both improvements and deteriorations to illness factors instead of recovery factors. For example, we tend to assume someone is taking their medications willingly because their symptoms were controlled enough for them to regain insight instead of because they developed a trusting relationship with their psychiatrist or because they were cooperating temporarily so they could get unlocked.) Actually these instances of disconnection are more common than not. Our entire illness-centered spectrum of services design is built on faulty assumptions for most people. If that's why it doesn't work very well, a person-centered spectrum of services might do better.

From a person-centered point of view symptom relief, functional improvement, and recovery are all relatively independent and all need to be included in choosing level of service. (For example, if someone is seriously suicidal with a plan and "unengaged" we're likely to respond in a way that tries to increase their engagement with services, whereas, if they're "engaged, but poorly self coordinating" we'll try to help them learn from the crisis what changes they need to make to avoid future crisis and what self care skills they need to develop, whereas, if they're "self-responsible" we'll work on implementing their WRAP plan for self care and increasing their community integration and supports.) Services respond primarily to the level of recovery rather than the level of symptoms. (For example, we might help someone get an apartment or a job even if they are psychotic or chronically suicidal.) Since we focus on the course of recovery rather than the course of the illness, symptom reduction isn't necessarily a sign of progress or the need for a lower level of care, nor is symptom increase necessarily a sign of personal deterioration or the need for more professional caretaking. If the system's levels form a recovery based spectrum (For example, outreach and engagement, case management and integrated services, wellness and community integration) people are likely to be able to flow as they recover. (We realized that the Village's spectrum of services was weak in the wellness and community integration areas and that those areas needed to be strengthened to support flow.)

The important implication in this formulation, which is often overlooked in recovery based system design, is that every symptom need and every functional need must be able to be met at every recovery based level of service. Otherwise people will be forced to move backwards or forwards to inappropriate levels to meet their needs, just like they do in the illness-centered system at present. (For example, if a Wellness Center can't handle crises within its self help, peer support model they will end up returning someone to a lower level of care, like an urgent care center or hospital, even if the person's recovery hasn't deteriorated. On the other side, if an outreach and engagement program doesn't have any employment services, like day labor or "work for a day – house for a day," they will end up promoting people to case management to make them eligible for vocational services even if they aren't engaged enough to use it.)

If recovery based services aren't seen as adjuncts to treatment, but instead are the framework upon which all services are provided, we can create a spectrum of services that would actually promote recovery and people would flow through it. I did an exercise with Santa Cruz county where we literally placed all their services and programs within a spectrum formed by the 8 Milestones of Recovery and they were able to see how people should be flowing through their system, which programs should be referring forwards and backwards to which other programs, and where people were being mismatched with services within their system. That clarity of vision simply isn't possible with an illness-centered spectrum because there are too many exceptions to the "illness treatment leads to life improvement" formula.

Here's a "generic" chart of a recovery based spectrum of services correlating level of recovery and services to help visualize how a person-centered paradigm plays out:

<table>
<tr><td colspan="6">Person-Centered Levels of Service
(Recovery Based Spectrum of Care)</td></tr>
<tr><td>Extreme risk</td><td colspan="2">Unengaged</td><td colspan="2">Engaged, but not self coordinating</td><td colspan="2">Self responsible</td></tr>
<tr><td>Locked setting</td><td>Outreach and engagement</td><td>Drop-in center</td><td>Intensive case management</td><td>Case management Team</td><td>Appointment based clinic</td><td>Wellness center</td></tr>
<tr><td>Extreme risk
(1)</td><td colspan="2">High risk, unengaged
(2)
Poorly coping, unengaged (4)</td><td>High risk, engaged
(3)</td><td>Poorly coping , engaged
(5)
Coping, rehabilitating
(6)</td><td colspan="2">Coping, rehabilitating
(6)
Early recovery
(7)</td></tr>
<tr><td>1:1 supervision</td><td colspan="2">Welcoming</td><td colspan="2">Case management</td><td colspan="2">Appointment based therapy</td></tr>
</table>

Legal interventions Community protection Acute treatment Engagement	Charity Evaluation and triage Documentation Benefits assistance Accessible medications Drop-in services	Integrated services Accessible medications Supportive services Direct subsidies Rehabilitation	"Medications only" Wellness activities (WRAP) Self-help Peer support Community integration

2) The need for services at various levels of engageability, appointment keeping, and self-responsibility

When most people look at that grid, after they orient themselves, they'll look for our "core services," the services we value most – ongoing medication and therapy – and notice somewhat resentfully that they seem to be stuck in the corner, seemingly pushed to the side by the large array of other services. This reprioritization reflects a disturbing reality buried in our usual paradigm: At its most traditional our mental health system can only treat people who are already easily engaged, keep appointments, and are self responsible. They must be able to come to clinics voluntarily, be able to describe their illness in depth for an intake evaluation, demonstrate insight by signing informed consent forms, and be responsible enough to follow treatment orders and return for further scheduled appointments all as a prerequisite for entering treatment. (For substance abuse treatment, in addition, they must agree they are addicted and stop using to enter treatment.)

The likely reality is that the majority of people, with or without mental illnesses, are not easily engageable enough or self responsible enough to use hardly any effective medical or mental health clinic treatment for any prolonged period of time. Yet all of our treatment systems act as though this isn't the case. The resulting mismatch between what we're offering and what people can use results in very few people benefiting from long term treatment. Consequently, the most common outcomes of our present system are "never began treatment" and "dropped out of treatment." That's not flow; that's spillage. While this may seem to help us keep caseloads down, it doesn't really, because we're often forced to clean up the spillage. We spend an enormous amount of money giving service to unengaged people. The process of spilling people out and then mopping them up is more likely to waste people's lives than to lead to much positive growth and flow.

Traditionally, if someone can't meet these prerequisites we assume it's because they are too ill. (For example, a recent discussion of the CATIE drug study where the majority of people discontinued treatment concluded that "patient-initiated drug discontinuation appears to be a core illness behavior from schizophrenia onset to chronic illness.") The next logical step is to force them to take medications so they will be less ill and therefore able and willing to come to a clinic for an intake assessment and ongoing appointments. Usually that doesn't actually work (and that's not just because hospital stays are too short to decrease symptoms – I doubt long term IMD and Board and Care discharges do much better).

In many places the only alternative to self responsible clinic treatment is involuntary hospitalization. Many clinicians and families are frustrated because the law doesn't permit involuntary treatment of everyone who isn't easily engaged and self responsible so they urge broader laws without ever

addressing if we need such difficult prerequisites in the first place: Do people really have to sit through intake assessments to get help? Do they really need to agree that they have a diagnosable major mental illness to take medications usefully? Do they really need to set goals and design treatment plans to be motivated? Do they really need to come to regular appointments?

From this perspective almost every programmatic advance whether day treatment, half way houses, board and cares, ACT teams, psychosocial rehabilitation, consumer run services, etc. can be seen as an effort to treat people who don't meet those prerequisites without locking them up. Unfortunately, almost all of these programs are seen as adjuncts to traditional clinic care rather than as precursors to it.

From a recovery point of view, the standard clinic is an appropriate treatment only for people who are already fairly far along in their recoveries - people who are engaged, self responsible, and have significant skills and supports in the community. Therefore, clinics are rarely the appropriate first level of treatment even though we usually think they should be our system's major front door.

Flow can only begin if we create "pre-clinic" services that meet people where they're at. These are outreach and engagement services. (Incidentally, they can be voluntary or involuntary. There's no law against long term involuntary outreach – say for two years – as long as we're not stalking.) What is available for people who want help besides appointment based intake assessments in a highly stigmatized, crowded clinic? (For example, would a home visit be as effective as dragging someone into the hospital?)

Levels of service should begin with outreach and engagement for people who aren't engaged. The next level to flow into once someone is engaged should be easily accessible, flexible services, which include staff to help coordinate services for you and who tolerate poor participation as they teach self responsibility. Only then are people likely to flow into a clinic as they're designed today and be able to benefit from it. (Of course, by then it's reasonable to wonder if they should be going to a Wellness Center instead. Exactly who is best served in a clinic?)

3) The need for services to be growth oriented instead of care taking

Once we create a full recovery based system of care including plenty of services for "unengaged" and "engaged, but poorly self coordinating" people we have to look at what services we're giving, and ask ourselves if they promote flow or not.

Traditional treatments are illness based, but we still must deal with the people who have the illnesses. The traditional overall approach is to take care of the person until their illness is treated enough that they are well enough to take care of themselves. This caretaking is usually seen as ancillary to the treatment and designed to facilitate the "real" treatment. By contrast growth oriented services are designed to teach people how to take care of themselves and use supports regardless of how ill they are. They are seen as crucial to promoting recovery as treatment itself. Here's a grid contrasting care taking and growth oriented services:

	Care taking services	Growth oriented services
Unengaged	Forced treatment Protection Benefits establishment Acute stabilization	Outreach and engagement Peer bridging Concrete quality of life goals Relationship building
Engaged, but poorly self-coordinating	Structure Making decisions for people Case management Chronic stabilization	Supportive services Skill building Personal service coordination Collaboration building
Self responsible	Benefits retention Maintenance therapy and medication	Community integration Self-help Peer support Wellness activities Growth promoting therapy

Notice that this grid is person centered, not illness centered: The rows are built on how far along the person is in their recovery, not how far along their illness is in its treatment (Illness centered rows by contrast would be: acutely ill / at risk, symptoms stabilized but interfering with function, and symptoms stabilized and ready to rebuild, for example).

Notice also that the services in both columns "work." People who are unengaged can benefit by being forced into treatment. Unfortunately, it rarely leads to them becoming engaged. Engaged, but poorly self-coordinating people can benefit from structure and other people making decisions for them (if they don't rebel and become unengaged again) but it rarely leads to them becoming self responsible. And self-responsible people can be maintained in treatment and on benefits, but it rarely leads to them becoming productive and integrated into the community. The difference between care taking and growth oriented services, and the reason for transforming, is not necessarily to achieve greater effectiveness, but to achieve greater flow. Absent a major breakthrough in a person's illness treatment (which would likely benefit either approach) the care taking services need to be ongoing while the growth oriented services may well be able to move many people on and open up space for the next person in need.

Consider the example of board and care homes vs. halfway houses: When the state hospitals first started closing it was considered too large a step for people to move directly into their own apartments. Halfway houses were set up so that people could get accustomed to their new neighborhood, learn where the doctor, the grocery, the bank, and the laundromat were, find an apartment they liked, and brush up on their independent living skills. They were designed as a growth oriented service. Over the years, however, board and care homes have evolved to take care of people who in the past may have been in state hospitals indefinitely. They take care of meals, laundry, housekeeping, pills, money, and even some social activities for their residents. There is generally no teaching component or expectation of moving on to your own apartment. Licensing overtly codified these caretaking responsibilities, but not the teaching responsibilities. By now there are large numbers of board and care homes and virtually no halfway houses. Because the board and care homes give care taking services with negligible positive flow, the "good ones" are always filled. Only the ones who inadvertently create substantial numbers of unengaged or extreme risk people seem to have new vacancies.

If we are going to create flow, we'll have to create large amounts of effective growth oriented services. Unfortunately we don't usually consider many of the items on either of these columns of services to be actual treatment (once again, because these services are person-centered, not illness-centered). They're not readily reimbursed or considered "treatment." Both sets tend to be relegated to lower paid, unlicensed, less highly educated staff (there doesn't even exist staff training programs for most of these service skills) and the higher paid, licensed, and highly educated staff in general avoid providing these services themselves. The growth oriented services require more skills, personnel, and resources to provide than the care taking services require (at least in the short run). Ultimately, there won't be enough talented people or resources to provide a full spectrum of growth oriented services if we merely transform care taking services into growth oriented services. We'll also have to transform some clinical treatment services into growth oriented services. Doing so will require a substantial power shift in our system.

4) The difference between growth oriented cultures and structures

One of the most concrete ways of promoting flow is to create time limits (e.g. "This is a 30-day rehab program" or "This is a 12 week skills building group therapy.") Unfortunately, time limits can be unrealistic or even destructive. Most real people actually grow and recover at a rate faster or slower than the program's "prescribed" rate and some people don't grow at all. Sometimes time limits can even backfire as people seem to regress as their time limit approaches to "prove" they're not ready to move on. On the other hand, growth is often dependent on effort, and without time limits there may be limited pressure to exert effort. Sometimes it seems like growth only happens once people are faced with a time limit. Both staff and the people being served are prone to these fluctuations in motivation and effort. Services without time limits seem to inhibit flow simply because of their permanent availability.

This dilemma is more easily resolved theoretically than practically. Theoretically people will move on when they've achieved the needed growth even if they did that faster or slower than predicted. Theoretically staff and the people they serve will maintain motivation because of the benefits of growth

alone without external pressures. Practically these desirable theoretically behaviors are only likely to happen with additional external motivation, either from the programs structure or its culture or both.

If a program can create and maintain a strong growth oriented culture it will need less structural pressures.

A growth oriented culture has many elements: Staff need to believe that growth and recovery is the expected, usual outcome. They need to view "stability" as stagnation, an inadequate outcome. They need to be hopeful and instill that hope in the people they serve. They need to emphasize possibilities instead of disabilities. They need to feel confident in their ability to promote growth and recovery. They need to focus their emotions more on celebrating successes than on avoiding blame for failures. They need to view setbacks as inevitable and opportunities for learning and further growth rather than as failures and reasons to give up. They need to promote growth oriented risk taking instead of risk avoidance.

A program's leadership can use structural elements - like time limits, case loads that go up if people aren't moved on, outcome measurement systems, or staff incentives – to help create and maintain the culture. If leaders instead rely on structural elements to create flow without creating a growth oriented culture, there is likely to be lots of conflict and evasive efforts.

5) The difficulties maintaining relationships as people grow and flow

One of the most difficult obstacles to flow is the changes in or even discontinuations of relationships that accompany growth and flow. Traditionally spectrums of care designs struggle terribly at the transition points because relationships with staff are disrupted precisely when people are trying to stretch themselves. Presumably it would be ideal for the same staff to maintain relationships with people even as they flow through various services and their needs change. Unfortunately, that's not a realistic solution, since different levels of services are likely to be in different places and staff may not be good at providing every level of service even if they could.

Recovery offers a new opportunity to deal with this obstacle because relationships between staff and the people they work with are different in the first place. In recovery programs staff must work together in true teams. People will regularly have relationships with a number of different staff on the team and staff will have a number of different roles with any given person they're working with. When contrasted with traditional programs, recovery programs tend not to restrict multiple relationships or roles. Boundaries tend to be much lower and more fluid. As a person changes, the expectation is that their relationships with staff will change. Within the recovery culture changing relationships are part and parcel of growth and recovery. (For example, a common "desirable" relationship conflict in a recovery program occurs when the person wants the staff to continue to do things for them while the staff wants them to grow and use their new skills to do things for themselves.)

The enduring core of the relationship is more likely to be their "real" relationship than their "therapeutic" relationship. Recovery relationships tend to extend beyond the walls of the office and the limits of the therapy. Therefore, even when someone "graduates" from a given program, or from

treatment altogether, they may still have a relationship with their old staff. The responsibilities and expectations will have drastically changed, but they're not "terminated." (For example, there are literally hundreds of people at the Village and graduates who have some relationship with me – perhaps just saying hi in passing, or my being their customer at the café, or sending me a Christmas card, or playing softball together, or being coworkers, or them showing me how much their child has grown, or inviting me to their wedding – but I am no longer their treating psychiatrist. Since we always had multiple roles and relationships, ending my medication prescribing relationship with them doesn't end our relationship entirely.)

The traditional severe restrictions on relationships between staff and the people they work with make the relationship transitions associated with flow and graduation much more disruptive and traumatizing than they are in a recovery program.

(Incidentally, there is a substantial benefit to staff if they continue to have some contact with people who have "moved on." We get to see the people we care about continue to grow and recover even after they leave us. And that can inspire and even transform us.)

6) The need for community integration to graduate people from professional services

As we started to graduate people and they've come back to tell us about both the good and bad things that have happened, we've begun to realize that their most serious difficulties weren't usually from their symptoms relapsing or their functional deficits or even from a lack of self-responsibility. They were usually from loneliness. They didn't really have much of a network of friends except the people they'd met at the Village. They hadn't really found a niche in the larger community. Our community just isn't really very welcoming.

Promoting community integration turns out to be an entirely different kind of work than we're used to or than we're good at. It isn't about accepting our members or really listening to them or treating them or skill building or even advocacy. It's a whole different thing. We're really only just beginning to learn how to do it.

I suspect promoting community integration is probably about helping our communities recover. After all how healthy can a community really be if it has to hire a lot of paid staff to care about people who just want the opportunity to have a life like everyone else now that they've struggled so hard to overcome their inner battles?