

Top 10 Strategies from the World of Recovery and Serious Mental Illness That Should be Used in Medical and Behavioral Health Homes

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The vast majority of the discussion about the Affordable Care Act has been on its payment provisions, but it also includes major clinical changes. Fragmented care, an over-reliance on specialists instead of primary care, an overuse of acute care settings, and a lack of focus on prevention, self care, and wellness are key clinical practices where cost savings could be realized. The creation of health homes is designed to transform our system into a coordinated, team based, primary care focused, prevention and wellness inclusive system of care. The world of recovery and severe mental illness has a lot to offer towards this clinical transformation.

Ever since deinstitutionalization and the beginning of Community Mental Health Centers mental health has been working to develop strategies to support complex, challenging people who do not respond well to standard medical model, clinic and hospital based services. With the emergence of the Recovery Movement over the last couple decades the pace of innovation has accelerated, bringing together efforts from the Consumer / Survivor Movement, psychosocial and psychiatric rehabilitation, integrated substance abuse treatment, an array of mental health professionals, families, civil rights advocates, community organizers, and even moral treatment. There have been major efforts to address widespread noncompliance and withdrawal from the treatment system by developing more collaborative, patient-centered treatment approaches. There have also been efforts to integrate fragmented services into a user friendly, “one-stop-shops” focusing all of our services on the client’s quality of life goals.

The jargon of our breakthroughs – housing first, harm reduction, supported employment, motivational interviewing, strengths based, resilience, community integration, protective factors, collaborative medication, shared decision making, client-driven, peer advocates, wellness recovery action plans, etc. – can seem overwhelming, irrational, and frankly, just too strange to be useful. And yet there are a lot of really practical, down-to-earth strategies mixed in there that can change lives.

This article is an effort to relatively briefly present a coherent set of strategies that directly address today’s clinical challenges in health reform and that, if well implemented would, I believe transform a clinic into a health home. The term “health home” evokes a different set of images than would’ve been evoked with “primary care clinic”, “health coordination center”, “health management organization” or

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any of a host of other alternatives. The metaphor of a “home” promises personal relationships, welcoming, belonging, security, caring, familiarity, comfort, acceptance, etc. The actualization of those promises will require shifts in staff emotions, values, relationships, and even treatment cultures that implementing these ten strategies leads us towards. Here’s my “Top Ten” list:

	Challenges	Clinical Strategies	Staff Impact
1	High cost, disruptive patients overusing acute care services with poor outcomes	ACT Teams (Assertive Community Treatment)	“No fail” commitment to challenging individuals Intense personal involvement Team work
2	High morbidity and mortality from pervasive substance abuse frustrating to staff and services	Integrating Substance Abuse Services	Removing judgment Compassion “Counterculture of acceptance”
3	Frequent crises for people with low protective factors Poor social determinants of health impact outcomes	Building Protective Factors / Integrating Poverty Services	Charity Social involvement
4	Poor self coordination of services and complex system combine to fragment treatment Difficult to access services	Case Management	Advocacy Welcoming Accessibility
5	Poor engagement with services and continuation of treatment	Linking Treatment to Patient-Driven Quality of Life Goals	Customer service Respectful power sharing
6	Poor buy-in to and compliance with treatment	Collaboration and Shared Decision Making	Empathy Shared perspectives Collaboration Humility

7	Passivity of patients with poor participation in treatment, rehabilitation, and self care. Patient dependency and burden of responsibility put on staff instead of patients for their lives	Self Help and Rehabilitation / Building Self-Responsibility	Providing secure foundation for growth instead of protectionism Trust Empowerment Supporting risk Shared responsibility
8	Longstanding disability and life impairments with chronic, incurable illnesses	Building Resilience, not Cure	Acceptance of symptoms Appreciation of strengths Community development Resilience
9	Hopelessness and demoralization Too much separation between ill people and well people.	Consumer and Peer Staff	Inclusion Hopefulness Togetherness Collegiality
10	Widespread unhealthy habits leading to serious morbidity and mortality	Health and Wellness	Long range perspective Mutual self care Prevention

1. ACT Teams

Every medical practice has within it a small number of people who require enormous amount of care, use up lots of resources and burn out the staff, often with disappointing results. These people are where the true cost savings from proactive, integrated care can be found. They can be helped by placing them in ACT teams and giving them highly coordinated intensive services.

In the 1970's the first Assertive Community Treatment (ACT) teams were developed in Madison Wisconsin to support people who were being released from long term institutionalization. Over the decades ACT teams have been adapted to "high utilizers", homeless people, jail diversion, and other highly complex populations. ACT teams excel in their ability to coordinate and integrate complex, highly intense, community based services, including medical, mental health, substance abuse, and social services (for example supported housing and employment, family preservation, and benefits assistance services).

ACT teams are small multidisciplinary teams with very low shared case loads (generally 15-20 patients per case management staff) who maintain frequent contacts (generally at least weekly and sometimes even daily) mostly in the community. The case loads are generally shared so that all the staff know and work with everyone and the staff have small team meetings daily to coordinate their services. This was originally conceived of as a “hospital without walls” and has evolved along with the recovery movement to focus more on building skills and supports to support patients achieve their chosen life goals.

Because ACT is such a costly service, it cannot be offered to everyone and must justify its expense through cost savings in acute and other intensive services (usually inpatient and ER services) for already costly patients. The case of “Million Dollar Murray” described by Malcolm Gladwell in the New Yorker describes a classic example of this type of “revolving door” patient. Atul Gawande described several innovative medical ACT like approaches in his article “The Hot Spotters: Can we lower medical costs by giving the neediest patients better care?” also in the New Yorker.

It is difficult to keep staff focused on a relatively few, high need patients while so many others are getting so little and clamoring in need. It doesn’t seem fair and it doesn’t seem right (in an almost moral sense of the word since many of these high need people just aren’t very likable or “deserving”). But it works in a way that no “one-size-fits-all approach ever can.

One of the key features of ACT teams is that they are “no fail” services. The team is responsible for the person’s services regardless of their compliance, cooperation, acuity, or risk. The vast majority of services are provided directly by the team, doing “whatever it takes”. If ER, hospital, or forensic services are required, even after hours, the team is expected to coordinate and actively participate in their care. This forces the team to “meet the person where they’re at” sharing in their life and their difficulties without pushing them off onto someone else or giving up on them. Staff treat them like family. The level of commitment this work requires is enormous given the intensity of relationships, involvement in their whole lives, and the extreme needs of the selected patients. To avoid vicarious traumatization and burnout the staff must work together as a team and be able to combine intervening courageously with the acceptance of a hospice worker.

2. Integrating Substance Abuse Services

Many patients who abuse drugs and alcohol have very poor health, mental health, and quality of life outcomes. They are often resistant to efforts to help them achieve abstinence and sobriety so they come back over and over in worse and worse shape. They often lie to us and even to themselves. The vicious cycle goes on and on, damaging everyone around them. Even when they see what’s happening, they too rarely can get out of it. Staff are often frustrated and feel ineffectual and like it’s a waste of time and resources to treat them at all. There must be some other place to send them to get rid of them. But specialty substance abuse services, rarely exist and even when they do most people refuse to go to. All staff need to face our frustrations, our judgments, and our rejections. Like it or not, all staff need to embrace that “we are the dual diagnosis system” if we’re ever going to be helpful.

A common structure for integrated substance abuse services is to divide them into four stages: Engagement (for those who deny they're abusing substances or having any negative impacts), persuasion (for those who realize they have a problem but aren't ready to stop), active treatment (for those who are ready to try to stop but need help doing so), and relapse prevention / remission (for those people who have stopped and are trying to maintain abstinence). Staff can learn to distinguish which stage each patient is in and offer services accordingly, reducing their frustration from mismatching their interventions with the person's needs and readiness.

Two new approaches have emerged within this approach: 1) Harm reduction which maintains that people don't change because they've suffered enough to learn their lesson or bottomed-out so we don't have to worry too much about "enabling them". It's more important to keep them alive, with enough strength and hope to enter active treatment, with something left to lose, and to keep them away from permanent damage (for example, brain damage, HIV, heart damage, felony convictions, losing their children, car accidents, etc.). 2) Motivational interviewing describes a series of therapeutic interactions that meet people where they are in the long, ambivalence filled, process of committing to substance abuse treatment and abstinence (pre-contemplation, contemplation, planning, action, and sustaining).

Motivational interviewing is a powerful tool for supporting people realistically as they work to make new decisions and develop new, healthier behaviors. Using motivational interviewing skillfully can transform a practice from a place of daily frustration dealing with noncompliant patients who won't follow staff recommendations to a nuanced partnership between staff and patients struggling to make changes together and celebrating those hard earned changes together.

Implementing motivational interviewing requires us to move from a strictly negative judgmental stance to look at what positive impacts people are getting from their substance abuse to help them decide to move on. Empathizing like that can feel disorienting as though we're losing our moral compass. However, almost no one lives "life on life's terms" without regularly manipulating our pleasure centers and our sense of well being. The list of ways we've discovered to do this is impressive including drugs, alcohol, cigarettes, sugar, caffeine, carbohydrates, fat, dark chocolate, extreme exercise, sex, love, empathy, meditation, prayer, risk taking, and thrill seeking. These choices vary a lot in their good and bad side effects. Our patterns of usage also vary widely including self regulation, binge usage, escapism, responding to stress or emotional unpleasantness, boredom relief, emptiness.

Most of us are heavily into rationalization and self denial about our own pleasure center manipulation usage and patterns to avoid judgment. Yet, for most of us, the single largest determinant of our health, and ill health, is what we use and how we use it to manipulate our pleasure centers. Health care needs to directly confront all of these behaviors, and our judgments about them, directly and intensively. Obese "food addicts", smokers, and crack addicts are all killing themselves and they need and deserve intensive treatment in all four stages from all of us. "Just say no" won't work for any of them.

Both harm reduction and motivational interviewing are designed to be integrated into all clinical interactions rather than separated out into specialized substance abuse treatment. In this paradigm the

substance abuse specialist's role is usually not to provide direct treatment as much as to support all the other staff in being comfortable and competent with substance abuse services and to facilitate coordination with active treatment resources. Every staff interaction includes some component of substance abuse treatment. Many people have strong emotional resistances to directly providing substance abuse services or even working with people who are actively abusing substances. A shift in individual and program culture is needed to create a "counterculture of acceptance" for people abusing substances to have a non-confrontational place to recover. The ability to work compassionately with active substance users is one of our key interview questions and a condition for employment.

3. Building Protective Factors / Integrating Poverty Services

There is a widespread recognition that social determinants of health have a massive impact on health outcomes often overshadowing illness factors. Nonetheless, most health centers consider it beyond their purview to directly address and impact these social factors. The results are predictably helplessness and frustration for both staff and patients. Some mental health centers have become actively involved in directly providing and collaborating with poverty services without saying "that's not my job." These services can include benefits establishment (providing medical documentation and advocacy), money management (SSI payee services), accessing subsidy programs, housing support (providing therapeutic housing and coordinating Section 8 vouchers), providing job training services and collaborating with vocational rehabilitation. We can also get involved with community and political advocacy efforts trying to improve conditions impacting our patients on a wider scale.

Most peoples in crisis have very low protective factors – safe housing, enough money to make it through the month and a little extra for emergencies, family connections and support, other supportive relationships, roles and activities of meaning apart from their illnesses, and spiritual sustenance – so they have a limited ability to withstand stressors, including illness based stressors, without going into crisis. Building protective factors directly dramatically decreases the need for crisis care without impacting the stressors directly.

Many people are in survival mode and do not attend to needed illness care well as a result. They are too focused on meeting their daily needs. When we neglect their survival needs and criticize them for neglecting their illness care needs it is difficult to engage them. Many times when a person first comes to see us, they want concrete assistance without having to do much, charity, and we offer them treatment plans they need to actively participate with instead. They're left feeling we're not very helpful and we're left feeling like they don't really want to get well. Simple acts of kindness that don't need to be repaid, whether sharing a sandwich, donating some old clothes, giving someone some bus tokens, or even a Christmas tree for their kids can be deeply touching. Charity can often be an effective engagement tool, building a relationship that can eventually be used for collaborative treatment after their daily needs are met. Unfortunately, staff often feel manipulated and misused by people who want charity and concrete assistance instead of treatment even lashing out at them losing focus on the big picture.

4. Case Management

The vast majority of our medical and social service systems unrealistically expect that patients will be act self responsibly and coordinate their own care and get upset when they don't. We expect unmotivated teenagers to attend high school and study, overwhelmed mothers to complete a series of parenting classes and other requirements to get their kids back, parolees to comply with drug testing, meeting with their parole officer, and doing what they're told to do, welfare recipients to comply with job search expectations, and physically ill people, in some cases with limited mobility, no money or form of transportation, to make doctor appointments, obtain and take medications, and negotiate with the government and insurance companies to pay for our services. A high portion of poor outcomes are due not to the difficulty in the treatment or social task, but from poor coordination and follow through.

We can approach this in two ways: 1) We can make our services more accessible and more integrated so they require less self responsibility and coordination to use. Practical examples include drop-in services, team work so more than one staff can help them to increase availability, expanded hours, "one-stop-shops", coordinated medical records, embedded pharmacy services, and insurance coordination. All of these strategies go against our normal prioritization of efficient usage of staff time over ease of use and convenience for our patients. 2) Case management - Existing staff can incorporate coordination tasks in our jobs and additional staff can be hired specifically to assist with coordination tasks. These tasks are likely to be disliked by staff, since they don't feel like "real treatment" and devalued despite how crucial they are to success.

Sometimes case management focuses on coordinating the requirements of other agencies, like social security and Medicaid benefits assistance, HUD requirements, vocational rehabilitation eligibility, etc. Sometimes case management coordinates our own services within and between programs with "service navigators", appointment reminders, annual service plans, etc. And sometimes case management coordinates our system requirements, like financial eligibility, insurance coverage, legal coordination, outcome and satisfaction surveys, etc. From the patient's point of view these all seem like burdens we've imposed upon them that we should handle for them. They sometimes feel like we're giving them unnecessary hoops to jump through, when the staff usually has little or no control over any of the requirements they're trying to coordinate.

When case management is seen just as a giant paperwork / coordination task by staff and patients lots of blaming, resentments, and burnout will likely result along with the actual tasks not getting done very well. On the other hand when we see these tasks as essential to welcoming, accessibility, and advocacy to "get the help you need" there is a greater chance of emotional satisfaction, shared responsibility, and feeling effective. There is also a greater chance of case management staff being valued and included as full members of the treatment team instead of demeaned as "go-fers".

5. Linking Treatment to Patient-Driven Quality of Life Goals

People are most likely to come to a clinic when they are in acute distress. They are most likely to be compliant with short term treatments, especially those that don't require behavioral changes. As a

result treating acute conditions is often both satisfying and effective. Unfortunately, the vast majority of people we currently treat have chronic, nagging, incurable conditions that require long term behavioral changes to overcome. We need to adapt our methods and our expectations to what's actually needed.

The more we try to treat chronic conditions or address overall health and prevention the more problematic engagement and compliance becomes: "Doc, can't you just give me a pill to make this all go away?" When we can't provide an effective acute treatment, only a small minority of people shift to successfully engage in and collaborate with long term medical or mental health care. Some go to an ER to get relief between appointments saying their doctor isn't helping them. Others stop showing up because they feel better and maybe their problem will just go away. Without realizing it they become problematic, frustrating patients.

The two systems respond somewhat differently. The medical system tends to view the problem as abuse and over usage of expensive emergency rooms and hospitals and the solution as better management of health care resources, while the mental health system sees the problem as a lack of insight and resistances inherent in the conditions themselves and the solution as increased coercive and forced treatment, especially hospitalization. Both approaches see the patient as the problem and taking control away from them for their own good as the only practical response.

We need to more directly face that treating chronic conditions is fundamentally different than treating acute conditions. My strategies five, six, and seven focus on collaborative approaches that engage the patient to work with us. Mental health's recovery movement with its empowered consumers and medical health's chronic illness management models with its activated patient have large areas of overlap.

For acute illnesses, recovery is cure, and therefore the treatment is best focused directly on treating the illness to eliminate it. Patients are likely to make substantial sacrifices and give over substantial power in return for rapid relief. For chronic illnesses, recovery is about overcoming illnesses by living as well as possible with them. Treatment is more likely to be evaluated in terms of its effect on "quality of life" than on symptom relief alone. People will make their own decisions balancing the negative impacts of treatment, including intrusiveness, loss of power, and stigma, with the functional benefits treatment facilitates. Consequently good acute illness care is likely to be illness centered, whereas good chronic illness care is likely to be person centered.

To increase engagement and collaboration, mental health has largely replaced the professionally created, diagnoses based, problem list with a patient generated, quality of life goal list "in the patient's own words". For example, instead of having a problem list that consisted of "hypertension, diabetes, smoking, arthritis, and moderate congestive heart failure", a client-driven quality of life problem list could be "I want to be able to walk 2 blocks, have sex, live to see my grandchildren get married, and not wake up in pain." When the patient creates the goals instead of the professionals there is an increased chance they will value the goals and participate in achieving them. There is also an increased chance that the professional will recommend interventions that most effectively lead to their goals and be able

to justify them to the patient in a way that will lead to actual collaboration. Ongoing evaluations, “check-ups” track progress in attaining the quality of life goals and changes in the goals over time. Each meeting includes, “What goals are we working on now?”

The power in the relationship shifts changing from focusing on how well patients are complying with staff orders to how well staff’s services are meeting patient’s goals. Service delivery priorities are more likely to reflect patient desires and satisfaction than “working up illnesses” or self protection of professionals.

6. Collaboration and Shared Decision Making

Collaboration and shared decision making differs from the more common “informed consent”. The basic informed consent process consists of a professional making a diagnosis, explaining several recommended treatment approaches (primarily drawn from medical research, availability and payment issues, and the professionals’ experiences), including the risks and benefits of each, and getting the patient to agree to one or more of the interventions. The role of the patient is more or less limited to prioritizing risks and benefits and including their personal preferences when treatments are comparable (for example between surgery and radiation). In contrast, shared decision making begins with the patient’s goals. The patient and the professional need to form some mutually acceptable understanding of what is wrong, which may or may not be expressed as a medical diagnosis (For example, “I’m under a lot of stress and my body is struggling with it” may be a more useful shared formulation than “Major depression”, “Psychosomatic symptoms”, or “chronic fatigue syndrome”.) Both the patient and the professional may have treatment recommendations they’ve gotten from a variety of sources. The decision making process is a collaborative one, reflecting mutual respect (like a couple deciding where to go on vacation together) likely with neither one getting everything they want, but hopefully an approach both will follow through on because they were included in the process. Sometimes the shared decision can be better than what either the patient or the professional would have thought of on their own (because it includes information one of them didn’t know).

Many professionals have concerns about this approach. They are afraid that we are neglecting our professional responsibilities. We can’t be letting patients make decisions about their treatments when they don’t have our education or when they have impaired judgment. We’re getting paid to be the experts. Somehow we’ve become more ethically comfortable with prescribing “correct” treatments that patients don’t comply with, than in collaborating to create a mutually acceptable compromise they will follow-up with. We feel better knowing we’re right than knowing we helped them do what was possible for them. Shared decision making doesn’t mean we have to go along with whatever the patient wants. For example we aren’t required to give them unlimited pain relievers, anti-anxiety pills, and stimulants or to do weight reduction surgeries upon demand. But it does mean we have open discussions about these requests and differences in opinion, hopefully producing greater understanding on both sides.

Shared decision making isn't just combining each other's priorities. It's built on combining each other's perspectives. For example, a mental health professional might view a person as a "non-compliant, manipulative, dually diagnosed patient", whereas that same person might view themselves as a "misunderstood prophet of God". If the professional doesn't incorporate some of the person's perspective, the patient will never collaborate with the treatment, but if the patient never incorporates any of the professional's perspective they're likely to be forever in conflict with the system and their community. A shared plan, for example, that incorporates how the person can be a more responsible community member so that their religious message will be taken more seriously, may not be exactly what either side wants, but it may be something they can work on together.

The emotional shift required here is from compassion to empathy. Staff are being compassionate when we visualize what it would be like for us if we had what's wrong with the patient. Our "hearts go out to them" as we feel what it would be like to "walk in their shoes". We feel a responsibility and even a burden to do something to help them. Staff are being empathetic when we have a vicarious experience of what the patient is feeling (especially if it's different than what we would feel with their condition). We "see things through their eyes". We feel a need to share our insight and understanding with them and to let them know they aren't alone. Both emotional stances can lead to helpful treatments, but empathy is required for true shared decision making.

This shift is difficult to make. It requires us recognizing our biases to move beyond our paradigms and perspectives. We make a leap of faith into their worlds leaving our comfort zones behind. It means that every new patient, is truly new and unique and not just another case of something we already know how to treat. Fortunately, staff who make this shift are likely to experience far less burnout. "Compassion burnout" is unfortunately very common, whereas "empathy burnout" doesn't seem to exist. True empathy leads to both patient and staff feeling more connected, stronger, more hopeful, and grateful to each other.

7. Self Help and Rehabilitation / Building Self-Responsibility

Many patients have concerns about shared decision making too. "You're the professional. You should be able to fix me. Tell me what to do. I can't make decisions like this. You're the expert." They want the responsibility for both the treatment and the outcome to fall on the professional. This can be effective for some acute conditions, but it is rarely effective for chronic conditions. Patients are rarely obedient to "Trust me. I'm a doctor. Just do what I say and you'll be fine." for more than a couple weeks. To deal effectively with chronic conditions and recover, the patient has to have more buy-in and do more to help themselves.

Unfortunately, for many conditions the answer to the patient's question, "Can't you just fix me?" is "No." Our ability to openly share our limitations and, by doing so, emphasize the need for the patient to help themselves is hard for many staff and patients. Staff may need to work hard to develop trusting relationships with patients so they don't leave to find "someone who can really help me." Staff may

need to assist patients with grief and acceptance to get to the point of self help. Too often we string people along with the hope of cure instead of guiding them to self help and recovery.

This shift impacts the way we view ourselves as healers. Can we temper the feelings of power and satisfaction that come from fixing people with our “evidence based practices” and treatments, with some humility and acceptance that we’re usually primarily in the role of facilitating the patient’s own internal healing and self help? Their recovery usually is more about them, and their strengths, than it is about us and our strengths.

Self help can focus either on coping with symptoms and dysfunctions caused directly by illnesses or on rebuilding lives including integrating their illnesses. Motivating, educating, and training are all key staff roles but they’re different than direct treatment roles. It feels different to teach someone to fish than to feed them fish directly.

Traditionally these kinds of rehabilitation efforts begin after medical treatment is complete, often by different staff than the treatment staff, often with very limited funding compared to treatment. However, with incurable, chronic conditions, rehabilitation must occur concurrently with ongoing treatment. Helen Keller couldn’t wait until her eyesight or hearing was restored to learn to speak. Christopher Reeves couldn’t wait until his spinal cord regrew to return to acting. Most chronic pain patients can’t wait to be pain free to go on with their lives. This means that these rehabilitative, self help efforts should be integrated throughout the treatment process, often like the substance abuse treatment, by the same staff.

Traditionally the treatment relationship is between a strong staff helping a weak, often passive, patient. When we’re finished treating them they move on to a rehabilitative relationship where the staff empower patients to grow by building skills and increasingly take care of themselves. For those two functions to be integrated, the treatment relationship also has to shift to an empowering, growth oriented relationship. This is a major relationship shift for most treatment staff.

Chronic illnesses have a tendency to permeate people’s entire self identity and the way they’re viewed by others in a way that acute illnesses do not. While we rarely meet an “influenzic” or a “broken-leg-ic”, we often meet diabetics, epileptics, paraplegics, and schizophrenics. Sometimes it is more difficult to recover from the impact on their self identity and stigma than from the symptoms themselves. The crippling can be more devastating than the injury. Some illnesses already have wide spread acknowledgement of this and integration of relevant supportive services, for example cancer survivors, dementia, and substance abuse. We should expand this approach to every chronic condition, because they are all likely to impact us in many ways. To truly recover from chronic conditions, we have to help people look at a wide range of impacts and resultant needs, not just illness treatment. Too many patients are chronically impaired and suffering even though “the treatment was a success”. There is more we can do, and there is more that they can do.

There are a great number of ways people, even those with incurable conditions, can rebuild their self identities, their connections with others, and ultimately, their lives, but it usually requires more self

help, not more treatment. Within mental health the list of productive self help activities includes: Talk to other people instead of isolating. Actively build security in your life – money to survive on, safe housing, connections with family, friends, and spirituality. Actually feel feelings and emotions instead of deadening them, medicating them, avoiding them, or getting high. Learn some emotional coping skills. Learn to “use” medications instead of just “taking” medications. Engage (or re-engage) in activities that make you more fun and interesting. Take responsibility for your own life and make some changes in yourself. Go to work even when you’re not feeling well. Do things outside of being a patient and outside the health system. Improve your health and wellness. Love other people – family, partners, and kids. Work on acceptance and forgiveness instead of blaming and vengeance. Give back by helping others. Find meaning and blessings in suffering and reconnect with God or other forms of spirituality. The staff roles in facilitating self help efforts like these are rich and rewarding.

Much of this may seem beyond the scope of medical practice, but it’s exactly what many people need to overcome their illnesses. These self help activities are how the loop is completed between their initial goals and their ultimate outcomes. Many staff will complain that there isn’t enough time to focus on self help and building self responsibility. There are too many people in need of basic treatment to indulge in rehabilitation. Almost paradoxically, the only real way to lower our caseloads is to move from caretaking to growth oriented services so that our patients take on increasing amounts of self responsibility and we have to do less and take less responsibility for them. A key part of recovery is replacing professional services and supports with self help and natural community supports. When patients move on we have openings in our case loads for new ones.

8. Building Resilience, not Cure

Recovery begins with hope. If we’re going to be more open about the limited hope for cure for most of the conditions and people we’re treating we’re going to have to replace that hope with something else or everything will stagnate. Without an alternative, both staff and patients desperately pursue more and more ineffective treatments and become demoralized and disengaged when it still doesn’t work. Recovery and resilience is that alternative hopeful vision: Although your seizures or pain crisis may well return, although you may never get out of that wheelchair or be able to eat whatever you want again, you can get strong enough to make it through the inevitable tough times and live well in spite of your illness.

Achieving resilience and recovery is counterintuitive in two crucial ways:

Firstly, we are used to improving things by fixing what’s wrong - whether it’s an illness, our job performance, our house, or our marriage – not by building on what’s right. Our knee-jerk reaction to crisis is to investigate to find out what went wrong and who’s to blame so we can be sure this crisis will never occur again. When it does occur again we assume we missed the real cause or didn’t do enough to eliminate it and redouble our efforts using the same thinking. We rarely change our approach to investigate what we’d need to do to reduce the damage of the inevitable next crisis, so we can better survive it. Resilience means having enough strength to overcome challenges, not eliminating the

challenges themselves. It is a “strengths based” approach instead of a “deficit based” approach. That’s unusual in medical practice. There are practical clinical tools like the WRAP (Wellness Recovery Action Plan) and mental health advanced directives that help people prepare for future crisis.

Secondly, we are used to relying on the strengths of the staff to protect us, not using the strengths of the patient to recover. It comes far more naturally to warn a medical student that they’d better learn all they can because someone’s life may depend on it someday than to warn a patient that they’d better learn all they can about their illness because their life may depend upon it. Sometimes we can use patient’s personal strengths, for example, a strong work ethic, good self esteem, intelligence, hopefulness, or a belief in God. Clinical charts should include these kinds of strengths and how they can be exploited. Sometimes we can use external strengths, for example, money, a caring spouse and family, strong relationships with helpful neighbors, or a supportive employer. We should practice community development to try to help strengthen these natural supports.

The emotional shift for clinicians is from a caretaking protective stance, where the patient is “under my medical care”, to a supportive stance where staff provide a secure foundation from which the patient can take the risks necessary to grow and recover. (Parents will recognize the challenges inherent in making this shift.) Instead of avoiding risks, we should coach people as they learn from constructive goal oriented risk taking. Sometimes the risk is as small as trying to walk with a walker after hip surgery. Sometimes it’s as big as returning to driving to work after a stroke. Staff should provide encouragement, guidance, and support, but the patient needs to take the risks themselves if they’re going to recover.

9. Consumer and Peer Staff

There is nothing that builds hope more concretely than having a staff worker who has recovered from the same condition you have, whether it be a vocational rehabilitation worker in a wheelchair, a nurse with an insulin pump, or a blind social worker. There is nothing that directly impacts staff perceptions of what people with serious illnesses and symptoms are capable of doing than working alongside them. Overall, the impact of hiring people with serious illnesses into a whole variety of staff roles in altering the culture of a program is hard to overestimate.

People with lived experience of illnesses add value to every job within a program. Their added ability to empathize with patients, to anticipate what issues they may face, and to make patients feel welcome builds trust and relationships. Substance abuse programs have known this for decades. In addition, there are some specific roles that only people with lived experience can do including: Consumer and family representative, peer advocate, peer supporter and peer bridger, peer counselor and peer case manager, and peer self-help participant and facilitator.

There are several affirmative action style strategies to help consumers and family members enter and be included in our worksites including specialized recruitment and training programs, set aside entry level positions only for people with lived experience, and specialized on site supervision and support. Then they can advance as far as their education and skills can take them. However, we need to remember

that we're hiring them and working alongside them, not out of compassion or charity, but because they make our services better.

The shift for staff is to adjust to the removal of the wall between sick people and well people. This desegregation is precisely what many people with serious illnesses need to be able to live well with their conditions among people without illnesses, but it can be stressful and disconcerting for staff. Many staff protect their own emotions by maintaining professional distance from their patients. Breaking down barriers between us can increase feelings of vulnerability. This is part of the reason "doctors make the worst patients" and why when doctors have to be patients their doctors continue to call them "doctor" and treat them more as colleagues than as patients sometimes waiving fees to emphasize the difference from the usual patient. It would be a challenge to treat all patients as colleagues, but the more usual it becomes the easier it will be. One largely unrecognized benefit of this approach is that staff who are desperately hiding their own serious illnesses, fearing they'd be viewed differently by their colleagues, experience significant relief by being able to come out of the closet. In a heavily integrated setting, we're all truly in this together.

10. Health and Wellness

The traditional view that health is the absence of illness is being increasingly challenged. Focusing on treating a problem list of illnesses does not necessarily lead to health and wellness. We're moving from a one-dimensional model where health and illness are on opposite ends of a single continuum to a two-dimensional model where one axis goes from not ill to ill and the other axis goes from unhealthy to healthy. We can all think of people who have serious illnesses, for example chronic back pain or a stroke, but are actually healthy people. We can also think of people who have unhealthy lives for years, but have no illnesses. However, the two dimensions are not independent. Living unhealthy lives is a major cause of unnecessary illnesses and even death.

Mental health is in the midst of a medical crisis because people with schizophrenia and other serious mental illnesses are dying 20 – 25 years earlier than the rest of the population, not because of the direct morbidity and mortality of their mental illnesses or even co-occurring substance abuse or medical illnesses, but because of their unhealthy lives. Common health risk factors – smoking, obesity, lack of exercise, high cholesterol, diabetes, and hypertension account for almost all of their early mortality. But even those factors are likely secondary to underlying lack of healthy habits including poor diet, lack of physical activity, poverty, limited social relationships, limited meaningful activity, not giving to others, and lack of spirituality. We can help them somewhat by increasing their access to treatment for those risk factors, but we'd help even more if we could facilitate more healthy lives and habits.

Those two strategies, increasing access to treatment for the consequences of unhealthy lives and promoting health and wellness directly, should be a part of all health homes or they're really "illness homes". The underlying healthy habits are the same for people with mental illnesses, physical illnesses, and substance abuse which should facilitate integrated services. For example, there are already a great deal of "health interventions" in the 12-step program and it has been successfully adapted to numerous

conditions beyond alcoholism. In the same way that we want to help people move beyond being a “dry drunk” to true health and recovery, we can help diabetics and smokers and hypertensives to move beyond regulated glucose levels, nicotine abstinence, and normal blood pressures to true health and recovery.

If we look back to the “self help activities to rebuild self identities” in section six, we can now recast them as “self help activities to build healthy lives”. By visualizing illness and health on separate dimensions it is possible to visualize rebuilding a healthy life even while living with a serious illness. If the person themselves is healthy enough, wellness is possible. Usually staff and patients need to take a very long range perspective and be patient for this to work.

For staff to be able to effectively promote healthy habits and wellness, it is important that we have healthy lives ourselves. Many wellness activities, for example, healthy eating, exercise, yoga, meditation, community volunteerism, and smoking cessation groups may be effective when staff and patients participate together working on their own lives side by side.

Usually prevention services are separated from treatment services. They have different programs, funding sources (if any), cultures, and approaches (more often favoring public health approaches over individual prevention). If we implement these strategies, especially addressing social determinants of health, building protective factors, increasing self help and self responsibility, building resilience, and focusing on health and wellness we should have a strong foundation to integrate prevention services within our health homes. From this point health care would be poised to include prevention of many common conditions.

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At this point let’s look back at the entirety of this set of 10 recommended strategies. If they’re implemented would they address our key challenges and are they the ingredients for a true health home?

Many clinic transformation efforts focus, as I have, on achieving measurable practice changes. Unfortunately, the results are frequently disappointing. I think that we need to focus not just on what we’re changing but also on how we’re changing it. Too often some authority presents a set of goals and changes to the staff with some training to implement them, some paperwork to increase accountability to the new practices, and hopefully some administrative and system changes to support the new practices. While some change can be achieved that way, there tends to be a lingering unpleasant sense that staff don’t really “get it” and some undesirable side effects of staff disconnection and resentment. Staff may do some things differently, but not actually change.

Throughout this article I have tried to emphasize the role of line staff in implementing these strategies, the challenges staff are likely to experience, the emotional shifts involved, and the desired impact on staff. Emotional changes are hard to facilitate, mandate, and evaluate, but really “getting it” and being able to sustain change requires changes be made on a deeper emotional level. I believe that to be

successful transformational leadership must focus on the complex, often messy, process that staff are going through as changes are implemented. Becoming a true health home requires shifts not just in financial systems and in clinical practice strategies though it will likely begin there. It also requires changes in individual staff values and program culture.

As we have worked on promoting recovery changes within the mental health system, we have had to increasingly focus on how we're leading transformation efforts. Whether we're a consultant, or an administrator, or a supervisor, or a contract developer, or an auditor it's important that we practice what we preach. We need to use recovery principles when we relate to staff if we're going to get them to use recovery principles when they deal with their patients.

Each of the 10 strategies I've described are also administrative strategies that can create the values and culture of a health home. If we want staff to individualize, share decision making, empower, engender hope and self responsibility, promote healthy lives and all the rest for their patients, administration needs to individualize, share decision making, empower, engender hope and self responsibility, promote healthy lives and all the rest for our staff.