Transcript: Right Med, Right Time: How Medication Can Support Recovery

Complex Clinical Decisions Podcast Series

Hello and welcome to the Recovery to Practice podcast series on Complex Clinical Decisions in Psychopharmacology. I'm Curley Bonds, the chief deputy director for clinical operations at the Los Angeles County Department of Mental Health, as well as a clinical professor of psychiatry at UCLA and a professor of psychiatry at Charles R. Drew University of Medicine and Science.

In today's podcast we're going to focus on medication optimization when working with individuals with serious mental illness. To help us, we have Dr. Pat Deegan and Dr. Tracee Burroughs-Gardner joining us today. Pat Deegan is an activist in the Disability Rights Movement and has lived her own journey of recovery after being diagnosed with schizophrenia as a teenager. She is an adjunct professor at the Dartmouth College Geisel School of Medicine. Dr. Deegan, welcome to the podcast.

Thanks for having me.

Dr. Burroughs-Gardner is a psychiatrist and chief executive officer of Urban Behavioral Associates, a multidisciplinary healthcare provider in Maryland. She is also involved with mental health prison reentry treatment programs. Dr. Burroughs-Gardner, welcome to the podcast.

Thank you so much for having me. Happy to be here.

Dr. Deegan, let's start with you. When you're training clinicians or working with families, how do you describe medication optimization?

I say, what does optimal use of medication look like, and then I have them imagine a dad out on a little league field tossing some pitches to his son, or a young person at a community college attending to a lecture in Computer Sciences. That's what medication optimization looks like. Using medications to manage mental health and wellness fades into the background, and living life takes center stage, and it's important to recognize that medication optimization is a journey. It doesn't happen overnight and it's not the same thing as being, quote, compliant with medication.

For me, medication optimization means using the fewest number of meds at the lowest effective dose, and this does not necessarily mean being free of all symptoms. Optimal use, for me, means discovering my own personal reason for using medication. So not my parents reason, not my spouses reason for wanting me to use meds, not my doctors or the judge's mandate, but my own unique reason for using meds. It also means that the tradeoffs of using medications, the risks and the benefits, are balanced, and at least they're livable and that we're not disabled by side effects, and this sounds really obvious, but, to me, medication optimization also means that we personally experience the medications as being helpful.

Thanks so much. So, it sounds like really looking at the individual's goals and then matching those with what they want to achieve not what other people want to achieve.

Absolutely. And too often there's a pretty wide gap between what clinicians expect that people want from medications and what individuals actually say they want from the use of medications. And so, closing that gap is central, and having defined common ground and a shared vision of where treatment is trying to get us to, that's very much part of medication optimization. In fact, it's the starting point.

Okay. Dr. Burroughs-Gardner, I understand that you work with assertive community treatment teams. Could you explain what those are and talk a little bit about what optimized medication means in that context.

Sure. So assertive community treatment teams are actually a wonderful model or modality in which we deliver services. We think about it as the hospital without walls. And there was a program that was designed in the 1970s to help individuals be able to get out hospitals and really live full lives in the community. So, ACT teams as we call them for short, normally have doctors, nurses, counselors, peer support, which is critical to the process, therapists, supported employment staff, and just, really, everything that individuals with serious mental illness need to be able to successfully live in the community. I have enjoyed working with ACT teams over the years.

And, as a psychiatrist on the team, I really do have to think about this concept of medication optimization and how do I help individuals live a full life while using medication as a tool to do just that. So, I love what Dr. Deegan said, about it really is just a tool, one of many. And so when I think of medication optimization, I think of it as working with the individual to determine what their life goals with and then seeing how we can use medication to help them get to their life goals. And, again, it's not necessarily total symptom reduction. That is not always the individual's goal, and that's fine. But how can we use medication to help them along that journey to their life goal.

Great. Thank you. Dr. Deegan, you focus much of your work on helping to promote and facilitate shared decision-making. Can you tell us how shared decision-making helps close the gap between the person's goals and the prescriber's understanding in a recovery-oriented way?

Yes. I think that shared decision-making requires that both the psychiatric care provider and the individual have a shared understanding of how treatment can help, and also have a clear understanding of what matters to the individual, what their values are, and what the individual perceives as an excellent outcome of treatment. That is a prerequisite to the shared decision-making process. And then shared decision-making, of course, helps to close the gap between what the psychiatric care provider may have in terms of goals for treatment and what the individual is saying.

It's really about making that shift from, hey, what's the matter with you, to what matters to you. So, an example might be a woman whose struggling with a major depressive disorder, and, for her, the most important thing in her life might be breastfeeding her infant and being a great mom; right? And if this individual is given a medication, which prevents her from being able to be a great mom and to be able to breastfeed the child, then that individual is going to disengage from care, because the treatment is interfering with what matters in her life. So, if we can sync up what matters in her life, being a great mom, breastfeeding her infant, and the medications that are being prescribed, then we have a much more focused program to live my life not just my diagnosis.

That's a great example. Thanks so much. I'm wondering if you could tell us a little bit about power statements. That's another concept that I've heard in this context. And can you help us understand what they are and how can you help a person meet their goals?

Yeah. So I developed a method called "Power Statements," that helps regular folks receiving services in public sector mental health settings to communicate their specific goals for treatment to the entire care team. A power statement is a self-advocacy statement, and it does three things: The first part of the statement introduces me to my care team and my psychiatric care provider as a person not a patient. The second thing that a power statement does is it tells my care team how I want medicine to help me, and the third thing a power statement does is to invite my psychiatric care provider and my care team to work with me to achieve my goals for my care.

So, an example of a power statement might be a person who says, you know, the most important thing in my life is being together with my boyfriend, and I want you to work with me so that I feel less suspicious so that I can be together with my boyfriend. And in that power statement, what we have is an incredibly

concise, simple, yet profound directive, roadmap how treatment is supposed to help, and it becomes almost an N of 1 study. If we want to know if treatment is successful, we have to ask ourselves at the end of the day, has this young woman been able to be together with her boyfriend? So, it's not just about suppressing symptoms of suspiciousness, but, rather, it's about helping to promote a relationship.

And so, for me, power statements help us get past the idea that the goal of treatment is taking meds as prescribed. I can't tell you how many times I've seen that on care plans. Instead, the goal of treatment is never to take meds as prescribed. The goal of treatment is to live my life and to do the things that matter to me. And medication becomes a means to an end, not an end in itself.

I couldn't agree with you more. I think these cookie cutter treatment plans sometimes guide us down the wrong path. We think about symptom reduction as opposed to function and living a life that person wants to live.

Yeah.

I want to switch gears and ask Dr. Burroughs-Gardner a question. Ultimately, people have the option of simply discontinuing their medication. How can that be done in the safest possible way?

Sure. So, whenever I work with people who tell me, "You know, Dr. Burroughs, I don't want to take my medicine anymore," the first question I always ask is, "Well, tell me why?" Because often when people are talking about they don't want to take their medicine, it's because they don't like the way it makes them feel. Very few people are just opposed to the idea of medication. Normally it's I don't like the way it makes me feel. I feel like a zombie. I'm gaining weight. It's something about the medication that is not consistent with the life they want to live, so we start with focusing on that. Okay, you don't like the Zyprexa because the Zyprexa has made you gain weight. And it has. So, what can we do to try and come up with a workaround? So that's the first step that I always try and do, let's figure out what the problem is and then develop a workaround if we can.

If the individual is just saying, "Dr. Burroughs, I don't want to take medicine. I don't like the idea that I have to take it." And I hear that quite a bit. "I don't want to feel like I'm sick. I don't want to take medication." Then we have to have a long conversation about what does that mean. And I always tell people that unless there is a safety concern, because I would be negligent if I did not keep safety concerns at the forefront of my mind, unless there is a safety concern, I will never force anyone to do anything that they don't want to do, A, because I don't have that power and they're not going to take the medications anyway, if they don't want to.

But I say, "Let's have a long conversation about what it means to not take the medicine. What should we be looking for that's telling us that maybe the medications were doing a little bit more than we thought they were doing," and I do that for a few different reasons. Number one, is it helps me to see what I should be looking for slowly, because oftentimes we don't catch things until there's a fire. Oh, my gosh this person is completely quote, unquote, decompensated, when, normally, there are signs leading up to it where we can intervene. So that's the first thing, is to help me be aware of what I'm looking for.

But the second thing is to help the individual tart to be able to identify in a way that they may not have been able to identify before what symptoms or what things they may be experiencing that medications are helpful with. Prime example, if I have an individual that I'm working with who is experiencing auditory hallucinations or hearing voices, and they're not hearing them at the moment, because the other time when we stop taking medicine is when we feel better. And anyone that's been on an antibiotic knows what that's like. So I say, "All right, you're not hearing the voices right now. What it will tell us, that maybe this medicine is doing more than we think it's doing, and so the individual and I will engage in that conversation. "Well, doc, maybe it will be, if I start to hear the voices a little bit more, or maybe it's when the voices start to get mean," because, again, it's not illegal to have symptoms. It's not illegal to have mental health experiences.

What we do is we're trying to help you feel better. So, I talk about what things that you are experiencing will tell us that maybe we need to get back on your medication. And then we start to come up with a plan. Perhaps I see them more frequently. Instead of seeing them once a month, I'll see them every two weeks. If I'm in a place where I can see them more often, maybe I see them once a week. Maybe I see them every day. It just depends on what that individual needs to be able to safely taper down off the medication if that is, in fact, what they want. So, it's all about having conversations with the individual, keeping in mind what the very real risks may be in having that plan in place.

So, it sounds like having an open conversation, where you really do some active listening is key. One thing, though, you mentioned was safety. For our listeners, can you maybe give us some examples that come to mind about when you would really feel that the person does need to be on medication, even though they may disagree with you. Or what type of circumstances come up in that regard?

Right. I had a young man that I was working with, gosh, several years ago on the Assertive Community Treatment Team who was conditionally released to us, and so what I mean by that, for people that aren't familiar with the Maryland system, is that he had been in a state psychiatric facility for a very long time, and he was released, and the court said in order for you to be able to stay out of the hospital you need to quote, unquote, comply with treatment, and he got out of the hospital, he was on our ACT team, he was doing well, and then he did not want to take his medication any longer. And we kept trying to have conversation with him about it, and why don't you want to take it, everything I talked about. Why don't you want to take it? What don't you like about it? You know, do you realize that when you don't take your medication you commit arson that can hurt people?

And so, in situations like that, we had to ultimately, have this person re-hospitalized for a short period of time. He did come back to us and he was fine. But it's situations where there's risk to the individual or risk to others and I just can't form that alliance with the person to come up with an alternate plan.

This is Pat, though. I would like to interject. There are a certain percentage of people that have no discernible benefit from antipsychotic medications for instance. And when I talk to psychiatric care providers about that percentage of people and why they continue antipsychotic medications to that subgroup of people who have no discernible positive effect from the medication, often they express concerns about safety. But I think it's critically important, when we talk about med optimization to remember that continuing to expose one's self to the risks that are associated with using these medications, whether that be tardive dyskinesia, whether that be cardio metabolic syndrome, et cetera, that too is a risk profile that needs to be assessed and that treatment teams need to grapple with the ethics of continuing to offer medications to individuals who seem to not respond in any discernible way to them.

And I'm actually glad that you said that, and it allows me to provide some clarity. So, the young man that I was mentioning was the one that actually did respond very well to medication, and so that was one of the reasons that we knew we needed to get him to a setting where he could get back on it. There are quite a few people -- you're absolutely right -- that we don't see a lot of benefit one way or the other, and they end up in situations where we ratchet up doses and we expose them to side effects, and so those are a population that we work with and say, all right, what else do we need to put in place?

Many of us find that the pathway into recovery is finding that right balance between the things that we do, our personal medicine, and the pills that we may use in our recovery, finding that right balance.

I couldn't have said it better myself. So, what you both brought up is the idea of balance, and on that scale, from one side to the other, are risks and benefits, and what I what I'm hearing is that you have to think of not only the benefits but the risks, and the benefits may sometimes, if they're not present, they may not be outweighed by the risks. Another question for both of you, sometimes finding the right dose can take some time. How can a prescriber be sensitive to an individual's fears as they work to find the right dose?

I use transparency, full transparency before we even start a medication. If the individual is open to taking a medication, I will let them know that, while psychiatry and the mental health field has made a lot of advances and we're very good at a lot of things, we are not sophisticated enough to be able to pinpoint the right medication on the first try all the time and that everybody responds to medication differently, and so we may have to try different medicines. We may have to try different doses. And if someone is ever in a position where they do not like the way the medication is making them feel, tell me, we stop, we adjust, we go from there.

I let individuals know what I look for that tells me we're on the right path, we need to adjust the dose, or we're not on the right path at all. So, I really set up a situation where we're fully transparent about what's going on so that people don't walk out of my office and feel like, well, the doctor just gave me this prescription but I don't really what's going on. It's a matter of being that partner in the medication decision-making.

Dr. Deegan, any input?

I agree with what is being said here; that it's about the communication. But there's an interesting question, you know, what does right dose even mean? And defining that collaboratively, I think, is critical. And it's not a thing that's defined once. As I said, medication optimization is a journey, and I would argue that, ultimately, it's an existential journey not just a journey of trying different combinations of medications at different dosages. I think that it's a very existential journey and that what might be working for me at one moment, in terms of med optimization, might, six months later, dramatically change.

Let me just give you a simple example. Let's say I'm a young man and I have been spending the last few months in bed. I'm feeling very, very depressed. In fact, I haven't been going to work, and I'm at danger of losing my job. I seek out psychiatric and behavioral health care. I am diagnosed with depression. I take some antidepressant medication. I begin feeling better. And I begin to notice that I'm having sexual side effects. But just being able to get back to work feels so important and so great that I'm feeling a hundred percent with the tradeoff between the sexual side effects and the relief I'm experiencing from my depression. But then, over the course of the next six, seven months, I begin to become romantically involved with a person, and suddenly what was working, in terms of tradeoff, is no longer working for me.

Right now, the sexual side effects, which were not an issue earlier on in my care, have become a significant blocker in terms of my desire or willingness to continue to use this medication. The balance has shifted, and it's shifted because what matters to me is evolving as my recovery evolves, and that is a critical conversation for the care team and the psychiatric care provider to be having on that ongoing basis with the individual.

And that's why when we talk about establishing that relationship, it's very important to have that sense of transparency and the conversation about what the goals are. You know, people always ask me, "Well, Dr. Burroughs, what is my diagnosis?" I'll tell them the diagnosis that I have to put on paper for billing and purposes and things like that. But I always tell them, really what we're working on is symptoms and getting you to life satisfaction. And so, if today the problem is I can't get out of bed, that's what we're working on, and we'll just adjust medications to get you to that point, and as well as other interventions.

Please let me be very clear that I do not believe medications are the end-all, be-all. In fact, I think in most cases, they maybe do 40 percent of the work. But you're right, in six months, the picture may change. Now I'm working.

I think a great story, actually, that a supervisor told me of a young woman he worked with who was experiencing psychotic symptoms. She was started on Zyprexa, which cleared up the symptoms beautifully. The problem is she gained a lot of weight, which made her feel very uncomfortable and self-conscious. And they kind of walked through this journey for a little while. She got a new job and she said, "All right, this is what I'm going to do. I am going to take the full dose, the dose that clears up all the psychotic symptoms of the Zyprexa, long enough for me to be able to get a full grasp of my job, even though I know it's going to cause me to gain some weight. After I get a full grasp of my job, I want to

reduce my dose. Yes, the thought disorganization will come back to some degree, but I can still function and I will lose the weight that I want to lose. I work with individuals like that.

I love that story, because it really paints the picture of medication being used as a tool to help individuals live the life that they want to live. I think for a long time we have not done a great job, as the psychiatric prescribers, of really making it clear that we're part of the team and our job is to really help individuals live the life that they want to live, and we use medicines as a tool. And there a lot of reasons for that. I couldn't agree more, and I'd like to add that.

For most psychiatric care providers and care teams that I consult to, the issue of time becomes critically important. How do we have these very important conversations when, in many cases, at least in the public sector, we're limited to a 15-to-20-minute Medicaid reimbursable medication consultation? So, I think we have to begin thinking much more creatively, given the time limitation in the clinical care consult that we reengineer the care pathway in order to support people more thoroughly in having this conversation not just with the psychiatric care provider but also with the extended team, case managers, therapists and peer supporters.

So, for instance in my work, one of the things that we've been working on now for about ten years is how can we create a decision support center that people visit prior to and after their visit with the psychiatric care provider so that the conversation that is started in the psychiatric care provider's office can continue and be informed by peer specialists who are trained to support people in gathering information, weighing the pros and cons, and taking their work back into their work with a therapist or with a case manager or back again with a doctor?

Thanks. So, you both brought up some great example of how treatment needs to be fluid, along with the person's life goals. As their situation changes, their relationships, or their roles and responsibilities, the need for a certain type of medication or a certain dose of medication may change. And we, as providers, need to be responsive to that. Do either of you have any other ideas about how can prescribers do a better job of having these conversations around medication adjustments so that they don't end up making those changes on their own or just stopping the medications without any support whatsoever?

Well, whenever I start a medicine, you know, we have, again, a great conversation about why we're using it, what we're targeting, how it can be beneficial, options, you know, here's one option, here's another option, we can try this if you'd like, really stressing that we're a team in this. I'm not telling you what to do. I have the medical training but you're the expert in your life. We're a team in this, and if you don't like where this is going, tell me, we shift gears. So, it's really empowering the individual to recognize that they're guiding the ship.

One of the things that I see happening a lot in the field is that a psychiatric care provider will say something like, "Well it sounds like you're really struggling with sleep and sedation, so we're going to adjust the medication and you should feel less somnolent, and why don't you come back in a month and we'll see how things are going." And the person nods their head yes and off they go. And, yet, an individual doesn't necessarily know what that even means.

In other words, treatment has begun and a new medication or a new dosage had been prescribed, but the individual has not answered the most fundamental question, which is how will I know if this medicine is working for me. So, saying, "Oh, your thoughts will become more organized" may be meaningless to me. But saying, "Hey, you'll be able to be more intimate with your partner again because you'll feel more trusting," that makes sense to me. And when I come back in a month I can report on not is the medicine working but am I feeling more trusting of my partner.

And one of the ways that we target that is we actually have the individual tell us, you know, when I work with someone and they come in, "I'm depressed." Okay. How will we know that the depression is getting better? You tell me. And it will be things, "Well, I'll read more books. I'll talk to my friends more often." Okay. So that's what's going to tell us that things are going better. So, then when they come in in a

month, I don't ask, "How's the depression," I'll ask, "How many times did you talk to you sister? How many books did you read?" And we'll track that, and that will let us know.

And you're right, there may be a new goal. "You know, doc I'm not worried about how often I talk to my sister anymore. This is what I'm worried about now." Okay. So now that's a new goal. And this is what I do when I talk to my therapist and kind of do a treatment plan, is that goals are fluent. The treatment plan can change every month if it has to, because goals should be fluid and consistent with the individual's life.

You've both brought up some great examples of what I think redefined what we've now come to call personalized medicine. This is really a good conversation. Dr. Deegan, are there strategies that you can recommend for a prescriber to effectively discuss medication side effects and medication concerns with an individual?

Well, I think we live in the age of Dr. Google, and people are coming to the consultation with information. Some of its accurate. Some of it is not so accurate. In terms of information, sometimes too much information can be paralyzing almost, and so I think we live in an age now where we have access to what are called "decision aids," which are carefully crafted tools that allow one to quickly review the pros and the cons, the benefits and the risks associated with different medications and compare that to what matters to me and what I value.

Probably the most universal decision aid that can easily be a pen and paper task, that there's even time to do it in the care consultation itself, would be to take out the decisional balance worksheet, and on the decisional balance worksheet one begins by listing out the options, so maybe three different options for m; taper medications, stay the same, or do watchful waiting and see what happens as we move forward. Then one can list out the pros and cons, if you will, the benefits or risk of each of the options.

But then, importantly -- and this is the part that a lot of folks leave out -- is that I then go back and I look at each of the pros and each of the cons and I rate them on a five-star rating scale, five being this is really important to me and one is this isn't important to me at all. And so, one person might say that weight gain associated with medication as a risk would be completely unacceptable and give it five stars, this really matters to me. But another person might only give that one start like, hey, right now just getting back on my feet and getting back to work is what matters to me, so I can deal with a little weight gain. So, I think so a decisional balance worksheet that includes the five-star rating system a practical simple tool that can be used in the context of the very hurried work in a clinic or a mobile team.

Just to let our listeners know, many of the tools that you'll hear our speakers talk about, they will be available on the website, the same place where you found this podcast. Dr. Burroughs-Gardner, how do you deal with the times when medication interferes with what the person says they want?

When the medications are interfering with what the person says they want, that tells me that we need to be doing something different with the medications, because it's always keeping in mind that we're using the medicines to help the person get to what they want, and so it's really striking the balance.

Dr. Deegan.

I would add that psychiatric care providers can't be magicians and have a limited number of effective meds with an evidence base behind them from which to prescribe. It's very powerful to hear from a psychiatric care provider that in addition to the meds, there are also things you can learn to do to help yourself. And outside my office is a decision support center, staff by peers who can help you discover a myriad of ways to support yourself or to make that referral to the therapist who can help that person with cognitive behavioral strategies for managing voices for instance. That message coming from the psychiatric care provider, the medical team, is critically important, that it's not just about tweaking meds. Recovery is about changes our live and not just changing our biochemistry. It's hard work. Change is hard, and I think people don't hear that often enough; that sitting back, waiting for meds to get tweaked is like -- that's not my experience of recovery.

So, another topic that sometimes comes up is the individual who is in treatment but doesn't really want to take medication, or maybe they are refusing to take medication for whatever reason, how do you all address that?

Whenever possible, my favorite saying is, "All right, we'll try it this way. But what else are we going to put in place to help you achieve the goals we're targeting?" Because, again, medication does maybe 40 percent of the work, depending on what's going on, and there are other ways to help people get better. Now, of course, there are those exceptions with their safety concerns, and, of course, that's a different conversation to have, even though you can still have this to some degree there.

But I do not believe in asking people to take medications that don't want to take them, because they're not going to. If my doctor gives me an antibiotic and I don't feel like I need it and I don't want to take it, I'll smile, I'll take the prescription home with me, and I'll never fill it, because you weren't hearing what I was saying. That's not what I want. And I may have the conversation, "I hear that you don't want to take medication. I respect that. Medications could be helpful for some of the things that are concerning you. We can try some other things." Always know that medications are always an option, and any decision that we make today, we can unmake tomorrow. There's no permanent decisions. That seems to work.

And I think that's such an important point, because I think when we say to people, "Hey, you're going to be ill for the rest of your life," and we also add to it, "and, oh, by the way, you're going to have to take these medications for the rest of your life," for me, that is a recipe for disaster. It's like a prescription for noncompliance, if you will. It's like who would do that. If you're going to be ill forever and you have to tolerate sometimes unwanted effects of meds for the rest of your life, I think the key is how can you be moving towards wellness, getting your life on track and your process of recovery, how can you do that and still manage symptoms, which, at times, can be experienced as being overwhelming. Building natural supports, building your capacity and skills that manage some of these things, that all takes time.

Another thing that I've done with folks who have said, "You know, I just don't want to use meds" -- I remember a young man one time, and he was using an antipsychotic medication that really seemed to be helpful, in terms of the perspective of his family, in terms of the perspective of his care team, and in terms of the perspective of his wife. But he decided that he didn't want to take these medicines anymore, and so he just kind of went off and didn't tell anybody, because he had been silenced before about speaking up about med discontinuation, so he just learned to keep it to himself and, like you said, walk out the door and do what he's going to do.

What ended up happening was that I began to talk to him about some of the things that happened when he is completely discontinued on medication, and one of the things that would happen is he became aggressive and frightened and intimidated, people at checkout counters or at the bank. So, we stated taking a look at what his beliefs are, and one of his beliefs are was I shouldn't be taking medicine. I don't need a crutch. I'm strong within that. I'm better in that.

But another one of his beliefs was that he was a Christian and that he was a good man and that he was a gentleman, and he never wanted to hurt anybody. That was also a belief. And so we kind of took those two beliefs and we took them out and we started examining them. And he began to try to get his head around the fact that these two beliefs don't work very well together. And that approach seemed to be a really respectful and empowering way for him to begin to think through for himself, not what his team wanted not what his wife wanted, what he wanted and the kind of person he wanted to be and that really seem today make a difference. And I'll always remember that.

That's a strong, strong message. Thanks so much. Working with a person's belief systems to ensure the best possible outcome is a great idea. I also heard you both talk about that in the shared decision-making process, there are two experts in the work, we as the prescribers may be the experts on the medications and the pharmacology, but the person is the expert on their condition and what helps them and. also, what their goals are, and both experts need to work hand in hand.

We know that medication is not the only solution. What are some of the non-medication tools and supports that you like to discuss with individuals? Dr. Deegan. Oh, gosh I could talk about that for three days. I mean, so a huge part of what I do is basically gather together collective wisdom of people with a lived experience of recovery and organize strategies that seem to be particularly effective, for instance for managing false beliefs or managing distressing voices or for dealing with negative thinking and organize these onto small cards that people can use, and on the front is a more generic strategy. But on the back of the card is the opportunity to really personalize the strategy so that it is meaningful and works for you in your life.

And so, on the front of the card it might say, "Hey, I will exercise to manage my depression." And on the back of the card it will say, "Hey, there have been studies that show that exercise can be a powerful antidepressant." And then there's a space to say, "You know, what is the specific kinds of exercise that I might be getting involved in." So, it might be playing wild air guitar in my apartment or vacuuming and cleaning, or it could be going to the gym and lifting weights. But people get an opportunity to personalize that more generic strategy. Staff really like it because it's a card and it's not complicated and you can quickly work with a person to try out the strategy and then track if it's being effective or not. And peers love it because it truly is peer support to share these strategies.

Another tool that you talked about in your work is a designated observer worksheet. Can you explain what that is and how you use it in your center.

Yeah, I sure will. So, what I would say is that sometimes in the process of shared decision-making there are two people in the room, but more often than not there's a third somebody in the room. If I'm a young person who has not come up age yet, I might, in fact, have a third person in room; my mom, my dad, my guardian. But also, a lot of times you get the feeling that somebody's husband or wife in the room even though they might not be physically present.

Sometimes it makes sense to bring what I call a "designated observer," literally, into the room. What I mean by a "designated observer" is a person that I, the person with the mental health challenge, I designate my partner, Debra, to be my designated observer, because I recognize that when I am going through a medication adjustment or a medication change I'm not necessarily fully transparent to myself. I might have blind spots. And so I might keep track of my observation of how I'm doing day by day during a medication trial or an adjustment, but I also invite my designated observer to do a daily tracker as well. And then I can bring in my designated observer's tracker and my tracker and put them in front of my psychiatric care provider, and we go over it together, looking for the areas where our observations overlap and also discussing those places where our observations seem to diverge. And I think that this is an extremely respectful way to include natural support in the overall conversation about medicine.

Dr. Burroughs?

I would piggyback on the use of the natural support system. It's a powerful tool that we use with individuals to help them kind of get an external set of eyes, and also someone to engage with. You know, I found that, over the years, most people want connection. They want to be connected to others. They want to be connected to communities and systems, and a lot of times, the mental health concern has gotten in the way of that. So, we really utilize natural supports, the ones that they have, and then helping them to develop a sense of community around them. We know that community is one of the protective factors against trauma-based illnesses and those types of things, so really developing a sense of community.

I also spend a lot of time working with individuals, just asking them, "What is it that you enjoy? What is it that makes your life meaningful? What is it that makes your life special?" And it's actually sad how often that people don't know the answer to that. And so, I have them think about that so we can bring that back into their lives, because, again, for many individuals those things have been lost, so natural supports, things that they enjoy, those wellness types of thing.

I think employment can be very beneficial. Not only does it help with the financial stressors that many people are under, but also gives people some place to be, something to do, and a group or setting where if you're not there you'll be missed. And employment doesn't necessarily have to be physical employment. It can be volunteerism. But just some place to get up and go every morning, which gives you a purpose, those are some of the things that I utilize or I have individuals that I work with utilize, in addition to the medications and more traditional forms of treatment.

We've been talking far while for optimizing medications and treatment. What final advice do you have for doctors who are interested in becoming more recovery oriented in their work?

So, I think the American Psychiatric Association has, actually, some wonderful tools on learning about recovery, and just what it means, but then also just spending some time talking to individuals that we work with. Our visits are short. They're 15 minutes. They're 20 minutes. But just a few extra minutes talking to the individual, what is it that you're look for? What would make your life better? Why are you coming in to see me? How can we help to get to where you are will, A, help people feel better, and that makes, B, the work, far more rewarding? So, resources from the APA, SAMHSA, of course, has wonderful recourses on the recovery model, and just spending more time talking with the individuals that we work with.

I've had the opportunity to interview many, many people about their recovery. They have never mentioned the stellar way in which a psychiatric care provider followed a particular algorithm for checking out the effectiveness of medications with me, not that skills aren't important, but that's not what seems to make the difference in people's reporting of recovery. What they talk about is the human connection.

So, I'm reminded of Harry Stack Sullivan, who, himself, as a young person, experienced a psychosis. He said, "We're all more human than not," and that that's a really profound insight, that our humanity forms the common ground upon which we build relationships and that, ultimately, it is relationships that heal, not medicine, and that relationships are built on a kind of reciprocity and a kind of mutual respect. And what folks need to hear is that they are respected; that they are encouraged to speak up; that they will not be punished or told that they're being junior physicians for daring to question or to complain about a side effect.

I remember a tragic story of a woman who lived with akathisia for many years, and as you know, akathisia can be an irrepressible urgent need to move and to clench and to pace, and she was afraid to bring up this disabling unwanted effect of her medication to her psychiatric care provider for fear of seeming ungrateful. And so I think the simple message of I respect you, I believe in you, I want to know you, not just as a patient but as a person goes a long, long way in terms of keeping the practitioner recovery-oriented and communicating hope that this individual can achieve their human potential through collaboration and care.

Thank you both for what is very sound advice. Dr. Deegan, Dr. Burroughs-Gardner, this has been a great discussion. Thank you for joining us.

Thank you.

Bye-bye.

Thank you for joining us for this Clinical Decision Support podcast. Links to relevant studies and sources of information for clinicians are included in the show notes. I hope you will listen to the other podcasts in this series. RTP is focused on improving the knowledge and skill of the behavioral health workforce to help expand the principles and practices of recovery-oriented behavioral health care across multiple service settings.

If you would like more information on this topic or other topics related to recovery from serious mental illness, please visit the Recovery to Practice website where you can watch archived webinars, subscribe to our newsletter, or learn more about our discipline-based curriculum.