Transcript: Recovery-oriented Approaches to Psychopharmacology

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.

This series is hosted by the Substance Abuse and Mental Health Services Administration's Recovery to Practice Initiative. Our goal is to help our fellow clinicians explore recovery-related issues so that we can all help the individuals we work with reach their goals.

In today's podcast, we're going to focus on recovery-oriented practices and prescribing for individuals with serious mental illness. To help us, we have Dr. Curtis Adams and Dr. Michael Birnbaum joining us today. Dr. Adams is a Senior Psychiatrist in the Division of Community Psychiatry at the University of Maryland Medical Center and also teaches Psychiatry at the University of Maryland School of Medicine.

Dr. Adams, welcome to the podcast.

Thank you, Curley.

Dr. Birnbaum is the Director of the Early Treatment Program at Northwell Medical Center. He also teaches Psychiatry at Hofstra/Northwell School of Medicine and is an investigator at the Center for Psychiatric Neuroscience at the Feinstein Institute for Medical Research.

Thanks for joining us.

Hi there. Great to be here.

So why don't we launch right in. Dr. Adams, can we start by having you describe the individuals that you encounter in your practice?

I work out of two separate clinical settings at University of Maryland. One is a community mental health clinic, the other is on an ACT Team. The folks that we serve there are similar. They often have persistent illness, sometimes severe illness. And some can come in and see us, and those are the folks that come to the community mental health clinic. And then some, we go and see them on the ACT Team. And in our community mental health clinic we have psychiatrists as prescribers along with therapists, social workers, and a therapist nurse. And on the ACT Team we have psychiatrists along with nurses, social workers, vocational specialists, consumer advocates. And all over Baltimore we treat people with substance use disorders along with their other problems and have a really good time doing that.

Great. Thanks. So it sounds like you're treating people in the community. The ACT or assertive community treatment means it happens out of the typical brick-and-mortar office places if I'm correct.

Absolutely. And it's – it's a huge advantage, actually, to see people there because there is a wealth of information that one gathers when one goes to someone else's home. And it can be very helpful in trying to serve folks and help them to – to move along in life and improve.

Great. Dr. Birnbaum, can you tell us more about the people that you work with?

Sure. So I run an early psychosis intervention clinic, and we work primarily with teenagers and young adults between the ages of 15 and 35 who are in the very early stages of developing a psychotic disorder, primarily schizophrenia and schizoaffective disorder. All of the folks that we work with have had symptoms for two years or less, and we help them get back on track with their lives despite struggling with psychotic symptoms.

So it sounds like a unique part of your practice is you're seeing people early on in the course of their illnesses.

Yes, absolutely. That's the key of the program is to catch it as early as possible before it really has a chance to metastasize and help keep young folks and their families on track with their lives.

Okay. So if you had to explain to one of your students or a new psychiatrist what are the basics of recovery-oriented practice, we hear that term tossed around a bit, but I just what to get at maybe some key concepts and key misconceptions.

Dr. Birnbaum let's start with you.

One of the main things that comes to mind is the fact that people with serious mental illness, including schizophrenia, can and do recover. People can continue to achieve their hopes and dreams, can continue to work and have loving and healthy relationships despite having a mental illness. And the fact that there is no ceiling, we really have an opportunity to get folks into our clinic and help them become their best selves.

So really, it sounds like with recovery, the sky is the limit. The person can go as far as they want to.

That's probably one of the biggest stigmas surrounding mental illness is that once you develop a mental illness, and certainly something like schizophrenia or schizoaffective disorder, which was previously viewed as a death sentence, we don't see it that way. And this has drastically transformed their lives but it doesn't mean that they can't continue doing all the things that they love to do, and even more so.

So Dr. Adams, anything to add?

Sure. In terms of recovery, in the front of my mind, always, is that the person is at the center of treatment and so it's very important to get at what that person's goals are. And their goals may be very different from what the typical student may think of as a goal. So we as practitioners might think, okay, well let's get remission of symptoms. That's the goal, and we've done enough, and so the voices are gone, so the treatment is done. And, in fact, recovery involves much, much more. In the front of my mind is the idea that the person is going have goals like work, and school, and family, social engagement. Just activity. All these things that make a whole life, not just remission of symptoms.

Great. I've heard the expression sometimes that recovery is a journey not a destination. And – and both of you have kind of validated that point.

I wonder about how the goals might differ from someone with a serious mental illness in treatment versus someone who doesn't have a serious mental illness. Some of the things you all have mentioned, schizophrenia, schizoaffective disorder, those are illnesses that we think of as being limiting, but in terms of setting goals, how might you adjust things?

I've seen people do amazing things with a psychotic illness. For instance, I have a young lady I work with who, as well at work – does well at work off of medication, and we've come to an agreement about that, that when she has a particular problem, like a sleep impairment, for example, that she is to call me and

then we can start talking about medication for that brief period of time when she might need it to get back to sleep. She's working. She's got a family life. She's got a full life, and she's busy, active. And so one wouldn't necessarily predict that a person with so-called schizophrenia would have this kind of life. But she does, and so I just don't put limits on people. I just – whatever they're interested in, that's where we're going to go, and we'll try to get there as slowly or as quickly as they want to go.

Mental illness, unfortunately, offers an added layer of complexity and a few extra hurdles, but nonetheless, many folks, with appropriate care and motivation, can overcome these hurdles. And I think that's the key, both for the clinician and also for the person that's coming to work with us and their family members, to be aware of this idea and to not let stigma or anything that's suggesting otherwise get in the way of their ability to keep doing so. For all of us, we need to do something during the day, whether it's work, volunteering, school, but something that gives us meaning and something that gives us purpose is really a major and crucial component of the recovery process.

So this all seems so simple and intuitive just to hear you gentlemen talk about it. You set goals with people. You help them achieve those goals. And you make it very centered towards their needs. So why aren't more of our practices recovery oriented? What do you think hinders the uptake of recovery principles throughout our field?

Well, I think one of the challenges is that we have been trained in a way that often focuses on what's wrong as opposed to what's right, on symptoms and deficits as opposed to strengths and abilities. So treatment is complete when the symptoms have entered into remission, and that's not fully accurate. We have very little control, and once you accept that, you can help people to formulate goals, develop them, work with them, and accept our position in that. And we're not the center of care, that the person is the center of care.

You know, we live in a world where efficiency is sort of governing medicine, and I think that it takes time to really focus on a – an entire person and to take a comprehensive approach. And that may be part of the challenge, to, is that you really need to put in the time and the energy and the effort to genuinely get to know somebody, and find out who they are, and who they were before they go till, and who they are now, and where they want to be, and how we can help them achieve those goals.

Even from an efficiency perspective, if you put the time in early on, it really pays off in the end. Because it becomes a collaborative effort, it could potentially speed things up the more you get to know somebody.

I think that's an excellent point. You mentioned time and efficiency. I know that in our current system often we get reimbursed based on how much time we spent and not so much on the outcomes. And there can be limitations to that. I wonder if there are any specific programs that either of you know about that can help us to engage with people around some of these principles or things that you've encountered that might be helpful for folks listening in?

One thing I think is helpful is to try to push for an extended amount of time with people in session. And so I'm very, very fortunate in our community mental health clinic, and I get to see people for 25, 30 minutes per session. And in 30 minutes a lot can get accomplished. We can talk about medicines, sure. And sometimes that can be very brief. But we can talk a lot of times about life, about other medical issues. And having that additional time and using it well is very important. And also recognizing that we're going to also rely on other people to do other parts of the care. Vocational specialists, consumer advocates, or therapists. There are lots of other people who are involved. And to make sure that when we spend that time, that 30 minutes, we learn about what will be helpful and to try to direct people towards those other resources in the community that will help them to improve, not just the idea that everything that is going to happen is going to happen in my office.

Yeah, I agree. And I think, you know, depending on where one works, the resources available to them are different. I'm lucky in the sense that I get to work in a pretty comprehensive program, and information comes to me through all different channels including licensed mental health counselors and psychologists and social workers, who all help just get to know the participant and also the family and the situation. But in general, sort of outpatient mental health clinics, you may not have access to those very helpful

resources to truly get to know somebody. And then I think we need to be a little bit more creative and think about how we can get collateral information from friends, from family, from other resources within the community, whatever they may be, but at the core I think is really sort of getting to know the person that we work with and figuring out exactly who they are and how we can help them best.

If you're lucky enough, like me, to be on an ACT Team, one of the things that we, as prescribers, do is we actually go out on our own to see folks. So, for instance, one time I went to see a gentleman, and he asked for me to take him to the grocery store. And he had some symptoms that suggested disorganization. So we went to the grocery store. And he was absolutely impressive in his ability to go up and down the aisles, pick out not only a healthy diet but one that fit within his budget. He asked me a couple of questions about nutrients and such, and then I took him back home. There's a ton of information that comes in that kind of encounter. And so, if he were seen in the hospital, he might be described as disorganized. But on the home visit, not even close. He was absolutely organized. And so if you can – if you can get into clinical situations where you can see people for extended periods of time outside of the office, you can learn a lot and then also be of more assistance to them. Because you just get so much more data that way.

Thanks, Dr. Adams.

So having people be observed in their own environment, being able to spend adequate time with them, sounds like those are key principles.

Absolutely.

And also just really focusing on the idea that we really need to spend more time and energy on exploring people's strengths as opposed to their weaknesses. Figuring out what they do well and how we can really harness those abilities and then expand upon them, as opposed to just trying to get rid of the things that are problematic.

So both of you have talked about getting to know the person that you are working with, understanding what they want to get from their treatment. As psychiatrists, what do you see your role in a person's recovery?

One of the main roles is to provide scientific input, providing information, and helping them to make informed decisions. So I think they come to me with a problem, I present a menu of solutions, and try to steer them in the way that I think would be best. But ultimately, it's up for – it's up to them to pick the one that makes the most sense for them in their lives. And, again, at the early treatment program, because we are working with young folks who are often living at home, caregivers are often a big part of the decision-making process.

And then following up on that, one bit of information that's really important is what – what my role is, and what I'm capable of and what I'm not capable of. And that my role is, in a way, relatively limited. Provide information about the illness as I see it, propose treatments, tradeoffs with the medication or not medication. Ultimately recovery is going to be something that you do and I help with. You can do it, we can help, is a good model for that kind of approach. Together we can go forward and see what happens.

So it sounds like working collaboratively with people is at the center of this approach. Let's talk about something else that often comes us, especially for us as physicians and psychiatrists. What do you think of as the role of medication in recovery?

Medication is important, but it's not everything. What I tell students, what I tell residents in our community clinics is that prescription pad will fix about ten percent of what the person is dealing with, and the other 90% happens in therapy and in the community. More so in the community, in fact. And so our role is to be smart with the medication, talking about benefits and side effects and such. And then prescribing in a way that helps people reach their goals. So, for instance, I've got a guy I've been working with for probably 15 years now. And even before me, he has been employed steadily for about 20 years at a big box retailer.

This is a gentleman with psychotic illness who also has a developmental disability. So he has a job coach that works with him.

Well, he works typically in the morning from 5:00 in the morning until about noon. And so him taking HS medication at, say, 9:00 p.m. makes sense. But when holidays come, he works overnight. So when does he take HS medication? Well, we talked about this, and he understands it very, very well. So when his shift moves from midnight to 6:00 a.m., he knows full well, and with my support, that his HS medicine now becomes 7:00 a.m. or 8:00 a.m. So my role is to be very, very flexible with him in prescribing so he can achieve his goals. Instead it's much better for him to take it when it's convenient, when it works for him, and allows him to go where he needs to go.

So making the treatment so that it's relevant to what the person is trying to accomplish in their life as opposed to just a standard, paternalistic approach of this is when it needs to happen.

Right.

Dr. Birnbaum, any comments?

I believe that medicines are a critical component to recovery, but they are just a piece of the puzzle. Ultimately I view medicines as a resource and a tool that are beneficial in order to allow life to happen. When somebody is ill, and not on medicine, often their symptoms are getting in the way of their life. Voices or delusions or depression that is preventing someone from doing things that they want to do. And so the medicines are really designed to dampen that so that somebody can continue to lead a healthy and successful life.

And, you know, I think that's an important concept especially when we are thinking about medicines because medicines are also associated with a number of very distressing side effects. And one of the challenges that we often have to work with is sort of the pros and cons of – of different medication adjustments. Up, or down, or different medicines. Again, the idea is that we – we want to create a space where somebody's life can flourish. And if the symptoms are getting in the way, if the auditory hallucinations are getting in the way, that's problematic. But if the fatigue is getting in the way, or a side effect from the medication, then that's just as problematic.

So you both pointed out that medications are important. They play a central role. But they're not the only thing. I was wondering if you all would be able to elaborate on some of these other components of treatment, what they're like, how do you make it comprehensive. A holistic approach, so to speak. What other things do you work with people on and encourage them to do?

So I'll give you an example. I have a woman I work with who is a Jehovah's Witness. So her family is extremely important. Her faith is extremely important. And the ministry as a part of the faith is extremely important. And so one of the things that we regularly talk about is are you able to do these things? She feels better, and does better, not just because of the medicine, but when she is doing her, as she calls it, field service. The ministry portion of it. When she can go to the Kingdom Hall. And if she is unable to do them, then we have a problem, and that's something that we work on.

So the Kingdom Hall is part of her treatment. The socialization, the friendships that she has associated with it are part of the treatment. Her family is a part of the treatment. And so there are just a couple of examples of non-medicine-based treatments.

I often, when I meet with someone for the first time, sort of ask them what they liked to do before all of this began. And how far are they today from where they would like to be. I think the key here is that there is no one-size-fits-all formula for what this looks like. It's dependent on – on the person who is sitting in front of us.

I really like the feedback that you two have given us about this. We talked about medications earlier. Going back to that topic, what about the person who is reluctant or refuses to take medications? How do you talk with people who may not yet be ready or not willing to take medication yet?

This is something that happens all the time. And to add to the complexity, there are different opinions coming from different family members. And it's hard to put all the pieces together, but I think that in the end this is an ongoing discussion. And I think the key is focusing on that specific goal and exploring how medicines may be helpful or harmful to achieve that goal. And what the young folks that we work with often find out is that despite a desire to see what life is like off medication, or to try to get a job off medication, they learn that unfortunately the symptoms are getting in the way of their goals. And so through this process they become aware of the benefit of medication. And that's the best case scenario as opposed to forcing somebody to take medication or prescribing medication that they're – that they're telling you that they are taking but actually they go home and throw it away, can be incredibly challenging, and it can be a very long process. And I've worked with some folks, unfortunately, who have had multiple relapses, and very severe relapses at that, before they finally come to the conclusion that yes, in fact, medications have a role in my health and my recovery. So it's really an ongoing discussion that happens every time I meet with somebody.

Absolutely. I agree with that. And then just because you're not interested in taking any medicine, or not interested in being fully adherent with medicine, doesn't mean that we can't offer psychotherapies, supportive therapies, and social interventions that help people to recover and improve. I worked with a gentleman who, for years, didn't take medicine. Or didn't take it reliably. Maybe once a week. Maybe Haldol here, Haldol there. Not much. And then just one day I happened to be strolling through the waiting room and I asked him was he interested in taking an injection of Haldol. And he said sure. And this was one – he was on the ACT Team, and he would be on the ACT Team for years. It ultimately ended up and he ended on this almost microscopic dose of Haldol (inaudible). Because of that he was able to come off of the ACT Team. And he's in the clinic. I see him from time to time. He's still doing well in the clinic. But we still – up to that time when he agreed to take the injection, were still offering all of the treatments of the ACT Team that weren't medicine. Either way is okay.

So what I'm hearing from both of you is that this discussion about medication is an ongoing conversation that may happen throughout a person's treatment. And that what works now may not work later. And I've also heard that one size doesn't fit all. So it's really tailoring the pharmacology to what the person's needs are.

So there are medication tools and non-medication tools that can support an individual in recovery. Why are these non-medication tools so important? And maybe we can talk a bit later about what some of those things are and how you interject them into your practices.

One of the important ones, for example, is work. Pride of accomplishment means a lot to all of us. And I want to be able to offer that to people who have had severe illness, psychotic illness, because it's a good feeling. But there are many, many barriers between a person working and where they are today. Some people are afraid that their check will get cut off. And one of the things that's really important and helpful is we have vocational specialist who can talk to people about how many hours they can work before their check gets affected at all if that's a concern.

Or another is that when we talk about work, people will think, all right, I'm going to have to work eight hours a day, five days a week. Forty hours a week. No, it doesn't have to be that. It could be two hours a day, one or two days a week. And so that we can give a good picture of what work potentially is.

And then just by introducing the topic to people it's important because what you're saying is, yeah, I know you have schizophrenia. Or, I know you take medication. But I've worked with people who have worked, and I believe you can work. And so you are giving them encouragement just by bringing the topic up alone.

Okay. Dr. Birnbaum, how does shared decision making take place in your actual practice? What does that look like?

Shared decision making is the process of coming up with these interventions together. Coming up with a plan together. Not necessarily making treatment demands, rather offering a menu of possibilities in helping somebody come to the conclusion of what works best for them. In the end, again, they're the one

who are driving the ship, and we can only be there to support them and to help them through the process of – of making these decisions.

For me, and for the young folks that I work with, shared decision making, again, is not only just working with somebody who is in my office, but really working with their family and figuring out how we are going to move from one step to another step in order to achieve goals based on who they are and what they want most for themselves.

Yeah. I like – I like how Dr. Birnbaum talks about we, and we make the decisions together, family, lots of people involved. And underlying it, I think, is the idea that we, as providers, don't know what's best for you. And so we can't make these decisions for you because we don't know what's best. So if we share our information on our side, you share your information, your interests, your concerns on your side. We compare. We look at goals. And from there decide together what we should tackle first. What we should tackle second. And try to proceed in a way that is taking care of the interests and concerns of the person that we're serving.

I work with a lot of young folks who are still in school. And sometimes the medications, unfortunately, don't work perfectly. They come with a whole host of side effects. And there was one person I was working with in particular who was telling me that although the voices were gone, she was falling asleep in class and was unable to pay attention. Her grades were suffering because of it. And she made the decision, or rather we made it together, that she would rather occasionally hear some voices but not be as sedated from the medication. She was able to stay alert and awake in class and do what she needed to do despite being on a somewhat lower dose. My goal would be to reduce the auditory hallucinations to zero, but together we decided that it would be in her best interests to be on a little bit of a lower dose, to have the voices occasionally, but to not be as tired in class.

I think that's a great example of how we have our own paradigms of treatment, and we come out with our own manualized approach to things. But really, ultimately, it has to be tailored to the person's needs. We're offering maybe several different choices from the menu, so to speak, and then you have to decide what items they want and in what portions that – and what their goals are. And what they are trying to achieve in their lives.

Along those lines, this involves the persons who we are treating to some degree doing some self-monitoring. And I wonder what type of advice or information do you give folks to help them understand how they can know when their treatment is effective. How do they know that it's working?

I think that if we can establish what the problem is together, and I say problem without being specific about symptom or challenge or whatever. What is the problem? And is the problem becoming more manageable, or is it dissolving, or is it going away, or is it coming back. And then, if it's coming back, what we, together, do about it.

So I have a lady who is pretty consistently hearing voices. But very recently it got so bad that she could not sit through church, which was really upsetting to her. As a part of her self-monitoring plan, she got a hold of her therapist, her therapist got a hold of me, and I got her into the – in a quick appointment. She has all along taken probably a little less clozapine than I would suggest she take, but that's what she wants to do. And so it has worked for her very, very well. Up to this point. We talked. She agreed to try an increase a little bit. And one week later she said she felt a little better but wasn't quite there, so we increased it further on her suggestion. So I'll wait to see how she responds to that.

And then at some point, probably before me, which is fine, she'll go down to 300 milligrams at night, and then to 200 milligrams, and see how things go. But she is fully aware of what the problem is. I'm fully aware of it. And we together came up with a plan to deal with it.

Dr. Birnbaum, anything to add?

Self-monitoring is tough, for all of us, including myself. I can't stress enough the importance of family. And I think family can mean a lot of different things.

You know, one of the things that we do when somebody comes into the early treatment program is ask who they trust. Who they love, who they know, who could be a part of the process here. One of the things that often happens if somebody gets ill is that their level of insight also sort of dwindles and they – they may not be aware that some of these things are happening as they are happening. One of the things that we like to do is find out who they can trust. To have somebody that they could bounce ideas off of. To say, hey, this is happening to me. What are your thoughts about it? Is it strange, is it not strange? Should I be worried about it? And they would be able to sort of help self-monitor.

And just to sort of to piggyback on that in terms of people outside of themselves being supportive, I had a young lady who recently, unfortunately, had lost a job because her employer thought her pace was too slow. And so we talked about that, and she just saw it as a disappointment. But on her next job application she told the hiring person, I have a mental health problem, and sometimes my pace can be slow. Hopefully that won't be a problem. And her manager responded very well to that, was very accepting of that. So when we review this portion of self-monitoring, she says that her manager is completely fine with her work. And that her pace is fine. But she is aware that it can be a potential problem, but she also was so proactive about it, that she has managed to get out ahead of it. And so she is using it to her advantage. It's really pretty terrific when it works out like this.

So we've talked about this idea that recovery doesn't really have a ceiling. And I'm wondering if either of you have an example from your work with someone who achieved things beyond what you would have expected. Whether they had a mental illness or not, this would have been an achievement that would have been considered remarkable. And if you are able to share that experience with us.

Sure. Some of the people that we work with are young individuals who are finishing up high school or in college. And some of them are in graduate school and medical school. And we've worked with a few folks at the early treatment program who, when we met, were incredibly ill, very much struggling and distressed by their psychotic symptoms. And remarkably and incredibly, they recovered beautifully and are now on their way to completing medical school or completing residency and continuing to achieve their hopes and dreams for themselves.

Again, this is not everybody's story, but it's – it's a 100% a possibility, and that is something that I think as clinicians we have to be well aware of. And that's the message that we should be sending to the people that we work with, that there is no ceiling. That recovery is possible. And that people can go on to achieve amazing things for themselves.

Thank you for sharing that story. My reaction to it is that a lot of times people who are in recovery don't necessarily advertise their limitations or their illness, and so we don't always know who is successful that might have a mental illness.

I think that's a good point. There are plenty of individuals who are out there struggling with mental illness, and we wouldn't necessarily know.

So, I met a gentleman probably in the late 1990s who came to our clinic. He was homeless. He was walking around with a tattered bag of accounting books. Had a criminal background and a history of being hospitalized. And was from North Carolina and here we are in Maryland. And he was able to get connected to us and was eventually able to get a place of his own. He then was able to start working part time. And then he talked to us about his interest in education. Well, he didn't have his GED yet. So he got connected to the Baltimore City Community College and started working on his GED and got his GED.

Great. He's working. He's housed. He then started saying he was interested in actually getting an Associate's degree. So he continued at the Baltimore City Community College. And in three years he was able to get his Associate's degree. Great! He's still working. He's doing great. It's exciting. He's fine.

Then he says, well, I actually think I really need to get my Bachelor's. He's in his mid-50s by now, and he has enrolled in the University of Baltimore. And he comes in. He is making progress in class. He talked to me one day about he had a group project to do and one of the people in the group project wasn't carrying

his or her weight, which makes sense. It happens to all of us. Just sort of an ordinary, normal thing that happens when one is working through college.

And in the interim, he's working part time. He comes in, and he's in his early sixties now, and he says, I really want to work full time. I just don't want to work part time. Do you think I can do it, Dr. Adams? I said, sure you can. And so we'd given him a letter that endorses that. He has taken it to his employer. So he's now working full time. He's got that one class to go. And he has made a remarkable amount of progress from where he started 15 years ago.

We talked about medication not being the only part of treatment. What are some of the other alternatives that you've been able to employ in your work with others that might have helped them avoid maybe unpleasant side effects or have a substitute for the medication when it wasn't doing what it should do?

So, therapy is an important adjunct to medication. I've worked with several young folks who, unfortunately, the medications may not work as well as we'd like them to work, and are still struggling with – with symptoms despite optimal medication management. And some of the things that we encourage at that point would be cognitive behavioral therapy for psychosis. That's something that we may add on regardless of medication or symptoms. And one of the things that that type of intervention can do is allow someone to learn how to cope with distressing symptoms and continue to do what they need to do despite having this added obstacle of potentially hearing a voice or having an unusual thought that pops into their head on a – on a regular basis. That some folks can learn to manage symptoms. Even if the medications can't get rid of them completely, there are opportunities to figure out how to navigate the world despite struggling with a running commentary or other forms of hallucinations or delusions that are getting in the way.

I had a gentleman who I worked with who had severe symptoms. Was on clozapine at a very high dose. And was still having persistent hallucinations and was very depressed. We added haloperidol. We added citalopram. And he continued to have these symptoms. He was hospitalized twice and in our crisis unit twice in a four-month period. So four institutional experiences in this stretch. And nothing seemed to be making much of a difference. And somehow, somewhere, someone suggested that he, in the interim, go to our clubhouse. We have a clubhouse in Baltimore called Be More Clubhouse. So someone suggested that to him. He went, and maybe it's coincidence, I just don't think so, but there's something about being at the clubhouse that helped him a tremendous amount to where it's been six or seven years. It ameliorated his symptoms to an extent that he could work, could socialize, be very active in his church. He hasn't been hospitalized in that six or seven years. He was on the ACT Team when he was experiencing this, and he has done so well that he has been able to go to a lower level of psychiatric care. He got a certificate from his pastor for being the person with the best attendance at church. But the thing that seemed to make a difference, and I'm convinced of it, was him going to the clubhouse. We had done what we could with the medicines, but the clubhouse helped him a great deal. It was fabulous!

Thanks. Those are great examples.

So you talked about, as a prescriber, supporting this process of shared decision making and collaboration. Do either of you have any more to add about how you incorporate that into your work?

So one of the things that we haven't talked much about, actually, is substance use and how that can complicate prescribing and treatment overall. And there are a number of folks I work with who sometimes use substances. It's a complicating factor. And people's recovery from substance use comes on its own time. It's important for us to talk about it, but not to be paternalistic about it. To be more on the motivational interviewing side of things as opposed to the paternalistic side.

So we've been talking about recovery-oriented practices and prescribing for a while. What advice would you two have for doctors that are interested in becoming more recovery oriented in their work?

I would encourage them to try. I would encourage them to read up on basic principles and go for it. There's certainly no harm in exploring – and really it should be the way we practice medicine, the way we practice psychiatry. It should be about recovery. And it's unfortunate that it hasn't been in the past. But

the good news is that seems to be the way things are – are heading in the future. It's about hope, and recovery, and resiliency. And that really should permeate everything you say and do.

In addition, we all have our CME requirements and such. And so focusing on lectures, discussions, workshops, and groups that aren't just talking about psycho pharm, for example, but are talking about motivational interviewing. Which is a really good gateway into recovery-oriented practice. It would be great if people could connect with other recovery-oriented psychiatrists out there to learn from them how they approach the problems that they see. How they have grown to become more person centered, recovery oriented, systems based. And learn from sort of some mentoring that way.

So I was just going to add, certainly when it comes to shared decision making, that's not something that necessarily comes naturally. Not necessarily something that is taught in medical school or residency. And there, too, I think that requires a little bit of practice and exploration and – and chatting with folks who have been doing it for a long time because often issues come up where it feels very much like perhaps we should not be doing shared decision making because it's making us, as clinicians, a little bit nervous. But nonetheless there's – there's always a role for shared decision making, and there is usually always room for a – for a collaborative decision to be made together.

And, frankly, it's a relief to actually employ shared decision making. I don't know everything. I don't have to make all the decisions. We, together, can do this, so we share this problem together, and we share the decision making as opposed to me somehow being so smart or so capable to have to figure this out. It's actually much less stressful to do things that way, believe it or not.

I agree completely.

Well, thank you both. It sounds like one of the key principles is making sure that the person receiving the treatment is in the decision-making process alongside us and that we're giving them the best advice.

Dr. Adams, Dr. Birnbaum, this has been a great discussion. I wanted to thank you both for joining us today.

Thank you.

Thank you.

Thank you for joining us for the 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 healthcare 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.