Transcript: A Psychiatrist's View: The Role of Medication in a Recovery-oriented Framework for Care

Hi, so it's folks, Happy Wednesday. Welcome to the final webinar in the Recovery to Practice series. We're hoping to end on a high note. It's been a great three years bringing you 12 webinars a year. And as the project wraps up, we're really feeling grateful for the amount of information that's been provided to the behavioral health workforce. We know that continuing education and staying up on the latest and greatest trends and practices in our field is very important, and we are glad that you've joined us today.

We are going to be continuing our discussion about the use of medication within a recovery-oriented framework. But before we begin with that content, let me give you a quick orientation to the room.

We have the Tech and Topic pod which is probably the most important area of the screen for you except for the presentation itself. The Tech and Topic questions just below the presentation. And that's where you want to type in any questions you have for the presenter or any concerns or needs you have from the Tech Support team. So if you're having a difficult time with sound, after turning up your own speakers, just let us know. Just type it into that section.

Closed captioning is available. If you would like to have access to real-time captioning, just click in the Captioning Information box and it will give you information for accessing that. Like the Chat pod in the Participant Chat is there for your use. Feel free to check in, say hello, leave comments about what's going on where you're from. And we know that a lot of people use that section for networking.

Also, please remember that you can get Continuing Education credit for attending this webinar. At the end you'll be given the opportunity to complete a very small quiz and download your CEU certificate at that time.

You can also get a certificate for attendance that just shows that you were here without taking the quiz. So if you don't need those hours specifically, then that's an option.

Please remember that this webinar, the views, opinions, and content expressed in the presentation do not necessarily reflect the views and opinions or policies of the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration, or the U.S. Department of Health and Human Services.

I would like to welcome our guest presenter today. Dr. Lisa Dixon is the professor – is a Professor of Psychiatry at Columbia University Medical Center and has – and the Director of the Center for Practice Innovation at Columbia as well. She has also been a Steering Committee member for Recovery to Practice and has helped influence the direction of this project for the last three years.

She is going to present to us on a psychiatrist's view of the role of medication in a recovery-oriented framework of care. And Lisa, I'd like to welcome you to the webinar and turn this presentation over to you now.

Great. Thank you so much. Can you hear me?

Yes.

Great. Super. I appreciate the introduction and I'm – I'm very excited to be here. Thanks, Melody, for kind of setting up the next hour or so, and I hope that I'm able to meet your needs, listeners' needs, and help you move forward with the topic and also get you talking with the folks in your – in your agencies and programs.

So I'm going to be dis – in the presentation I'm going to be discussing the evolving role of the psychiatrist in community psychiatric practice. The imperative to provide person-centered care and person-centered psychopharmacology, and the two words "care" and "psychopharmacology" in that order are very deliberately placed. The role of shared decision making in person-centered psychopharmacology. And then some challenges for the future.

And, you know, I want to say that my perspective is informed by – by a number of my own experiences. I – I am a psychiatrist, and I – I have a small psychiatric practice. And so I – I have to try to live this every day, and I try to think about what I would like my patients, clients, people that I serve, what I would like them to say about the care I provide.

I also direct OnTrackNY, which is New York state's coordinated specialty program. And – and this program, I mean, the notion of recovery-oriented prescribing, I can't think of a place where, or a context where, it's more important. Well, it's important everywhere, but it's really important because for many of the young people it's their very first exposure to the – to the option of medication and – and it can sort of set the stage for – for the future in terms of how they think about it and what they expect of their individuals with whom – the psychiatric care providers.

And I also have a family member – I've dealt with medication in lots of different areas of my life. So – so it all kind of comes together here today.

Okay. So I want to start with, you know, sort of, you know, the bad/the good. The bad is where we – to some extent, is where – where we find ourselves often today. And I just – the notion of the infamous med check I think is, you know, captures well where we are today often and where we don't want to be moving forward. And I – and I just looked – I want to do a shout out to an article by Will Torrey called Beyond Med Management. And some of what I'm about to say comes directly from this article which is in Psychiatric Services, the journal that – I have a little bit of a conflict of interest. I edit the journal, so I'd love for everybody to go and look at this article.

But what Will and his coauthors do is they sort of – they describe this thing called the Med Check, which I assume most everyone here listening is familiar with. It is – it's sort of, you know, what's the psychiatrist's or the nurse practitioner's schedule as they come into the clinic? Well, they have these Med Checks, all right. And they're often very short, 15 to 20 minutes, and as is outlined in the article, which has some – also had some qualitative data, these – quote/unquote – med checks are focused on assessing symptoms, the impact of medications on symptoms and side effects, and this is supposed to sort of constitute the – the role of the psychiatrist or the nurse practitioner often in care.

And here's a quote that I just – I think says a lot. Unless I have a lot of time I try not to be too open ended in terms of how are you, how's it going type stuff. But I try to keep it fairly focused in terms of how they're doing with their symptoms, how they're doing with their meds. Do they have any side effects? Are they compliant?

Now does that sound like care? Does that sound like recovery-oriented care? No, it doesn't. and – and it's – it's really – has – I mean we can – we can make a long list of all the things that are wrong with it.

So how did we get here? And, again, I'm not – this is not a – a discussion of history, but, you know, I think there are a number of important threads. You know, the increase in the number of people using mental health services and its cost. The therapeutic importance of medications. The shortage of psychiatric care providers, which is really profound in a lot of areas of the country. Funding constraints and policies. Volume generates revenue, so this notion of the more – you know. All these things sort of come together, and the more individuals are seen, the more billing, the more revenue. And, you know, we're often working in agencies that are – that are surviving, you know, just barely. You know, overall rates of reimbursement are low in a lot of public agencies that serve individuals with serious mental illness.

So – so we have, you know, this is kind of how it all happened.

And – and, you know, this notion of the profession's desire to be seen to practice like other doctors is kind of an interesting observation of the part of Torrey and colleagues, you know, that if you go – often if you go to, you know, the primary care doc, or you go to the gynecologist or whatever, you know, you go, and you sit, and you wait. And it's a brief visit and then maybe you have a couple of minutes afterwards to talk with the doctor. And now more and more, of course, you know, the doctor is sitting behind some kind of electronic health record entering data as you're speaking.

So, you know, in some ways this is a little bit of a problem across medicine.

But, at any rate, that's – that's a little bit of how we got here with this notion of the 15 or 20-minute med check, which I would put forward, you know, makes it very difficult to – to do recovery-oriented prescribing.

So, you know, what to do. How to address this. And, you know, I hope that this doesn't all sound like pie in the sky. Hopefully we'll, you know, there are some – going to be some practical tips and ways to – to move forward.

But I really do think we have to move back to the fundamentals of person-centered practice. And we have to consider strategies to reconcile fiscal and organizational realities. You know, we can't live in a world that doesn't exist. We can't pretend that reimbursement is higher than it is.

We need to think about, again, how to reconcile these realities and balance them with the imperative to provide person – to provide high-quality person-centered care. And we have to really identify evidence-based practices appropriate for the individual.

So, you know, where does it all start? It all starts, and this is, you know, this is psychiatric care providers as human beings, and individuals receiving services as human beings. And all care starts with connecting and understanding to the person and their goals.

And there is really no other place to start with the delivery of recovery-oriented care.

And these – some of these slides that I'm going – that I've included here are not unique to this talk. There are slides that have been used in other RTP webinars and also in the previous webinar that Kim and (Inaudible) and Melanie did.

You know, the recovery process is driven by the individual and supported by the clinician. And driven by the individual. All right, we start with the individual with a focus on hope. And important goals. Understanding people in the context of their whole lives. Helping with skills. Inspiring a positive self-image. Promoting collaborative doctor-patient relationships and partnerships. And emphasizing education and self-help.

And, again, so if, you know, if we don't – if we don't start here, we – we get nowhere.

And I would – I would put forward – I would put forward that one can do that even when pressed for time. Okay. And – and some of that is, you know, being strategic. But it, you know, a two, or three, or a four, or a five-minute conversation can get us off on the – on the right foot in terms of person-centeredness.

So after that, after in some way we've established that we're not just there to push meds, or to evaluate compliance, or to focus on the extent of hallucinations and how often they are, etc., etc., we're actually there to care for the person, is to considering the role of medication in helping the individual reach their goals. All right, so we can talk about their goals. The treatment is not about our goals. The treatment is not about medication compliance. The treatment is about helping people to meet their goals.

And this is, you know, again, this may be stating the obvious, but, you know, I'm seeing more and more in kind of overseeing the field and seeing papers that get submitted and seeing the dialogue, that I do think it's important to state, you know, to prove – at least to put forward a basic assumption that I believe is true based on solid scientific evidence, that medication does play a role. Medication plays a role. Medication has a role in the care of people who have serious mental illnesses. And, again, here's a slide that came

from the previous webinar. Medications can treat a wide array of disorders including psychosis, mood disorders, anxiety, and alcohol-drug use. This is the up side of medication.

Distressing symptoms can – can be reduced and sometimes eliminated. Medications can help prevent relapses in more intense levels of care like the need for such things as hospital or jail.

And I know that it's – there's controversy these days around, you know, are medications being over used? Are medications – is the benefit of medications being overstated? But I – I would put forward to you that, you know, we have very, very solid evidence that medications can be beneficial.

What are the challenges? Medications don't fix everything, and work best when use is supported with other interventions. You know, you sort of don't get something for nothing. Side effects can be extremely difficult to manage or live with, and – and for many people, you know, unacceptable.

Another really important issue that I think is somewhat glossed over is that not everyone benefits from taking medication. And, you know, depending on the medication and depending on the condition there is – there are significant rates of nonresponse.

And finally, or next, it can be very difficult to find the right medicine. It's not simply a matter of, you know, let's turn on the TV and check this channel and this channel and this channel. You can't, you know, taking a medication and having a medication trial, you know, can take months. And difficult months.

And – and I think, you know, this notion – the decision to use medicine is complex and personal. And actually I – I believe that the field – and when I say the field, I mean the psychiatric field – has not been particularly – hasn't appreciated this as well as it could. And sort of viewed it as automatic, oh yeah, medication is fine. But – but in fact, I think, lots of us have really no interest in taking medication, and – and, you know, just the – the thinking about it, you know, can be quite complex indeed.

So, but again, there are upsides and challenges to using medication.

All right. So then, how – how to use medication in a recovery-oriented framework for care. This is where we go to this notion shared decision making, or SDM. And I – I have to say, in the last maybe like ten years of my career, which is only a short part of my entire career, which means I'm getting old, I have just – I found – I didn't know anything about shared decision making. I didn't learn anything about shared decision making. I would have had no idea what you were talking about if you mentioned it to me when I was in my – earlier in my training. Or even as a young – a young psychiatrist.

So even though it's been around for a while, it hasn't really been a part of our landscape in mental health until maybe the last, again, you know, five, ten years. We've been a little bit behind other fields of medicine.

And so what is it? You know, everybody uses it now, and I - that kind of bothers – people use it imprecisely. I like precision.

But shared decision making is a process. It's – it's a decision making collaborative process in which clinicians and individuals in service work together to make decisions and select tests, treatments, and care plans. So the first thing you get from this definition is that it's not just about choosing a medication, it's about choosing – any of the decisions that one would make around one's care.

Based on clinical evidence. Okay. So you – you have – it's – it's – an important part of shared decision making is that your – it's evidence driven. That we have to look at what is known from the – the scientific studies. That balances risks and expected outcomes with patient preferences and values. Patient preferences and values. And so it – it's sort of a way – and we'll talk a little bit more about how it's done in a moment – but it's a way to sort of moosh together all these important things because what we know, in sort of science, about a particular – let's just take medication since that's what we're talking about – with – the imperative to – it balances the what we know with the individual's experience and ideas and preferences and – and – and what they want out of their care. So it's a way to do all this.

So what are the key components of shared decision making? And, again, this is, you know, sort of Lisa stating the – somewhat stating the obvious, but the obvious is sometimes overlooked.

So there's a clear decision to be made. Okay. And, you know, sometimes it's not so hard – it's not so easy to know when there's a decision to be made. Sometimes, again, we overlook that.

And in shared decision making, a decision-making preference is evaluated. Decision making – not everybody – this is something people forget – not everybody want to make all the decisions. And – and I think in the case of a person who says, you know, can you make the decision, doc, or, you know, to the therapist, I don't really want to make that decision. There's a whole sort of set of things – how do you deal with that. And, you know, decision-making preference can be culturally driven. It can be age driven. There's a lot of things that – that can – that can – can inform it. But I would just say in my own work, I try to explore it a bit and then just maximize the extent to which a person does engage in the decision.

And just going back up for the moment to the clear decision to be made, we're going to get back to this. The decision has to be preference sensitive, and we're going to talk about that later on.

Okay. There needs to be shared information in a u sable format from an unbiased source. So a part of the process of shared decision making is sharing information. But the information, again, can't be in the form of a scientific paper with graphs that the individual who is the service recipient doesn't understand. It has to be comprehensible.

And the information provides a range of evidence-based alternatives and the strength of the evidence. So, again, we're giving the person information about kind of what we know, we meaning sort of the sciences, medicine in this case. And the strength of the evidence. And there's a procedure, again which we'll talk about, to elicit preferences and weigh options. So part of this is, you know, not only giving the individual the information, but then helping them to – to apply – to understand their preferences and values and apply those to the decision in front of them.

And then there is a decision that is at least clear if not agreed upon by all parties. And one of the things that's important to know about SDM is that, you know, it doesn't – it doesn't have to result in everybody agreeing, but, you know, we – we follow the – the – the decision that is made as a part of the process.

Okay. So this is from Glyn Elwyn. Another – if you're interested in shared decision making I do recommend reading some of his work. And this kind of breaks down the steps in shared decision making. I just – I just really like it. I like this slide because I like the little word bubble because it gives me some words that I can use when I'm talking with my patients. So we have Team Talk. That's the first step. And – and in this – in this component – or in this part of shared decision making, it's – the idea is that you're introducing the notion to the – to the patient that you're working together as a team. You are a team. It's not me telling you what to do. It's not you telling me, you know, necessarily, in the absence of dialogue what you want. But it's – it's really we're working together as a team.

And, you know, again, describe choices, offer support, and ask about goals. And – and let's work – so here's the statement – let's work as a team to make a decision that suits you best. Okay.

Then, option talk. In Option Talk we discuss the alternatives using risk communication principles. And here again, we don't have a lot of time to go into that, but this really relates to the notion of – of speaking in language that people can understand. And, again, sort of the – the word bubble for there would be, let's compare the possible options and let's understand, you know, you can do this, you can have this treatment or that treatment. We're going to talk a little bit about that in a moment.

And then finally is there is Decision Talk, which is getting to informed preferences and making preference-based decisions. And how – what – what facilitates that, this notion of telling me – tell me what matters most to you for this decision. And that allows – that kind of drives – begins to drive out what the individual's preferences and values are.

Okay. So I thought (inaudible) getting to medication, I'd say, well what – what are the things that happen all the time, every day in the care – when the psychiatrist or nurse practitioner is working with someone and prescribing. Or, you know, with this notion of trying to prescribe.

So one – one – really, I think, there's one set of medications is should I use – one of set of questions is should I use medication at all? All right. Is medication effective for my problem? What are the alternatives? So these are some of the questions that you would ask. What are the alternatives to medication? Are those alternatives effect – effective? And how badly does this problem, the problem for which I might be taking medication, interfere with my life?

So, should I use medication?

Another very common question that we face in – in psychiatric practice that lends itself often to share decision making is, what medications, say within a class of medications like antidepressants, or mood stabilizers, or antipsychotics, should I use? Which one?

Okay. So here are some of the questions that one might want to ask, you know, as context. Do – do different medications have different levels of effectiveness? Do different medications have different side effects? And, again, this applies to the different types of – of classes of medications.

And – and what about other medications I take for my physical health? So, you know, how might those interact or relate to the medications that we're considering, so – because we have different what we call drug-drug interactions.

Okay. So I wanted to give you a very – now getting really drilled down into a, I think, a medication decision that we see now, again, a lot, we struggle in early psychosis treatment. And I just – I – we're not going to, you know, go into a – all the details about all the different medicines, but – but I think that this – this is – this sort of is an example, I think, that shows you why and how people can have highly variable responses or preferences relative to the – to the decision to take LAIs, or Long Acting Injectable medications. So those are LAIs. Versus oral medications. All right?

So let's just think about the pros and cons of long-acting injectables and the pros and cons of oral medications.

So this is someone, you know, pretend you're somebody who's – you've agreed you're going to take an antipsychotic medication. But what you don't know is whether you're going to take a long-acting injectable or you're going to take a pill. Okay.

So what are the pros of long-acting injectable medications? You have to deal with medication less often. So if you only have to take the medication once every month or once every three months, that's different from having to take it, say, every day. You don't have to be reminded of psychosis daily. And what we mean by that, and I would just say like these pros come not just from – from like providers, but – but consumers and individuals who are taking these medications have articulated these different pros and cons.

So to the extent that an individual might sort of feel like they have to be taking a pill every day reminds them that they have this condition, taking – having a long-acting injectable which has a much more fre – less frequent dosing, you don't have to be reminded.

There's no – there's more privacy, or there could be more privacy. There's no pill bottle around.

There may be fewer side effects due to more steady (inaudible) bubble.

So those are some pros of long-acting injectables.

Some cons of long-acting injectables are the need to get a needle prick. There may be some pain or swelling at the injection site.

When traveling, they may need to make special arrangements.

On the oral medication side of the street, what are some of the pros of oral medication?

Well, if a side effect develops, you can stop the medication immediately, which you can't – you can – you can stop the medication with long-acting injectables but it takes a longer time for the – for the medication to leave the system.

Another pros is there's no shots.

And, um, I'm not sure of this one. I have to look at this. It looks like I missed it, so we're going to leave that last one out. I'm not – I guess what that – what I meant with that one – the last one was that you may be taking other oral medications other than just the – the antipsychotic. So if you're just taking one medication, maybe it's just as easy to take more.

The cons of oral medication are: the need to remember to take pills every day. Have to remember to take pills with me if I don't stay at home. You know, if you're staying – going overnight somewhere, or on a trip or a vacation.

And, you may still need oral medication with the injectable so that, in some ways, you know, you don't get the advantage.

So I – I put this here just so you can see that different people might have very, very, very different opinions or values regarding each of these things. To me it's completely to be expected that, you know, this is a preference-sensitive decision. That this is a decision that, you know, we basically, you know, those are quite reasonable choices. But depending on who you are and what matters to you, you can make a different choice.

Okay. So, you know, again, as we said, many – this come from a great RTP slide – you know, these are tough decisions. Many healthcare decisions have alternatives that have both desirable and undesirable outcomes, you know, with one decision or the other, and that no alternative will satisfy all our personal objectives, and no alternative – alternative is without its risks of undesirable outcomes. And, you know, that's just the way it is in life.

So, in terms of, you know, how to move forward with this, and how to move forward in the context of a relatively brief visit, because no matter what we do, you know, it's unlikely that we're going to have a situation where we're going to have very, very – the opportunity for very, very long visits with the psychiatric professional. But this is where the use of decision aids is really, really important. decision support tools.

And there are many of them. They're – they're on the internet. One can find, you know, our slide here provides some examples. But what these do is they take all the knowledge that we have and – and translate them into, again, the kind of – deliver the information in a way that people can use and understand.

And good decision support tools will just make the – the pros and the cons and – and – and the effectiveness, you know, pop right out so an individual can understand, you know, what – what they're working with. And also the prescriber can understand, you know, the – the pros and cons and the data that we have.

So I would really encourage you in some sense not to go at it alone with shared decision making, but – but to use the available tools. And I would just say that also if you're not – as the audience here, if you're not a psychiatrist or nurse practitioner, and you're not prescribing, you can go and get these tools and give them to – to the individuals that you are – to the psychiatrists you are working with. And let's all work as a team.

So what are some of the challenges to using shared decision making? And I don't want to – I don't want to make this sound like it's just so, you know, you can do it and it's, you know, like getting up and having breakfast. I mean, it's hard work. It's really hard work.

And I wanted to take a minute to talk about preference-sensitive decisions because this is – this gets to be somewhat controversial.

So a preference-sensitive decision is a decision for which there is no clear gold-standard choice. In these situations there is more than one reasonable path forward, and therefore patient values and preferences must guide the decision.

Okay. So, the – the types of decisions that are – are the best, you know, are the best for shared decision making, when shared decision making should be applied, is preference-sensitive decisions. So, again, you know, the – the – where there's no gold standard like the use of a long-acting injectable versus oral medications, perhaps the, you know, the use of antidepressants for someone with a mild depression or mild-to-moderate depression.

But we get into a little bit of controversy and argument when some decisions – we actually can't agree on whether they are preference-sensitive or not. And I – I just go right – I like to go right to the controversy.

There is some controversy, say in psychosis, as to whether the – the decision to take medication, to take antipsychotic medication, is a preference-sensitive decision. Some would argue that it's not a preference-sensitive decision, that there's a clear gold standard that, you know, the medications are beneficial, there's really no other effective alternative.

I'm not saying I – I agree with that position. I'm just saying that that is a position that many people would take. And I don't – I don't – I don't think it's unreasonable.

Others would say, no, it is a preference-sensitive decision. The – there's a good proportion of people who don't respond to medications. Many people – there's a significant number, particularly in the early psychosis stage, you know, who knows, maybe it's as high as 20 to 30%, who may not need it. And then another, you know, the rest where there's really significant side effects.

And so I think that it – it's oversimplifying the challenge of doing recovery-oriented decision-mak – recovery-oriented prescribing with shared decision making to say that, you know, we just have to use shared decision making. Because there is – the field is still evolving and not everybody agrees on – on whether there's a gold standard.

So – so what do we do in this kind of situation? I would – I would still put forward that we – we need to – the prescriber, the psychiatric professional, still needs to provide information, still needs to listen, still needs to educate. But in this case where the psychiatric professional does not think, you know, has a very, you know (inaudible) believes that there is a gold standard, believes that there is a best approach, at least in that particular case, the psychiatric care professional just needs to make that clear and communicate it.

And I believe, you know, this is – this is something that they can do. It's within their purview to do if that's how they view it. And – and – but it doesn't mean – it's not – a decision – if we say that a decision is not preference sensitive, it doesn't abrogate the psychiatric professional from the responsibility of still doing, you know, providing information and listening and helping the person make a decision. It just means that the nature of the information that they give may differ.

Other challenges in using shared decision making are dealing with issues of safety, and – and dealing with issues of risk management. You know, it's a – it's a - we live in a time when we're all very aware of the high risk of – of suicide where, you know, the psychiatric professional does feel a lot of pressure around safety issues. And, again, it does not mean that that person is not – should not be partnering with their patients and their clients, and not listen – not – does not relieve them of the responsibility of listening and working together. I just – I'm just saying that it's something that weighs heavily on the minds of the

psychiatric professional. And this is one of the reasons why at the end I'm going to talk about the need to really support the psychiatric prescriber in doing this work where the – in the hierarchy of an organization, the psychiatric prescriber needs – needs strong support from their own leaders, and their own supervisors, to work with clients and – and not just sort of be – have worry and risk management issues drive their – their practice.

Dealing with issues of capacity, engagement. You know, again, just getting to what I see as some of the toughest issues. In – in the care of people with serious mental illness, you know, we do sometimes see people whose symptoms really make it difficult for them to evaluate their situation accurately. They may – may not – may not at all understand that – that a symptom that they have is due to a mental illness. They may think they're really under attack or being victimized. And, again, this doesn't mean that we – we – we don't listen and that we don't try to understand and – and have the individual's goals and perspectives an important part of the dialogue. But there are times when an individual simply is not in – in a position to make a decision that, you know, that conforms to, in a meaningful way, to the real world.

And those are just – they just happen. I don't think it's all that common, but it does happen.

In doing – in doing – using shared decision making in challenges, we as the psychiatric professionals want to, and we need to work, with the team. We may not know all the issues. We may not be aware of all the issues because of limited time. And so – but if you're forced, in the context of treatment, to make decisions and recommendations without family, without other team members, it can be a real challenge.

Other issues are, again, choices. When the choice is limited by insurance coverage or formularies. Again, it's a real day-to-day issue that the psychiatric provider faces.

And then, finally, this notion of disagreement. And, you know, I would say that in the case of, you know, a preference-sensitive decision, it – it's – it may very well be that the psychiatrist, you know, might think something is – you know, wishes that the individual would make a different choice because he or she may have a little bit of discomfort and be worried just because of who that person is. Right. But in – in, you know, in preference-sensitive decisions I think, you know, the commitment that we make is that, you know, that we – we're not the ones taking the medicine. We're not – and we – we need to – our job is – the right decision is the decision that's made by the individual that conforms to, you know, to their preferences and values.

When you have a situation that – where – where the psychiatrist does not think it's a preference-sensitive decision, again, that's a situation where the psychiatrist believes that there is a gold standard in the same way that insulin is the, say, you know, would be the treatment for someone who has severe diabetes. Then in that particular situation, a disagreement, is – is challenging, and this is where I think people try things, but, again, like motivational interviewing and also, you know, where you have to then just do kind of – undertake strategies to minimize risk and minimize harm.

So, you know, in my own practice, again, I try to be open and sort of as honest as possible where I'm coming from. But remembering that I am not the one taking the medicine. It is that individual who I'm working with whose life is being affected.

So, strategies to move forward and come to a close here. You know, I have work as a team, work as a team, work as a team. And I just – should I say it one more time? Working as a team here. This is – this is how we are going to overcome the – the 15-to-20-minute med check problem. This is how we're going to overcome – this is how we can, I think, as – as a community of individuals receiving services, as family members supporting people receiving services, as psychiatric care providers, and as care providers who – who are not psychiatric – who are not, say, in the prescriber arena, this is how we're going to do this recovery-oriented framework.

And – and, again, you know, it's a little bit easier when you have a designated team, whether it's a coordinated specialty care team, or an ACT team, or a – or a team within a clinic. But we have to find our team. We have to build our team. In – in our programs. And I think that requires – it's not – it's not a problem that's just going to be solved by an individual provider. It's going to – it's going to have to be

solved and addressed at the level of – of our, you know, concerted agencies, of our program. Really implementing – first, you know, having dialogue, and then building policies and procedures to support shared decision making and person-centered psychiatric practice.

And Bill Torrey, in the – in the article that I referred to earlier called Beyond Med Management, he outlines some really interesting ideas to kind of redesign the workflow so that the – (inaudible) each visit is not just a 15-minute med check-type of visit, but where – where the – the individual receiving services may touch or consider different people who would then, you know, do different aspects of the – of the care, so even like getting a weight, blood pressure, and using measurement-based approaches. So we can sit there and we don't have to go through all the symptoms because we have – the individual has done some – used some standardized assessments, and we can – we can look at those together. There's so much evidence that the evidence-based approaches – the measurement-based approaches produce better outcomes, and make people feel heard. And they can also create efficiencies in the delivery of recovery – recovery-oriented care.

Psychiatrists need support from leadership. And I referred to this earlier, that it's – this is hard work. It – it – really listening to people, I think, creates, from the psychiatrist's perspective, the need to take more risks. And I believe in taking risks because, again, I – I have tried to listen to what consumers have told us, and we've learned about the dignity of risk.

And so – but in order to do that, the psychiatrist needs support. And, you know, the best support, or, you know, available support, I think first may come from leadership, that you still feel you're doing a good job and that you're being – you're being – the type of practice you want to do is the type of practice your agency wants to do.

And then, you know, I always end, I think we should all be curious, we should all be impatient to get more knowledge so, you know, we can learn – we can learn more about what are people's preferences for being involved in decisions? If they don't, why not? What are, you know, let – let's do more on what – what kinds of decision support tools really, really help people understand their choices. We need more knowledge. And I don't mean just the traditional bio-psychosocial randomized control trials. I mean – I mean research that – that has all the voices in it of all the stakeholders.

So just to end, you know, medication is one of many recovery tools. When the person and team work together to achieve the best outcomes. Those – those, and again, I don't want to end with medication. I want to end with medication as a part of someone's life and as a tool to live a better life.

And – but, you know, the choice of medication, you know, really has to be made as a part of a person-centered process with engaged decision making informed by the individual's goals and values. And tightly coordinated. And by that I mean sort of working with the team to ensure that everyone is working toward the same outcome.

I think that's it!

I think, you know, we would have time for questions.

We do have – we do have a few minutes for some questions, and we've got some great ones from the audience. And I'll try to get through those as quickly as possible.

So, one of – one of the interesting questions that – that came across, how do you fit assisted outpatient treatment into a recovery-oriented approach? So you've got folks who are being, you know, maybe court ordered to be at the program, or even to take medicines. Is there still room to try to build in a recovery-oriented approach in that instance?

You know, I would say absolutely yes. And I'm sure you would agree, Melody.

Um hmm.

I think that, you know, what – what I try to do, and I've been in this position when I was an acting doc now years back, is – is, you know, I sort of shared, you know, we're in this situation. We're in it. You know, I – we – we – this is where we are. And so what we want to try to do, we have – we have to take the whatever the constraints are as a given. But then there's a ton of decisions that we can make together. So if you have to take medication, okay, well, which one? How? You know, in what way? You know, what are the – what are – what are your preferences? Let's really, you know, I want to give you – let's give you as much control as – as, you know, we're going to help you to take as much control as possible within the constraints of whatever, you know, kind of legal requirement you have.

And, you know, I think – there's a wonderful paper, in Psychiatric Services, that – that was a qualitative paper. And it – and it – it asked people about their experiences with – with actually I think it was seclusion and restraint. And – and what – what was so notable about it was that even the context of the most awful, you know, potentially sort of traumatic clinical experience, individuals noted when someone made a caring comment, or someone indicated, you know, again, gave – gave someone some little bit of control in that – in that – in that moment, how appreciative, and how meaningful that was.

And so if we think about that, you know, in – in the context of any interaction, whether it's firm, externally imposed, you know, or some imposed restriction of freedom, liberties, or whatever, there's always room to be a human being.

Yeah.

And I think there's often room for – for decision making within the constraints of, you know, whatever the ruling is.

Yeah. I – I do agree with you, Lisa, on that, and that – that the lack of decision for autonomy in one area of your life doesn't mean you've sacrificed it everywhere. And that part of a trusting relationship is finding the room for collaboration. And really, if we want to help people successfully get off of assisted outpatient treatment, that's going to happen when trusting relationships, human relationships and autonomy are grown. And so I do agree with you.

You know, another – another question that came through, and I was trying to kind of get these to where they would move from one to another but they – they aren't going to do that so smoothly. But you talked about teams, and I definitely believe that, you know, teams exist on – in every kind of care, we just don't necessarily formalize them. So the – the question was from someone who asked do you think that a peer specialist as a member of the team or within the team, or within the care setting, has a role when it comes to medication?

I – I certainly think so. I don't know why they wouldn't. To me, you know, the – they would – they would have as much of a role as anybody else. And so maybe I'll just leave it at that. I don't – I don't – I don't think - I think that it, you know, I've worked in – I've worked in programs with peer – with peers, and many of the programs that I oversee have peers. And it is – it is like so much of psychiatric care, I mean it's – again, and we have to – the words become – we have to be very careful with words here, but the – the challenge of doing this is we're always a work in progress. And – and – optimizing and figuring out and defining the role of the peer in different programs, and then – and scaling that, you know, is a challenge. But I would think that peers would be really important members of the team in – in addressing, you now, questions. I could imagine that there may be situations where an individual might be more comfortable talking to a peer about their concerns about medication, and that would be, you know, would be extremely valuable.

Yeah. Oh, yeah.

I think that – as a person who has helped develop curricula for people being trained to be certified as a peer specialist, one of the conversations is always about kind of scope of practice and not giving advice. And I think people get hung up on that as opposed to being a vehicle for providing information. And that, you know, hence giving some – helping somebody find reliable information is very different than giving

medical advice. And I think people need help – I think the system needs help teasing out that difference and knowing that it's a different process.

The same challenge is given to other nonmedical providers as well, you know, so as a social worker or anybody else.

So I agree that all those team members – and so another team member question is, how do you think we can help bring physicians, bring psychiatrists into the team? Because so often they either say or seem to act as though they are outside of the team. And do you have any recommendations for bringing the docs into the team?

Well, you know, the first recommendation that I would do is I would get Bill Torrey's article –

Um hmm.

And – and give it to them. And to the boss in the program.

And, you know, one of the things – I heard Bill talk, and one of the things that he said, and I really do think this is true, he said most people who go into psychiatry want to help people. They want to feel like they're making a difference in someone's life. They want to feel that what they're doing is helping someone meet their goals. And yet they find themselves, I think, in these very uncomfortable situations where they're – like in the article he talked about like the McDonald's drive through for the med check. So, no one likes that. No one likes that.

And so, you know, you kind of have to view it as – as a place where we've all arrived, not, you know, where it's nobody's fault. And then it becomes a matter of, I think, there is training involved because it is – I would – I would say that there are – there are a lot of psychiatrists out there who haven't really been exposed to recovery-oriented practice. But there's a certain – there are resources, you know, even just watching videos to see if action can be so powerful.

And, um, and then – and then sort of structuring the care because it becomes – you know, you can want to do it, but if you don't have a way to do it, then, you know, it just – then it just becomes another source of frustration.

So, you know, this is where it's a level of a particular program. You know, there has to be some thought given, okay, how – how are we going to take, you know, our current resources and – and build a slightly different way of doing things so that we can emphasize the team-ness.

So I – I tell you if – if given the opportunity and some support in doing this, I really think, you know, it's not going to be true of 100% of psychiatrists, but I think it will be true of a lot of them that they'll grab it. and then other people will want to work there because it'll be a positive experience as opposed to this kind of nagging, awful feeling that you're not doing a good job. And you're not doing what you wanted to do when you became a psychiatrist.

Yeah. Yeah. And, you know, on the – the slide that talked about the team, and, again, from the Torrey paper that changed the workflow, seems to be the crux of successfully adapting the system to make room for recovery-oriented approach to medication appointments.

And using measurement-based care, you know, really using some of these tools.

Yeah. Yeah. Absolutely. Somebody asked a question about, you know, do you think that shared decision making is empowering for people, and I – I think that, you know, the – and how empowering is it. I think decision making is empowering for everybody, for the whole team. Not just for the person, but for the – for the case manager who is making decisions in a respectful way with people. And for – and for the nurse. And for the therapist. That it becomes – collaboration is always empowering.

Right. So, you know, and I – I'm – I'm – before we run out of time, I want to –

Yeah.

I want to say that – that we did a study, it was a randomized trial in the VA, and it was a study of a strategy to use a shared decision-making approach to – to consider – actually to promote the inclusion of family members in care. So we said, okay, this is – this is a – we're going to approach this using the shared decision-making principles. And you know what we found? We found that not only did the inclusion of family members in care increase, but people had greater scores on our recovery measures.

Yeah.

So that's exactly what, you know, relative to – actually it was a pretty good control. You know, we offered really good, I thought, family – family-friendly, family-centered services. But without that shared decision making, without that empowering, you know, this is your choice, these are your options, let's think about how this helps you meet your goals, without that, you know, we didn't get the family involvement and the recovery-orientation. But with it, those both improved.

So it was just – it was exactly what the questioner was asking –

Absolutely.

(inaudible) this data.

Yeah.

Lisa, thank you so much. Dr. Dixon, thank you so much. In both of those roles. In all of those roles because your approach to medicine and to continue – continuing to educate people and help the system transform.

Thank you.

I want to be sure and thank SAMHSA for their support of Recovery to Practice. This particular cycle, the last three years, (inaudible), has been a part of and has really – I mean we're so committed to the ongoing support, education, and development for the workforce. And we'll consistently provide services to help the workforce be as strong and resilient as possible. But we appreciate the backing and support of SAMHSA and its position on recovery-oriented care.

We have the resources available for our attendees in the PowerPoint. Documentation and references as well as some additional articles that you can access should you want to continue your learning.

The same is true with shared decision making. There are a number of webinars and tools that are available online through the SAMHSA site. And google shared decision making. There's a lot of great information out there to learn from.

We have a companion newsletter for this series on medication and recovery. If you've not received it, again download the PowerPoint and you'll have a link to be able to get the newsletter.

And we have online courses now that you can access, too. Our brand new peer support for people experiencing homelessness and integrated behavioral health. Both of those are important topics.

In addition, there are 48 excellent Recovery to Practice webinars on the SAMHSA website and the YouTube channel. Access those, continue your learning. It's the best thing you can do for your career whether you're a peer specialist or a psychiatrist or somewhere in that arena.

So don't forget about the quiz and getting a certificate of attendance or your Continuing Education credit.

Thank you, thank you, thank you for joining us. If this was your first time, we're glad you made it. If this was your forty-eighth time, thanks for (end audio)