OPENING DOORS TO THE FUTURE

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What I hope to cover:

- What makes for good medicine makes for good behavioral health care
- What makes for evidence-based medicine makes for evidence-based psychiatry
- What you want from your own health care is what your patients want from you
- Recovery can be a vehicle for reclaiming your field as your patients /clients reclaim their lives

Effectiveness of Colonoscopy*

"The overall rate of detection of adenomas among endoscopists who had relatively slow mean withdrawal times was nearly four times as great as the rate among endoscopists who had relatively fast withdrawal times."

(6 - 12 mins.) = 4 X (0 - 6 mins.)

*Barclay RL, Vicari JJ, Doughty AS, Johanson JF, & Greenlaw RL: Colonoscopic withdrawal times and adenoma detection during screening colonoscopy. *N Engl J Med*, 2006, 355, 24: 2533-2541.

Longer Primary Care Visit is associated with:

- Doctors whose average consultation length was less than 7 minutes were less likely than those doctors who had an average consultation length of 9 minutes or more to recognize and deal with long-term and psychosocial problems.
- Doctors who had average consultation lengths of 7.3 minutes were less likely to enable their patients to engage in self-care than those doctors whose average consultation length was 9.4 minutes.
- Doctors who had longer average consultation lengths prescribed less, were more likely to include lifestyle advice and preventive activities, received more information, dealt with more problems, and required fewer follow-up visits.

Wilson A & Childs S: The relationship between consultation length, process and outcomes in general practice: a systematic review. *British Journal of General Practice,* 2002, 52, 1012-1020.

Malpractice Claims as a Function of Average Visit Time*

- Physicians who had one or more malpractice claims — 15 min
- Physicians who did not have any malpractice claims — 18.3 min.

*Levinson W; Roter DL; Mullooly JP; Dull VT; & Frankel RM: Physician patient communication: The relationship with malpractice claims among primary care physicians and surgeons. *JAMA,* 1997, 277:553-559.

Moral of the story

- Practicing medicine well takes time
- Rushed practice leads to errors, lack of access to important information, inefficient and poor quality care, higher rates of recidivism, and more malpractice claims
- Same is probably true for psychiatry

Evidence-Based Medicine

- The term "evidence-based medicine" appeared first in the medical literature in 1992 in Guyatt G, Cairns J, Churchill D, et al. ['Evidence-Based Medicine Working Group'] "Evidence-based medicine. A new approach to teaching the practice of medicine." *JAMA,* 1992, 268: 2420-5.

- The term has been defined as the integration of at least three main elements: "best research evidence with clinical expertise and patient values" (Sackett, 2000).

Response to Criticism

According to Sackett, *BMJ,* 1996, 312: 71-72: "Evidence based medicine is not 'cookbook' medicine. Because it requires a bottom up approach that integrates the best external evidence with individual clinical expertise and patients' choice, it cannot result in slavish, cookbook approaches to individual patient care."

How does this relate to mental health and recovery?

At its most basic level, the recovery movement argues that people with serious mental illnesses and/or addictions be offered evidence-based medicine just like everyone else. That, in most instances, they be treated in the same way that all other individuals are treated. In this case, that they have the same freedom to choose, and right to consent to or decline any given intervention that we might suggest.

This is because the recovery movement argues that people with serious mental illnesses and/or addictions have been, are, and remain people just like everyone else, with the same rights and responsibilities as everyone else—even that their crises should be managed like everyone else's.

How Else to Promote Recovery?

- Decrease stigma, discrimination, and other barriers to access to care
- Facilitate early identification and ensure timely access to early intervention
- Utilize practices that are effective (i.e., that are evidence-based)
- Eliminate health care disparities based on race, culture, and ethnicity (2001 report)

But is this enough to ensure recovery?

- We know that only about 1/3 of individuals in need of psychiatric treatment for a serious mental illness receive psychiatric care (the number for addiction is 1 out of 7)
- We know currently that ever fewer people receive effective care in a timely fashion (~17%)
- We know that current interventions are limited in their efficacy (e.g., to 70% of population, to positive symptoms, etc.)
- We know that less than 20%, and as low as 5%, of those being prescribed medications are receiving the most appropriate and effective care available (i.e., evidence-based)

We also know that …

- About 80% of people will be rehospitalized within 5 years following a first episode
- Cognitive remediation has small-to-moderate effects on neuropsychological performance, symptom severity, and cognitive functioning
- Supported employment is received by less than 1% of population and tends to lead to part-time employment, with job tenure averaging < 6 months, and monthly earnings averaging only $122/month or $1,464/year
- ACT significantly increases housing stability and moderately improves symptoms and quality of life, but also is received by very few people—as are most 'evidence-based practices' (less than 5% of population)

If this were all we knew, there would be ample cause for pessimism and concern

However, we also know that …

What we know about recovery

- Domains of functioning are only loosely linked
- There is a broad heterogeneity in outcome
- 45-65% of people with *DSM-IV-TR* psychosis experience significant improvement over time, many recovering fully
- Unfortunately, people also will lose on the average 25 years of life due to co-morbid medical conditions and poor quality care (i.e., the longer they live the better their chances at recovery)

An Intriguing Discrepancy

- Few people (~5%) benefit from the few effective interventions we have, and the effects of these interventions are only small to moderate.
- Yet over half will experience partial to full recovery over time, with only 15-25% experiencing a deteriorating condition.

How are we to understand this?

- May need to rethink relationship of care to recovery
- May need to rethink role of practitioner
- May need to shift focus from what we can't change to what we can
- Transformation may involve even more change on the part of persons with behavioral health illnesses than on the part of practitioners

Two common reactions (sometimes from the same person):

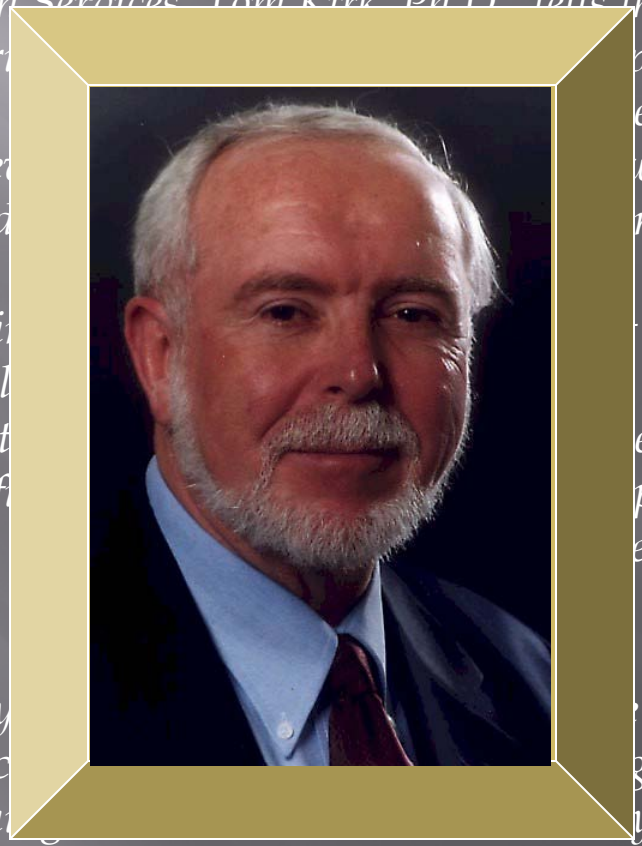
- Recovery is not possible for my patients. Talking about "recovery" with them just builds up false hopes and is cruel.
- There is nothing new about recovery. We already practice in a recovery-oriented way. It's just a new name for old values.

Let's get concrete.

Recovery-oriented care is different.

The Story of 'Steve'

In his frequent efforts to promote the transformation agenda in Connecticut, Commissioner of Mental Health and Addiction Services, Tom Kirk, Ph.D., tells the story of a 27 year-old man named Steve who he met dur[illegible]program. When he asked the staff how Steve was doing in [illegible]eports that they responded favorably about how well Ste[illegible]wing the rules, taking his medication as prescribed, and[illegible]nder control.



When asked if this was the ki[illegible] man for the foreseeable future, the staff seemed puzzl[illegible] their best. His condition, after all, was stable and he had not[illegible]everal years. Commissioner Kirk, however, was not satisf[illegible]p further and consider whether or not this would be [illegible]em content were they in Steve's place.

Once it was phrased this way[illegible] could be done for, and more could be expected from, this c[illegible]gaging, loved cars and racing, and had aspirations of becom[illegible]y help him with that? They had little idea as to what they could do beyond treating his schizophrenia and encouraging him to participate in program activities as a way of luring him away from his television set. Becoming a mechanic seemed a long way off, if it was to be possible at all.

The Crux of the Problem

Well, this is a very impressive resume, young man. I think you're going to make a fine patient."

What lessons can we learn from Steve's story?

- People with behavioral health conditions may want the same things out of life as other people do.
- People are not their diagnoses, are not subsumed entirely by the illness/addiction, and continue to exist alongside of the illness/addiction.
- Behavioral health care has addressed illness and its symptoms more so than the person and his or her everyday life.

Growing consensus

- President's New Freedom Commission on Mental Health: Current mental health system "simply manages symptoms and accepts long-term disability" (DHHS, 2003, p. 1).
- "I don't know how to find my way in the world" – Participant in "A Day in the Life" Study (Davidson, Shaw, Welborn, et al., 2010)
- "I had to learn how to be human again. I had to relearn how to be a dweller." -- formerly homeless man in "A Day in the Life"
- "To be able to participate in person-centered care, first you have to believe that you have the right to be a person" -- Ed Knight

Conclusion

- Behavioral health care needs to be a form of health care
- "Exceptionalism" did not work in anyone's favor
- It's time to start over

What the Affordable Care Act will promote

- Accountability in health care
- Emphasis on increasing quality (and decreasing costs)
- Person-centered health homes
- Collaborative/shared decision-making

Increasing Accountability & Quality (while decreasing costs)

- "Maintenance" can no longer be a goal for behavioral health care (any more than it can for other types of health care). Services that aim at nothing more than maintenance will be reduced.
- Self-care is to be the aim of health care for persons with long-term conditions, including some psychiatric disorders (e.g., schizophrenia). Persons with health care conditions will be expected, and empowered, to manage their own conditions and their own care.
- Practitioners will learn not to prescribe or deliver treatments to people who do not want or choose them, cutting down on both non-adherence and waste.

Person-Centered Health Homes

The American College of Physicians defines a Patient-Centered Medical Home as:

"a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. The PCMH practice is responsible for providing for all of a patient's health care needs or appropriately arranging care with other qualified professionals. This includes the provision of preventive services, treatment of acute and chronic illness, and assistance with end-of-life issues. It is a model of practice in which a team of health professionals … works collaboratively to provide high levels of care, access and communication, care coordination and integration, and care quality and safety."

Person-centered health homes

1. **Comprehensive care management**, which includes:
   a. Identification of high-risk individuals and use of client information to determine level of participation in care management services;
   b. Assessment of preliminary service needs; care plan development, which will include client goals, preferences, and optimal clinical outcomes;
   c. Assignment of health team roles and responsibilities;
   d. Development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
   e. Monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines and;
   f. Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery, and costs.

2. **Care coordination** is the implementation of the individualized care plan (with active client involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports, including referral and linkages to long term services and supports. Specific activities include, but are not limited to: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and clients/family members.

3. **Health promotion** shall minimally consist of providing health education specific to an individual's chronic conditions, development of self-care plans with the individual and family, education regarding the importance of immunizations and screenings, providing support for improving social networks and providing health- promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity. Health promotion services also assist clients to participate in the implementation of the care plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions. Peer recovery specialists and other models of health navigators can be extremely effective in many of these roles.

4. **Comprehensive transitional care from inpatient to other settings, including appropriate follow-up.** In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long term services and supports, and interrupt patterns of frequent hospital emergency department use. The health team collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the care plan with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self management.

5. **Individual and family support, which includes authorized representatives (e.g. individuals with Power of Attorney) ,** include, but are not limited to: advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. A primary focus will be increasing health literacy, ability to self manage their care and facilitate participation in the ongoing revision of their care plan.

6. **Referral to community and social support services,** including long term services and supports, involves providing assistance for clients to obtain and maintain eligibility for healthcare, disability benefits, housing, personal need and legal services, as examples.

Collaborative/Shared Decision-Making

- Shared-decision making has always been a part of evidence-based medicine
- Shared-decision making tools are being developed for behavioral health care
- Collaboration in care goes beyond shared-decision making to areas in which the person is the primary and self-determined agent
- Tools (decisional aids) are in development to facilitate this also, especially for persons with long-term disabilities

What does all of this look like?

- "Steve," like all teens, would have received education in school about the early warning signs of mental illness and the importance of accessing effective care
- If he did not seek care himself, Steve would have been assessed either by school-based health center or pediatric practitioners for his anomalous experiences and school difficulties
- Steve and his family would have been offered counseling and support in a non-stigmatizing setting, which might include (but would not be limited to) the prescription of medication

- Upon high school graduation, Steve would have been supported in his desire to become an auto mechanic by a supported education program at a local community or technical college

- Steve would move out of his parents' home into his own apartment with supportive friends

- Steve would learn to manage the residual symptoms of schizophrenia through a combination of cognitive-behavioral strategies and social support

- Should Steve find antipsychotic medications helpful in managing symptoms, his health care practitioners would encourage and facilitate Steve's joining a local fitness center to counter-act the inertia and metabolic side effects of the medications and to remain healthy

- Steve would die in his 70's like most other people in the U.S. in the 21st Century

With this perspective

- Psychiatric care comes to resemble medical care (at least disease management for long-term conditions)
- You know what people want from you, because it is the same thing you want for yourself and your loved ones in your own health care
- You can reclaim your field as your patients/ clients reclaim their own lives

- Impossible?
- That's what we are aiming for …